

**Australian Government
Department of Health and Ageing**

Medicare Benefits Schedule Book

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

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

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G.1.1. MEDICARE - AN OUTLINE

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

- (a). Free treatment for public patients in public hospitals.
- (b). The payment of 'benefits', or rebates, for professional services listed in the Medicare Benefits Schedule (MBS). In general, the Medicare benefit is 85% of the Schedule fee, otherwise the benefits are
 - i. 100% of the Schedule fee for services provided by a general practitioner to non-referred, non-admitted patients;
 - ii. 100% of the Schedule fee for services provided on behalf of a general practitioner by a practice nurse or registered Aboriginal Health Worker;
 - iii. 75% of the Schedule fee for professional services rendered to a patient as part of an episode of hospital treatment (other than public patients);
 - iv. 75% of the Schedule fee for professional services rendered as part of a privately insured episode of hospital-substitute treatment.

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

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

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

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

G.1.2. MEDICARE BENEFITS AND BILLING PRACTICES

Key information on Medicare benefits and billing practices

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

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

Billing practices contrary to the Act

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

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

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

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

Potential consequence of improperly issuing an account

The potential consequences for improperly issuing an account are

- (a). No Medicare benefits will be paid for the service;
- (b). The medical practitioner who issued the account, or authorised its issue, may face charges under sections 128A or 128B of the *Health Insurance Act 1973*.
- (c). Medicare benefits paid as a result of a false or misleading statement will be recoverable from the doctor under section 129AC of the *Health Insurance Act 1973*.

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

G.2.1. PROVIDER ELIGIBILITY FOR MEDICARE

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

- (a) be a recognised specialist, consultant physician or general practitioner; or
- (b) be in an approved placement under section 3GA of the *Health Insurance Act 1973*; or
- (c) be a temporary resident doctor with an exemption under section 19AB of the *Health Insurance Act 1973*, and working in accord with that exemption .

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

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

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

Non-medical practitioners

To be eligible to provide services which will attract Medicare benefits under MBS items 10950-10977 and MBS items 80000-89000, allied health professionals, dentists, and dental specialists must be

- (a) registered according to State or Territory law or, absent such law, be members of a professional association with uniform national registration requirements; and
- (b) registered with Medicare Australia to provide these services.

G.2.2. PROVIDER NUMBERS

Practitioners eligible to have Medicare benefits payable for their services and/or who for Medicare purposes wish to raise referrals for specialist services and requests for pathology or diagnostic imaging services, may apply *in writing* to Medicare Australia for a Medicare provider number for the locations where these services/referrals/requests will be provided. The form may be downloaded from www.medicareaustralia.gov.au

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

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

When a practitioner ceases to practice at a given location they must inform Medicare promptly. Failure to do so can lead to the misdirection of Medicare cheques and Medicare information.

Practitioners at practices participating in the Practice Incentives Program (PIP) should use a provider number linked to that practice. Under PIP, only services rendered by a practitioner whose provider number is linked to the PIP will be considered for PIP payments.

G.2.3. LOCUM TENENS

Where a locum tenens will be in a practice for more than two weeks *or* in a practice for less than two weeks but on a regular basis, the locum should apply for a provider number for the relevant location. If the locum will be in a practice for less than two weeks and will not be returning there, they should contact Medicare Australia (provider liaison – 132 150) to discuss their options (for example, use one of the locum's other provider numbers).

A locum must use the provider number allocated to the location if

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

G.2.4. OVERSEAS TRAINED DOCTOR

Ten year moratorium

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

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

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

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

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

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

G.2.5. ADDRESSES OF MEDICARE AUSTRALIA

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

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

NEW SOUTH WALES The Colonial State Bank Tower 130 George Street PARRAMATTA NSW 2165	VICTORIA State Headquarters 460 Bourke Street MELBOURNE VIC 3000	QUEENSLAND State Headquarters 444 Queen Street BRISBANE QLD 4000
SOUTH AUSTRALIA State Headquarters 209 Greenhill Road EASTWOOD SA 5063	WESTERN AUSTRALIA State Headquarters Bank West Tower 108 St. George's Terrace PERTH WA 6000	TASMANIA 242 Liverpool Street HOBART TAS 7000
NORTHERN TERRITORY As per South Australia	AUSTRALIAN CAPITAL TERRITORY 134 Reed Street TUGGERANONG ACT 2901	

G.3.1. PATIENT ELIGIBILITY FOR MEDICARE

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

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

G.3.2. MEDICARE CARDS

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

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

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

G.3.3. VISITORS TO AUSTRALIA AND TEMPORARY RESIDENTS

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

G.3.4. RECIPROCAL HEALTH CARE AGREEMENTS

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

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

Exceptions:

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

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

G.4.1. GENERAL PRACTICE

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

- vocationally registered under section 3F of the *Health Insurance Act 1973* (see General Explanatory Note 4.3 below); or
- a Fellow of the Royal Australian College of General Practitioners (FRACGP), who participates in, and meets the requirements for the RACGP Quality Assurance and Continuing Medical Education Program; or
- a Fellow of the Australian College of Rural and Remote Medicine (FACRRM) who participates in, and meets the requirements for the ACRRM Quality Assurance and Continuing Medical Education Program; or

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

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

Vocational recognition of general practitioners

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

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

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

Further information on eligibility for recognition should be directed to:

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

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

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

How to apply for vocational recognition

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

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

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

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

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

Continued vocational recognition is dependent upon:

- (a) the practitioner's practice continuing to be predominantly in general practice (for medical practitioners in the Register only); and
- (b) the practitioner continuing to meet minimum requirements for participation in continuing professional development programs approved by the RACGP or the ACRRM.

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

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

Removal of vocational recognition status

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

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

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

G.5.1. RECOGNITION AS A SPECIALIST OF CONSULTANT PHYSICIAN

A medical practitioner who:

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

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

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

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

Once the practitioner is recognised as a specialist or consultant physician for the purposes of the *Health Insurance Act 1973*, Medicare benefits will be payable at the appropriate higher rate for services rendered in the relevant speciality, provided the patient has been referred in accordance with General Explanatory Note 6.

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

G.5.2. EMERGENCY MEDICINE

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

- (a) at risk of serious morbidity or mortality requiring urgent assessment and resuscitation; or
- (b) suffering from suspected acute organ or system failure; or
- (c) suffering from an illness or injury where the viability or function of a body part or organ is acutely threatened; or
- (d) suffering from a drug overdose, toxic substance or toxin effect; or

- (e) experiencing severe psychiatric disturbance whereby the health of the patient or other people is at immediate risk; or
- (f) suffering acute severe pain where the viability or function of a body part or organ is suspected to be acutely threatened; or
- (g) suffering acute significant haemorrhage requiring urgent assessment and treatment; and
- (h) treated in, or via, a bona fide emergency department in a hospital.

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

G.6.1. REFERRAL OF PATIENTS TO SPECIALISTS OR CONSULTANT PHYSICIANS

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

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

What is a Referral?

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

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

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

The exceptions to the requirements in paragraph above are that

- (a) sub-paragraphs (i),(ii) and (iii) do not apply to
 - a pre-anaesthesia consultation by a specialist anaesthetist (items 16710-17625);
- (b) sub-paragraphs (ii) and (iii) do not apply to
 - a referral generated during an episode of hospital treatment, for a privately insured service provided or arranged by that hospital, where the hospital records provide evidence of a referral (including the referring practitioner's signature); or
 - an emergency where the referring practitioner or the specialist or the consultant physician was of the opinion that the service be rendered as quickly as possible; and
- (c) sub-paragraph (iii) does not apply to instances where a written referral was completed by a referring practitioner but was lost, stolen or destroyed.

Examination by Specialist Anaesthetists

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

Who can Refer?

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

Referrals are to be made as follows:-

- (a) to a recognised consultant physician -
 - (i) by another medical practitioner; or
 - (ii) by an approved dental practitioner¹ (oral surgeon), where the referral arises out of a dental service;
- (b) to a recognised specialist -
 - (i) by another medical practitioner; or
 - (ii) by a registered dental practitioner², where the referral arises out of a dental service; or
 - (iii) by a registered optometrist where the specialist is an ophthalmologist.

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

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

Billing

Routine Referrals

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

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

Special Circumstances

(i) Lost, stolen or destroyed referrals.

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

(ii) Emergencies

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

(iii) Hospital referrals.

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

Public Hospital Patients

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

Bulk Billing

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

Period for which Referral is Valid

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

Specialist Referrals

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

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

Referrals by other Practitioners

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

Definition of a Single Course of Treatment

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

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

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

However, where the referring practitioner:-

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

Retention of Referral Letters

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

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

A specialist or a consultant physician is required, if requested by the Managing Director of Medicare Australia, to produce to a Medical Adviser, who is an officer of Medicare Australia, the instrument of referral within seven days after the request is received. Where the referral originates in an emergency situation or in a hospital, the specialist or consultant physician is required to produce such information as is in his or her possession or control relating to whether the patient was so treated.

Attendance for Issuing of a Referral

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

Locum-tenens Arrangements

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

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

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

Self Referral

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

Referrals by Dentists or Optometrists

For Medicare benefit purposes, a referral may be made to

- (i) a recognised specialist:
 - (a) by a registered dental practitioner, where the referral arises from a dental service; or
 - (b) by a registered optometrist where the specialist is an ophthalmologist; or
- (ii) a consultant physician, by an approved dental practitioner (oral surgeon), where the referral arises out of a dental service.

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

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

G.7.1. BILLING PROCEDURES

Itemised Accounts

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

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

- (i) patient's name;
- (ii) the date the professional service was rendered;
- (iii) the amount charged for the service;
- (iv) the total amount paid in respect of the service;
- (v) any amount outstanding in respect of the service;
- (vi) for professional services rendered to a patient as part of a privately insured episode of hospital treatment; an asterisk '*' directly after an item number where used; or a description of the professional service sufficient to identify the item that relates to that service, preceded by the word 'admitted patient' ;
- (vii) for professional services rendered as part of a privately insured episode of hospital-substitute treatment and the patient who receives the treatment chooses to receive a benefit from a private health insurer, the words 'hospital-substitute treatment' directly after an item number where used; or a description of the professional service sufficient to identify the item that relates to that service, preceded by the words 'hospital-substitute treatment';
- (viii) the name and practice address or name and provider number of the practitioner who actually rendered the service; (where the practitioner has more than one practice location recorded with Medicare Australia, the provider number used should be that which is applicable to the practice location at or from which the service was given);
- (ix) the name and practice address or name and provider number of the practitioner claiming or receiving payment of benefits, or assignment of benefit:-
 - - for services in Groups A1 to A14, D1, T1, T4 to T9 of the General Medical Services, Groups O1 to O7 (Oral and Maxillofacial services), and Group P9 of Pathology - where the person claiming payment is NOT the person who rendered the service;
 - - for services in Groups D2, T2, T3, I2, to I5 - for every service;
- (x) if the service was a Specified Simple Basic Pathology Test (listed in Category 6 - Pathology, Group P9 of the Schedule) that was determined necessary by a practitioner who is another member of the same group medical practice, the surname and initials of that other practitioner;
- (xi) where a practitioner has attended the patient on more than one occasion on the same day and on each occasion rendered a professional service to which an item in Category 1 of the Medicare Benefits Schedule relates (i.e. professional attendances), the time at which each such attendance commenced; and
- (xii) where the professional service was rendered by a consultant physician or a specialist in the practice of his/her speciality to a patient who has been referred:- (a) the name of the referring medical practitioner; (b) the address of the place of practice or provider number for that place of practice; (c) the date of the referral; and (d) the period of referral (where other than for 12 months) expressed in months, e.g. "3", "6" or "18" months, or "indefinitely".

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

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

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

Claiming of Benefits

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

Paid Accounts

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

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

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

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

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

Unpaid and Partially Paid Accounts

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

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

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

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

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

Assignment of Benefit (Direct – Billing) Arrangements

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

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

Under these arrangements:-

- the patient's Medicare number must be quoted on all direct-bill assignment forms for that patient;
- the assignment forms provided are loose leaf to enable the patient details to be imprinted from the Medicare Card;
- the forms include information required by Regulations under Section 19(6) of the Health Insurance Act;

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

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

Use of Medicare Cards in Direct Billing

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

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

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

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

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

Assignment of Benefit Forms

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

- (1) Form DB2-GP. This form is designed for the use of optical scanning equipment and is used to assign benefits for General Practitioner Services other than requested pathology, specialist and optometrical services. It is loose leaf for imprinting and comprises a throw away cover sheet (after imprinting), a Medicare copy, a Practitioner copy and a Patient copy. There are 4 pre-printed items with provision for two other items. The form can also be used as an "offer to assign" when a request for pathology services is sent to an approved pathology practitioner and the patient does not attend the laboratory.
- (2) Form DB2-OP. This form is designed for the use of optical scanning equipment and is used to assign benefits for optometrical services. It is loose leaf to enable imprinting of patient details from the Medicare card and is similar in most respects to Form DB2-GP, except for content variations. This form may not be used as an offer to assign pathology services.
- (3) Form DB2-OT. This form is designed for the use of optical scanning equipment and is used to assign benefits for all specialist services. It is loose leaf to enable imprinting of patient details from the Medicare card and is similar in most respects to Form DB2-GP, except for content variations. There are no pre-printed items on this form.
- (4) Form DB3. This is used to assign or offer to assign benefits for pathology tests rendered by approved pathology practitioners. It is loose leaf to enable imprinting of patient details from the Medicare card and is similar in most respects to Form DB2, except for content variations. The form may not be used for services other than pathology.

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

The Claim for Assigned Benefits (Form DB1N, DB1H)

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

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

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

Direct-Bill Stationery (Forms DB6Ba & DB6Bb)

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

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

Time Limits Applicable to Lodgement of Claims for Assigned Benefits

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

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

G.8.1. PROVISION FOR REVIEW OF INDIVIDUAL HEALTH PROFESSIONALS

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

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

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

Following a review, the Director must:

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

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

The Committee is authorized to:

- (a) investigate any aspect of the provision of the referred services, and without being limited by the reasons given in the review request or by a Director's report following the review;

- (b) hold hearings and require the person under review to attend and give evidence;
- (c) require the production of documents (including clinical notes).

The methods available to a PSR Committee to investigate and quantify inappropriate practice are specified in legislation:

(a) Patterns of Services - The *Health Insurance (Professional Services Review) Regulations 1999* specify that when a general practitioner or other medical practitioner reaches or exceeds 80 or more attendances on each of 20 or more days in a 12-month period, they are deemed to have practiced inappropriately.

- (i) A professional attendance means a service of a kind mentioned in group A1, A2, A5, A6, A7, A9, A11, A13, A14, A15, A16, A17, A18, A19, A20, A21, A22 or A23 of Part 3 of the General Medical Services Table.
- (ii) If the practitioner can satisfy the PSR Committee that their pattern of service was as a result of exceptional circumstances, the quantum of inappropriate practice is reduced accordingly. Exceptional circumstances include, but are not limited to, those set out in the *Regulations*. These include:
 - a. an unusual occurrence;
 - b. the absence of other medical services for the practitioner's patients (having regard to the practice location); and
 - c. the characteristics of the patients.

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

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

Additional Information

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

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

If a PSR Committee finds that the person under review has engaged in inappropriate practice, the findings will be reported to the Determining Authority to decide what action should be taken:

- (i) a reprimand;
- (ii) counselling;
- (iii) repayment of Medicare benefits; and/or
- (iv) complete or partial disqualification from Medicare benefit arrangements for up to three years.

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

G.8.2. MEDICARE PARTICIPATION REVIEW COMMITTEE

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

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

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

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

G.8.3. REFERRAL OF PROFESSIONAL ISSUES TO REGULATORY AND OTHER BODIES

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

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

G.8.4. MEDICARE BENEFITS CONSULTATIVE COMMITTEE

G.8.5. MEDICAL SERVICES ADVISORY COMMITTEE

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

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

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

G.8.6. PATHOLOGY SERVICES TABLE COMMITTEE

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

G.8.7. MEDICARE CLAIMS REVIEW PANEL

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

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

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

Applications for approval should be addressed to:

The MCRP Officer
PO Box 1001
Tuggeranong ACT 2901

G.9.1. PENALTIES AND LIABILITIES

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

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

G.10.1. SCHEDULE FEES AND MEDICARE BENEFITS

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

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

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

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

There are presently three levels of Medicare benefit payable:

- (a) **75% of the Schedule fee:**
- i. for professional services rendered to a privately insured patient as part of an episode of hospital treatment (other than public patients). Medical practitioners must indicate on their accounts if a medical service is rendered in these circumstances by placing an asterisk '*' directly after an item number where used; or a description of the professional service, preceded by the word 'patient';
 - ii. for professional services rendered as part of an episode of hospital-substitute treatment, and the patient who receives the treatment chooses to receive a benefit from a private health insurer. Medical practitioners must indicate on their accounts if a medical service is rendered in these circumstances by placing the words 'hospital-substitute treatment' directly after an item number where used; or a description of the professional service, preceded by the words 'hospital-substitute treatment'.
- (b) **100% of the Schedule fee** for non-referred attendances by general practitioners to non-admitted patients and services provided by a practice nurse or registered Aboriginal Health Worker on behalf of a general practitioner.
- (c) **85% of the Schedule fee**, or the Schedule fee less \$68.10 (indexed annually), whichever is the greater, for all other professional services.

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

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

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

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

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

G.10.2. MEDICARE SAFETY NETS

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

- (a). Under the extended safety net, Medicare rebates 80% of out-of-pocket expenses for non-admitted services, once certain thresholds are reached. In 2008, concession cardholders, families receiving Family Tax Benefit (Part A) and families that qualify for notional Family Tax Benefit (Part A) are eligible for the extended Medicare safety net when their cumulative out-of-pocket expenses reach \$529.30; all other singles, couples and families are eligible when their cumulative out-of-pocket expenses reach \$1,058.70. The extended Medicare safety net operates with the original safety net.
- (b). In 2008, under the original safety net, the Medicare benefit for non-admitted services increases to 100% of the Schedule fee, once cumulative out-of-pocket expenses reach \$365.70. Thereafter, any remaining out-of-pocket expenses count towards meeting the extended Medicare safety net threshold.

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

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

G.11.1. SERVICES NOT LISTED IN THE MBS

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

Enquiries about services not listed or on matters of interpretation should be directed to Medicare Australia. The following telephone numbers are reserved for MBS enquiries:

NSW - 02 9895 3346
VIC - 03 9605 7964
QLD - 07 3004 5280
SA - 08 8274 9788
NT - 08 8274 9788
WA - 08 9214 8488
TAS - 03 6215 5740
ACT - 02 6124 6362

G.11.2. MINISTERIAL DETERMINATIONS

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

G.12.1. PROFESSIONAL SERVICES

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

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

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

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

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

G.12.2. SERVICES RENDERED ON BEHALF OF MEDICAL PRACTITIONERS

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

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

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

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

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

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

G.12.3. MASS IMMUNISATION

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

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

G.13.1. SERVICES WHICH DO NOT ATTRACT MEDICARE BENEFITS

Services not attracting benefits

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

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

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

Unless the Minister otherwise directs

Medicare benefits are not payable where:

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

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

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

Pain pumps for post-operative pain management

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

Non Medicare Services

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

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

Health Screening Services

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

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

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

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

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

- an examination interval of two years for women who have no symptoms or history suggestive of abnormal cervical cytology, commencing between the ages of 18 to 20 years, or one or two years after first sexual intercourse, whichever is later;
- cessation of cervical smears at 70 years for women who have had two normal results within the last five years.

Women over 70 who have never been examined, or who request a cervical smear, should be examined.

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

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

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

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

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

a spouse, in relation to a dependant person means:

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

a child, in relation to a dependant person means:

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

G.14.1. PRINCIPLES OF INTERPRETATION OF THE MBS

Each professional service listed in the MBS is a complete medical service. Where a listed service is also a component of a more comprehensive service covered by another item, the benefit for the latter service will cover the former.

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

G.14.2. SERVICES ATTRACTING BENEFITS ON AN ATTENDANCE BASIS

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

G.14.3. CONSULTATION AND PROCEDURES RENDERED AT THE ONE ATTENDANCE

Where, during a single attendance, a consultation (under Category 1 of the MBS) and another medical service (under any other Category of the Schedule) occur, benefits are payable subject to certain exceptions, for both the consultation and the other service. Benefits are not payable for the consultation in addition to an item rendered on the same occasion where the item is qualified by words such as "each attendance", "attendance at which", "including associated attendances/consultations", and all items in Group T6 and T9. In the case of radiotherapy treatment (Group T2 of Category 3) benefits are payable for both the radiotherapy and an initial referred consultation.

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

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

G.14.4. AGGREGATE ITEMS

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

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

G.14.5. RESIDENTIAL AGED CARE FACILITY

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

G.15.1. PRACTITIONERS SHOULD MAINTAIN ADEQUATE AND CONTEMPORANEOUS RECORDS

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

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

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

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

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

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

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

MISCELLANEOUS SERVICES
CATEGORY 8

SUMMARY OF CHANGES

The 1/08/2008 changes to the MBS are summarised below and are identified in the Schedule pages by one or more of the following symbols appearing above the item number

- (a) new item †
- (b) amended description ‡
- (c) fee amended +
- (d) item number changed *

New items

10987 81300 81305 81310 81315 81320 81325 81330 81335 81340 81345 81350 81355 81360

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

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

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

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

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

Item 10990 or item 10991 can be claimed for each item of service claimable under the MBS (other than diagnostic imaging services and pathology services), provided the conditions of the relevant item, 10990 or 10991, are satisfied. For example, item 10990 or 10991 can be claimed in conjunction with attendance items, procedural items (other than diagnostic imaging or pathology items) or services provided by a practice nurse on behalf of a medical practitioner (items 10993, 10996, 10998 and 10999). In some cases, this will mean that item 10990 or 10991 can be claimed more than once in respect of a patient visit.

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

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

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

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

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

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

After-hours services provided in areas eligible for the higher bulk billing payment (item 10992)

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

- Item 10992 must be claimed in conjunction with one of the items listed in item 10992. These items are for services provided after-hours outside of consulting rooms or hospital.
- Item 10992 can only be used where the service is provided in one of the eligible areas listed in item 10992 by a medical practitioner whose practice location (ie the location associated with the medical practitioner's provider number) is not in one of these areas.
- Medical practitioners whose practice location is inside one of these listed locations should claim item 10991 for eligible services.

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

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

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

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

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

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

M.2.1. SERVICES PROVIDED BY A PRACTICE NURSE ON BEHALF OF A MEDICAL PRACTITIONER - (ITEMS 10993 TO 10999)

Immunisation services provided by a practice nurse (item 10993)

Item 10993 can only be claimed by a medical practitioner (not including a specialist or consultant physician) where an immunisation is provided to a patient by a practice nurse on behalf of the medical practitioner.

Item 10993 can be claimed only once per patient visit, even if more than one vaccine is administered during the same patient visit.

A practice nurse means a registered nurse or an enrolled nurse who is employed by, or whose services are otherwise retained by, a general practice. The practice nurse must be appropriately qualified and trained to provide immunisations. This includes compliance with any state or territory requirements. For example, in some states and territories, some nurses can only administer a vaccine following an order or direction from a medical practitioner.

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

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

A registered vaccine means a vaccine that is included on the Australian Register of Therapeutic Goods. This includes all vaccines on the Australian Standard Vaccination Schedule and vaccines covered in the Australian Immunisation Handbook 8th edition. The following substances cannot be claimed under this item: vaccines used experimentally; homeopathic substances; immunotherapy for allergies (eg de-sensitisation preparations); and other substances that are not vaccines. There may also be state or territory limitations on the administration of some vaccines, such as those for tuberculosis, yellow fever and Q-fever.

All GPs whether vocationally registered or not are eligible to claim this item.

Where the medical practitioner also provides a service to the patient in addition to the immunisation being administered by the practice nurse, the medical practitioner is able to claim for the professional service they provide to the patient.

Item 10990 or item 10991 can also be claimed in conjunction with item 10993 provided the conditions of the relevant item, 10990 or 10991, are satisfied (see explanatory note M.1).

Wound management services provided by a practice nurse (item 10996)

Item 10996 can only be claimed by a medical practitioner (not including a specialist or consultant physician) where wound management (other than normal aftercare) is provided to a patient by a practice nurse on behalf of the medical practitioner.

Item 10996 can be claimed only once per patient visit, even if more than one wound is treated during the same patient visit.

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

The practice nurse must be appropriately qualified and trained to treat wounds.

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

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

Where a practice nurse provides ongoing wound management, the medical practitioner is not required to see the patient during each subsequent visit.

All GPs whether vocationally registered or not are eligible to claim this item.

Where the medical practitioner also provides a service to the patient in addition to the treatment by the practice nurse, the medical practitioner is able to claim for the professional service they provide to the patient.

Item 10990 or item 10991 can also be claimed in conjunction with item 10996 provided the conditions of the relevant item, 10990 or 10991, are satisfied (see explanatory note M.1).

Pap smear services and preventive checks provided by a practice nurse (item 10994, 10995, 10998 and 10999)

Items 10994 and 10995 require taking of a Pap smear **and at least one** preventive check.

Item 10994 can be claimed by a medical practitioner (not including a specialist or consultant physician) where a Pap smear **and at least one** preventive check is taken by a practice nurse on behalf of the medical practitioner.

Item 10995 can be claimed by a medical practitioner (not including a specialist or consultant physician) where a Pap smear **and at least one** preventive check is taken by a practice nurse on behalf of the medical practitioner **and** the patient is a woman, between the ages of 20 and 69 inclusive, who has not had a Pap smear in the last 4 years.

Items 10994 and 10995 include a Pap smear and preventive checks associated with women's sexual and reproductive health, which would routinely be undertaken in conjunction with a Pap smear. A preventive check is a service which is reasonably necessary and appropriate for preventive care based on evidence of effectiveness and efficacy appropriate to the age of the patient.

M.2.20 Services for items 10994 and 10995 must include a Pap smear and at least one preventive check from the following:

- Checks for sexually transmitted infections (including chlamydia)
- Taking of a sexual and reproductive history
- Advice on contraception
- Breast awareness education
- Advice on post natal issues
- Continence advice and education;

and may also include:

- Smoking, Nutrition, Alcohol and Physical Activity (SNAP) behavioural risk factor assessment
- Blood pressure measurement.

General practices are referred to the Royal Australian College of General Practitioners' (RACGP) *Guidelines for preventive activities in general practice – 6th edition* (Red Book), the RACGP (2004) *SNAP guide: a population health guide to behavioural risk factors in general practice* and National Aboriginal Community Controlled Health Organisations (NACCHO) 2005 *National Guide to a preventive health assessment in Aboriginal and Torres Strait Islander peoples* for recommendations on appropriate checks for women in particular age ranges.

Where, in the course of discussion of sexual history and current sexual activity, a practice nurse becomes aware that one of the checks listed for another age group is appropriate, the practice nurse may include that check as part of the service provided.

Patients with symptoms should be referred to their GP for diagnosis and management.

Items 10994 and 10995 cannot be claimed together or in conjunction with items 10998, 10999, 2497-2509 or 2598-2616.

Items 10998 and 10999 apply to the taking of a Pap smear only.

Item 10998 can be claimed by a medical practitioner (not including a specialist or consultant physician) where a Pap smear is taken by a practice nurse on behalf of the medical practitioner.

Item 10999 can be claimed by a medical practitioner (not including a specialist or consultant physician) where a Pap smear is taken by a practice nurse on behalf of the medical practitioner **and** the Pap smear is taken from a woman between the ages of 20 and 69 inclusive, who has not had a Pap smear in the last 4 years.

Where the medical practitioner claims item 10995 or 10999 instead of a Practice Incentives Program (PIP) item (2497 - 2509 and 2598 - 2616) for an unscreened or significantly underscreened woman, a PIP cervical screening incentive will be available. This incentive will be paid to the medical practitioner claiming item 10995 or 10999 if the service was provided in a general practice participating in the PIP. A further PIP incentive is paid to practices that reach target levels of cervical screening for their female patients aged 20-69. More detailed information on these incentives is available from the Medicare Australia PIP enquiry line on 1800 222 032 or www.medicareaustralia.gov.au/pip

Items 10998 and 10999 cannot be claimed in conjunction with each other or with items 10994, 10995, 2497- 2509 or 2598 - 2616.

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

The practice nurse must be appropriately qualified and trained to take cervical smears and other preventive checks. This means that where credentialling arrangements are in place, the practice nurse should be credentialled as qualified and trained to take Pap smears. All practice nurses taking Pap smears and other preventive checks should have undertaken an accredited training course.

Continuing professional development is a compulsory part of the credentialling arrangements and is recommended for all nurses taking Pap smears and providing preventive checks in jurisdictions where there are currently no credentialling arrangements.

General practices, where nurses take Pap smears and provide preventive checks, should also have a written clinical risk management strategy covering issues like clinical roles, pathology follow-up and patient consent.

In all cases, the medical practitioner under whose supervision the Pap smear and preventive checks are provided retains responsibility for the health, safety and clinical outcomes of the patient. The medical practitioner must be satisfied that the practice nurse is appropriately qualified and trained to perform Pap smears and other preventive checks. Medical practitioners are advised to consult their insurer concerning indemnity coverage for services performed on their behalf.

The supervising medical practitioner and practice nurse must also comply with any relevant legislative or regulatory requirements, including those applying to state and territory cervical cytology registers or laboratories and disease notification registers.

The medical practitioner is not required to be present while the Pap smear and preventive checks are undertaken. It is up to the medical practitioner to decide whether they need to see the patient. Where the medical practitioner has a consultation with the patient, then the medical practitioner is entitled to claim a Medicare item for the time and complexity of their personal attendance on the patient. The time the patient spends receiving a service from the practice nurse is itemised separately under item 10994, 10995, 10998 or 10999 (as applicable) and should not be counted as part of the Medicare item claimed for time spent with the medical practitioner.

All GPs whether vocationally registered or not are eligible to claim these items.

Item 10990 or 10991 can be claimed in conjunction with item 10994, 10995, 10998 or 10999 provided the conditions of item 10990 or 10991 are satisfied (see explanatory note M.1).

Provision of monitoring and support for a person with a chronic disease by a practice nurse or registered Aboriginal Health Worker (item 10997)

Item 10997 may be claimed by a medical practitioner, including a general practitioner but not including a specialist or consultant physician, where a monitoring and support service for a person with a chronic disease care plan is provided by a practice nurse or registered Aboriginal Health Worker on behalf of that medical practitioner.

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

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

provided by practice nurses or registered Aboriginal Health Workers salaried by or contracted to, the Service or health clinic. All requirements of the item must be met.

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

Item 10997 may be used to provide:

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

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

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

Item 10997 may only be accessed by a patient with a GP Management Plan, Team Care Arrangements or Multidisciplinary Care Plan (items 721, 723, 725, 727, 729, 731).

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

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

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

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

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

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

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

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

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

M.3.1. ALLIED HEALTH AND DENTAL CARE SERVICES - (ITEMS 10950 TO 10970)

ELIGIBLE PATIENTS

Medicare benefits are available for certain services provided by eligible allied health professionals to people with chronic conditions and complex care needs who are being managed by a GP under an Enhanced Primary Care (EPC) plan. The allied health services must be recommended in the patient's EPC plan as part of the management of their chronic condition.

Chronic conditions and complex care needs

A chronic medical condition is one that has been or is likely to be present for at least six (6) months including, but not limited to, asthma, cancer, cardiovascular illness, diabetes mellitus, mental disorders, arthritis and musculoskeletal conditions. A patient is considered to have complex care needs if they require ongoing care from a multidisciplinary team consisting of their GP and at least two (2) other health or care providers.

EPC plan

Patients are considered to be managed under an EPC plan, if during the last two years:

- their GP has put in place a GP Management Plan (MBS Chronic Disease Management (CDM) item 721) **and** Team Care Arrangements (MBS Chronic Disease Management (CDM) item 723); or
- their GP has reviewed their existing EPC plan and claimed MBS item 725 and 727; or
- their GP has contributed to or reviewed a multidisciplinary care plan prepared for them as a resident of an aged care facility and claimed item 731.

For more information on the CDM EPC planning items, refer to the explanatory notes for these items – Note A.30.

Important note: Before a Medicare rebate can be paid for the allied health service, either the patient must have already claimed a rebate for the relevant EPC planning item/s, or the GP must have lodged a direct bill (bulk billing) claim with Medicare Australia for the relevant EPC planning item/s and that claim has been processed.

EPC planning team

The allied health professional providing the service may be part of the EPC planning team convened by the GP to manage a patient's chronic and complex care needs. However, the service may also be provided by an allied health professional that is not part of the EPC planning team, provided that the service has been identified as necessary by the patient's GP.

Group services

In addition to individual services, patients who have type 2 diabetes may also access new MBS items 81100 to 81125 which provide allied health group services – refer M.9.

M.3.2. ALLIED HEALTH AND DENTAL CARE SERVICES - (ITEMS 10950 TO 10970)

REFERRAL REQUIREMENTS

Referral form

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

GPs may use one referral form to refer patients for single or multiple services of the same service type (eg five chiropractic services). If referring a patient for single or multiple services of different service types (eg 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.

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

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

The referral form may be downloaded from the Department of Health and Ageing website at www.health.gov.au/epc or ordered by faxing (02) 6289 7120 or phoning (02) 6289 4297. GPs may modify the referral form to suit their practice needs (for example, relevant software packages) as long as the information is substantially retained.

Referral validity

Medicare benefits are available for up to five (5) allied health services per patient per calendar year. If a patient has not used all of their allied health services under a referral in a calendar year, it is not necessary to obtain a new referral for the “unused” services. However, any “unused” services received from 1 January in the following year under that referral will count as part of the total of five services for which the patient is eligible in that calendar year.

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

It is not necessary to have a new EPC plan prepared 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 an EPC plan as long as the need for eligible services continues to be recommended in their plan.

M.3.3. ALLIED HEALTH AND DENTAL CARE SERVICES - (ITEMS 10950 TO 10970)

ELIGIBLE ALLIED HEALTH SERVICES

Eligible allied health providers

The following groups of allied health professionals are eligible to provide services under Medicare for patients with a chronic condition and complex care needs. Allied health professionals must meet the provider eligibility requirements set out at paragraph M.3.4, and be registered with Medicare Australia.

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

Number of services per year

Medicare benefits are available for up to five (5) allied health services per eligible patient, per calendar year. The Medicare rebate for each allied health service is \$47.85.

The five allied health services can be made up of one type of service (eg five physiotherapy services) or a combination of different types of services (eg one dietetic and four podiatry services).

Checking patient eligibility for allied health services

Patients seeking Medicare rebates for allied health services will need to have an EPC program referral form for allied health services under Medicare signed by their GP. If there is any doubt about a patient's eligibility, Medicare Australia will be able to confirm whether there is an EPC plan in place and the number of allied health services already claimed by the patient during the calendar year. The allied health professional or the patient can call Medicare Australia on 132 011 to check this information.

Service length and type

Services provided under the allied health items must be of at least 20 minutes duration and provided to an individual patient, not to a group. The allied health professional must personally attend the patient.

Reporting back to the GP

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

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

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

Out-of-pocket expenses and Medicare Safety Net

Allied health professionals 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 that patient. Allied health services in excess of five (5) in a calendar year will not attract a Medicare benefit and the Safety Net arrangements will not apply to costs incurred by the patient for such services.

Publicly funded services

Items 10950 to 10970 do not apply for services that are provided by any Commonwealth or State funded services or provided to an admitted patient of a hospital.

However, where an exemption under subsection 19(2) of the Health Insurance Act 1973 has been granted to an Aboriginal Community Controlled Health Service or State/Territory Government health clinic, items 10950 to 10970 can be claimed for services provided by eligible allied health professionals salaried by, or contracted to, the Service or health clinic. All requirements of the relevant item must be met, including registration of the allied health professional with Medicare Australia. These services must also be direct billed (that is, the Medicare rebate is accepted as full payment for services).

Private health insurance

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

M.3.4. ALLIED HEALTH AND DENTAL CARE SERVICES - (ITEMS 10950 TO 10970)

ALLIED HEALTH PROFESSIONAL ELIGIBILITY REQUIREMENTS

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

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

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

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

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

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

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

Mental Health Workers

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

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

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

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

- a registered mental health nurse in Tasmania or the Australian Capital Territory (ACT), if providing mental health services in Tasmania or the ACT; or

- a ‘Credentialled Mental Health Nurse’ as certified by the Australian College of Mental Health Nurses, if providing mental health services in other States or the Northern Territory.

A **social worker** must be a ‘Member’ of the Australian Association of Social Workers (AASW) and be certified by AASW as meeting the standards for mental health set out in AASW’s ‘Standards for Mental Health Social Workers 1999’, as in force on 1 November 2006.

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

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

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

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

Psychologists must be registered, without limitation, with the Psychologists Registration Board in the State or Territory in which they are practising.

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

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

Registering with Medicare Australia

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

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

Changes to provider details

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

M.3.5. ALLIED HEALTH AND DENTAL CARE SERVICES - (ITEMS 10950 TO 10970)

FURTHER INFORMATION

Further information about Medicare Benefits Schedule items is available on the Department of Health and Ageing’s website at www.health.gov.au/epc. For providers, further information is also available from the Medicare Australia provider inquiry line on 132 150.

M.5.1. FOLLOW UP SERVICE PROVIDED BY A PRACTICE NURSE OR REGISTERED ABORIGINAL HEALTH WORKER, ON BEHALF OF A GP, FOR AN INDIGENOUS PERSON WHO HAS RECEIVED A HEALTH CHECK (ITEM 10987)

Item 10987 may be claimed by a medical practitioner, including a general practitioner but not including a specialist or consultant physician, where a follow up service is provided by a practice nurse or registered Aboriginal Health Worker on behalf of that medical practitioner for an Indigenous person who has received a Health Check.

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

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

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

Item 10987 may be used to provide:

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

Item 10987 may be claimed up to a maximum of 5 times per patient per calendar year.

Item 10987 may be accessed by an Indigenous patient who has received a health check (eg. an Aboriginal and Torres Strait Islander Child Health Check, an Aboriginal and Torres Strait Islander Adult Health Check, health checks for people of Aboriginal or Torres Strait Islander descent aged 55 years + (Items 704, 706, 708 and 710), or a Child who has received a health check as part of the Northern Territory Emergency Response (NTER)).

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

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

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

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

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

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

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

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

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

M.5.2. SERVICES PROVIDED BY A REGISTERED ABORIGINAL HEALTH WORKER ON BEHALF OF A MEDICAL PRACTITIONER - (ITEMS 10987, 10988, AND 10989)

Immunisation services provided by a registered Aboriginal Health Worker (item 10988)

Item 10988 can only be claimed by a medical practitioner (not including a specialist or consultant physician) where an immunisation is provided to a patient by a registered Aboriginal Health Worker on behalf of the medical practitioner.

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

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

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

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

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

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

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

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

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

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

Item 10991 can also be claimed in conjunction with item 10988 provided the conditions of both items are satisfied (see explanatory note M.1).

Wound management services provided by a registered Aboriginal Health Worker (item 10989)

Item 10989 can only be claimed by a medical practitioner (not including a specialist or consultant physician) where wound management (other than normal aftercare) is provided to a patient by a registered Aboriginal Health Worker on behalf of the medical practitioner.

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

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

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

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

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

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

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

The wound management must be performed by the registered Aboriginal Health Worker in accordance with the Central Australian Rural Practitioners Association (CARPA) Standard Treatment Manual.

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

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

Item 10991 can also be claimed in conjunction with item 10989 provided the conditions of both items are satisfied (see explanatory note M.1).

M.5.3. WOUND MANAGEMENT SERVICES PROVIDED BY A REGISTERED ABORIGINAL HEALTH WORKER (ITEM 10989)

Item 10989 can only be claimed by a medical practitioner (not including a specialist or consultant physician) where wound management (other than normal aftercare) is provided to a patient by a registered Aboriginal Health Worker on behalf of the medical practitioner.

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

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

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

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

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

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

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

The wound management must be performed by the registered Aboriginal Health Worker in accordance with the Central Australian Rural Practitioners Association (CARPA) Standard Treatment Manual.

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

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

Item 10991 can also be claimed in conjunction with item 10989 provided the conditions of both items are satisfied (see explanatory note M.1).

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

OVERVIEW

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

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

M.6.2. PSYCHOLOGICAL THERAPY SERVICES ATTRACTING MEDICARE REBATES

Eligible psychological therapy services

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

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

Referrals and Referral Validity

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

- a referral has been made by a GP who is managing the patient under a GP Mental Health Care Plan (item 2710);
- a referral has been made by a GP who is managing the patient under a referred psychiatrist assessment and management plan (item 291); or
- a referral has been made by a psychiatrist or paediatrician from an eligible psychiatric or paediatric service (see Referral Requirements for further details regarding psychiatrist and paediatrician referrals).

Number of services per year

Medicare rebates are available for up to twelve allied mental health services in a calendar year. The twelve services may consist of: GP focussed psychological strategies services (items 2721 to 2727); and/or psychological therapy services (items 80000 to 80015); and/or focussed psychological strategies – allied mental health services (items 80100 to 80115; 80125 to 80140; 80150 to 80165 and/or Access to Allied Psychological Services (ATAPS) consultations under the Better Outcomes in Mental Health Care Program. Referrals should be provided, as required, in one or more groups of up to six sessions.

In addition, the referring practitioner may consider that in exceptional circumstances the patient may require an additional six services above those already provided (to a maximum total of 18 individual services per patient per calendar year). Exceptional circumstances are defined as a significant change in the patient's clinical condition or care circumstances which make it appropriate and necessary to increase the maximum number of services. It is up to the referring practitioner to determine that the patient meets these requirements. In these cases a new referral should be provided, and exceptional circumstances noted in that referral. Invoices for services provided under exceptional circumstances must state that exceptional circumstances apply.

Patients will also be eligible to claim up to 12 separate services within a calendar year for group therapy services involving 6-10 patients to which items 80020 (psychological therapy – clinical psychologist), 80120 (focussed psychological strategies – psychologist), 80145 (focussed psychological strategies – occupational therapist) and 80170 (focussed psychological strategies - social worker) apply. These group services are separate from the individual services and do not count towards the 12 service calendar year maximum associated with those items.

Service length and type

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

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

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

Course of treatment and reporting back to the referring medical practitioner

Patients are eligible to receive up to twelve individual services (up to eighteen in exceptional circumstances) and up to twelve group sessions in a calendar year.

Within this maximum service allocation, the clinical psychologist can provide one or more courses of treatment. For the purposes of the allied mental health items, a course of treatment consists of up to six services (but may involve less than six depending on the referral). This enables the referring medical practitioner to consider a report from the clinical psychologist on the services provided to the patient, and the need for further treatment.

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

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

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

Out of pocket expenses and Medicare safety net

Charges in excess of the Medicare benefit for these items are the responsibility of the patient. However, such out-of-pocket costs will count toward the Medicare safety net for that patient. Psychological therapy services and/or focussed psychological strategies – allied mental health services in excess of twelve (12) individual services (apart from where exceptional circumstances apply) and twelve (12) group sessions in a calendar year will not attract a Medicare benefit and the safety net arrangements will not apply to costs incurred by the patient for such services.

Eligible patients

Items 80000 to 80020 (inclusive) apply to people with an assessed mental disorder and where the patient is referred by a GP who is managing the patient under a GP Mental Health Care Plan (item 2710), or under a referred psychiatrist assessment and management plan (item 291); or on referral from an eligible psychiatrist or paediatrician.

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

Checking patient eligibility for psychological therapy services

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

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

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

Publicly funded services

Psychological therapy items 80000 to 80020 do not apply for services that are provided by any other Commonwealth or State funded services or provided to an admitted patient of a hospital. However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or

State/Territory clinic, the items apply for services that are provided by eligible clinical psychologists salaried by, or contracted to, the service as long as all requirements of the items are met, including registration with Medicare Australia. These services must be direct billed (that is, the Medicare rebate is accepted as full payment for services).

Private health insurance

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

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

Referrals

Patients must be referred for psychological therapy services by a GP managing the patient under a GP Mental Health Care Plan (item 2710); or a referred psychiatrist assessment and management plan (item 291); or on referral from a psychiatrist or a paediatrician.

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

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

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

Referral validity

Medicare benefits are available for up to twelve (12) individual (up to 18 services where exceptional circumstances apply) and/or twelve (12) group psychological therapy services and/or focussed psychological strategies services per patient per calendar year. Referrals should be made in one or more groups of up to six sessions. If a patient has not used all of their psychological therapy services and/or focussed psychological strategies services under a referral in a calendar year, it is not necessary to obtain a new referral for the "unused" services. However, any "unused" services received from 1 January in the following year under that referral will count as part of the total of twelve services for which the patient is eligible in that calendar year.

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

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

M.6.4. CLINICAL PSYCHOLOGIST PROFESSIONAL ELIGIBILITY

Eligible clinical psychologists

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

Registering with Medicare Australia

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

Further information

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

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

on 132 150

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

OVERVIEW

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

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

FOCUSED PSYCHOLOGICAL STRATEGIES – ALLIED MENTAL HEALTH SERVICES ATTRACTING MEDICARE REBATES

Eligible focussed psychological strategies services

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

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

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

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

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

- A referral has been made by a GP who is managing the patient under a GP Mental Health Care Plan (item 2710);
- A referral has been made by a GP who is managing the patient under a referred psychiatrist assessment and management plan (item 291); or
- A referral has been made by a psychiatrist or paediatrician from an eligible psychiatric or paediatric service (see Referral Requirements for further details regarding psychiatrist and paediatrician referrals).

Number of services per year

Medicare rebates for up to twelve individual allied mental health services in a calendar year. These twelve services may consist of: GP focussed psychological strategies services (items 2721 to 2727); and/or psychological therapy services (items 80000 to 80015); and/or focussed psychological strategies – allied mental health services (items 80100 to 80115; 80125 to 80140; 80150 to 80165 and/or Access to Allied Psychological Services (ATAPS) consultations under the Better Outcomes in Mental Health Care Program. Referrals should be provided, as required, in one or more groups of up to six sessions.

In addition, the referring practitioner may consider that in exceptional circumstances the patient may require an additional six services above those already provided (to a maximum total of 18 services per patient per calendar year). Exceptional circumstances are defined as a significant change in the patient’s clinical condition or care circumstances which make it appropriate and necessary to increase the maximum number of services. It is up to the referring practitioner to determine that the patient meets these requirements. In these cases a new referral should be provided, and exceptional circumstances noted in that referral. Invoices for services provided under exceptional circumstances must state that exceptional circumstances apply.

Patients will also be eligible to claim up to 12 separate services within a calendar year for group therapy services involving 6-10 patients to which items 80020 (psychological therapy – clinical psychologist), 80120 (focussed psychological strategies – psychologist), 80145 (focussed psychological strategies – occupational therapist) and 80170 (focussed psychological strategies - social worker) apply. These group services are separate from the individual services and do not count towards the 12 service calendar year maximum associated with those items.

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

Service length and type

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

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

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

These are:

- 1. Psycho-education**
(including motivational interviewing)
- 2. Cognitive-behavioural Therapy including:**
 - **Behavioural interventions**
 - Behaviour modification
 - Exposure techniques
 - Activity scheduling
 - **Cognitive interventions**
 - Cognitive therapy
- 3. Relaxation strategies**
 - Progressive muscle relaxation
 - Controlled breathing
- 4. Skills training**
 - Problem solving skills and training
 - Anger management
 - Social skills training
 - Communication training
 - Stress management
 - Parent management training
- 5. Interpersonal Therapy** (especially for depression)

There is flexibility to include narrative therapy for Aboriginal and Torres Strait Islander people.

Course of treatment and reporting back to the referring medical practitioner

Patients are eligible to receive up to twelve individual services (up to eighteen in exceptional circumstances) and up to twelve group sessions in a calendar year.

Within this maximum service allocation, the allied mental health professional can provide one or more courses of treatment. For the purposes of the allied mental health items, a course of treatment consists of up to six services (but may involve less than six depending on the referral). This enables the referring medical practitioner to consider a report from the allied mental health professional on the services provided to the patient, and the need for further treatment.

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

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

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

Out of pocket expenses and Medicare safety net

Charges in excess of the Medicare benefit for these items are the responsibility of the patient. However, such out-of-pocket costs will count toward the Medicare safety net for that patient. Psychological therapy services and/or focussed psychological strategies services in excess of the maximum annual allowance of twelve (12) (apart from where exceptional circumstances apply) and twelve group sessions in a calendar year will not attract a Medicare benefit and the safety net arrangements will not apply to costs incurred by the patient for such services.

Eligible patients

Items 80100 to 80170 (inclusive) apply to people with an assessed mental disorder and where the patient is referred by a GP who is managing the patient under a GP Mental Health Care Plan (item 2710), or under a referred psychiatrist assessment and management plan (item 291); or from an eligible psychiatrist or paediatrician.

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

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

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

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

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

Publicly funded services

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

Private health insurance

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

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

Referrals

Patients must be referred for focussed psychological strategies – allied mental health services by a GP managing the patient under a GP Mental Health Care Plan (item 2710), or a referred psychiatrist assessment and management plan (item 291); or on referral from a psychiatrist or a paediatrician.

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

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

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

Referral validity

Medicare benefits are available for up to twelve (12) individual (up to 18 services where exceptional circumstances apply) and/or twelve (12) group psychological therapy services and/or focussed psychological strategies services per patient per calendar year. Referrals should be made in one or more groups of up to six sessions. If a patient has not used all of their psychological therapy services and/or focussed psychological strategies services under a referral in a calendar year, it is not necessary to obtain a new referral for the "unused" services. However, any "unused" services received from 1 January in the following year under that referral will count as part of the total of twelve services for which the patient is eligible in that calendar year.

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

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

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

ALLIED MENTAL HEALTH PROFESSIONAL ELIGIBILITY

Eligible allied health professionals

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

- A psychologist registered with the Psychologists Registration Board in the State or Territory in which they are practising. (Psychologists whose State/Territory registration includes any limitation, for example, where marked 'provisional registration', are not eligible to register with Medicare Australia to use the FPS item); or
- A full or part-time member of OT AUSTRALIA with a minimum of two years of experience in mental health and an undertaking to abide by The Australian Competency Standards for Occupational Therapists in Mental Health; or
- A member of the Australian Association of Social Workers (AASW), including certification by the AASW as meeting the standards for mental health set out in the AASW's 'Standards for Mental Health Social Workers 1999'.

Registering with Medicare Australia

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

Further information

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

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

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

ELIGIBLE PATIENTS

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

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

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

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

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

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

These notes relate to items 81000-81010. Explanatory notes relating to item 4001 are available at note A.51.

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

Service length and type

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

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

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

Number of services per year

Medicare benefits are available for up to three (3) eligible non-directive pregnancy support counselling services per patient, per pregnancy, provided using items 81000, 81005, 81010 and 4001 (see Explanatory notes A.51). The Medicare benefit payable for an eligible service provided using item 81000, 81005 or 81010 is \$56.20.

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

Out-of-pocket expenses and Medicare Safety Net

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

Publicly funded services

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

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

Private health insurance

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

M.8.3. PREGNANCY SUPPORT COUNSELLING - (ITEMS 81000 TO 81010) - REFERRAL REQUIREMENTS (GPs TO ALLIED HEALTH PROFESSIONALS)

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

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

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

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

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

Referral validity

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

Subsequent Referrals

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

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

Eligible allied health professionals

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

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

To be eligible to provide services using MBS Item 81005, a social worker must be a 'Member' of the Australian Association of Social Workers (AASW), be certified by AASW either as meeting the standards for mental health set out in AASW's 'Standards for Mental Health Social Workers 1999', (as in force on 1 November 2006) or as an Accredited Social Worker, and have completed appropriate non-directive pregnancy counselling training;

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

REGISTERING WITH MEDICARE AUSTRALIA

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

Further information

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

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

M.9.1. ALLIED HEALTH GROUP SERVICES - (ITEMS 81100 TO 81125)

ELIGIBLE PATIENTS

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

Services available under these new items are in addition to the five individual allied health services available to patients each calendar year (refer to items 10950 to 10970 in explanatory note M.3).

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

- a GP Management Plan (GPMP) (item 721); or
- where a patient has an existing GP Management Plan, the GP has reviewed that plan (item 725); or
- for a resident of a residential aged care facility, the GP must have contributed to, or reviewed, a care plan prepared for them by the facility (item 731). [Note: Generally, residents of an aged care facility rely on the facility for assistance to manage their type 2 diabetes. Therefore, the resident may not need to be referred for allied health group services under these items, as the self management approach offered in group services may not be appropriate.]

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

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

It is important to note that:

- before a Medicare rebate can be paid for the allied health assessment item (items 81100, 81110 or 81120) either the patient or the GP must have lodged a claim with Medicare Australia for the relevant GP care planning item and received payment for that claim; and
- before a Medicare rebate can be paid for the allied health group items (81105, 81115 and 81125) either the patient or the allied health professional must have lodged a claim with Medicare Australia for the assessment item and received payment for that claim.

M.9.2. GP REFERRAL REQUIREMENTS

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

When referring patients, GPs need to use the *Referral form for allied health group services under Medicare*, provided by the Commonwealth Department of Health and Ageing. The referral form can be downloaded from the Department of Health and Ageing website at www.health.gov.au/epc or ordered by faxing (02) 6289 7120. The form can be modified to suit practice needs (for example, relevant software packages) as long as the information is substantially retained.

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

M.9.3. ELIGIBLE ALLIED HEALTH PROFESSIONALS

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

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

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

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

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

M.9.4. ASSESSMENT FOR GROUP SERVICES (ITEMS 81100, 81110 AND 81120)

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

The purpose of this service is to undertake an individual assessment of the patient and preparing him/her for an appropriate group services program. It involves taking a comprehensive patient history, identification of individual goals and preparing the patient for the group service. This may also provide an opportunity to identify any patient who is likely to be unsuitable for group services.

Number of services per year

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

If there is any doubt about a patient's eligibility for items 81100, 81110 or 81120, the allied health professional should contact Medicare Australia to confirm whether the appropriate care planning item is in place and/or the number of assessment services already claimed by the patient in the calendar year. Allied health professionals can call Medicare Australia on 132 011 to check this information.

Referral Form

The GP must refer the patient using the *Referral form for allied health group services under Medicare*. The allied health professional undertaking the assessment service will need to complete Part B of this form, and the patient will then need to present this form to the provider/s of group services.

Length of service

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

Rebate

The Medicare rebate for the assessment items is \$61.30.

Reporting Requirements

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

M.9.5. GROUP SERVICES (ITEMS 81105, 81115 AND 81125)

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

Number of services per year

Patients are eligible for up to eight (8) allied health group services in total (81105, 81115 and 81125 inclusive) per calendar year. Each separate group service must be provided to the patient by only one type of allied health professional (i.e. either a diabetes educator, exercise physiologist or dietitian). However, the overall group services program provided for the patient could be comprised of one type of service only (eg 8 diabetes education services) or a combination of services (eg 3 diabetes education services, 3 dietitian services and 2 exercise physiology services). An eligible allied health professional with more than one Medicare provider number (eg 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.

Where a patient receives more than the limit of 8 group services in a calendar year, the additional service/s will not attract a Medicare benefit and the MBS Safety Net arrangements will not apply to costs incurred by the patient for the service/s.

If there is any doubt about a patient's eligibility for group services, the allied health professional should contact Medicare Australia to confirm the number of group services already claimed by the patient in the calendar year. Allied health professionals can call Medicare Australia on 132 011 to check this information.

Multiple Services on the Same Day

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

Referral Form

The allied health professional/s undertaking the group services will need to receive the *Referral form for allied health group services under Medicare*, for which Part B has been completed by the provider who has undertaken the assessment service.

Group Size

The service must be provided to a person who is part of a group of between 2 and 12 persons.

Length of service

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

Rebate

The Medicare rebate for items 81105, 81115 and 81125 is \$15.30 for each patient.

Reporting Requirements

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

M.9.6. ADDITIONAL REQUIREMENTS

Retention of Referral Form for Medicare Australia Audit Purposes

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

Publicly funded services

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

Private Health Insurance

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

Out-of-pocket expenses and Medicare Safety Net

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

M.9.7. FURTHER INFORMATION

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

M.10.1. PROVISION OF PERVASIVE DEVELOPMENTAL DISORDER SERVICES BY ALLIED HEALTH PROFESSIONALS - (ITEMS 82000 TO 82025)

OVERVIEW OF THE PERVASIVE DEVELOPMENTAL DISORDER ITEMS

MBS items (82000 to 82025) are available for allied health professional services for children (aged under 13 years for diagnosis and under 15 years for treatment) with autism or any other pervasive developmental disorder (PDD). These items apply to services provided by eligible psychologists, speech pathologists and occupational therapists, on referral from a consultant psychiatrist or paediatrician. These items cover two specific types of service that allow the relevant allied health professionals to:

- assist the referring practitioner in the diagnosis of the child — aged under 13 years — and/or development of the child’s PDD treatment plan (items 82000, 82005 and 82010); and
- provide treatment to the child — aged under 15 years (and who was aged under 13 years at the time of receiving their PDD treatment plan) for their particular condition, consistent with the treatment plan prepared by the referring practitioner (items 82015, 82020 and 82025).

ASSESSMENT SERVICES ATTRACTING MEDICARE REBATES

Eligible allied health assessment services

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

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

- a referral has been made by a consultant psychiatrist or paediatrician from an eligible psychiatric or paediatric service (see 'REFERRAL REQUIREMENTS' section) who, as part of the referral, requests the allied health professional's assistance in assessing the patient and/or preparing a treatment plan for the patient.

Number of services

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

TREATMENT SERVICES ATTRACTING MEDICARE REBATES

Eligible allied health treatment services

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

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

- a referral has been made by a consultant psychiatrist or paediatrician from an eligible psychiatric or paediatric service (see 'REFERRAL REQUIREMENTS' section) who is managing the child under a PDD treatment plan (item 135 or 289);

Number of services

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

CONDITIONS GOVERNING THE PROVISION AND CLAIMING OF ITEMS

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

Service length and type

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

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

It is also expected that participating allied health providers will deliver treatment under these items that is consistent with the PDD treatment plan prepared by the psychiatrist or paediatrician, and in keeping with commonly established PDD interventions as practised by their profession and appropriate for the age and particular needs of the child being treated.

Course of treatment and reporting back to the referring practitioner

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

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

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

On completion of the course of treatment, the eligible psychologist, speech pathologist and occupational therapist must provide a written report to the referring consultant psychiatrist or paediatrician which includes information on:

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

A written report must also be provided to the referring consultant psychiatrist or paediatrician at the completion of any subsequent course(s) of treatment provided to the child.

Out of pocket expenses and Medicare safety net

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

Eligible patients

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

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

Checking patient eligibility for allied health pervasive developmental disorder services

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

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

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

Publicly funded services

Allied health PDD assessment and treatment items 82000 to 82025 do not apply for services that are provided by any other Commonwealth or State funded services or provided to an admitted patient of a hospital. However, where a direction under subsection 19(2) of the *Health Insurance Act 1973* has been made in regard to an Aboriginal Community Controlled Health Service or State/Territory clinic, the items apply for services that are provided by eligible allied health professionals salaried by, or contracted to, the service as long as all requirements of the items are met, including registration with Medicare Australia. These services must be direct billed (that is, the Medicare rebate is accepted as full payment for services.)

Private health insurance

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

REFERRAL REQUIREMENTS (PSYCHIATRISTS OR PAEDIATRICIANS TO ALLIED HEALTH PROFESSIONALS)

Referrals

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

An eligible allied health professional can provide PDD assessment items (82000-82010) to a child where:

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

An eligible allied health professional can provide PDD treatment items (82015-82025) to a child where:

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

An allied health professional wanting to provide any of the items 82000-82025 must be in receipt of a current referral provided by a consultant physician paediatrician or a consultant physician psychiatrist. With specific regard to the treatment items, a patient must have a previous claim for item 135 or 289.

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

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

Referral validity

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

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

PSYCHOLOGIST, SPEECH PATHOLOGIST AND OCCUPATIONAL THERAPIST PROFESSIONAL ELIGIBILITY

Eligible allied health professionals

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

- A psychologist registered, without limitation, with the Psychologists Registration Board in the State or Territory in which they are practising. (Psychologists whose State/Territory registration includes any limitation, for example, where marked 'provisional registration', are not eligible to register with Medicare Australia to use the items); or
- A speech pathologist (in Queensland) registered with the Speech Pathologist Board of Queensland. In all other States and Territories, participating speech pathologists must be a 'Practising member' of Speech Pathology Australia; or
- An occupational therapist in Queensland, Western Australia, South Australia or the Northern Territory who is registered with the Occupational Therapists Board in the State or Territory in which they are practising. In other States and the Australian Capital Territory, the occupational therapist must be a 'Full-time Member' or 'Part-time Member' of OT AUSTRALIA, the national body of the Australian Association of Occupational Therapists.

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

Registering with Medicare Australia

Advice about registering with Medicare Australia to provide allied health professional services using items 82000-82025 inclusive is available from the Medicare Australia provider inquiry line on 132 150.

Further information

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

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

M.11.. FOLLOW-UP ALLIED HEALTH SERVICES FOR INDIGENOUS AUSTRALIANS WHO HAVE HAD A HEALTH CHECK (ITEMS 81300 TO 81360)

ELIGIBLE PATIENTS

Aboriginal or Torres Strait Islander Australians who have had a health check may be referred by a GP for allied health services under items 81300 to 81360. It is expected that the GP will undertake a health check consistent with the Aboriginal and Torres Strait Islander Medicare health checks (item 704, 706, 708 or 710) and, if a need for follow-up allied health services is identified, will refer the patient to an eligible allied health professional.

These items are similar to the existing allied health items (items 10950 to 10970) available to patients who have an Enhanced Primary Care (EPC) plan prepared by their GP. However items 81300 to 81360 provide an alternative referral pathway for Aboriginal or Torres Strait Islander people to access allied health services.

A new practice nurse/Aboriginal health worker item (10987) has also been introduced for Indigenous Australians who have received a health check. This item enables Aboriginal or Torres Strait Islander people to receive follow-up services from a practice nurse or registered Aboriginal health worker on behalf of a GP. More detail on this item is provided at explanatory note M2 of the Medicare Benefits Schedule.

ELIGIBLE ALLIED HEALTH SERVICES

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

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

Publicly funded services

Items 81300 to 81360 do not apply for services that are provided by any Commonwealth or State or Territory Government funded services or provided to an admitted patient of a hospital.

However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or State/Territory health clinic, items 81300 to 81360 can be claimed for services provided by eligible allied health professionals salaried by, or contracted to, the Service or health clinic. All requirements of the relevant item must be met, including registration of the allied health professional with Medicare Australia.

Medicare services provided under a subsection 19(2) exemption must be bulk billed.

Number of services per year

Medicare benefits are available for up to five (5) allied health services per eligible patient, per calendar year. The five allied health services can be made up of one type of service (eg five physiotherapy services) or a combination of different types of services (eg: one dietetic, two podiatry and two physiotherapy services).

The annual limit of five (5) allied health services per patient under items 81300 to 81360 is in addition to:

- allied health services for patients with an EPC plan on referral from a GP under items 10950 to 10970

Checking patient eligibility for items 81300 to 81360

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

Service length and type

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

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

Private health insurance

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

Reporting back to the GP

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

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

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

Out-of-pocket expenses and Medicare safety net

Allied health professionals are free to determine their own fees for the professional service, except where the service is provided under a subsection 19(2) exemption. Charges in excess of the Medicare benefit for the allied health items are the responsibility of the patient. However, such out-of-pocket costs will count toward the Medicare safety net for that patient. Allied health services in excess of five (5) in a calendar year will not attract a Medicare benefit and the safety net arrangements will not apply to costs incurred by the patient for such services.

REFERRAL REQUIREMENTS

Referral form

For Medicare benefits to be payable, the patient must be referred to an eligible allied health professional by their GP using a *Referral form for follow-up allied health services under Medicare for Indigenous Australians who have had a health check*.

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

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

Allied health professionals are required to retain the referral form for 24 months from the date the service was rendered (for Medicare Australia auditing purposes). A copy of the referral form is **not** required to accompany Medicare claims.

The referral form may be downloaded from the Department of Health and Ageing website at www.health.gov.au/epc or ordered by faxing (02) 6289 7120 or calling (02) 6289 4297. GPs may modify the referral form to suit their practice needs (for example, relevant software packages) as long as the information contained therein is substantially retained.

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 (5) rebates for allied health services available to the patient during that calendar year.

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

ALLIED HEALTH PROFESSIONAL ELIGIBILITY

Items 81300 to 81360 can only be claimed for services provided by eligible allied health professionals who are registered with Medicare Australia.

Allied health professionals already registered with Medicare (eg: for items 10950 to 10970) do not need to register again to claim these items.

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

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

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

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

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

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

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

Mental Health Workers

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

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

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

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

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

To be eligible to provide mental health services for the purposes of this item, a **social worker** must be a 'Member' of the Australian Association of Social Workers (AASW); and be certified by AASW as meeting the standards for mental health set out in AASW's 'Standards for Mental Health Social Workers 1999' as in force on 1 November 2006.

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

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

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

Podiatrists in all States and the Australian Capital Territory must be registered, without any limitations, with the Podiatrists Registration Board in the State or Territory in which they are practising. If practising in the Northern Territory, podiatrists must be registered with the Podiatrists Registration Board in any other State or the Australian Capital Territory, or be a 'Full Member' of the Australian Podiatry Association (ApodA) in any other State or the Australian Capital Territory.

Psychologists must be registered, without any limitation, with the Psychologists Registration Board in the State or Territory in which they are practising.

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

Registering with Medicare Australia

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

FURTHER INFORMATION

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

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

- (c). Free treatment for public patients in public hospitals.
- (d). The payment of 'benefits', or rebates, for professional services listed in the Medicare Benefits Schedule (MBS). In general, the Medicare benefit is 85% of the Schedule fee, otherwise the benefits are
 - i. 100% of the Schedule fee for services provided by a general practitioner to non-referred, non-admitted patients;
 - ii. 100% of the Schedule fee for services provided on behalf of a general practitioner by a practice nurse or registered Aboriginal Health Worker;
 - iii. 75% of the Schedule fee for professional services rendered to a patient as part of an episode of hospital treatment (other than public patients);
 - iv. 75% of the Schedule fee for professional services rendered as part of a privately insured episode of hospital-substitute treatment.

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

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

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

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

GROUP M3 - ALLIED HEALTH SERVICES

ABORIGINAL HEALTH WORKER SERVICE

Aboriginal or Torres Strait Islander health service provided to a person by an eligible Aboriginal health worker if:

- (a) the service is provided to a person who has a chronic condition and complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under an EPC plan; and
- (b) the service is recommended in the person's EPC plan as part of the management of the person's chronic condition and complex care needs; and
- (c) the person is referred to the eligible Aboriginal health worker by the medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with 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 gives a written report to the referring medical practitioner mentioned in paragraph (c):
 - (i) if the service is the only service under the referral - in relation to that service; or
 - (ii) if the service is the first or the last service under the referral - in relation to that service; or
 - (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and
- (h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of 5 services (including any services to which items 10950 to 10970 apply) in a calendar year

+
10950 **Fee:** \$57.55 **Benefit:** 85% = \$48.95

DIABETES EDUCATION SERVICE

Diabetes education health service provided to a person by an eligible diabetes educator if:

- (a) the service is provided to a person who has a chronic condition and complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under an EPC plan; and
- (b) the service is recommended in the person's EPC plan as part of the management of the person's chronic 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 substantially complies with 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 that service; or
 - (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and
- (h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of 5 services (including any services to which items 10950 to 10970 apply) in a calendar year

+
10951 **Fee:** \$57.55 **Benefit:** 85% = \$48.95

MENTAL HEALTH SERVICE

Mental health service provided to a person by an eligible mental health worker if:

- (a) the service is provided to a person who has a chronic condition and complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under an EPC plan; and
- (b) the service is recommended in the person's EPC plan as part of the management of the person's chronic 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 substantially complies with 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 that service; or
 - (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and
- (h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of 5 services (including any services to which items 10950 to 10970 apply) in a calendar year

+ (See para M3.1 of explanatory notes to this Category)

10956 **Fee:** \$57.55 **Benefit:** 85% = \$48.95

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 a chronic condition and complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under an EPC plan; and
- (b) the service is recommended in the person's EPC plan as part of the management of the person's chronic 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 substantially complies with 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 that service; or
 - (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and
- (h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of 5 services (including any services to which items 10950 to 10970 apply) in a calendar year

+ (See para M3.1 of explanatory notes to this Category)

10958 **Fee:** \$57.55 **Benefit:** 85% = \$48.95

PHYSIOTHERAPY

Physiotherapy health service provided to a person by an eligible physiotherapist if:

- (a) the service is provided to a person who has a chronic condition and complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under an EPC plan; and
- (b) the service is recommended in the person's EPC plan as part of the management of the person's chronic 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 substantially complies with 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 that service; or
 - (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and
- (h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of 5 services (including any services to which items 10950 to 10970 apply) in a calendar year

+ (See para M3.1 of explanatory notes to this Category)

10960 **Fee:** \$57.55 **Benefit:** 85% = \$48.95

<p>+ 10962</p>	<p>PODIATRY Podiatry health service provided to a person by an eligible podiatrist if:</p> <ul style="list-style-type: none"> (a) the service is provided to a person who has a chronic condition and complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under an EPC plan; and (b) the service is recommended in the person's EPC plan as part of the management of the person's chronic 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 substantially complies with the form issued by the Department; and (d) the person is not an admitted patient of a hospital; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible podiatrist gives a written report to the referring medical practitioner mentioned in paragraph (c): <ul style="list-style-type: none"> (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and (h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of 5 services (including any services to which items 10950 to 10970 apply) in a calendar year <p><i>(See para M3.1 of explanatory notes to this Category)</i> Fee: \$57.55 Benefit: 85% = \$48.95</p>
<p>+ 10964</p>	<p>CHIROPRACTIC SERVICE Chiropractic health service provided to a person by an eligible chiropractor if:</p> <ul style="list-style-type: none"> (a) the service is provided to a person who has a chronic condition and complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under an EPC plan; and (b) the service is recommended in the person's EPC plan as part of the management of the person's chronic 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 substantially complies with the form issued by the Department; and (d) the person is not an admitted patient of a hospital; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible chiropractor gives a written report to the referring medical practitioner mentioned in paragraph (c): <ul style="list-style-type: none"> (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and (h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of 5 services (including any services to which items 10950 to 10970 apply) in a calendar year <p><i>(See para M3.1 of explanatory notes to this Category)</i> Fee: \$57.55 Benefit: 85% = \$48.95</p>
<p>+ 10966</p>	<p>OSTEOPATHY Osteopathy health service provided to a person by an eligible osteopath if:</p> <ul style="list-style-type: none"> (a) the service is provided to a person who has a chronic condition and complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under an EPC plan; and (b) the service is recommended in the person's EPC plan as part of the management of the person's chronic 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 substantially complies with the form issued by the Department; and (d) the person is not an admitted patient of a hospital; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible osteopath gives a written report to the referring medical practitioner mentioned in paragraph (c): <ul style="list-style-type: none"> (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and (h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of 5 services (including any services to which items 10950 to 10970 apply) in a calendar year <p><i>(See para M3.1 of explanatory notes to this Category)</i> Fee: \$57.55 Benefit: 85% = \$48.95</p>

	<p>PSYCHOLOGY</p> <p>Psychology health service provided to a person by an eligible psychologist if:</p> <ul style="list-style-type: none"> (a) the service is provided to a person who has a chronic condition and complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under an EPC plan; and (b) the service is recommended in the person's EPC plan as part of the management of the person's chronic 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 substantially complies with the form issued by the Department; and (d) the person is not an admitted patient of a hospital; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible psychologist gives a written report to the referring medical practitioner mentioned in paragraph (c): <ul style="list-style-type: none"> (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and (h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of 5 services (including any services to which items 10950 to 10970 apply) in a calendar year <p>(See para M3.1 of explanatory notes to this Category)</p> <p>+ 10968 Fee: \$57.55 Benefit: 85% = \$48.95</p>
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	<p>SPEECH PATHOLOGY</p> <p>Speech pathology health service provided to a person by an eligible speech pathologist if:</p> <ul style="list-style-type: none"> (a) the service is provided to a person who has a chronic condition and complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under an EPC plan; and (b) the service is recommended in the person's EPC plan as part of the management of the person's chronic 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 substantially complies with 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): <ul style="list-style-type: none"> (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and (h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of 5 services (including any services to which items 10950 to 10970 apply) in a calendar year <p>(See para M3.1 of explanatory notes to this Category)</p> <p>+ 10970 Fee: \$57.55 Benefit: 85% = \$48.95</p>
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GROUP M5 - ABORIGINAL HEALTH WORKER	
† 10987	<p>Follow up service provided by a practice nurse or registered Aboriginal health worker, on behalf of a GP, for an Indigenous person who has received a health check if:</p> <p>a) The service is provided on behalf of and under the supervision of a medical practitioner; and</p> <p>b) the person is not an admitted patient of a hospital; and</p> <p>c) the service is consistent with the needs identified through the health check; - to a maximum of 5 services per patient in a calendar year</p> <p><i>(See para M5.1 of explanatory notes to this Category)</i></p> <p>Fee: \$22.20 Benefit: 100% = \$22.20</p>
10988	<p>Immunisation provided to a person by a registered Aboriginal Health Worker if:</p> <p>(a) the immunisation is provided on behalf of, and under the supervision of, a medical practitioner; and</p> <p>(b) the person is not an admitted patient of a hospital.</p> <p><i>(See para M5.2 of explanatory notes to this Category)</i></p> <p>Fee: \$11.10 Benefit: 100% = \$11.10</p>
10989	<p>Treatment of a person's wound (other than normal aftercare) provided by a registered Aboriginal Health Worker if:</p> <p>(a) the treatment is provided on behalf of, and under the supervision of, a medical practitioner; and</p> <p>(b) the person is not an admitted patient of a hospital.</p> <p><i>(See para M5.2 of explanatory notes to this Category)</i></p> <p>Fee: \$11.10 Benefit: 100% = \$11.10</p>

A medical service to which item 1, 97, 601, 697, 5003, 5007, 5010, 5023, 5026, 5028, 5043, 5046, 5049, 5063, 5064, 5067, 5220, 5223, 5227, 5228, 5240, 5243, 5247, 5248, 5260, 5263, 5265 or 5267 applies if:

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

(See para M1.1 of explanatory notes to this Category)

10992

Fee: \$9.80

Benefit: 85% = \$8.35

GROUP M2 - SERVICES PROVIDED BY A PRACTICE NURSE ON BEHALF OF A MEDICAL PRACTITIONER	
10993	<p>Immunisation provided to a person by a practice nurse if:</p> <p>(a) the immunisation is provided on behalf of, and under the supervision of, a medical practitioner; and</p> <p>(b) the person is not an admitted patient of a hospital.</p> <p><i>(See para M2.1 of explanatory notes to this Category)</i></p> <p>Fee: \$11.10 Benefit: 100% = \$11.10</p>
10994	<p>Services provided by a practice nurse, being the taking of a cervical smear and preventive checks, if:</p> <p>(a) the service is provided on behalf of, and under the supervision of, a medical practitioner; and</p> <p>(b) the person is not an admitted patient of a hospital.</p> <p>This item cannot be claimed with items 2497-2509, 2598-2616, 10995, 10998 or 10999.</p> <p><i>(See para M2.1 of explanatory notes to this Category)</i></p> <p>Fee: \$22.20 Benefit: 100% = \$22.20</p>
10995	<p>Service provided by a practice nurse, being the taking of a cervical smear from a woman between the ages of 20 and 69 inclusive, who has not had a cervical smear in the last 4 years, and preventive checks if:</p> <p>(a) the service is provided on behalf of, and under the supervision of, a medical practitioner; and</p> <p>(b) the person is not an admitted patient of a hospital.</p> <p>This item cannot be claimed with items 2497-2509, 2598-2616, 10994, 10998 or 10999.</p> <p><i>(See para M2.1 of explanatory notes to this Category)</i></p> <p>Fee: \$22.20 Benefit: 100% = \$22.20</p>
10996	<p>Treatment of a person's wound (other than normal aftercare) provided by a practice nurse if:</p> <p>(a) the treatment is provided on behalf of, and under the supervision of, a medical practitioner; and</p> <p>(b) the person is not an admitted patient of a hospital.</p> <p><i>(See para M2.1 of explanatory notes to this Category)</i></p> <p>Fee: \$11.10 Benefit: 100% = \$11.10</p>
10997	<p>Service provided to a person with a chronic disease by a practice nurse or registered Aboriginal Health Worker if:</p> <p>(a) the service is provided on behalf of and under the supervision of a medical practitioner; and</p> <p>(b) the person is not an admitted patient of a hospital; and</p> <p>(c) the person has a GP Management Plan, Team Care Arrangements or Multidisciplinary Care Plan in place; and</p> <p>(d) the service is consistent with the GP Management Plan, Team Care Arrangements or Multidisciplinary Care Plan</p> <p>to a maximum of 5 services per patient in a calendar year</p> <p><i>(See para M2.1 of explanatory notes to this Category)</i></p> <p>Fee: \$11.10 Benefit: 100% = \$11.10</p>
10998	<p>Service provided by a practice nurse, being the taking of a cervical smear from a person, if:</p> <p>(a) the service is provided on behalf of, and under the supervision of, a medical practitioner; and</p> <p>(b) the person is not an admitted patient of a hospital.</p> <p>This item cannot be claimed with items 2497-2509, 2598-2616, 10994, 10995 or 10999.</p> <p><i>(See para M2.1 of explanatory notes to this Category)</i></p> <p>Fee: \$11.10 Benefit: 100% = \$11.10</p>
10999	<p>Service provided by a practice nurse, being the taking of a cervical smear from a woman between the ages of 20 and 69 inclusive, who has not had a cervical smear in the last 4 years, if:</p> <p>(a) the service is provided on behalf of, and under the supervision of, a medical practitioner; and</p> <p>(b) the person is not an admitted patient of a hospital.</p> <p>This item cannot be claimed with items 2497-2509 and 2598-2616, 10994, 10995 or 10998.</p> <p><i>(See para M2.1 of explanatory notes to this Category)</i></p> <p>Fee: \$11.10 Benefit: 100% = \$11.10</p>

GROUP M7 - FOCUSED PSYCHOLOGICAL STRATEGIES (ALLIED MENTAL HEALTH)	
80100	<p>Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a psychologist registered with Medicare Australia as meeting the credentialing requirements for provision of this service - lasting more than 20 minutes, but not more than 50 minutes - where the patient is referred by a medical practitioner, as part of a GP Mental Health Care Plan; or a psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics.</p> <p>These services are time limited, being deliverable, in general, in up to 12 planned sessions in a calendar year (including services to which items 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 and the Better Outcomes in Mental Health Care Program Access To Allied Psychological Services apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply.</p> <p>(Professional attendance at consulting rooms) (See para M7.1 of explanatory notes to this Category)</p> <p>Fee: \$65.30 Benefit: 85% = \$55.55</p>
80105	<p>Professional attendance at a place other than consulting rooms.</p> <p>As per the psychologist service requirements outlined for item 80100. (See para M7.1 of explanatory notes to this Category)</p> <p>Fee: \$88.80 Benefit: 85% = \$75.50</p>
80110	<p>Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a psychologist registered with Medicare Australia as meeting the credentialing requirements for provision of this service - lasting more than 50 minutes - where the patient is referred by a medical practitioner, as part of a GP Mental Health Care Plan; or a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics.</p> <p>These services are time limited, being deliverable, in general, in up to 12 planned sessions in a calendar year (including services to which items 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 and the Better Outcomes in Mental Health Care Program Access To Allied Psychological Services apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply.</p> <p>(Professional attendance at consulting rooms) (See para M7.1 of explanatory notes to this Category)</p> <p>Fee: \$92.20 Benefit: 85% = \$78.40</p>
80115	<p>Professional attendance at a place other than consulting rooms.</p> <p>As per the psychologist service requirements outlined for item 80110. (See para M7.1 of explanatory notes to this Category)</p> <p>Fee: \$115.75 Benefit: 85% = \$98.40</p>
+ 80120	<p>Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a psychologist registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting for at least 60 minutes duration where the patients are referred by a medical practitioner, as part of a GP Mental Health Care Plan; or a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics.</p> <p>These therapies are time limited, being deliverable, in general, in up to 12 planned sessions in a calendar year (including services to which items 80020, 80145 and 80170 apply).</p> <p>GROUP THERAPY with a group of 6 to 10 patients, EACH PATIENT (See para M7.1 of explanatory notes to this Category)</p> <p>Fee: \$23.50 Benefit: 85% = \$20.00</p>

GROUP M9 - ALLIED HEALTH GROUP SERVICES

DIABETES EDUCATION SERVICE – 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 725], 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 substantially complies with 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) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit.

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

(See para M9.1 of explanatory notes to this Category)

81100 **Fee:** \$73.75 **Benefit:** 85% = \$62.70

DIABETES EDUCATION SERVICE – 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; 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) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit;

- to a maximum of eight (8) GROUP SERVICES (including services to which items 81105, 81115 and 81125 apply) in a calendar year.

(See para M9.1 of explanatory notes to this Category)

81105 **Fee:** \$18.40 **Benefit:** 85% = \$15.65

EXERCISE PHYSIOLOGY SERVICE – ASSESSMENT FOR GROUP SERVICES

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

- (a) the service is provided to a person who has type 2 diabetes; and
- (b) the person is being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under a GP Management Plan [ie item 721 or 725], 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 substantially complies with the form issued by the Department; and
- (d) the person is not an admitted patient of a hospital; and
- (e) the service is provided to the person individually and in person; and
- (f) the service is of at least 45 minutes duration; and
- (g) after the service, the eligible exercise physiologist gives a written report to the referring medical practitioner mentioned in paragraph (c); and
- (h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit.

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

(See para M9.1 of explanatory notes to this Category)

81110

Fee: \$73.75**Benefit:** 85% = \$62.70**EXERCISE PHYSIOLOGY SERVICE – GROUP SERVICE**

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

- (a) the person has been assessed as suitable for a type 2 diabetes group service under assessment item 8100, 81110 or 81120; and
- (b) the service is provided to a person who is part of a group of between 2 and 12 patients; and
- (c) the person is not an admitted patient of a hospital; and
- (d) the service is provided to a person involving the personal attendance by an eligible exercise physiologist; and
- (e) the service is of at least 60 minutes duration; and
- (f) after the last service in the group services program provided to the person under items 81105, 81115 or 81125, the eligible exercise physiologist prepares, or contribute to, a written report to be provided to the referring medical practitioner; and
- (g) an attendance record for the group is maintained by the eligible exercise physiologist; and
- (h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit;

- to a maximum of eight (8) GROUP SERVICES (including services to which items 81105, 81115 and 81125 apply) in a calendar year.

(See para M9.1 of explanatory notes to this Category)

81115

Fee: \$18.40**Benefit:** 85% = \$15.65

DIETETICS SERVICE – ASSESSMENT FOR GROUP SERVICES

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

- (a) the service is provided to a person who has type 2 diabetes; and
- (b) the person is being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under a GP Management Plan [ie item 721 or 725], 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 substantially complies with the form issued by the Department; and
- (d) the person is not an admitted patient of a hospital; and
- (e) the service is provided to the person individually and in person; and
- (f) the service is of at least 45 minutes duration; and
- (g) after the service, the eligible dietitian gives a written report to the referring medical practitioner mentioned in paragraph (c); and
- (h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit.

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

(See para M9.1 of explanatory notes to this Category)

81120 **Fee:** \$73.75 **Benefit:** 85% = \$62.70

DIETETICS SERVICE – GROUP SERVICE

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

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

- to a maximum of eight (8) GROUP SERVICES (including services to which items 81105, 81115 and 81125 apply) in a calendar year.

(See para M9.1 of explanatory notes to this Category)

81125 **Fee:** \$18.40 **Benefit:** 85% = \$15.65

	<p>GROUP M11 - ALLIED HEALTH SERVICES FOR INDIGENOUS AUSTRALIANS WHO HAVE HAD A HEALTH CHECK</p>
<p>† 81300</p>	<p>ABORIGINAL OR TORRES STRAIT ISLANDER HEALTH SERVICE provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible Aboriginal health worker if:</p> <ul style="list-style-type: none"> (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; and (b) the person is referred to the eligible Aboriginal health worker by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible Aboriginal health worker gives a written report to the referring medical practitioner mentioned in paragraph (b): <ul style="list-style-type: none"> (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters <p>- to a maximum of 5 services (including services to which items 81300 to 81360 inclusive apply) in a calendar year (See para M11 of explanatory notes to this Category) Fee: \$57.55 Benefit: 85% = \$48.95</p>
<p>† 81305</p>	<p>DIABETES EDUCATION HEALTH SERVICE provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible diabetes educator if:</p> <ul style="list-style-type: none"> (a) a medical practitioner has identified a need for follow-up allied health services; and (b) the person is referred to the eligible diabetes educator by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible diabetes educator gives a written report to the referring medical practitioner mentioned in paragraph (b): <ul style="list-style-type: none"> (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters; <p>- to a maximum of 5 services (including services to which items 81300 to 81360 inclusive apply) in a calendar year (See para M11 of explanatory notes to this Category) Fee: \$57.55 Benefit: 85% = \$48.95</p>
<p>† 81310</p>	<p>AUDIOLOGY HEALTH SERVICE provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible audiologist if:</p> <ul style="list-style-type: none"> (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; and (b) the person is referred to the eligible audiologist by the medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible audiologist gives a written report to the referring medical practitioner mentioned in paragraph (b): <ul style="list-style-type: none"> (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters; <p>- to a maximum of 5 services (including services to which items 81300 to 81360 inclusive apply) in a calendar year (See para M11 of explanatory notes to this Category) Fee: \$57.55 Benefit: 85% = \$48.95</p>

† 81315	<p>EXERCISE PHYSIOLOGY HEALTH SERVICE provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible exercise physiologist if:</p> <ul style="list-style-type: none"> (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; and (b) the person is referred to the eligible exercise physiologist by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible exercise physiologist gives a written report to the referring medical practitioner mentioned in paragraph (b): <ul style="list-style-type: none"> (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters; <p>- to a maximum of 5 services (including services to which items 81300 to 81360 inclusive apply) in a calendar year (See para M11 of explanatory notes to this Category) Fee: \$57.55 Benefit: 85% = \$48.95</p>
† 81320	<p>DIETETICS HEALTH SERVICE provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible dietitian if:</p> <ul style="list-style-type: none"> (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; and (b) the person is referred to the eligible dietitian by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible dietitian gives a written report to the referring medical practitioner mentioned in paragraph (b): <ul style="list-style-type: none"> (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters <p>- to a maximum of 5 services (including services to which items 81300 to 81360 inclusive apply) in a calendar year (See para M11 of explanatory notes to this Category) Fee: \$57.55 Benefit: 85% = \$48.95</p>
† 81325	<p>MENTAL HEALTH SERVICE provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible mental health worker if:</p> <ul style="list-style-type: none"> (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; and (b) the person is referred to the eligible mental health worker by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible mental health worker gives a written report to the referring medical practitioner mentioned in paragraph (b): <ul style="list-style-type: none"> (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters <p>- to a maximum of 5 services (including services to which items 81300 to 81360 inclusive apply) in a calendar year (See para M11 of explanatory notes to this Category) Fee: \$57.55 Benefit: 85% = \$48.95</p>

† 81330	<p>OCCUPATIONAL THERAPY HEALTH SERVICE provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible occupational therapist if</p> <ul style="list-style-type: none"> (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; and (b) the person is referred to the eligible occupational therapist by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible occupational therapist gives a written report to the referring medical practitioner mentioned in paragraph (b): <ul style="list-style-type: none"> (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters <p>- to a maximum of 5 services (including services to which items 81300 to 81360 inclusive apply) in a calendar year (See para M11 of explanatory notes to this Category)</p> <p>Fee: \$57.55 Benefit: 85% = \$48.95</p>
† 81335	<p>PHYSIOTHERAPY HEALTH SERVICE provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible physiotherapist if:</p> <ul style="list-style-type: none"> (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; and (b) the person is referred to the eligible physiotherapist by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible physiotherapist gives a written report to the referring medical practitioner mentioned in paragraph (b): <ul style="list-style-type: none"> (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters <p>- to a maximum of 5 services (including services to which items 81300 to 81360 inclusive apply) in a calendar year (See para M11 of explanatory notes to this Category)</p> <p>Fee: \$57.55 Benefit: 85% = \$48.95</p>
† 81340	<p>PODIATRY HEALTH SERVICE provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible podiatrist if:</p> <ul style="list-style-type: none"> (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; and (b) the person is referred to the eligible podiatrist by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible podiatrist gives a written report to the referring medical practitioner mentioned in paragraph (b): <ul style="list-style-type: none"> (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters <p>- to a maximum of 5 services (including services to which items 81300 to 81360 inclusive apply) in a calendar year (See para M11 of explanatory notes to this Category)</p> <p>Fee: \$57.55 Benefit: 85% = \$48.95</p>

† 81345	<p>CHIROPRACTIC HEALTH SERVICE provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible chiropractor if:</p> <ul style="list-style-type: none"> (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; and (b) the person is referred to the eligible chiropractor by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible chiropractor gives a written report to the referring medical practitioner mentioned in paragraph (b): <ul style="list-style-type: none"> (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters <p>- to a maximum of 5 services (including services to which items 81300 to 81360 inclusive apply) in a calendar year (See para M11 of explanatory notes to this Category)</p> <p>Fee: \$57.55 Benefit: 85% = \$48.95</p>
† 81350	<p>OSTEOPATHY HEALTH SERVICE provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible osteopath if:</p> <ul style="list-style-type: none"> (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; and (b) the person is referred to the eligible osteopath by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible osteopath gives a written report to the referring medical practitioner mentioned in paragraph (b): <ul style="list-style-type: none"> (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters <p>- to a maximum of 5 services (including services to which items 81300 to 81360 inclusive apply) in a calendar year (See para M11 of explanatory notes to this Category)</p> <p>Fee: \$57.55 Benefit: 85% = \$48.95</p>
† 81355	<p>PSYCHOLOGY HEALTH SERVICE provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible psychologist if:</p> <ul style="list-style-type: none"> (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; and (b) the person is referred to the eligible psychologist by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible psychologist gives a written report to the referring medical practitioner mentioned in paragraph (b): <ul style="list-style-type: none"> (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters <p>- to a maximum of 5 services (including services to which items 81300 to 81360 inclusive apply) in a calendar year (See para M11 of explanatory notes to this Category)</p> <p>Fee: \$57.55 Benefit: 85% = \$48.95</p>

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

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

- to a maximum of 5 services (including services to which items 81300 to 81360 inclusive apply) in a calendar year

(See para M11 of explanatory notes to this Category)

†
81360

Fee: \$57.55

Benefit: 85% = \$48.95

GROUP M10 - PERVASIVE DEVELOPMENTAL DISORDER SERVICES	
82000	<p>PSYCHOLOGY Psychology health service provided to a child, aged under 13 years, by an eligible psychologist where:</p> <p>(a) the child is referred by an eligible practitioner for the purpose of assisting the practitioner with their diagnosis of the child; or (b) the child is referred by an eligible practitioner for the purpose of contributing to the child’s pervasive developmental disorder (PDD) treatment plan, developed by the practitioner; and (c) the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; and (d) the psychologist attending the child is registered with Medicare Australia as meeting the credentialing requirements for provision of these services; and (e) the child is not an admitted patient of a hospital; and (f) the service is provided to the child individually and in person; and (g) the service lasts at least 50 minutes in duration.</p> <p>These items are limited to a maximum of four services per patient, consisting of any combination of the following items — 82000, 82005 and 82010 (See para M10.1 of explanatory notes to this Category)</p> <p>Fee: \$92.20 Benefit: 85% = \$78.40</p>
82005	<p>SPEECH PATHOLOGY Speech pathology health service provided to a child, aged under 13 years, by an eligible speech pathologist where:</p> <p>(a) the child is referred by an eligible practitioner for the purpose of assisting the practitioner with their diagnosis of the child; or (b) the child is referred by an eligible practitioner for the purpose of contributing to the child’s pervasive developmental disorder (PDD) treatment plan, developed by the practitioner; and (c) the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; and (d) the speech pathologist attending the child is registered with Medicare Australia as meeting the credentialing requirements for provision of these services; and (e) the child is not an admitted patient of a hospital; and (f) the service is provided to the child individually and in person; and (g) the service lasts at least 50 minutes in duration.</p> <p>These items are limited to a maximum of four services per patient, consisting of any combination of the following items — 82000, 82005 and 82010 (See para M10.1 of explanatory notes to this Category)</p> <p>Fee: \$81.25 Benefit: 85% = \$69.10</p>
82010	<p>OCCUPATIONAL THERAPY Occupational therapy health service provided to a child, aged under 13 years, by an eligible occupational therapist where:</p> <p>(a) the child is referred by an eligible practitioner for the purpose of assisting the practitioner with their diagnosis of the child; or (b) the child is referred by an eligible practitioner for the purpose of contributing to the child’s pervasive developmental disorder (PDD) treatment plan, developed by the practitioner; and (c) the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; and (d) the occupational therapist attending the child is registered with Medicare Australia as meeting the credentialing requirements for provision of these services; and (e) the child is not an admitted patient of a hospital; and (f) the service is provided to the child individually and in person; and (g) the service lasts at least 50 minutes in duration.</p> <p>These items are limited to a maximum of four services per patient, consisting of any combination of the following items — 82000, 82005 and 82010 (See para M10.1 of explanatory notes to this Category)</p> <p>Fee: \$81.25 Benefit: 85% = \$69.10</p>

82015	<p>PSYCHOLOGY Psychology health service provided to a child, aged under 15 years, for treatment of a pervasive developmental disorder (PDD) by an eligible psychologist where:</p> <ul style="list-style-type: none"> (a) the child has been diagnosed with PDD; and (b) the child has received a PDD treatment plan (while aged under 13 years) as prepared by an eligible practitioner; and (c) the child has been referred by an eligible practitioner for the provision of services that are consistent with the PDD treatment plan; and (d) the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; and (e) the psychologist attending the child is registered with Medicare Australia as meeting the credentialing requirements for provision of these services; and (f) the child is not an admitted patient of a hospital; and (g) the service is provided to the child individually and in person; and (h) the service lasts at least 30 minutes in duration. <p>These items are limited to a maximum of 20 services per patient, consisting of any combination of items — 82015, 82020 and 82025 (See para M10.1 of explanatory notes to this Category)</p> <p>Fee: \$92.20 Benefit: 85% = \$78.40</p>
82020	<p>SPEECH PATHOLOGY Speech pathology health service provided to a child, aged under 15 years, for treatment of a pervasive developmental disorder (PDD) by an eligible speech pathologist where:</p> <ul style="list-style-type: none"> (a) the child has been diagnosed with PDD; and (b) the child has received a PDD treatment plan (while aged under 13 years) as prepared by an eligible practitioner; and (c) the child has been referred by an eligible practitioner for the provision of services that are consistent with the PDD treatment plan; and (d) the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; and (e) the speech pathologist attending the child is registered with Medicare Australia as meeting the credentialing requirements for provision of these services; and (f) the child is not an admitted patient of a hospital; and (g) the service is provided to the child individually and in person; and (h) the service lasts at least 30 minutes in duration. <p>These items are limited to a maximum of 20 services per patient, consisting of any combination of items — 82015, 82020 and 82025 (See para M10.1 of explanatory notes to this Category)</p> <p>Fee: \$81.25 Benefit: 85% = \$69.10</p>
82025	<p>OCCUPATIONAL THERAPY Occupational therapy health service provided to a child, aged under 15 years, for treatment of a pervasive developmental disorder (PDD) by an eligible occupational therapist where:</p> <ul style="list-style-type: none"> (a) the child has been diagnosed with PDD; and (b) the child has received a PDD treatment plan (while aged under 13 years) as prepared by an eligible practitioner; and (c) the child has been referred by an eligible practitioner for the provision of services that are consistent with the PDD treatment plan; and (d) the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; and (e) the occupational therapist attending the child is registered with Medicare Australia as meeting the credentialing requirements for provision of these services; and (f) the child is not an admitted patient of a hospital; and (g) the service is provided to the child individually and in person; and (h) the service lasts at least 30 minutes in duration. <p>These items are limited to a maximum of 20 services per patient, consisting of any combination of items — 82015, 82020 and 82025 (See para M10.1 of explanatory notes to this Category)</p> <p>Fee: \$81.25 Benefit: 85% = \$69.10</p>