



Australian Government
Department of Health

AskMBS Advisory

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Non-GP specialist and consultant physician services

<https://www.health.gov.au/resources/collections/askmbs-advisories>



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Introduction

The AskMBS advice service is located in the Australian Government Department of Health (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 will publish future advisories on a quarterly basis as well as *ad hoc*, 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 (including COVID-19 services)
5. Consultant physician treatment and management plans
6. Case conferences

At the end of the advisory we also provide metrics on our performance against key performance indicators. 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.

Note also that the information in this advisory is current and accurate as of September 2021. 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 of Health 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 reason 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 Act). See below for more information on signing electronic referrals.

A patient may consult any specialist directly without obtaining a referral from another medical practitioner, but these attendances will attract a Medicare benefit under a non-referred item at the lower non-referred rate, rather than the referred specialist 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 is not eligible to provide services attracting Medicare benefits acts as a locum for any practitioner who is eligible to provide services attracting Medicare benefits.

Note also that while the terms 'referral' and 'request' are often used interchangeably, a 'referral' is required to a specialist or consultant physician for a referred specialist attendance item listed in the General Medical Services Table and does not constitute a request for diagnostic imaging or pathology. A 'request' is required for services contained in the Diagnostic Imaging Services Table and the Pathology Services Table. These are legal terms and are specified in the legislation which governs the MBS.

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. Examples of electronic signatures include:

- a hard copy document which is signed and then provided electronically (e.g. by fax);
- a typed signature block at the end of an email (e.g. Yours faithfully, Dr Joan Brown) which has been sent from Dr Brown's email account;
- a pdf which has been electronically signed; or
- medical software which requires doctors to log on (with a password) in order to generate and securely send a referral to a specialist.

There is no requirement for the software to store or attach a scanned hard copy of the doctor's signature, provided:

- there is an appropriately reliable method for ensuring that the referral was actually authorised by the named doctor; and
- the practice saves, stores and retains access to electronic referrals so they can be retrieved unaltered (e.g. where the Department of Health requests a copy).

12 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 three months, except where the referred patient is an admitted hospital patient. For admitted patients, the referral is valid for three months or the duration of the admission whichever is the longer. 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 a referral lasts for a period longer than three months.

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. 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.

13 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.)

However, 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.

If it is 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.

14 Can a doctor refer themselves to a specialist?

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

15 Is a referral still valid if the referring GP or specialist changes practice 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. In these circumstances, the specialist may wish to satisfy themselves that the information in the referral letter is up to date and that advice given by the specialist will be appropriately actioned. They may also ask for a new referral.

16 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 allowing the billing of an initial attendance. In the continuing management / treatment situation 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, and a new valid referral is in place for the new attendance.

2 MBS services in public hospitals

21 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, which governs the provision of MBS services 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. 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 Commonwealth.

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 also funded by another form of payment from one of the entities listed in subsection 19(2). This is generally known as 'double dipping'.

For example, Medicare benefits are not payable for a service provided by a salaried medical practitioner working in a public hospital if the service is provided at the same time as the practitioner is being paid a salary by the relevant state or territory government. However, under long-standing arrangements, 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 bill Medicare 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 if the patient is treated as a public patient for the purposes of the National Health Reform Agreement.

22 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 National Health Reform Agreement (especially clauses G17, G18, G19 and G20) 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:

- An eligible patient presenting at a public hospital emergency department will be treated as a public patient, before any clinical decision to admit. On admission,

- the patient will be given the choice to elect to be a public or private patient.
- An eligible patient presenting at a public hospital outpatient department will be treated free of charge as a public patient unless the patient has been referred to a named medical specialist who is exercising a right of private practice and the patient chooses to be treated as a private patient.
 - Referral pathways must not be controlled so as to deny access to free public hospital services.

23 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. 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.

24 How do referrals work within public hospitals?

Under the National Health Reform Agreement, which governs the provision of MBS-eligible services to private patients in public hospitals, patients presenting at a public hospital outpatient department, wishing to be treated as a private patient by a specialist exercising rights of private practice, must be in possession of 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 Electronic Transaction Act 1999).

Referrals for private in-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 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.

25 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 until the patient ceases to be a patient in the hospital.

2.6 How do locum arrangements apply to referrals within 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 in-patient treatment as a public patient, routine and non-routine aftercare directly related to that episode of admitted care is expected to be provided free of charge as part of the service, as required under the National Health Reform Agreement, and Medicare benefits are not payable.

It is expected that hospital patients on discharge 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 general practitioner 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 episode of care, and is at the recommendation of a practitioner working in the public hospital, the follow-up treatment would be considered an intrinsic 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 in hospital (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 involving 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. 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.

For example, an attendance is provided before performing peritoneal dialysis under item 13112. The item descriptor for 13112 is: Peritoneal dialysis, establishment of, by abdominal puncture and insertion of temporary catheter (including associated consultation). An attendance item is not payable separately because this service is included in item 13112.

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 the second (and any following) attendances are not a continuation of the initial or earlier attendances. 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.

For example, a preliminary eye examination may be concluded with the instillation of a mydriatic agent and then an hour or so later, eye refraction is undertaken. These sessions are regarded as being one attendance for Medicare billing purposes. Further examples are the case of skin sensitivity testing, and the situation where a patient is issued a prescription for a vaccine and subsequently returns to the surgery for the injection.

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 intrinsic to another service should not be billed separately.

Specialists should note in particular that subsequent attendance items 105, 116, 119, 386 2806, 2814, 3010, 3014, 6019, 6052, and 16404 cannot be billed on the same day as items in MBS Group T8 (Surgical operations) which have a schedule fee equal to or greater than \$309.35. This restriction recognises that the procedural item covers 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 \$309.35 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 delay represents a clinical risk to the patient. In all situations the specialist must be satisfied that there is a clinical risk to defer the attendance for the patient at this time and patient records clearly identify why the attendance is considered necessary for the patient including the clinical risk to defer 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 could be appropriate to bill item 115.

4. Specialist telehealth services (including COVID-19 services)

4.1 What specialist telehealth services were available prior to the COVID-19 services?

There were a range of MBS telehealth services available prior to the introduction in March 2020 of the COVID-19 services, and these continue to be available.

Since 2011, Medicare items have been available for video attendances between specialists, including psychiatrists, and patients, for:

- patients in telehealth eligible areas throughout Australia (where there is a distance of at least 15 km between the patient and the specialist); and
- residents in eligible residential aged care facilities and patients in eligible Aboriginal Medical Services throughout Australia (regardless of location).

These services are not payable for telephone attendances and are not available to admitted hospital and hospital-in-the-home patients.

Geographic eligibility for these telehealth services via videoconferencing are determined according to the Australian Standard Geographical Classification Remoteness Area (ASGC-RA) 2006 classifications. Telehealth Eligible Areas for specialist services are all those regions that are outside a Major City (RA2-5).

A patient's geographic eligibility can be checked by using the Health Workforce Locator Map on the Department of Health DoctorConnect website at www.health.gov.au/resources/apps-and-tools/health-workforce-locator/health-workforce-locator. Choose the 'ASGC Remoteness Areas Layer' 2006 and enter the address of your patient's location during the attendance.

These telehealth services via videoconferencing are billed by co-claiming a telehealth 'enabling' item with a standard attendance item. Items 99, 112, 149, 288, 389, 2820, 3015, 6016, 13210, 16399 and 17609 allow a range of existing MBS attendance items to be provided via videoconferencing. These items have a derived fee which is equal to 50% of the schedule fee for the attendance item claimed (e.g. 50% of the schedule fee for item 104) when billed with one of the associated consultation items (such as 104). A patient benefit of 85% of the derived fee is payable.

Six MBS items (113, 114, 384, 2799, 3003 and 6004) provide for an initial attendance via videoconferencing by a specialist, consultant physician, consultant occupational physician, pain medicine specialist/consultant physician, palliative medicine specialist/consultant physician or neurosurgeon where the service is 10 minutes or less.

These items are stand-alone items and do not have a derived fee (i.e. they cannot be claimed with an 'enabling' telehealth item).

There are also items for patient-end support services provided by GPs and specialists. In addition, telepsychiatry items 353 to 361 were introduced in 2002 for professional attendances by a consultant physician in the practice of their specialty of psychiatry for a referred patient located in a regional, rural or remote area (RRMA 3-7 area under the Rural Remote Metropolitan Areas classification system). It is the intention of these items that they be provided by videoconference.

42 What is the difference between the pre-existing telehealth services and the tele-psychiatry services?

When specialist videoconferencing telehealth items were introduced in 2011, the decision was made to retain the existing items for telepsychiatry as different patients are potentially eligible under each set of items and having both sets of items would enable the greatest number of patients in rural and remote areas to access specialist psychiatric care.

For example, geographical restrictions do not apply to patients in RACFs for the telehealth items but do apply to the telepsychiatry items.

The main difference between telepsychiatry items and telehealth items, other than patient location eligibility and the 15km distance restriction, is the provision of patient-end support services funded under Medicare for the telehealth services. Patient-end services provide clinical support to the patient during a video consultation with the psychiatrist. These services may be provided by a GP, other medical practitioner, a participating nurse practitioner, a participating midwife, an Aboriginal health worker or a practice nurse.

A patient-end support service is only eligible for Medicare funding if the service provided by the psychiatrist is also an eligible MBS telehealth service. MBS funding for patient-end support services is not available for telepsychiatry items 353 to 361.

The decision as to whether the patient requires clinical support at the patient end of the psychiatry service is based on whether this support is necessary for the provision of the psychiatry service. This is a clinical decision for the specialist in consultation with the patient.

There are a range of time-tiered items for patient-end support services in various settings including, consulting rooms, other than consulting rooms, eligible residential aged care services and Aboriginal Medical Services. The supporting health practitioner must be present with the patient during part or all of the attendance in order to bill an appropriate time-tiered MBS item. See MBS notes AN.0.67, AN.7.26 and MN.12.5 for further information on the support items available for the GP, other medical practitioners and other eligible health professionals at www.mbsonline.gov.au

The supporting health practitioner attending at the patient end of the video attendance does not need to be present for the entire attendance, only as long as is clinically necessary—this can be determined with the specialist. The MBS item billable for the supporting health practitioner will be determined by the total time spent assisting the patient. This time does not need to be continuous.

Specialist telehealth services can also be provided to patients when there is no patient-end support service provided.

Further information on these psychiatrist attendances via videoconferencing is provided in MBS explanatory note AN.0.68 and the telepsychiatry attendances in note AN.0.59, both available at www.mbsonline.gov.au.

43 What are the differences between the pre-existing telehealth services and the new COVID-19 telehealth and telephone services?

In response to the COVID-19 pandemic, the Australian Government introduced a number of new MBS services. New MBS attendance items, as well as new pathology items, have been introduced to allow doctors and other health professionals to deliver services via telehealth and telephone.

The attached link to MBS Online provides fact sheets on these services:

www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-TempBB

Pre-existing specialist telehealth services, which were available prior to the COVID-19 items, are only payable for video attendances and not for telephone attendances.

The eligible patient location for these pre-existing telehealth services is determined according to the Australian Standard Geographical Classification Remoteness Area (ASGC-RA) classifications 2006. Telehealth eligible areas are those regions that are outside a Major City (RA2-5). You can check if a location is telehealth eligible by using the Health Workforce Locator Map on the Department of Health DoctorConnect website at www.health.gov.au/resources/apps-and-tools/health-workforce-locator/health-workforce-locator. Choose the 'ASGC Remoteness Areas Layer' 2006 and enter the address of your patient's location during the attendance.

Patients must be located in a telehealth-eligible area at the time of the attendance and if the patient is located at their home address at the time of the attendance then this must be in an eligible telehealth area. In addition, the specialist and the patient are required to be at least 15km apart by road at the time of the attendance.

These restrictions do not apply to the COVID-19 telehealth services. In addition, while MBS telehealth services are historically videoconference services only, and this remains the preferred approach for substituting a face-to-face consultation, in response to the COVID-19 pandemic, providers are also able to offer audio-only services via telephone if video is not available.

Please check MBS Online (www.mbsonline.gov.au) regularly for any further policy announcements in relation to the COVID-19 pandemic.

44 Can a practitioner bill a COVID-19 initial specialist consultation by videoconference or telephone (item 91822 or 91832) and then a face-to-face initial specialist consultation (item 104)?

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. For more on initial attendances and a single course of treatment please refer to MBS explanatory note GN.6.16 which can be viewed on MBS Online by using the search function.

45 If a patient is eligible for the pre-existing specialist telehealth service, can a practitioner bill these items instead of the COVID-19 specialist telehealth item?

The pre-existing telehealth items are specifically intended to improve access to specialist services for patients in rural and remote areas. The new COVID-19 telehealth items are intended to continue access to essential care where the patient or the provider are unable to attend a face-to-face service due to the COVID-19 pandemic.

Providers are expected to bill the MBS item which best describes the service provided, noting that all requirements of the item, as set out in the descriptor and any associated explanatory notes, must be fully met. It should be noted that there are geographical and distance restrictions on the pre-existing telehealth items, which includes the requirement for the patient to be at least 15km by road from the provider and in a telehealth-eligible area at the time of the service.

For the pre-existing specialist telehealth items, such as item 99 or 112, a telehealth eligible area is determined according to the Australian Standard Geographical Classification Remoteness Area (ASGC-RA) classifications 2006. Telehealth eligible areas are those regions that are outside a Major City (RA2-5). A patient's geographic eligibility can be checked by using the Health Workforce Locator Map on the Department of Health DoctorConnect website at www.health.gov.au/resources/apps-and-tools/health-workforce-locator/health-workforce-locator. Choose the 'ASGC Remoteness Areas Layer' 2006 and enter the address of your patient's location during the attendance.

5 Consultant physician treatment and management plans

5.1 When can I bill items 132 and 133?

Item 132 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 facilitate the complex management of patients by the referring practitioner 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 the receiving consultant physician is aware of the purpose of the service. The consultant physician cannot assume the referring practitioner is requesting a comprehensive assessment with a treatment and management plan, instead of routine/ongoing care under consultant physician attendance items such as item 110.

The item has a minimum time requirement of 45 minutes, may only be billed once in any 12-month period, and will require the receipt of a new referral if a new plan is necessary. A referral for a new plan would generally be required where the patient's condition or care requirements have changed and this necessitates a new plan and the billing of item 132.

Item 132 is not intended for routine use.

Where a consultant physician is caring for a patient in a regular 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 or 133.

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

MBS item 133 provides for a subsequent attendance in a single course of treatment for the detailed review of a treatment and management plan developed under item 132 which has been claimed 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 plan. The review consultation has a minimum time requirement of 20 minutes and is only payable twice in any 12-month period. For example, if 132 was claimed on 1/1/2020 and again on 1/1/2021, and item 133 was claimed on 1/6/2020 and again on 1/11/2020, item 133 is not payable again until 1/6/2021 as two item 133s have already been claimed in the past 12-month period. Should further review/s of the consultant physician treatment and management plan be required, the appropriate item for such service/s is item 116.

Item 133 is not intended for routine use.

52 When can I bill items 135 and 132?

MBS item 135 is a referred service at the request of the patient's usual practitioner and provides for assessment, diagnosis and the creation of a detailed treatment and management plan by a consultant physician in paediatrics. It has a minimum time requirement of 45 minutes. This item provides for early diagnosis and treatment of autism or other pervasive development disorder (PDD) for children aged under 13 years, and provides access to Medicare allied health services for the treatment of autism or other PDD. This item is payable once per patient per lifetime.

Item 135 is provided in consulting rooms or a hospital and is not payable where item 137, 139 or 289 has been claimed for the same patient.

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.

53 When can I bill items 137 and 132?

Item 137 is a referred service at the request of a referring practitioner and provides for the assessment, diagnosis and preparation of a treatment and management plan, by a specialist or consultant physician, for a child aged under 13 years with an eligible disability. The item has a minimum time requirement of 45 minutes and is payable once per patient per lifetime. This item is provided in consulting rooms or a hospital and is not payable where item 135, 139 or 289 has been paid for the same patient.

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, for a condition which cannot be appropriately managed under item 137, 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.

54 When can I bill items 141 and 132?

Items 141 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 (review of plan) are intended to facilitate the complex management of 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 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.

Items 132 and 133 are not intended to be billed in addition to items 141/145 and 143 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. Explanatory note AN.0.26 provides advice on geriatric items that may be a useful reference, available at MBS Online.

Items 141 and 145 are not intended for routine use.

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 on 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. MBS explanatory notes are available at www.mbsonline.gov.au by using the reference provided in the search function (e.g. AN.0.51).

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 participants 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, allied health providers 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.

MBS case conferences include the following:

- 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

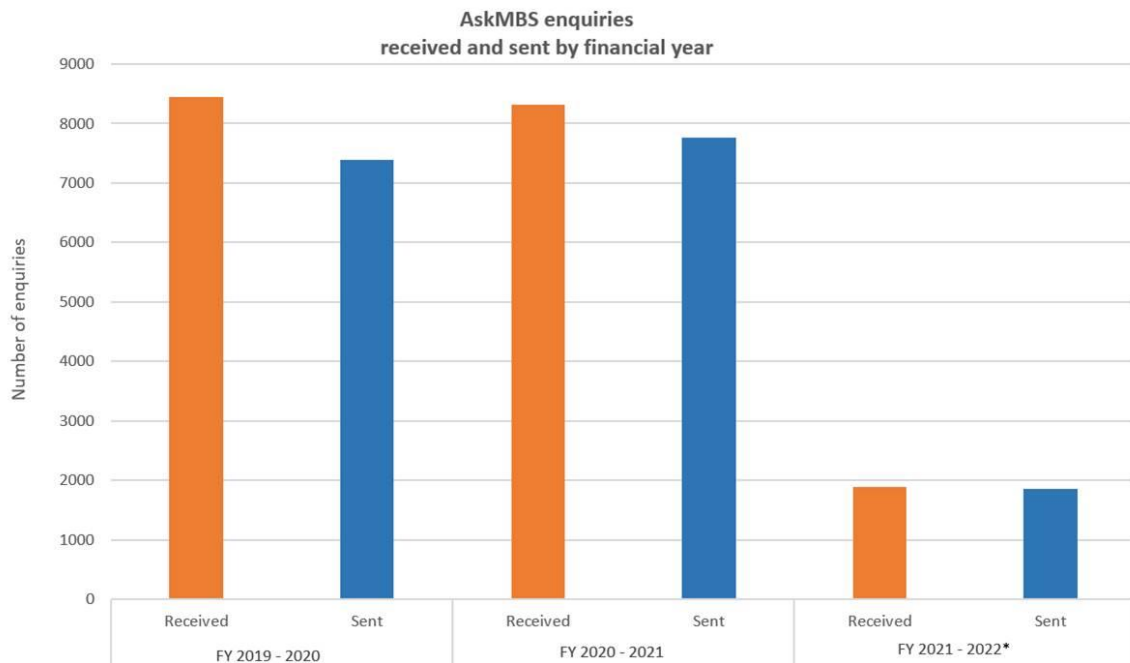
case conference of at least 10 minutes but less than 30 minutes. See MBS note AN.0.63.

- 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 explanatory note AN.0.62.

7. AskMBS metrics

1 March 2019 – 31 August 2021

Between the commencement of the AskMBS function in the Department of Health on 1 March 2019, and 31 August 2021, AskMBS has received a total of 20,883 enquiries and sent 20,447 responses. The chart below shows figures for the current financial year and the previous two full financial years.



* Please note, FY 2021-2022 includes data from 1 July 2021 to 31 August 2021