Australian Government
Department of Health, Disability and Ageing

AskMBS Advisory

Non-GP specialist and consultant physician services – *October 2026*

Table of Contents

Introduction iv

1 Referrals 1

1.1 What is the role of referrals in relation to the MBS? 1

1.2 How long do referrals last? 3

1.3 Do referrals have to be to a named specialist? 3

1.4 Can a doctor refer themselves to a specialist? 4

1.5 Is a referral still valid if the referring practitioner changes practice location or retires after issuing the referral? 4

1.6 Can I bill an initial attendance every time I accept a referral? 4

2 MBS services in public hospitals 6

2.1 When is it permissible for specialists working in public hospitals to bill the MBS? 6

2.2 What determines whether a patient is public or private? 6

2.3 Why are Medicare benefits paid at different rates? 7

2.4 How do referrals work within public hospitals? 8

2.5 Can registrars make referrals? 8

2.6 How do locum arrangements apply to referrals in hospitals? 9

2.7 What are the arrangements for continued specialist care following a patient's discharge from hospital? 9

3 Co-claiming multiple items for the same patient on the same day 10

3.1 When can I bill multiple attendance items for the same patient on the same day? 10

3.2 When can I bill an attendance item with a procedural item? 10

4 Specialist telehealth services 12

4.1 Are all face-to-face specialist attendance items replicated in telehealth items? 12

4.2 Do I need to have seen the patient in person before providing a telehealth service to them? 12

4.3 Can a practitioner bill an initial specialist consultation by video and then a face-to-face initial specialist item? 13

4.4 Are telehealth services available to hospital inpatients? 13

5 Consultant physician treatment and management plans 14

5.1 When can I bill items 132 and 133? 14

5.2 When can I bill items 135 and 132? 15

5.3 When can I bill items 137 and 132? 16

5.4 When can I bill items 141 and 132? 16

5.5 Can I bill item 110 and 132 under the same referral? 17

6 Case conferences 18

6.1 What are the MBS arrangements for case conferences by specialists, consultant physicians and consultant psychiatrists? 18

6.2 Are there case conferences items for specialists? 19

6.3 Are case conferences available to hospital inpatients? 19

Appendix A 20

Introduction

The AskMBS advice service is located in the Australian Government Department of Health, Disability and Ageing (the department). AskMBS is an email service (askmbs@health.gov.au) providing information and advice to health providers and other users of the Medicare Benefits Schedule (MBS) on the interpretation and application of MBS items, explanatory notes and associated legislation, to assist them in billing Medicare correctly.

In this and other AskMBS advisories we provide targeted advice on 'hot' topics, i.e. topics on which we get many enquiries. We have published advisories relevant to various MBS provider groups and will publish future advisories should we identify a need.

We expect that each advisory will focus on a particular provider group or area of practice and non-GP specialist and consultant physician services are the subject of this issue. The issues addressed in this advisory, in a question-and-answer format, are:

1. Referrals
2. MBS services in public hospitals
3. Co-claiming multiple items for the same patient on the same day
4. Specialist telehealth services
5. Consultant physician treatment and management plans
6. Case conferences

The complete MBS and a range of related information resources are available at: MBS Online.

Note that some of the information in this advisory is necessarily broad in nature, reflecting AskMBS responses to a range of enquiries. Please contact AskMBS for clarification of any specific issues. **Note also that, for the sake of brevity, the term 'specialist' is taken here to refer to both non-GP specialists and consultant physicians, except where further distinction is required.**

The information in this advisory is current and accurate as of September 2026. Medicare policy changes over time in response to a range of factors, and providers of MBS services should maintain their awareness of current policy settings and item requirements by monitoring advice issued by the department through channels such as direct communications and MBS Online, and by seeking clarification from AskMBS when necessary.

1 Referrals

1.1 What is the role of referrals in relation to the MBS?

The current Medicare referral system was developed in conjunction with the medical profession and the Australian Medical Association. The system supports the concept of the GP as gatekeeper for referred services, in recognition that GPs play a major role in the primary care of their patients and should generally be the first point of contact in determining the treatment a patient receives.

The referral system was introduced to allow medical practitioners to refer patients to specialists where their specific skills and expertise are required to assist with the diagnosis and treatment of the patient. It is not intended to allow medical practitioners to refer patients to themselves.

For a valid referral, a referring practitioner must:

- consider the need for the referral;
- identify themselves as the referring practitioner;
- explain the reasons for the referral, including providing relevant clinical information about the patient's condition for investigation, opinion, treatment and/or management; and
- sign and date the referral. Electronic referrals can meet these requirements if the referral complies with the *Electronic Transactions Act 1999* (The ETA). See below for more information on electronic referrals.

If the treating practitioner is not satisfied with the details provided on a referral, they can refuse to accept it and advise the referring practitioner accordingly. The accepting practitioner should consider whether they have adequate evidence that a referral was in place at the time of the service to satisfy the legislative requirements in the case of an audit.

A patient may consult any specialist directly without obtaining a referral from another medical practitioner. Attendances in these circumstances can be provided using the appropriate non-referred 'other medical practitioner' item in MBS Group A2, attracting a Medicare benefit at the lower non-referred benefit (rebate) rate, rather than the referred rate (unless the patient is a medical practitioner who has referred themselves).

If a practitioner accepts a referral related to a specific specialty, it is not appropriate to bill referred attendance items under that referral where the service is not related to that specialty. In this case, the appropriate non-referred 'other medical practitioner' item in MBS Group A2 should be billed.

A referral (named or unnamed) is valid only for the services rendered by the practitioner who accepts that referral. Once a service has been rendered using that referral, it cannot be shared or transferred to another specialist. A patient cannot change specialists without obtaining a new referral from their GP. If the treating specialist is unavailable (e.g. they are on leave and are not replaced by a locum) and another specialist attends the patient, the appropriate non-referred attendance items are to be billed.

It should be noted that where a non-specialist medical practitioner acts as a locum for a specialist or consultant physician, or where a specialist acts as a locum for a consultant physician, Medicare benefits are only payable at the level appropriate for the particular locum e.g. GP level for a GP locum and specialist level for a referred service rendered by a specialist locum.

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

Note that while the terms ‘referral’ and ‘request’ are often used interchangeably, for Medicare purposes, a ‘referral’ and a ‘request’ are distinct documents with different purposes. A 'referral' is made to a specialist or consultant physician for opinion or management under a referred specialist attendance using an item listed in the Health Insurance (General Medical Services Table) Regulations 2021 (GMST) and does not constitute a request for diagnostic imaging or pathology. Conversely, a request for a diagnostic imaging service does not constitute a referral for a GMST service e.g. a specialist attendance.

Electronic signatures

It is sufficient to indicate on the face of the electronic referral that it has been ‘signed electronically’ by the referrer, provided that the specialist or consultant physician, as the person accepting the referral, consents to this approach.

This means that a specialist or consultant physician could accept an electronic referral which simply states that it is “digitally signed by [provider name]”. If a referral is clear in the reasons for the referral and identifies the referring party and is submitted electronically, then there would be no need for a hard copy signature.

Additionally, in order for the ETA to apply, a signature must be captured and communicated electronically. Any break in the electronic chain of actions, for example manually signing and then emailing a document, does not meet the ETA requirements, though it does satisfy signature requirements.

Services Australia's website provides some examples of acceptable electronic signatures:

- inserting a digital copy of the referrer’s signature in the document
- sending the referral from an email account owned by the referrer
- using an online or digital platform that securely links the referrer’s identity to the referral or securely transmits it.

The Attorney-General’s department provides further examples of electronic signatures:

- drawn onto a screen or uploaded from a picture, before being sent electronically
- made by emailing a signature, or a statement of acceptance
- done by clicking an ‘I accept’ box on an online form before submitting
- made and sent through a digital signing platform.

1.2 How long do referrals last?

A referral is valid for the period specified in the referral, which is taken to commence on the date of the specialist's first service covered by that referral, not the date of the referral itself. Where the referral originates from a practitioner other than a specialist, usually a GP, and no validity period is specified, the referral is valid for a default period of 12 months. However, the referring practitioner can specify a period of more or less than 12 months, including indefinite validity. If the practitioner accepting the referral is in any doubt about its intended duration, they should clarify this with the referring practitioner.

Where a referral is from one specialist to another, it is valid for 3 months, except where the referred patient is an admitted hospital patient. For admitted patients, the referral is valid for 3 months. However, if the duration of the admission is longer than 3 months, the referral is valid for the duration of the admission. While specialists can specify that a referral is valid for less than three months, should they consider it appropriate to do so, they cannot specify that a referral lasts for a period longer than three months.

As it is expected that the patient's GP 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 GP, nurse practitioner or midwife. 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 GP. Where a patient is unable or unwilling to nominate a general practitioner, practice, nurse practitioner or midwife, this must be stated in the referral.

As noted above, the period of a referral's duration commences when the specialist provides the first service. This means that there could be a gap (potentially of more than 12 months) between when the GP referred the patient and when the specialist sees the patient. In these circumstances, the specialist may wish to contact the patient's referring GP to see if the referral is still clinically relevant and/or necessary, and whether there is any new information relevant to their treatment of the patient. The specialist may also ask the patient to seek a new referral.

However, the referral will still be valid for the purposes of the MBS.

1.3 Do referrals have to be to a named specialist?

Referrals for services in a community setting (i.e. not a public hospital outpatient setting) do not need to be made out to a named specialist or consultant physician.

Named referrals have a special role in relation to MBS services provided in public hospitals (see advice in Section 2: MBS services in public hospitals).

In a community setting, even where a specialist is named, the patient can still choose to see a different specialist (within the same specialty) than the one named on a referral, provided this choice is made prior to the commencement of the patient's course of treatment. It is not necessary for the patient to revisit their GP to obtain an updated or new referral.

Equally, subject to anti-discrimination legislation, any receiving practitioner is not obliged to accept any referral, whether named on the referral or not.

However, if a specialist is named, it is best clinical practice for the patient to receive treatment and/or management from that specialist, and for that specialist to communicate the outcome to the GP managing the patient's care.

In the case of an emergency, or if the referral has been lost, stolen or destroyed, a written referral does not need to be received before providing an initial service to the patient. In these circumstances the medical record should contain a note with the words "lost referral" or "emergency". However, a referral must be received prior to any subsequent services.

Non-MBS services and the fees charged for them are a matter for the practitioner and the patient.

1.4 Can a doctor refer themselves to a specialist?

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

1.5 Is a referral still valid if the referring practitioner changes practice location or retires after issuing the referral?

Yes. When a referring practitioner leaves a practice, retires, dies or gets a new provider number, a referral from that practitioner continues to be valid for the original period of the referral, as long as the referring practitioner's provider number was open/valid on the date the referral was made.

If a referring practitioner is no longer practising, a practitioner who has replaced the referring practitioner can choose to:

- retain the existing referral and assume the role of the referring practitioner; or
- issue the patient with a new referral with themselves as the referring practitioner.

As noted above, any receiving practitioner is not obliged to accept any referral, whether named on the referral or not.

1.6 Can I bill an initial attendance every time I accept a referral?

An initial attendance can only be billed once in a single course of treatment, which is defined as including:

- the initial attendance on the patient by a specialist;
- the continuing management or treatment up to and including the stage when the patient is referred back to the care of the referring practitioner; and
- any subsequent review of the patient's condition by the specialist that may be necessary, whether the review is initiated by the referring practitioner or by the specialist.

The receipt by a specialist 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 that allows the billing of an initial attendance.

Once an MBS item for an initial consultation is claimed, all subsequent services related to the same condition are considered to be part of a single course of treatment. The specialist must claim MBS items for subsequent attendances for the continuing management of a condition.

In the continuing management / treatment situation, the purpose of the new referral is to allow the billing of referred rather than non-referred items, and the payment of benefits at the referred rate rather than the lower non-referred rate. Another initial attendance may be billed, and another single course of treatment commenced, if:

- the patient develops a new or unrelated condition, and there is a new referral in place related to that condition; or
- the patient's condition remains substantially the same but a significant period of time (more than 9 months) has elapsed since the previous attendance, so as to warrant a new history and assessment, the referring practitioner considers the attendance necessary for the patient’s condition to be renewed, and a new valid referral is in place for the new attendance.

2 MBS services in public hospitals

2.1 When is it permissible for specialists working in public hospitals to bill the MBS?

MBS services provided in public hospitals must comply both with the rules for the claiming of Medicare benefits under the *Health Insurance Act 1973* (the Act), and with the requirements of the National Health Reform Agreement (NHRA), which sets out the arrangements under which MBS services may be provided to private patients in public hospitals.

It is only permissible for salaried specialists working in public hospitals to bill the MBS when they are providing services to their private patients under rights of private practice arrangements. All services to public patients, including any diagnostic tests, must be provided free of charge. Bulk-billed services are not 'free of charge' because, while there may be no out-of-pocket cost for the patient, the Medicare benefit paid is a cost to the Australian Government.

A key provision in the Act is subsection 19(2), which prohibits the payment of Medicare benefits for medical services rendered under an arrangement with the Commonwealth, a state or territory, a local governing body or an authority established under Commonwealth, state or territory law.

In broad terms, this means that Medicare benefits are not payable for a medical service that is also funded by, or that should have been funded by, another form of payment from one of the entities listed in subsection 19(2).

For example, Medicare benefits are not payable for a service provided by a salaried medical practitioner working in a public hospital if public funding, either through salary or other arrangements, covers the time, or period of day during which the service is performed.

However, it is possible for salaried practitioners employed within public hospitals to exercise rights of private practice while working within those hospitals and see their own patients on a private basis, and to claim Medicare benefits in respect of those services.

As long as there is a clear demarcation between a practitioner's public (salaried) and private (MBS) work, no breach of subsection 19(2) should occur.

No component of the care provided to a patient (such as diagnostic tests, pathology, diagnostic imaging, or follow-up appointments) can be billed to the MBS, including as a bulk-billed service, if the patient is treated as a public patient for the purposes of the NHRA.

2.2 What determines whether a patient is public or private?

It is fundamentally a matter of patient choice whether the patient is public or private. A number of provisions in the NHRA, (especially clauses J16 - J23 and J30), relate to the distinction between public and private hospital patients and set out central principles underscoring the patient's right to choose, free of influence from the hospital, to be treated as a public patient.

Where a patient chooses to be treated as a public patient, all components of the public hospital service (such as pathology and diagnostic imaging) will be regarded as a part of the patient's treatment and will be provided free of charge. In particular, note that:

- Election by eligible patients to receive admitted and non-admitted (outpatient) public hospital and health services as a public or private patient will be exercised in writing before, at the time of, or as soon as possible after presentation to a hospital or health service and must be made in accordance with the minimum standards set out in the NHRA.
- The patient's election applies to all services provided as part of the same episode of care or course of treatment to manage a specific health condition.
- Patient election status can only be changed in the event of unforeseen circumstances and only once. Examples of unforeseen circumstances include, but are not limited to, the following:
  - patients who are receiving care for a particular procedure but are found to have complications requiring additional procedures
  - patients whose length of stay or course of treatment has been extended beyond those originally and reasonably planned by an appropriate health care professional
  - patients whose social circumstances change while admitted or during a course of treatment (for example, loss of job)
- In situations where a valid election is made, then changed at some later point in time because of unforeseen circumstances, the change in patient status is effective from the date of the change onwards and should not be retrospectively backdated to the date of admission.
- An eligible patient presenting at a public hospital emergency department will be treated as a public patient, before any clinical decision to admit. If a decision is made to admit, the patient must be given the choice to elect to be treated as a public or private patient.
- Under the 2026-31 NHRA, once election requirements are fully implemented, an eligible patient presenting at a public hospital outpatient department must be given the choice to be treated as a public or private patient. The patient may elect to be treated as a private patient where they been referred to a named medical specialist who is exercising a right of private practice.
- Referral pathways must not be controlled so as to deny access to free public hospital services as a public patient.

2.3 Why are Medicare benefits paid at different rates?

Medicare benefits are paid at different rates depending on the setting of the service. MBS services rendered to a private patient as part of an episode of hospital treatment are rebated at 75% of the MBS fee.

Currently the definition of hospital treatment is governed by legislation, the Act using the definition contained in Division 121-5 (1) (c) of the *Private Health Insurance Act 2007*. Hospital treatment is treatment provided at a hospital, or treatment that is provided, or arranged, with the direct involvement of a hospital.

Hospital treatment includes services provided to admitted patients, patients in the outpatient department (non-admitted patients) of a declared hospital or in a ‘day-hospital’ of a declared hospital.

Some services, like consultations, most diagnostic imaging and pathology services, are specifically excluded from being classified as ‘hospital treatment’ services, unless certified as a Type C service.

MBS services eligible for provision in an out-of-hospital or community setting are rebated at 85% (or 100% for GP attendances). While some MBS services can be provided in either setting, if a service is only rebated at the 75% rate the item only applies to a service performed or provided in a hospital.

Bulk-billed diagnostic imaging services are rebated at 95% of the MBS fee.

For MBS purposes, the benefit amount does not depend on whether or not a patient has signed an admission form. If a patient has an operation which includes an item with only a 75% rebate and other services formed part of this operation, then all services are only payable at the 75% rate.

2.4 How do referrals work within public hospitals?

Under the NHRA, a patient presenting at a public hospital outpatient department electing to be treated as a private patient by a specialist exercising rights of private practice, must have a named referral at the time of presentation.

Where a referral is generated during an episode of hospital treatment for a private patient 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 or an entry in an electronic record that complies with the ETA).

Referrals for private admitted patients do not require a referral letter or note to a named specialist but the hospital record (e.g. the patient’s chart) should describe the patient’s condition and include evidence of the referral.

If a medical practitioner’s provider number is used to raise a referral, that medical practitioner is taking responsibility for the accuracy and appropriateness of the referral. Referrals should not be made by an intern or registrar using another practitioner’s provider number.

2.5 Can registrars make referrals?

Generally, a registrar has referral rights under a valid provider number. However, registrars, resident medical officers, interns and principal house officers are not considered specialists for the purposes of claiming Medicare benefits and therefore their referrals are valid for 12 months by default or for another period specified in the referral. However, a hospital referral for a professional service to a private patient in a hospital is valid for the duration of the patient’s admission.

2.6 How do locum arrangements apply to referrals in hospitals?

A referral is valid for the services rendered by the initial practitioner who accepts the referral or if that practitioner is absent, doctors acting on behalf of that practitioner in a locum tenens arrangement. Medicare will recognise locum tenens arrangements and pay a benefit where a locum renders a service on behalf of the principal provider, and the account documents have the word 'Locum' or the letters 'LT' to show it is a locum service. The payee in these instances is based on the arrangement for payment between the locum and principal practitioner.

New referrals are not required for locums acting for the principal practitioner according to accepted medical practice. Referrals to the principal are accepted as applying to the locum and benefits are not payable at the initial attendance rate for a locum attendance if the principal has already performed an initial attendance in respect of that referral. A referral cannot be shared or transferred to another specialist.

2.7 What are the arrangements for continued specialist care following a patient's discharge from hospital?

Where a patient has received admitted treatment as a public patient, any routine and non-routine aftercare directly related to that episode of admitted care must be provided free of charge as part of the public hospital service, as required under the NHRA. Medicare benefits are not payable for that aftercare. It is expected that hospital patients on discharge will have a discharge summary sent to their GP which includes any follow-up plans or instructions for the appropriate management of the patient's needs. The patient's GP can then determine if a referral to a specialist is clinically relevant.

A hospital discharge summary is not designed to be a referral, and it would not necessarily meet the requirements for a referral. Discharge summary documents support the transfer of a patient from a hospital back to the care of their nominated primary healthcare provider.

If a follow-up after discharge is a necessary component of the public hospital admitted episode of care and is at the recommendation of a practitioner working in the public hospital, the follow-up treatment would be considered an integral part of the public hospital service and should not be billed to the MBS. If the care is considered necessary by the treating physician in a public hospital, it would not be appropriate to send the patient to their GP merely for a referral to a named specialist at the public hospital.

It is important to note that if the patient is receiving the same course of treatment that began as part of admitted care (that is, continued care), it would not be appropriate to bill an initial attendance. The receipt by a specialist or consultant physician of a new referral for an existing patient does not necessarily indicate the commencement of a new course of treatment allowing the billing of an initial attendance.

3 Co-claiming multiple items for the same patient on the same day

3.1 When can I bill multiple attendance items for the same patient on the same day?

An attendance item may only be billed if a substantive attendance is clinically warranted and the relevant referral requirements are satisfied. It is a core principle of Medicare that each professional service listed in the MBS is a complete medical service.

This means that any tasks that would be considered integral to a particular service should not be claimed separately under another MBS item.

Noting these principles, Medicare benefits may be paid for more than one attendance for a patient on the same day by the same practitioner, provided that:

- the second (and any following) attendances are not a continuation of the initial or earlier attendances;
- each service is distinct and clinically relevant;
- the requirements of each item (including time requirements) are fully independently met; and
- there is no duplication of services.

A medical service is considered clinically relevant if it is generally accepted in the medical profession as necessary for the appropriate treatment of the patient.

The patient record should reflect all consultations and the indications for additional attendances. It can be helpful to record the times of each attendance on the account.

Practitioners are required to satisfy themselves that each professional service they provide meets the requirements of the MBS item descriptor. They also need to exercise care to ensure that their conduct in relation to rendering services cannot be characterised as inappropriate practice i.e. practice that a practitioner's peers could reasonably conclude was unacceptable to the general body of their profession.

3.2 When can I bill an attendance item with a procedural item?

In general, where, during the course of a single attendance by a medical practitioner both an attendance and another medical service are rendered, Medicare benefits are generally payable for both the attendance and the other service subject to certain exceptions. These exceptions reflect the principle that each service listed on the MBS is a complete medical service and a service which is integral to another service should not be billed separately.

All procedural items include any associated clinical interactions which would be reasonably required for the routine performance of the service, including obtaining informed consent,

routine pre-operative examination and post-operative review, discussion with the patient of post-operative care and, unless otherwise stated, the provision of routine aftercare.

Where the clinical interactions with a patient do not extend beyond what would be reasonably required for the routine performance of the service, no additional MBS item should be claimed. However, where clinical interactions do extend beyond what would be reasonably required for the routine performance of the service, such as the discussion of results and management options regarding a lesion, then an appropriate attendance item for such a service may be claimed. An attendance item may also be claimed on the same day as a procedure where a separate and distinct clinical issue is being addressed. In both cases, the item requirements, as set out in the item descriptor and associated explanatory notes, must be met in full.

Specialists should note in particular that subsequent attendance items 105, 116, 119, 386, 2806, 2814, 3010, 3014, 6009 to 6015, 6019, 6052, 16404, 91823, 91825, 91826, 91833, 91836, 92611, 92612, 92613, 92614, 92618, 92749, 92750, 92752, 92753, 92754, 92756, 92757, 92758, 92760, 92761, 92765 and 92766 cannot be billed on the same day as items in MBS Group T8 (Surgical operations) which have a schedule fee (at time of publication of this advisory) equal to or greater than $359.05 (indexed annually). The full list of attendance items and the threshold amount are specified in MBS explanatory note AN.3.1. This restriction recognises that these high value procedural items cover any necessary consultation with the patient.

There are exceptions to this rule allowing for particular circumstances. MBS items 111, 117 and 120 provide a same-day exception and allow a subsequent attendance item to be co-claimed with a Group T8 item with a schedule fee greater than $359.05 on the same occasion where, during the subsequent attendance, the specialist determines the need to perform an operation on the patient that had not otherwise been scheduled.

In addition, MBS item 115 is for use where there is a scheduled operation, and an attendance for a matter unrelated to the booked Group T8 procedure is required. It is important that the nature of the attendance is unexpected, and a delay in providing it would represent a clinical risk to the patient. In all situations the specialist or consultant physician must be satisfied that there is a clinical risk in deferring the attendance for the patient, and patient records clearly identify why the attendance is considered necessary, including the clinical risk in deferring the attendance.

For example, it would not be appropriate to bill item 115 if a patient attends for the booked operation, and prior to surgery an examination is conducted relevant to performing that procedure, together with a discussion of the outcomes and aftercare. However, if the consultation extends beyond this, including for example the development of a management plan involving a broader diagnosis, prognosis, associated treatments and follow-up, then it may be appropriate to bill item 115.

4 Specialist telehealth services

4.1 Are all face-to-face specialist attendance items replicated in telehealth items?

Broadly speaking, face-to-face specialist attendances are replicated in video attendance items, but not in phone items in all cases. An important example is specialist and consultant physician initial attendance items 104 and 110. While these are replicated in video items 91822 and 91824 respectively, there are no corresponding phone items.

The full list of specialist telehealth items is set out in MBS explanatory note AN.40.1 and in a factsheet on MBS Online.

Note that video and phone items cannot be used interchangeably. Telehealth items specify whether the service is to be provided by video or by phone. Where no telehealth modality is specified, the service must be provided face-to-face, with the exception of multidisciplinary case conferences. Where an item specifies a video attendance, both audial and visual contact with the patient must be maintained for the entirety of the attendance.

4.2 Do I need to have seen the patient in person before providing a telehealth service to them?

No, not when you are providing referred services. As set out in MBS explanatory note AN.1.1, it is a legislative requirement that medical practitioners billing non-referred services (using items from Group A40 Subgroup 1, 2, 11, 13, 15, 16, 17, 19 and 20) must only perform a telehealth (video or phone) service if:

- the patient is registered in MyMedicare and the telehealth service is from the patient's registered practice; or
- the provider qualifies as the patient's eligible telehealth practitioner, or an exemption applies.

An eligible telehealth practitioner is defined as:

1. the medical practitioner who performs the service has provided a face-to-face service to the patient in the last 12 months; or
2. the medical practitioner who performs the service is located at a medical or nurse practitioner practice, and the patient has a face-to-face service arranged by that practice in the last 12 months. The service must be billed to the MBS and can be performed by another medical or nurse practitioner located at the practice, or a service performed on behalf of a medical practitioner by another health professional located at the practice (such as a practice nurse or Aboriginal and Torres Strait Islander health practitioner or Aboriginal and Torres Strait Islander health worker); or

3. the medical practitioner who performs the service is a participant in the Approved Medical Deputising Service (AMDS) program, and the Approved Medical Deputising Service provider (AMDS provider) that employs the medical practitioner has a formal agreement with a medical practice that has provided at least one face-to-face service to the patient in the last 12 months.

This means that specialists provided non-referred telehealth services would need to meet the eligible telehealth practitioner requirement.

4.3 Can a practitioner bill an initial specialist consultation by video and then a face-to-face initial specialist item?

No. An initial specialist attendance item is only payable once in a single course of treatment, regardless of the method by which the attendance is delivered. Where an initial attendance has already been claimed for an existing patient during the same course of treatment, another is not payable.

4.4 Are telehealth services available to hospital inpatients?

In general, no. Currently, the only exceptions are certain items available to consultant psychiatrists. Items 91874, 91875, 91876, 91877, 91878, 91882 and 91883 or 91884 provide for video and phone attendances for the interview of a person other than the patient when the patient is not in attendance. For these items, the person being interviewed may be an admitted hospital patient, but this is not mandatory.

On the other hand, items 92478, 92479, 92480, 92481, 92482, and 92483 specifically provide for attendances on hospital inpatients. The purpose of these items is to provide for one video consultation on admission and one subsequent video consultation per week of admission with the remaining consultations to be provided face to face using existing in-hospital subsequent consultation items. Additional guidance is given in explanatory note AN.8.1.

5 Consultant physician treatment and management plans

5.1 When can I bill items 132 and 133?

Item 132 (and video equivalent item 92422) has a specific purpose and is not intended for routine care. Item 132/92422 is a referred service at the request of a referring practitioner and provides for a comprehensive initial assessment by a consultant physician of a patient with at least two morbidities, which may include complex congenital, developmental and behavioural disorders, requiring the preparation of a treatment and management plan of significant complexity. This item is intended to assist the referring practitioner in the management of clinically complex patients by providing them with a comprehensive treatment and management plan. The item has a minimum time requirement of 45 minutes.

A "treatment and management plan" is a distinct requirement of certain attendance items that distinguishes such items from routine attendance items. While the descriptor for item 132/92422 does not require the referral to specifically request a treatment and management plan, the reason for the attendance should be clear to the receiving practitioner. Where the intent and requirements of the referring practitioner are unclear, clarification should be sought.

As specified in the item descriptor and explanatory note AN.0.23, the treatment and management plan should address the specific questions and issues raised by the referring practitioner, and include an opinion on diagnosis and risk assessment, treatment options and decisions, and medication recommendations. It should include a planned follow-up of issues and/or conditions, including an outline of the recommended intervention activities and treatment options, and alternative measures that might be taken in the future if the clinical situation changes. Consideration should also be given to recommendations for allied health professional services, where appropriate.

It is anticipated that the majority of patients will be able to be managed effectively by the referring practitioner using this plan without the need for regular care by the consultant physician.

Where a consultant physician is caring for a patient in a routine capacity, MBS items 110 (for an initial attendance), and 116 or 119 (for subsequent attendances) should be used. Items 110, 116 or 119 are not payable if provided on the same day to the same patient as item 132/92422 or 133/92423/92443.

Item 132/92422 has a minimum time requirement of 45 minutes and may only be billed once in any 12-month period. A new referral would generally be required if the patient’s condition or care requirements have changed such that a new plan is needed.

An indefinite referral does not allow a consultant physician to bill a new item 132/92422, even after 12 months has elapsed. This is because item 132/92422 covers an initial assessment and there can only be one initial assessment in a 'single course of treatment'.

MBS item 133/92423/92443 provides for a subsequent attendance in a single course of treatment for detailed review of a treatment and management plan developed under item 132/92422. This includes reviewing the patient's response to the recommended treatment. Item 133/92423/92443 is payable only where item 132/92422 has been claimed by the same practitioner in the previous 12 months. This service is intended for use in the event of a change to the circumstances or condition of the patient which requires a modified treatment and management plan to be provided to the referring practitioner.

This review may be instigated by the referring practitioner, or the need for a review may have been noted by the consultant physician in the initial plan. The review consultation has a minimum time requirement of 20 minutes and is only payable twice in any 12-month period. Should further reviews of the treatment and management plan be required, the appropriate item for such service(s) is 116/91825/92440.

Item 133/92423/92443 is not intended for routine use.

Further guidance is available in a quick reference guide at Appendix A.

5.2 When can I bill items 135 and 132?

Item 135 (and video equivalent item 92140) is intended for the treatment of complex conditions, characterised by multi-domain cognitive and functional impairment. Patient eligibility (up to 25 years of age) is for neurodevelopmental disorders, assessed to be complex and where patients will require support across multiple domains. The diagnosis of a complex neurodevelopmental disorder requires evidence of requiring support and showing impairment across two or more neurodevelopmental domains; with complexity characterised by multi-domain cognitive and functional disabilities.

This item provides access to treatment, through the development of a treatment and management plan by a paediatrician, once in a patient's lifetime. Note that a service under item 135/92140 must be provided to a patient before they can be referred for allied health services for the treatment of their complex neurodevelopmental disorder.

Item 135 is not payable where this item or item 137, 139, 289, 92140, 92141, 92142 or 92434 has been claimed for the same patient.

It is important to note that item 135/92140 requires the medical practitioner to make a diagnosis. When the diagnosis is not conclusive, the item cannot be billed.

It is preferable that a child has only one management plan in place for the treatment of their condition. However, where the referring practitioner is of the clinical opinion that the patient requires a separate treatment and management plan through item 132, for a condition which cannot be appropriately managed under item 135, item 132 can be billed provided a referral for this plan has been received and all the requirements of the item have been met and the service is clinically relevant.

5.3 When can I bill items 137 and 132?

Item 137 (and video equivalent item 92141) is intended for patient assessment and the development of a treatment and management plan for individuals under the age of 25 diagnosed with an eligible disability. A list of eligible disabilities which are intended under this item is given in MBS explanatory note AR.29.1.

This item provides access to treatment, through the development of a treatment and management plan by a specialist or consultant physician. Note that a service under item 137 must be provided to a patient before they can be referred for allied services for the treatment of their eligible disability.

It is important to note that item 137/92141 requires the medical practitioner to make a diagnosis. When the diagnosis is not conclusive, the item cannot be billed.

Item 137/92141 is available once per lifetime and is not payable where item 135, 139, 289, 92140, 92141, 92142 or 92434 has been claimed for the same patient.

MBS explanatory note AN.0.25 provides further guidance.

It is preferable that a child has only one management plan in place for the treatment for their condition. However, where the referring practitioner is of the clinical opinion that the patient requires a separate treatment and management plan through item 132/92422, for a condition which cannot be appropriately managed under item 137/92141, item 132/92422 can be billed provided a referral for this plan has been received and all the requirements of the item have been met and the service is clinically relevant.

5.4 When can I bill items 141 and 132?

Items 141 (and telehealth equivalent 92623) and 145 are referred services by the patient's GP or a nurse practitioner to a consultant physician or specialist in the specialty of geriatric medicine. These items provide for the comprehensive assessment of, and the development of a treatment and management plan for, frail older patients, older than 65, with complex, often interacting medical, physical and psychosocial problems who are at significant risk of poor health outcomes. This service provides for the development of a holistic plan that delivers optimal patient-centred care where a patient has complex medical problems that may be treated by multiple practitioners.

These items and item 143/92624/92448 (review of plan) are intended to facilitate the complex management of complex patients by GPs by providing them with a treatment and management plan that facilitates clear and effective management. The referral should specify that such a plan is required to ensure that the receiving practitioner is aware of the purpose of the service. The receiving practitioner cannot assume the referring practitioner is requesting a comprehensive assessment with a treatment and management plan, instead of routine care. The GP must specify in the referral that the service is for the provision of this plan in order for the service to be billed.

Item 141/92623 is provided in consulting rooms or a hospital and item 145 at a place other than consulting rooms or hospital. Both have a time requirement of more than 60 minutes and can only be claimed once in a 12-month period for the same patient by the same practitioner. These

items are not payable where either has been provided to the same patient by the same practitioner in the preceding 12 months. Explanatory note AN.0.26 provides further guidance.

Items 132/92422 and 133/92423/92443 are not intended to be billed in addition to items 141/92623/145 and 143/92624/92448 for the same patient by the same practitioner, as this could be considered a duplication of services and may be characterised as inappropriate practice i.e. practice that a practitioner's peers could reasonably conclude was unacceptable to the general body of their profession.

Items 141/92623 and 145 are not intended for routine use.

5.5 Can I bill item 110 and 132 under the same referral?

No. Items 110/91824 and 132/92422 are both initial attendance items and can only be claimed once in a course of treatment. Furthermore, item 110/91824 is for routine care by a consultant physician while item 132/92422 is specifically for the development of a treatment and management plan for the use of the referring practitioner.

If the receiving specialist is in any doubt about a referral's purpose, clarification should be sought from the referring practitioner.

For patients whose condition requires ongoing involvement by the consultant physician after their development of a treatment and management plan under item 132/92422, standard subsequent attendance items, such as MBS items 116/91825/92440 and 119/91826/91836, can be used.

6 Case conferences

6.1 What are the MBS arrangements for case conferences by specialists, consultant physicians and consultant psychiatrists?

Case conferences are multidisciplinary team meetings to encourage clinically relevant participation in determining and developing a management plan for an individual patient. Medicare benefits are not payable for a general discussion amongst health professionals of multiple patients.

The appropriate case conference item will depend on the practitioner providing the service, patient eligibility and the clinical scenario. Please see references to the relevant MBS explanatory notes for guidance on item requirements. The explanatory notes here are linked but can generally be found by searching for the note number at www.mbsonline.gov.

Case conferences have specific requirements depending on whether an item is claimed for organising or participating in the conference.

All requirements of the item descriptor must be satisfied for services to be payable. These include the number of formal care providers required to participate, time requirements and reporting requirements. The practitioner organising and co-ordinating the conference is responsible for inviting participates to attend. A patient (and/or their informal carer or agent) may attend a case conference but cannot be counted toward the minimum number of participants. Formal care providers may include, but are not limited to, allied health professionals, community service providers, and the patient's usual GP. Attending non-treating clinicians, and support staff are not eligible to bill for these services.

Patient consent to the case conference must be obtained before the conference is conducted. This provides an opportunity for the patient to discuss up-to-date medical history, diagnoses and care preferences. It also allows the patient to specify what information they agree to be released at the forthcoming conference. The patient should be advised if there will be an out-of-pocket charge for the conference. The consent of the patient or the patient's agent must be noted in the patient's file.

Each billing practitioner must ensure that their patient is informed that a charge will be incurred for the case conference for which a Medicare benefit will be payable.

The following is a list of case conference items available to specialists, referencing explanatory notes which give detailed guidance. Item descriptors and explanatory notes can be viewed by searching for the item or note number at www.mbsonline.gov.au

- Six consultant physician community case conference items, with durations of 15 to 30 minutes, 30 to 45 minutes and at least 45 minutes, including items for organisers and participants. See MBS note AN.0.51.

- Six consultant physician discharge case conference items, with durations of 15 to 30 minutes, 30 to 45 minutes and at least 45 minutes, including items for organisers and participants. See MBS note AN.0.51.
- Two specialist/consultant physician case conference items for patients with cancer, including items for organisers and participants. See MBS note AN.0.65.
- Twelve pain medicine case conference items, with durations of 15 to 30 minutes, 30 to 45 minutes and at least 45 minutes, including items for discharge and community conferences, and for organisers and participants. See MBS note AN.0.58.
- Twelve palliative medicine case conference items, with durations of 15 to 30 minutes, 30 to 45 minutes and at least 45 minutes, including items for discharge and community conferences, and for organisers and participants. See MBS note AN.0.58.
- One geriatric and rehabilitation medicine case conference item to coordinate a case conference of at least 10 minutes but less than 30 minutes. See MBS note AN.0.63.
- Eight addiction medicine community case conference items, with durations of less than 15 minutes, 15 to 30 minutes, 30 to 45 minutes and at least 45 minutes, including items for organisers and participants. See MBS note AN.0.51.
- Eight sexual health medicine community case conference items, with durations of less than 15 minutes, 15 to 30 minutes, 30 to 45 minutes and at least 45 minutes, including items for organisers and participants. See MBS note AN.0.51.
- Two TAVI case conference items, including items for coordinating and attending. See MBS note AN.33.1.
- Six consultant psychiatrist case conference items. See MBS note AN.0.62.

6.2 Are there case conferences items for specialists?

Broadly speaking, MBS case conference items are available only to consultant physicians, GPs and allied health practitioners. The case conference items for specialists are those in pain medicine, palliative medicine, geriatric medicine, addiction medicine, transcatheter aortic valve implantation (TAVI) case conferences and cancer case conferences. Please refer to the relevant explanatory notes linked in section 6.1 for information on these items.

In general, whether an item can be used by specialists or consultant physicians will be specified in the item descriptor.

6.3 Are case conferences available to hospital inpatients?

Case conferences are largely for patients in the community or who are being discharged from hospital (this is specified in the related items). Case conferences for inpatients are limited to those for cancer, geriatric rehabilitation and TAVI. Please refer to the relevant explanatory notes linked in section 6.1 for information on these case conferences.

Choosing the right MBS attendance item

MBS online
Item descriptors

Item 110

New course of treatment

Initial consultant physician attendance

New referral must support a new course of treatment

New referral does not automatically mean an item 110

Item 116

Ongoing care

Subsequent consultant physician attendance

Same condition or ongoing management

Patient remains under an existing course of treatment

Item 132

Initial complex assessment and management plan

Initial comprehensive assessment

Multiple morbidities

At least 45 minutes

Management plan developed for the GP to implement

Item 133

Complex plan review

Review of a previous item 132 management plan

At least 20 minutes

Management plan reviewed, updated and provided to referring practitioner

Maximum 2 services per patient per 12 months

Note items 110 and 132 cannot be claimed using the same referral as are both items are initial attendances and can only be claimed once in a course of treatment

Health.gov.au

All information in this publication is correct as at 1 October 2026

