Guideline for substantiating Medicare Benefits schedule requirements for a patient with Type 2 Diabetes

What you need to know

This guideline is for Allied Health Professionals, particularly diabetes educators, exercise physiologists or dietitians. It relates to Medicare Benefits Schedule (MBS) items 81100 to 81125 and may assist you substantiating that the requirements for an assessment service or group allied health service for a patient with type 2 diabetes have been met.

The guideline is not exhaustive, and you can respond to a Medicare compliance audit or review using any documents you think substantiate the concern raised.

However, we may determine more information is needed and request additional documentation to substantiate services you have claimed.

Read the health professional guidelines about substantiating claims for Medicare compliance purposes before proceeding.

Documents you may use to substantiate a claim

Any document you give us should have been created during or as soon as practicable after the treatment occurred. It should include the patient's name and the date the treatment was provided.

To substantiate that a valid allied health service was provided under MBS items 81100 to 81125 you may provide:

- **a copy or excerpt of a referral form from a medical practitioner** - that has been issued by the Department of Health, Disability and Ageing, or a referral form that contains all the components of that form. The form must include the patient details, the referring medical practitioner details and should be dated and signed by the medical practitioner
- **a copy or excerpt of a written report given to the referring medical practitioner** - on completion of an assessment service under MBS items 81100, 81110 or 81120. The report provided should outline the assessment undertaken, the decision that the patient is suitable for group services and if so, the type of group services to be delivered
- a copy or excerpt of a written report, which the allied health practitioner has prepared or contributed to, given to the referring medical practitioner - on completion of the last service in a group services program under MBS items 81105, 81115 and/or 81125

Note: the group services program may be provided by an individual or more than one allied health professional. However, if there is more than one allied health professional, all must contribute to a report.

- **a copy or excerpt of attendance records** for group services that have been provided under MBS items 81105, 81115 or 81125

Note: schedule 2, Part 4 of the Health Insurance (Allied Health Services) Determination 2011, as reflected in MBS item descriptors and explanatory notes M9.1-M9.7, outlines all required components of MBS items 81100 to 81125

In most cases, a patient's clinical information will be the only way to confirm that a valid allied health service was provided, and to substantiate you received the correct Medicare benefit.

If you need to use a patient's clinical information you can censor any details that aren't relevant. You can also choose to provide the information to one of our medical advisers.

Resources

- Health Insurance (Allied Health Services) Determination 2014
- MBS Online