THE AUSTRALIAN GOVERNMENT
DEPARTMENT OF HEALTH AND AGEING

MEDICARE BENEFITS SCHEDULE
ALLIED HEALTH SERVICES

1 JULY 2012

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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PART 1
INFORMATION FOR ALLIED HEALTH PROVIDERS

1.1 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 form Medicare Australia on 132 150 or at www.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.

1.2 ELIGIBILITY OF PATIENTS

Eligibility requirements for each of the allied health items available under Medicare are outlined below. The requirements for each item are also 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. Allied health professionals or GPs can call Medicare Australia on 132 150 to check. Patients can call Medicare Australia on 132 011.

Eligible patients	***Number of allied health services per patient***	***Allied health professional eligible to provide the service***
Patients who have a chronic (or terminal) medical condition and complex care needs requiring a multidisciplinary approach (refer Part 2)	Up to five individual services (in total) per calendar year (no exceptions)	Aboriginal and Torres Strait Islander health practitioner Aboriginal health worker Audiologist Chiropractor Diabetes educator Dietitian Exercise physiologist Mental health worker Occupational therapist Osteopath Physiotherapist Podiatrist Psychologist Speech pathologist

Eligible patients	*Number of allied health services per patient*	*Allied health professional eligible to provide the service*
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 or terminal medical condition and complex care needs)	Aboriginal and Torres Strait Islander health practitioner 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 or terminal medical condition and complex care needs)	Diabetes educator Dietitian Exercise physiologist
Patients with an assessed mental disorder (refer Parts 5 and 6)	Up to ten individual services and an additional six services in exceptional circumstances (to a maximum of 16 individual services per patient from 1 March 2012 to 31 December 2012) and up to ten group therapy services per calendar year. Services provided under the Access to Allied Psychological Services (ATAPS) should not be used in addition to the ten (up to 16 services where exceptional circumstances apply) psychological therapy services (items 80000 to 80020), focussed psychological services-allied mental health services (items 80100 to	Clinical psychologist Psychologist Occupational therapist Social worker (Note: services can also be provided by a qualified medical practitioner)

Eligible patients	*Number of allied health services per patient*	*Allied health professional eligible to provide the service*
	80170 and/or GP focussed psychological strategies services (items 2721 to 2727).	
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 qualified medical practitioner)
Children with autism, pervasive developmental disorder (PDD) or disability – aged under 13 years for diagnosis services and under 15 years for treatment services (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).	Audiologist Occupational therapist Participating Optometrist Orthoptist Physiotherapist Psychologist Speech pathologist

A calendar year is the one-year period of time that begins on 1 January and ends on 31 December.

1.3 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).

1.4 MULTIPLE CONSULTATIONS ON THE SAME DAY

Consultations that run longer than the minimum time specified in the Item Descriptor 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, 81125 and the autism/PDD or disability items 82000 - 82035).

1.5 SERVICE REQUIREMENTS

The service requirements for each allied health item are contained in the Item Descriptors provided at the end of each Part of this document. These are legislative requirements contained in the *Health Insurance (Allied Health Services) Determination 2011* (as amended) 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.

1.6 MEDICARE BENEFIT/REBATE

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

1.7 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.

1.8 FEE SETTING AND OUT-OF-POCKET COSTS

With the exception of participating optometrists, 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.

1.9 MEDICARE SAFETY NET

For information about the original and the extended Medicare Safety Nets, refer to the General Explanatory notes for the Medicare Benefits Schedule (MBS).

1.10 PUBLICLY FUNDED SERVICES AND 19(2) EXEMPTIONS

Allied health items do not apply to services that are already funded by the Commonwealth or State or Territory governments or services 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.

1.11 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 allied health services. They cannot use their private health ancillary cover to ‘top up’ the Medicare rebate paid for the service.

1.12 CLAIMING FROM MEDICARE

1.12.1 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.

1.12.2 Paid accounts

A patient may choose to pay the account provided by the allied health professional in full and present the itemised account receipt 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.

1.12.3 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 contact Medicare Australia on 1800 700 199.

1.12.4 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.

1.12.5 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.

1.13 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 any updates about Medicare rebateable allied health services.

1.14 MEDICARE AUSTRALIA CONTACT DETAILS

Medicare Australia is responsible for the operation of Medicare and the payment of Medicare benefits.

Listed below are the contact details for Medicare Australia and the locations of Medicare offices:

Postal: Medicare, GPO Box 9822, in the Capital City in each State

Telephone: Australia wide at the cost of a local call.
Provider enquiries: 132 150
Public enquiries: 132 011

NEW SOUTH WALES
Medicare Australia Parramatta Office
130 George Street
PARRAMATTA NSW 2150

VICTORIA
Medicare Australia Melbourne Office
Level 10
595 Collins Street
MELBOURNE VIC 3000

QUEENSLAND
Medicare Australia
Brisbane Office
143 Turbot Street
BRISBANE QLD 4000

SOUTH AUSTRALIA
Medicare Australia Adelaide Office
209 Greenhill Road
EASTWOOD SA 5063

WESTERN AUSTRALIA
Medicare Australia Perth Office
Level 4
130 Stirling Street
PERTH WA 6003

TASMANIA
Medicare Australia Hobart Office
199 Collins Street
HOBART TAS 7000

NORTHERN TERRITORY
As per South Australia

AUSTRALIAN CAPITAL TERRITORY
Medicare Australia National Office
134 Reed Street North
GREENWAY ACT 2901

1.15 DEPARTMENT OF HEALTH AND AGEING CONTACT DETAILS FOR ITEMS IN THIS SCHEDULE

Telephone: 02 6289 1555
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.

PART 2
INDIVIDUAL ALLIED HEALTH SERVICES FOR PATIENTS WHO HAVE A CHRONIC CONDITION AND COMPLEX CARE NEEDS
(ITEMS 10950 TO 10970)

2.1 ELIGIBLE PATIENTS

Patients in the community or private in-patients of a hospital may be eligible for individual allied health services (items 10950-10970) if they have a chronic or terminal medical condition and complex care needs that are being managed by their GP through the following Chronic Disease Management (CDM) services:

- A GP Management Plan – MBS item 721 (or review item 732); and
- Team Care Arrangements – MBS item 723 (or review item 732).

Patients who are permanent residents of an aged care facility may be eligible for individual allied health services (items 10950-10970) if they have a chronic or terminal medical condition and complex care needs and their GP has contributed to a multidisciplinary care plan prepared for them by the aged care facility or to a review of such a plan (MBS item 731).

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.

2.1.1 Chronic medical condition

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.

2.1.2 Complex care needs

A patient is considered to have complex care needs if they require care from a multidisciplinary team consisting of their GP and at least two other health or care providers, each of whom provides a different kind of treatment or service to the patient.

2.2 SERVICES AVAILABLE UNDER MEDICARE

2.2.1 Number of services per year

Medicare benefits are available for up to five allied health services per eligible patient, per calendar year (i.e. the period of time between 1 January and 31 December inclusive). 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 the number of allied health services already claimed by the patient in the calendar year, the allied health professional or patient can call Medicare Australia to check this information.

2.2.2 Service length and type

Each service must be of at least 20 minutes duration and be provided to an individual not a group. The allied health professional must personally attend the patient. All the requirements of the relevant item must be met for Medicare benefits to be payable.

2.3 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 and Torres Strait Islander health practitioners must be registered with the Aboriginal and Torres Strait Islander Health Practice Board of Australia. Aboriginal and Torres Strait Islander health practitioners may use any of the titles authorised by the Aboriginal and Torres Strait Islander Health Practice Board: Aboriginal health practitioners; Aboriginal and Torres Strait Islander health practitioners; or Torres Strait Islander health practitioners.

Aboriginal health workers in a State or Territory other than the Northern Territory must have been awarded either:

a. a Certificate III in Aboriginal and/or Torres Strait Islander Primary Health Care (or an equivalent or higher qualification) by a registered training organisation; or
b. a Certificate III in Aboriginal and Torres Strait Islander Health (or an equivalent or higher qualification) by a registered training organisation before 1 July 2012.

Note: Where individuals consider their qualification to be equivalent to or higher than the qualifications listed above, they will need to contact a registered training organisation in their State or Territory to have the qualification assessed as such before they can register with Medicare Australia. In the Northern Territory, a practitioner must be registered with the Aboriginal and Torres Strait Islander Health Practice Board of 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).

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

Chiropractors must be registered with the Chiropractic Board of Australia.

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

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

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

- psychologists;
- mental health nurses;
- occupational therapists;
- social workers;
- Aboriginal and Torres Strait Islander health practitioners, and
- Aboriginal health workers.

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

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

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

Occupational therapists must be registered with the Occupational Therapy Board of Australia.

Note: A transitional provision is in place to ensure that the move to national registration for occupational therapists does not disrupt the provision of Medicare rebateable services to patients. Until 31 October 2012, anyone who was an occupational therapist in relation to an occupational therapy or mental health service on 30 June 2012 will be taken to be an occupational therapist in relation to those services. From 1 November 2012, occupational therapists must be registered with the Occupational Therapy Board of Australia to be eligible to provide Medicare services.

Osteopaths must be registered with the Osteopathy Board of Australia.

Physiotherapists must be registered with the Physiotherapy Board of Australia

Podiatrists must be registered with the Podiatry Board of Australia.

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

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

2.3.1 Registering with Medicare Australia

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

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

2.3.2 Changes to provider details

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

2.3.3 Allied health membership of a multidisciplinary care team

The allied health professional providing the allied health service may be a member of the multidisciplinary care team convened by the GP to manage a patient's chronic condition and complex care needs under Team Care Arrangements (TCAs). However, this is not a mandatory requirement. The allied health service can 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.

2.4 REFERRAL REQUIREMENTS

2.4.1 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 Department of Health and Ageing referral form can be downloaded 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.

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

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

A copy of the referral form does not need to be sent to the Australian Government Department of Health and Ageing.

2.4.2 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.

2.5 REPORTING REQUIREMENTS

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

Where an allied health professional provides *multiple* services to the same patient under referral, the allied health professional must provide a written report back to the referring GP after the first and last services, 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 of the patient's condition or problem.

2.6 FURTHER INFORMATION

For more information refer to the explanatory notes for these items in the general Medicare Benefits Schedule (MBS) which can be found at www.health.gov.au/mbsonline or visit www.health.gov.au/mbsprimarycareitems and follow the link to 'Allied health individual services for patients with a chronic medical condition and complex care needs under Medicare'.

ITEM DESCRIPTORS

MISCELLANEOUS	MISCELLANEOUS
	GROUP M3 - ALLIED HEALTH SERVICES
10950	**ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH SERVICE** Aboriginal or Torres Strait Islander health service provided to a person by an eligible Aboriginal health worker or eligible Aboriginal and Torres Strait Islander health practitioner 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 Aboriginal health worker or eligible Aboriginal and Torres Strait Islander health practitioner 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 Aboriginal health worker or eligible Aboriginal and Torres Strait Islander health practitioner 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 *- to a maximum of 5 services (including any services to which items 10950 to 10970 inclusive apply) in a calendar year* Fee: $61.10 Benefit: 85% = $51.95
10951	**DIABETES EDUCATION** Diabetes education health service provided to a person by an eligible diabetes educator 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 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 (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 diabetes educator 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 *- to a maximum of five services (including any services to which items 10950 to 10970 inclusive apply) in a calendar year* Fee: $61.10 Benefit: 85% = $51.95

10952	**AUDIOLOGY** Audiology health service provided to a person by an eligible audiologist 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 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): (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters *- to a maximum of five services (including any services to which items 10950 to 10970 inclusive apply) in a calendar year* Fee: $61.10 Benefit: 85% = $51.95
10953	**EXERCISE PHYSIOLOGY** Exercise Physiology service provided to a person by an eligible exercise physiologist 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 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): (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters *- to a maximum of five services (including any services to which items 10950 to 10970 inclusive apply) in a calendar year* Fee: $61.10 Benefit: 85% = $51.95

10954	**DIETETICS** Dietetics health service provided to a person by an eligible dietitian 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 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): (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* Fee: $61.10 Benefit: 85% =$51.95
10956	**MENTAL HEALTH** Mental health service provided to a person by an eligible mental health worker 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 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): (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* Fee: $61.10 Benefit: 85% = $51.95

<table>
<tr><td>10958</td><td>OCCUPATIONAL THERAPY
Occupational therapy health service provided to a person by an eligible occupational therapist 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 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):
(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;
- to a maximum of five services (including any services to which items 10950 to 10970 inclusive apply) in a calendar year
Fee: $61.10 Benefit: 85% = $51.95</td></tr>
<tr><td>10960</td><td>PHYSIOTHERAPY
Physiotherapy health service provided to a person by an eligible physiotherapist 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 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):
(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;
- to a maximum of five services (including any services to which items 10950 to 10970 inclusive apply) in a calendar year
Fee: $61.10 Benefit: 85% = $51.95</td></tr>
</table>

 10962	**PODIATRY** Podiatry health service provided to a person by an eligible podiatrist 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 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): (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 *- to a maximum of five services (including any services to which items 10950 to 10970 inclusive apply) in a calendar year* Fee: $61.10 Benefit: 85% = $51.95
 10964	**CHIROPRACTIC** Chiropractic health service provided to a person by an eligible chiropractor 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 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): (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* Fee: $61.10 Benefit: 85% = $51.95

	OSTEOPATHY Osteopathy health service provided to a person by an eligible osteopath 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 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): (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*
10966	Fee: $61.10 Benefit: 85% = $51.95
	PSYCHOLOGY Psychology health service provided to a person by an eligible psychologist 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 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): (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*
10968	Fee: $61.10 Benefit: 85% = $51.95

10970	**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* Fee: $61.10 Benefit: 85% = $51.95

PART 3
GROUP ALLIED HEALTH SERVICES FOR PATIENTS WITH TYPE 2 DIABETES (ITEMS 81100 TO 81125)

3.1 ELIGIBLE PATIENTS

Medicare benefits are available for group allied health services for patients with type 2 diabetes.

Services available under these items are in addition to the five individual allied health services that are available to eligible patients each calendar year and outlined in Parts 2 and 4.

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

- a GP Management Plan (GPMP) (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 Arrangements service (item 723) in order for the patient to be referred for group allied health services under Medicare.

3.2 SERVICES AVAILABLE UNDER MEDICARE

3.2.1 Assessment for group services (items 81100, 81110 and 81120)

The purpose of the assessment service is to undertake an individual assessment of the patient preparing him/her for an appropriate group services program. The service 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. An assessment service has to be of at least 45 minutes duration. It can be provided by a diabetes educator, an exercise physiologist or a dietitian on referral from a GP.

3.2.2 Group services (items 81105, 81115 and 81125)

These services are provided in a group setting to assist with the management of type 2 diabetes. Group services have to be of at least 60 minutes duration. They can be provided to the patient by a diabetes educator, exercise physiologist or dietitian on referral from a GP.

3.2.3 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.

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

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.

If a patient with type 2 diabetes also has complex care needs and the GP has coordinated their care using Team Care Arrangements (item 723) in addition to providing a GP Management Plan, the patient may also be eligible for up to five individual allied health services per calendar year (items 10950 – 10970).

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.

3.2.4 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.

3.3 ELIGIBLE ALLIED HEALTH PROVIDERS

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

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

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

3.4 REFERRAL REQUIREMENTS

The patient must be referred by their GP to an eligible allied health professional. 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.

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

A copy of the referral form does not need to be sent to the Australian Government Department of Health and Ageing.

3.5 REPORTING REQUIREMENTS

On completion of an 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.

On completion of a group service, 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.

3.6 FURTHER INFORMATION

For more information refer to the explanatory notes for these items in the general Medicare Benefits Schedule (MBS) which can be found at www.health.gov.au/mbsonline or visit www.health.gov.au/mbsprimarycareitems and follow the link to ‘Allied health group services under Medicare for patients with type 2 diabetes’.

ITEM DESCRIPTORS

MISCELLANEOUS	MISCELLANEOUS
	GROUP M9 - ALLIED HEALTH GROUP SERVICES
81100	**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: (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. 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:** $78.35 **Benefit:** 85% = $66.60
81105	**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: (a) the person has been assessed as suitable for a type 2 diabetes group service under assessment item 81100, 81110 or 81120; and (b) the service is provided to a person who is part of a group of between 2 and 12 patients inclusive; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to a person involving the personal attendance by an eligible 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. *- to a maximum of eight GROUP SERVICES (including services in items 81105, 81115 and 81125) in a calendar year.* **Fee**: $19.55 **Benefit:** 85% = $16.65

81110	**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: (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. 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:** $78.35 **Benefit:** 85% = $66.60
81115	**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: (a) the person has been assessed as suitable for a type 2 diabetes group service under assessment item 81100, 81110 or 81120; and (b) the service is provided to a person who is part of a group of between 2 and 12 patients inclusive; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to a person involving the personal attendance by an eligible exercise physiologist; and (e) the service is of at least 60 minutes duration; and (f) after the last service in the group services program provided to the person under items 81105, 81115 or 81125, the eligible exercise physiologist prepares, or contribute to, a written report to be provided to the referring medical practitioner; and (g) an attendance record for the group is maintained by the eligible exercise physiologist; and (h) 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. *- to a maximum of eight GROUP SERVICES (including services in items 81105, 81115 and 81125) in a calendar year.* **Fee**: $19.55 **Benefit:** 85% = $16.65

81120	**DIETETICS – ASSESSMENT FOR GROUP SERVICES** Dietetics health service provided to a person by an eligible dietitian for the purposes of ASSESSING a person's suitability for group services for the management of type 2 diabetes, including taking a comprehensive patient history, identifying an appropriate group services program based on the patient's needs, and preparing the person for the group services, if: (a) the service is provided to a person who has type 2 diabetes; and (b) the person is being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under a GP Management Plan [ie item 721 or 732], or if the person is a resident of an aged care facility, their medical practitioner has contributed to a multidisciplinary care plan [ie item 731]; and (c) the person is referred to an eligible dietitian by the medical practitioner using a referral form that has been issued by the Department of Health and Ageing, or a referral form that contains all 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. 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:** $78.35 **Benefit:** 85% = $66.60
81125	**DIETETICS – GROUP SERVICE** Dietetics health service provided to a person by an eligible dietitian, as a GROUP SERVICE for the management of type 2 diabetes if: (a) the person has been assessed as suitable for a type 2 diabetes group service under assessment item 81100, 81110 or 81120; and (b) the service is provided to a person who is part of a group of between 2 and 12 patients inclusive; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to a person involving the personal attendance by an eligible dietitian; and (e) the service is of at least 60 minutes duration; and (f) after the last service in the group services program provided to the person under items 81105, 81115 or 81125, the eligible dietician 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. *- to a maximum of eight GROUP SERVICES (including services in items 81105, 81115 and 81125) in a calendar year.* **Fee**: $19.55 **Benefit:** 85% = $16.65

PART 4
FOLLOW-UP ALLIED HEALTH SERVICES FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES WHO HAVE HAD A HEALTH ASSESSMENT (ITEMS 81300 TO 81360)

4.1 ELIGIBLE PATIENTS

Items 81300 to 81360 can be accessed by Aboriginal and Torres Strait Islander peoples who have had a health assessment. A person who is of Aboriginal or Torres Strait Islander descent may be referred by their GP for allied health services under these items when the GP has undertaken a health assessment and identified a need for allied health services.

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

Items 81300 to 81360 do not apply to an admitted patient of a hospital.

4.2 SERVICES AVAILABLE UNDER MEDICARE

Medicare benefits are available for up to five allied health services per eligible patient, per calendar year. Services must be of at least 20 minutes duration and the allied health professional must personally attend the patient. 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 follow-up allied health services per patient under items 81300 to 81360 is in addition to the individual allied health services for patients with a chronic medical condition and complex care needs (MBS items 10950 to 10970).

4.3 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 and Torres Strait Islander health practitioners must be registered with the Aboriginal and Torres Strait Islander Health Practice Board of Australia.

Aboriginal health workers in a State or Territory other than the Northern Territory must have been awarded either:

c. a Certificate III in Aboriginal and/or Torres Strait Islander Primary Health Care (or an equivalent or higher qualification) by a registered training organisation; or

d. a Certificate III in Aboriginal and Torres Strait Islander Health (or an equivalent or higher qualification) by a registered training organisation before 1 July 2012.

Note: Where individuals consider their qualification to be equivalent to or higher than the qualifications listed above, they will need to contact a registered training organisation in their State or Territory to have the qualification assessed as such before they can register with Medicare Australia. In the Northern Territory, a practitioner must be registered with the Aboriginal and Torres Strait Islander Health Practice Board of 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 Chiropractic Board of Australia.

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

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

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

Mental health workers
'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;
- Aboriginal and Torres Strait Islander health practitioners, and
- Aboriginal health workers.

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

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

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

Occupational therapists must be registered with the Occupational Therapy Board of Australia.

Note: A transitional provision is in place to ensure that the move to national registration for occupational therapists does not disrupt the provision of Medicare rebateable services to patients. Until 31 October 2012, anyone who was an occupational therapist in relation to an occupational therapy or mental health service on 30 June 2012 will be taken to be an occupational therapist in relation to those services. From 1 November 2012, occupational therapists must be registered with the Occupational Therapy Board of Australia to be eligible to provide Medicare services.

Osteopaths must be registered with the Osteopathy Board of Australia.

Physiotherapists must be registered with the Physiotherapy Board of Australia.

Podiatrists must be registered with the Podiatry Board of Australia.

Psychologists must be registered with the Psychology Board of Australia.

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

4.4 REFERRAL REQUIREMENTS

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.

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.

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

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

A copy of the referral form is not required to accompany Medicare claims.

A copy of the referral form does not need to be sent to the Department of Health and Ageing.

4.5 REPORTING REQUIREMENTS

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

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

Written reports should include:

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

4.6 FURTHER INFORMATION

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

ITEM DESCRIPTORS

MISCELLANEOUS	MISCELLANEOUS
	GROUP M11 - ALLIED HEALTH SERVICES FOR INDIGENOUS AUSTRALIANS WHO HAVE HAD A HEALTH CHECK
81300	**ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH 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 or eligible Aboriginal and Torres Strait Islander health practitioner if: (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; and (b) the person is referred to the eligible Aboriginal health worker or eligible Aboriginal and Torres Strait Islander health practitioner 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 or eligible Aboriginal and Torres Strait Islander health practitioner gives a written report to the referring medical practitioner mentioned in paragraph (b): (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters *- to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year* Fee: $61.10 Benefit: 85% = $51.95
81305	**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: (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): (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters *- to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year* Fee: $61.10 Benefit: 85% = $51.95

	AUDIOLOGY Audiology health service provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible audiologist if: (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; and (b) the person is referred to the eligible 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): (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters *- to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year*
81310	Fee: $61.10 Benefit: 85% = $51.95
	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: (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): (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters *- to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year.*
81315	Fee: $61.10 Benefit: 85% = $51.95

	DIETETICS Dietetics health service provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible dietitian if: (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; and (b) the person is referred to the eligible 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): (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters *- to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year.*
81320	Fee: $61.10 Benefit: 85% = $51.95
	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: (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): (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters *- to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year.*
81325	Fee: $61.10 Benefit: 85% = $51.95

81330	**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: (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): (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters *- to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year.* Fee: $61.10 Benefit: 85% = $51.95
81335	**PHYSIOTHERAPY** Physiotherapy health service provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible physiotherapist if: (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; and (b) the person is referred to the eligible 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): (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters *- to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year.* Fee: $61.10 Benefit: 85% = $51.95

	PODIATRY Podiatry health service provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible podiatrist if: (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; and (b) the person is referred to the eligible 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): (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters *- to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year.*
81340	Fee: $61.10 Benefit: 85% = $51.95
	CHIROPRACTIC Chiropractic health service provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible chiropractor if: (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; and (b) the person is referred to the eligible 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): (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters *- to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year.*
81345	Fee: $61.10 Benefit: 85% = $51.95

81350	**OSTEOPATHY** Osteopathy health service provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible osteopath if: (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; and (b) the person is referred to the eligible 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): (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters *- to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year.* Fee: $61.10 Benefit: 85% = $51.95
81355	**PSYCHOLOGY** Psychology health service provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible psychologist if: (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; and (b) the person is referred to the eligible 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): (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters *- to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year.* Fee: $61.10 Benefit: 85% = $51.95

	SPEECH PATHOLOGY Speech pathology health service provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible speech pathologist if: (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; and (b) the person is referred to the eligible speech pathologist by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible speech pathologist gives a written report to the referring medical practitioner mentioned in paragraph (b): (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters *- to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year.*
81360	Fee: $61.10 Benefit: 85% = $51.95

PART 5
PSYCHOLOGICAL THERAPY SERVICES
(ITEMS 80000 TO 80020)

5.1 ELIGIBLE PATIENTS

Items 80000 to 80020 (inclusive) apply to people with an assessed mental disorder and where the patient is:

- referred by a GP who is managing the patient under a GP Mental Health Treatment Plan (item 2700, 2701, 2715 or 2717); or
- referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan (item 291); or
- on referral 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.

5.2 SERVICES AVAILABLE UNDER MEDICARE

5.2.1. Eligible psychological therapy services

There are five MBS items (80000, 80005, 80010, 80015, 80020) 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 at 5.3.1 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 2700, 2701, 2715 or 2717);
- a referral has been made by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan (item 291); or
- a referral has been made by a psychiatrist or paediatrician from an eligible psychiatric or paediatric service (see Referral Requirements for further details regarding psychiatrist and paediatrician referrals).

5.2.2 Number of services per year

Medicare rebates are available for up to ten **individual** allied mental health services in a calendar year. These ten services may consist of:

- GP Focussed Psychological Strategies (FPS) services (items 2721 to 2727); and/or
- Psychological therapy services (items 80000 to 80015); and/or
- FPS allied mental health services (items 80100 to 80115; 80125 to 80140; 80150 to 80165).

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

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

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

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

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

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

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

5.2.3 Service length and type

Services provided by eligible clinical psychologists under these items must be within the time period specified in 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.

5.3 ELIGIBLE ALLIED HEALTH PROFESSIONALS

5.3.1 Eligible clinical psychologists

All consultations providing psychological therapy services must be rendered by a clinical psychologist who is registered without limitation to provide clinical psychology services under the applicable law in force in the State or Territory in which the service is provided, and be either:

(i) a member of the College of Clinical Psychologists of the Australian Psychological Society (APS) or;
(ii) assessed by the APS as meeting the requirements for membership of that College and continues to meet those requirements; or
(iii) endorsed by the Psychology Board of Australia to practice in clinical psychology.

The clinical psychologist must be registered with Medicare Australia.

5.3.2 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.

5.4 REFERRAL REQUIREMENTS

5.4.1 Referrals

Patients must be referred for psychological therapy services:

- by a GP managing the patient under a GP Mental Health Treatment Plan (item 2700, 2701, 2715 or 2717); or
- by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan (item 291);
- or on referral from a psychiatrist or a paediatrician.

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

consultant physician paediatricians the eligible services are consultant physician attendance items 110 through 133.

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

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

A copy of the referral form does not need to be sent to the Australian Government Department of Health and Ageing.

5.4.2 Referral validity

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

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

It is not necessary to have a new GP Mental Health Treatment Plan and/or a psychiatrist assessment and management plan prepared each calendar year in order to access a new referral(s) for eligible psychological therapy services and/or FPS services. Patients continue to be eligible for rebates for psychological therapy services and/or FPS 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.

5.5 REPORTING REQUIREMENTS

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

Within the maximum service allocation, the clinical psychologist 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 in the patient's referral (up to a maximum of six in any one referral). This enables the referring medical practitioner to consider a report from the clinical psychologist on the services provided to the patient, and the need for further treatment.

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

- assessments carried out on the patient;

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

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

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

5.6 FURTHER INFORMATION

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

ITEM DESCRIPTORS

MISCELLANEOUS	MISCELLANEOUS
	GROUP M6 - PSYCHOLOGICAL THERAPY SERVICES
Amend 80000	**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 referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These therapies are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply (to a maximum total of 16 individual services per patient from 1 March 2012 to 31 December 2012). (Professional attendance at consulting rooms) **Fee:** $97.90 **Benefit:** 85% = $83.25
80005	**CLINICAL PSYCHOLOGY** Professional attendance at a place other than consulting rooms. As per the service requirements outlined for item 80000. **Fee:** $122.35 **Benefit:** 85% = $104.00
Amend 80010	**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 referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These therapies are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply (to a maximum total of 16 individual services per patient from 1 March 2012 to 31 December 2012). (Professional attendance at consulting rooms) **Fee:** $143.70 **Benefit:** 85% = $122.15
80015	**CLINICAL PSYCHOLOGY** Professional attendance at a place other than consulting rooms As per the service requirements outlined for item 80010. **Fee:** $168.15 **Benefit:** 85% = $142.95

	CLINICAL PSYCHOLOGY – GROUP SERVICE Professional attendance for the purpose of providing psychological therapy for a mental disorder by a **clinical psychologist** registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting for at least 60 minutes duration where the patients are referred by a medical practitioner, as part of a GP Mental Health Treatment Plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These therapies are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 80120, 80145 and 80170 apply). GROUP THERAPY with a group of 6 to 10 patients, EACH PATIENT
80020	**Fee:** $36.50 **Benefit:** 85% = $31.05

PART 6
FOCUSSED PSYCHOLOGICAL STRATEGIES
(ITEMS 80100 TO 80170)

6.1 ELIGIBLE PATIENTS

The Focussed Psychological Strategies (FPS) items 80100 to 80170 (inclusive) apply to people with an assessed mental disorder and where the patient:

- is referred by a GP who is managing the patient under a GP Mental Health Treatment Plan (item 2700, 2701, 2715 or 2717); or
- is referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan (item 291); or
- on referral 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 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.

6.2 SERVICES AVAILABLE UNDER MEDICARE

6.2.1 Eligible FPS services

There are fifteen MBS items for the provision of FPS services to eligible patients by allied health professionals:

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

The allied health professional must meet the provider eligibility requirements set out at 6.3 and be registered with Medicare Australia.

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

- a referral has been made by a GP who is managing the patient under a GP Mental Health Treatment Plan (item 2700, 2701, 2715 or 2717); or
- a referral has been made by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan (item 291); or

- a referral has been made by a psychiatrist or paediatrician from an eligible psychiatric or paediatric service (see Referral Requirements for further details regarding psychiatrist and paediatrician referrals).

6.2.2 Number of services per year

Medicare rebates are available for up to ten individual allied health services in a calendar year. These ten services may consist of:

- GP Focussed Psychological Strategies (FPS) services (items 2721 to 2727); and/or
- Psychological therapy services (items 80000 to 80015); and/or
- FPS allied mental health services (items 80100 to 80115; 80125 to 80140; 80150 to 80165).

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

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

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

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

Referrals should be provided, as required, for an initial course of treatment (a maximum of six services but may be less depending on the referral and the patient's clinical need) to a maximum of 10 services per calendar year (up to 16 services from 1 March 2012 to 31 December 2012 where exceptional circumstances apply). For the purposes of these services, a course of treatment will consist of the number of services stated in the patient's referral (up to a maximum of six in any one referral).

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

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

Benefits Schedule initiative per calendar year. Allied Mental health professionals delivering services under the ATAPS program should refer to the ATAPS Operational Guidelines.

6.2.3 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 health professional must personally attend the patient.

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

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

These are:

1. Psycho-education
   (including motivational interviewing)
2. Cognitive-behavioural Therapy including:
   - Behavioural interventions
     - Behaviour modification
     - Exposure techniques
     - Activity scheduling
   - Cognitive interventions
     - Cognitive therapy

3. Relaxation strategies
   - Progressive muscle relaxation
   - Controlled breathing
4. Skills training
   - Problem solving skills and training
   - Anger management
   - Social skills training
   - Communication training
   - Stress management
   - Parent management training
5. Interpersonal Therapy (especially for depression)
6. Narrative therapy for Aboriginal and Torres Strait Islander people.

6.3 ELIGIBLE ALLIED HEALTH PROFESSIONALS

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

(a) the person is a psychologist who is registered without limitation as a person who may provide that kind of service under the applicable law in force in the State or Territory in which the service is provided;

(b) the person is a member of the Australian Association of Social Workers (AASW) and certified by AASW as the meeting the standards for mental health set out in the

document published by AASW titled 'Practice Standards for Mental Health Social Workers', as in force on 8 November 2008;

(c) the person:
  (i) is an occupational therapist who is registered as a person who may provide that kind of service under the applicable law in force in the State or Territory in which the service is provided; and
  (ii) is accredited by Occupational Therapy Australia as:
    - having a minimum of two years experience in mental health; and
    - having undertaken to observe the standards set out in the document published by Occupational Therapy Australia 'Australian Competency Standards for Occupational Therapists in Mental Health' as in force on 1 November 2006.

Note: A transitional provision is in place to ensure that the move to national registration for occupational therapists does not disrupt the provision of Medicare rebateable services to patients. Until 31 October 2012, anyone who was an occupational therapist in relation to an FPS health service on 30 June 2012 will be taken to be an occupational therapist in relation to those services. From 1 November 2012, occupational therapists must be registered with the Occupational Therapy Board of Australia to be eligible to provide Medicare services.

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

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

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

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

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

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

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

6.4.1 Referrals

Patients must be referred for FPS services by a medical practitioner managing the patient under:

- a GP Mental Health Treatment Plan (item 2700, 2701, 2715 or 2717); or
- a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan (item 291); or
- on referral from a psychiatrist or a paediatrician.

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

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

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

A copy of the referral form does not need to be sent to the Australian Government Department of Health and Ageing.

6.4.2 Referral validity

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

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

It is not necessary to have a new GP Mental Health Treatment Plan and/or a psychiatrist assessment and management plan prepared each calendar year in order to access a new referral(s) for eligible psychological therapy services and/or FPS services. Patients continue to be eligible for rebates for psychological therapy services and/or FPS 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.

6.5 REPORTING REQUIREMENTS

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

Within the maximum service allocation, the allied health professional 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 in the patient's referral (up to a maximum of six in any one referral). This enables the referring medical practitioner to consider a report from the 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.

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

6.6 FURTHER INFORMATION

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

ITEM DESCRIPTORS

MISCELLANEOUS	MISCELLANEOUS
	GROUP M7 - FOCUSSED PSYCHOLOGICAL STRATEGIES (ALLIED MENTAL HEALTH)
Amend 80100	**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 referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These services are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply (to a maximum total of 16 individual services per patient from 1 March 2012 to 31 December 2012). (Professional attendance at consulting rooms) **Fee:** $69.35 **Benefit:** 85% = $58.95
80105	**PSYCHOLOGY** Professional attendance at a place other than consulting rooms. As per the psychologist service requirements outlined for item 80100. **Fee:** $94.35 **Benefit:** 85% = $80.20
Amend 80110	**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 referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These services are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply (to a maximum total of 16 individual services per patient from 1 March 2012 to 31 December 2012). (Professional attendance at consulting rooms) **Fee:** $97.90 **Benefit:** 85% = $83.25
80115	**PSYCHOLOGY** Professional attendance at a place other than consulting rooms. As per the psychologist service requirements outlined for item 80110. **Fee:** $122.95 **Benefit:** 85% = $104.55

80120	**PSYCHOLOGY – GROUP SERVICE** Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a **psychologist** registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting for at least 60 minutes duration where the patients are referred by a medical practitioner, as part of a GP Mental Health Treatment Plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These therapies are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 80020, 80145 and 80170 apply). GROUP THERAPY with a group of 6 to 10 patients, EACH PATIENT **Fee:** $25.00 **Benefit:** 85% = $21.25
Amend 80125	**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 referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These services are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply (to a maximum total of 16 individual services per patient from 1 March 2012 to 31 December 2012). (Professional services at consulting rooms) **Fee:** $61.10 **Benefit:** 85% = $51.95
80130	**OCCUPATIONAL THERAPY** Professional attendance at a place other than consulting rooms. As per the occupational therapist service requirements outlined for item 80125. **Fee:** $86.05 **Benefit:** 85% = $73.15
Amend 80135	**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 referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These services are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply (to a maximum total of 16 individual services per patient from 1 March to 31 December 2012). (Professional attendance at consulting rooms) **Fee:** $86.30 **Benefit:** 85% = $73.40
80140	**OCCUPATIONAL THERAPY** Professional attendance at a place other than consulting rooms. As per the occupational therapist service requirements outlined for item 80135. **Fee:** $111.25 **Benefit:** 85% = $94.60

80145	**OCCUPATIONAL THERAPY – GROUP SERVICE** 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 referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These therapies are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 80020, 80120 and 80170 apply). GROUP THERAPY with a group of 6 to 10 patients, EACH PATIENT **Fee:** $21.95 **Benefit:** 85% = $18.70
Amend 80150	**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 referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These services are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply (to a maximum total of 16 individual services per patient from 1 March 2012 to 31 December 2012). (Professional attendance at consulting rooms) **Fee:** $61.10 **Benefit:** 85% = $51.95
80155	**SOCIAL WORKER** Professional attendance at a place other than consulting rooms. As per the social worker service requirements outlined for item 80150. Fee: $86.05 Benefit: 85% = $73.15
Amend 80160	**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 referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These services are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply (to a maximum total of 16 individual services per patient from 1 March 2012 to 31 December 2012). (Professional attendance at consulting rooms) Fee: $86.30 Benefit: 85% = $73.40
80165	**SOCIAL WORKER** Professional attendance at a place other than consulting rooms. As per the social worker service requirements outlined for item 80160. Fee: $111.25 Benefit: 85% = $94.60

	SOCIAL WORKER – GROUP SERVICE 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 referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These therapies are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 80020, 80120 and 80145 apply). GROUP THERAPY with a group of 6 to 10 patients, EACH PATIENT
80170	Fee: $21.95 Benefit: 85% = $18.70

PART 7
PREGNANCY SUPPORT COUNSELLING
(ITEMS 81000 TO 81010)

7.1 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.

7.2 SERVICES AVAILABLE UNDER MEDICARE

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.

7.2.1 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.

7.2.2 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.

7.3 ELIGIBLE ALLIED HEALTH PROFESSIONALS

The allied health items (81000 to 81010) 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.

A person is an allied health professional in relation to the provision of non-directive pregnancy support counselling health service if the person meets one of the following requirements:

(a) the person is certified by the Australian College of Mental Health Nurses:
  (i) as a credentialed mental health nurse, and
  (ii) as appropriately trained in non-directive pregnancy counselling;

(b) the person is registered, without any limitation, with the Psychologists Registration Board established under the applicable law in force in the State or Territory in which the service is provided and certified by the Australian Psychological Society as appropriately trained in non-directive pregnancy counselling;

(c) the person is:
  (i) a member of the Australian Association of Social Workers (AASW); and
  (ii) certified by AASW either as meeting the standards for mental health set out in the document published by that Association titled 'Practice Standards for Mental Health Social Workers', as in force on 8 November 2008 or as an accredited social worker; and
  (iii) certified by AASW as appropriately trained in non-directive pregnancy counselling.

For this health service, a person is appropriately trained in non-directive pregnancy counselling if the person has undergone training based on the key criteria contained in the document published by the Department titled 'Key Criteria for non-directive pregnancy counselling training to GPs and allied health professionals in relation to the Medicare non-directive pregnancy support counselling items' as in force on 1 November 2006.

7.3.1 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.

7.4 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. The psychologist, social worker or mental health nurse may check with Medicare Australia on 132 150.

The relevant allied health professional must be in receipt of the referral at the first non-directive pregnancy support counselling service. It is recommended that they retain the referral for 24 months 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.

7.4.2 Referral validity

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

7.4.3 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.

ITEM DESCRIPTORS

MISCELLANEOUS	MISCELLANEOUS
	GROUP M8 - PREGNANCY SUPPORT COUNSELLING
81000	**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. 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. 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:** $71.80 **Benefit**: 85% = $61.05
81005	**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. 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. 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:** $71.80 **Benefit**: 85% = $61.05
81010	**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. 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. 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:** $71.80 **Benefit**: 85% = $61.05

PART 8
CHILDREN WITH AUTISM, PERVASIVE DEVELOPMENTAL DISORDER OR DISABILITY
(ITEMS 82000 TO 82035)

8.1 ELIGIBLE PATIENTS

MBS items 82000 to 82035 are for allied health professional services for children with autism, pervasive developmental disorder (PDD) or disability.

Assistance with assessment and diagnosis and treatment items are available. Assessment and diagnosis and development of a treatment plan (items 82000-82010 and 82030) apply to children aged under 13 years, where the child is referred by an eligible consultant psychiatrist or paediatrician for autism/PDD or by a specialist, consultant physician or general practitioner for disability. Treatment services (items 82015-82025 and 82035) apply to children aged under 15 years, where the child was aged under 13 years at the time of receiving an autism/PDD or disability management and treatment plan.

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.*

Eligible disabilities for the purpose of these services means any of the following:

- (a) sight impairment that results in vision of less than or equal to 6/18 vision or equivalent field loss in the better eye, with correction;
- (b) hearing impairment that results in:
  - (i) a hearing loss of 40 decibels or greater in the better ear, across four frequencies; or
  - (ii) permanent conductive hearing loss and auditory neuropathy;
- (c) cerebral palsy;
- (d) Down syndrome; and
- (e) Fragile X syndrome.

8.2 SERVICES AVAILABLE UNDER MEDICARE

The autism/PDD and disability items are for services provided by eligible audiologists, occupational therapists, optometrists, orthoptists, physiotherapists, psychologists and speech pathologists, on referral from a consultant psychiatrist or paediatrician for autism/PDD or by a specialist, consultant physician or general practitioner for disability. They cover two specific types of service that allow the relevant allied health professionals to:

- assist the referring practitioner in the assessment and diagnosis and development of a treatment plan for the child ─ aged under 13 years ─ and/or development of the child's autism/PDD or disability treatment plan (items 82000, 82005, 82010 and 82030); and
- provide treatment to the child ─ aged under 15 years (and who was aged under 13 years at the time of receiving their autism/PDD or disability treatment plan) consistent with the treatment plan prepared by the referring practitioner (items 82015, 82020, 82025 and 82035).

8.2.1 Number of assessment services

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

8.2.2 Eligible allied health assessment services

Four MBS items are available for eligible audiologists, occupational therapists, optometrists, orthoptists, physiotherapists, psychologists and speech pathologists to assist a referring practitioner in the assessment and diagnosis and development of a treatment plan for a child (aged under 13 years) and/or preparation of an autism/PDD or disability treatment plan for that child. Allied health professionals wanting to provide these items must meet the provider eligibility requirements set out at section 8.3 and be registered with Medicare Australia.

Services provided for assisting in the assessment and diagnosis, and development of a treatment plan for a child will not attract a Medicare rebate unless a referral has been made by a consultant psychiatrist or paediatrician for autism/PDD or by a specialist, consultant physician or general practitioner for disability who, as part of the referral, requests the allied health professional's assistance. (see section 8.4)

8.2.3 Number of treatment services

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

8.2.4 Eligible allied health treatment services

There are four MBS items (up to twenty services) for eligible audiologists, occupational therapists, optometrists, orthoptists, physiotherapists, psychologists and speech pathologists to provide treatment services to eligible children ─ aged under 15 years (and who were aged under 13 years at the time of receiving an autism/PDD or disability treatment plan). Allied health professionals wanting to provide these items must meet the provider eligibility requirements set out in section 8.3 and be registered with Medicare Australia.

Services provided for the treatment of children with autism/PDD or disability will not attract a Medicare rebate unless referral has been made by a consultant psychiatrist or paediatrician for autism/PDD (using item 135 or 289) or by a specialist, consultant physician or general practitioner for disability (using item 137 or 139), who, as part of the referral, requests the allied health professional's assistance. (see section 8.4)

8.2.5 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.

A child may receive up to four Medicare eligible services from an allied health professional on the same day.

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 autism/PDD or disability treatment plan prepared by the medical practitioner, and is in keeping with commonly established autism/PDD or disability interventions as practised by their profession and appropriate for the age and particular needs of the child being treated.

8.3 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 meet the specific eligibility requirements detailed below:

- **Audiologist** must be either a 'Full Member' of the Audiological Society of Australia Inc (ASA), who holds a 'Certificate of Clinical Practice' issued by the ASA; or an 'Ordinary Member – Audiologist' or 'Fellow Audiologist' of the Australian College of Audiology (ACAud);
- **Occupational Therapist** must be registered with the Occupational Therapy Board of Australia;
- **Optometrist** must be registered as an optometrist or optician under a law of a State or an internal Territory that provides for the registration of optometrists or opticians, and be a participating optometrist;
- **Orthoptist** must be registered with the Australian Orthoptic Board and have a Certificate of Currency; and be a member of Orthoptics Australia;
- **Physiotherapist** must be registered with the Physiotherapy Board of Australia;
- **Psychologist** must hold General Registration with the Psychology Board of Australia; or
- **Speech Pathologist** in Queensland must be registered with the Speech Pathologist Board of Queensland. In all other States, the Australian Capital Territory and the Northern Territory, they must be a 'Practising Member' of Speech Pathology Australia.

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

Note: A transitional provision is in place to ensure that the move to national registration for occupational therapists does not disrupt the provision of Medicare rebateable services to patients. Until 31 October 2012, anyone who was an occupational therapist in relation to an occupational therapy health service on 30 June 2012 will be taken to be an occupational therapist in relation to that service. From 1 November 2012, occupational therapists must be registered with the Occupational Therapy Board of Australia to be eligible to provide Medicare services.

8.4 REFERRAL REQUIREMENTS

8.4.1 Referrals

An allied health professional wanting to provide any of the items 82000-82035 must be in receipt of a current referral provided by an eligible medical practitioner.

Referrals from consultant psychiatrists and paediatricians to allied health professionals are only valid when prerequisite MBS services have been provided:

An eligible allied health professional can provide **assessment items** (82000-82010, and 82030) to a child where:

- for the autism program, the child has previously been provided with any MBS service covering items 110 through 131 inclusive, as provided by an eligible consultant paediatrician; or
- for the autism program, 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; or
- for the disability program, the child has previously been provided with any MBS service covering items 104 through 131 inclusive, or items 296 through 370 (excepting item 359) inclusive by a specialist or consultant physician; or
- for the disability program, the child has previously been provided with any MBS service covering items 3 through 51, by a general practitioner.

An eligible allied health professional can provide **treatment items** (82015-82025, and 82035) to a child where:

- the child has previously been provided with a treatment plan (MBS item 135) by an eligible consultant paediatrician; or
- the child has previously been provided with a treatment plan (MBS item 289) by an eligible consultant psychiatrist; or
- the child has previously been provided with a treatment plan (MBS item 137) by a specialist or consultant physician; or
- the child has previously been provided with a treatment plan (MBS item 139) by a general practitioner.

If the referring service has not yet been claimed, Medicare Australia will not be aware of the child's eligibility and Medicare benefits can not be paid. Medicare Australia will be able to confirm whether a relevant MBS service has been claimed and/or the number of allied health services already claimed by the child. Allied health professionals can call the Medicare Australia provider line on 132 150. Parents and carers can call the patient information line on 132 011.

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

Referring medical 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 health professional signed and dated by the referring practitioner.

8.4.2 Referral validity

Medicare benefits are available for up to four allied health assessment and diagnosis and development of a treatment plan and up to twenty allied health treatment services per patient in total.

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

8.5 REPORTING REQUIREMENTS

A written report must be provided to the referring medical practitioner by the allied health professional(s) after having provided the **assessment** and diagnosis and development of a treatment plan service(s) to the child.

Within the maximum service allocation of twenty services for the **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 audiologist, occupational therapist, optometrist, orthoptist, physiotherapist, psychologist and speech pathologist must provide a written report to the referring medical practitioner which includes information on:

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

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

8.6 FURTHER INFORMATION

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

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

ITEM DESCRIPTORS

	GROUP M10 – AUTISM, PERVASIVE DEVELOPMENTAL DISORDER AND DISABILITY SERVICES
82000	**PSYCHOLOGY** Psychology health service provided to a child, aged under 13 years, by an eligible psychologist where: (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) or disability treatment plan, developed by the practitioner; and (c) for a child with PDD, the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; or for a child with disability, the eligible practitioner is a specialist, consultant physician or general practitioner; 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. These items are limited to a maximum of four services per patient, consisting of any combination of the following items ─ 82000, 82005, 82010 and 82030 **Fee:** $97.90 **Benefit:** 85% = $83.25
82005	**SPEECH PATHOLOGY** Speech pathology health service provided to a child, aged under 13 years, by an eligible speech pathologist where: (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) or disability treatment plan, developed by the practitioner; and (c) for a child with PDD, the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; or for a child with disability, the eligible practitioner is a specialist, consultant physician or general practitioner; 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. These items are limited to a maximum of four services per patient, consisting of any combination of the following items ─ 82000, 82005, 82010 and 82030 **Fee:** $86.30 **Benefit:** 85% = $73.40
82010	**OCCUPATIONAL THERAPY** Occupational therapy health service provided to a child, aged under 13 years, by an eligible occupational therapist where: (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) or disability treatment plan, developed by the practitioner; and (c) for a child with PDD, the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; or for a child with disability, the eligible practitioner is a specialist, consultant physician or general practitioner; 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. These items are limited to a maximum of four services per patient, consisting of any combination of the following items ─ 82000, 82005, 82010 and 82030 **Fee:** $86.30 **Benefit:** 85% = $73.40

82015	**PSYCHOLOGY** Psychology health service provided to a child, aged under 15 years, for treatment of a pervasive developmental disorder (PDD) or eligible disability by an eligible psychologist where: (a) the child has been diagnosed with PDD or an eligible disability; and (b) the child has received a PDD or disability 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 or disability treatment plan; and (d) for a child with PDD, the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; or for a child with disability, the eligible practitioner is a specialist, consultant physician or general practitioner; and (e) the psychologist 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. These items are limited to a maximum of 20 services per patient, consisting of any combination of items ─ 82015, 82020, 82025 and 82035 **Fee:** $97.90 **Benefit:** 85% = $83.25
82020	**SPEECH PATHOLOGY** Speech pathology health service provided to a child, aged under 15 years, for treatment of a pervasive developmental disorder (PDD) or eligible disability by an eligible speech pathologist where: (a) the child has been diagnosed with PDD or eligible disability; and (b) the child has received a PDD or disability 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 or disability treatment plan; and (d) for a child with PDD, the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; or for a child with disability, the eligible practitioner is a specialist, consultant physician or general practitioner; 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. These items are limited to a maximum of 20 services per patient, consisting of any combination of items ─ 82015, 82020, 82025 and 82035 **Fee:** $86.30 **Benefit:** 85% = $73.40
82025	**OCCUPATIONAL THERAPY** Occupational therapy health service provided to a child, aged under 15 years, for treatment of a pervasive developmental disorder (PDD) or eligible disability by an eligible occupational therapist where: (a) the child has been diagnosed with PDD or eligible disability; and (b) the child has received a PDD or disability 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 or disability treatment plan; and (d) for a child with PDD, the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; or for a child with disability, the eligible practitioner is a specialist, consultant physician or general practitioner; 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. These items are limited to a maximum of 20 services per patient, consisting of any combination of items ─ 82015, 82020, 82025 and 82035 **Fee:** $86.30 **Benefit:** 85% = $73.40

82030	**AUDIOLOGY, OPTOMETRY, ORTHOPTIC OR PHYSIOTHERAPY** Audiology, optometry, orthoptic or physiotherapy health service provided to a child, aged under 13 years, by an eligible audiologist, optometrist, orthoptist or physiotherapist where: (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) or disability treatment plan, developed by the practitioner; and (c) for a child with PDD, the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; or for a child with disability, the eligible practitioner is a specialist, consultant physician or general practitioner; and (d) the audiologist, optometrist, orthoptist or physiotherapist 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. These items are limited to a maximum of four services per patient, consisting of any combination of the following items ─ 82000, 82005, 82010 and 82030 **Fee:** $86.30 **Benefit:** 85% = $73.40
82035	**AUDIOLOGY, OPTOMETRY, ORTHOPTIC OR PHYSIOTHERAPY** Audiology, optometry, orthoptic or physiotherapy health service provided to a child, aged under 15 years, for treatment of a pervasive developmental disorder (PDD) or eligible disability by an eligible audiologist, optometrist, orthoptist or physiotherapist where: (a) the child has been diagnosed with PDD or eligible disability; and (b) the child has received a PDD or disability 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 or disability treatment plan; and (d) for a child with PDD, the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; or for a child with disability, the eligible practitioner is a specialist, consultant physician or general practitioner; and (e) the audiologist, optometrist, orthoptist or physiotherapist 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. These items are limited to a maximum of 20 services per patient, consisting of any combination of items ─ 82015, 82020, 82025 and 82035 **Fee:** $86.30 **Benefit:** 85% = $73.40