Australian Government
Department of Health

ASKMBS ADVISORY

Allied health services – Part A
Chronic disease management

Updated October 2021

A message from the Chief Allied Health Officer

Australia's 195,000 allied health professionals comprise a significant proportion of the health workforce and provide essential services in primary care generally and chronic disease management (CDM) specifically. The approximately 200 million allied health MBS services provided annually are an indicator of the value of and strong demand for these services.

In particular, I would like to take this opportunity to recognise the major contribution allied health professionals have made to supporting Australians with the challenges presented by the COVID-19 pandemic, including patients in regional and rural areas.

The Department of Health's AskMBS email advice service plays a key role in assisting all providers of Medicare Benefits Schedule (MBS) services with the correct billing of MBS items. I am pleased that allied health providers are proactively seeking guidance on the policy settings and billing rules underpinning allied health MBS items. In addition to providing responses to individual enquiries, AskMBS issues regular advisories.

This is the first of two complementary AskMBS advisories focusing on allied health Medicare MBS items. This issue provides information about the following issues in a Q&A format:

1. Bulk billing—Additional charges and split billing
2. Chronic disease management allied health items
3. Follow-up services for people who have received an Aboriginal and Torres Strait Islander health assessment
4. Group allied health services for patients with type 2 diabetes
5. Autism, pervasive developmental disorder or disability services
6. COVID-19 MBS allied health telehealth services
7. New items for services in residential aged care facilities

The next allied health-specific AskMBS advisory will include advice on allied mental health MBS services.

I trust you will find this document useful and encourage you to continue to use AskMBS to clarify any issues arising in your practice on the correct use of MBS items.

Dr Anne-marie Boxall

Chief Allied Health Officer

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The AskMBS advice service

AskMBS is located in the Australian Government Department of Health. AskMBS is an email advice service providing 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.

This and other AskMBS advisories focus on a particular provider group or area of practice, and allied health services have been selected as the focus of this issue. Here you will find targeted advice on 'hot' topics i.e. topics on which AskMBS gets many enquiries. Future advisories will be published on a quarterly basis as well as ad hoc, as required.

At the end of the advisory we also provide metrics on AskMBS's performance in 2020. The complete MBS, including item descriptors and explanatory notes as well as a range of related information resources, are available at: MBS Online.

For the sake of brevity, the abbreviation 'AHP' is used throughout to refer to 'allied health professional'. Note that some of the information in this advisory is necessarily broad in nature, reflecting AskMBS responses to a range of enquiries on the same issue. Please contact AskMBS at askMBS@health.gov.au for clarification of any specific issues.

Disclaimer: The information in this advisory is current and accurate as of October 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. Bulk billing

Relevant items: All items

1.1. Am I required to bulk bill?

You are required to bulk bill only where a mandatory bulk billing requirement applies to specified items, as was briefly the case, for example, with the COVID-19 telehealth items following their introduction. Where bulk billing is not an item requirement, a Medicare provider is not required to bulk bill and is free to set the fee they charge for a professional service. This is called private or patient billing. This allows an AHP, for example, to charge a single fee for an extended consultation which compensates them for the additional time spent.

Where a provider charges more than the Medicare rebate for a consultation (or any MBS item) the professional service cannot be bulk billed and the patient will need to pay the account then claim their Medicare rebate. The patient will be responsible for the difference between the rebate and the actual cost of the service. Under the principle of informed financial consent, patients should be made aware in advance of any out-of-pocket costs they may have to pay for a service.

1.2. When bulk billing a service, can I charge the patient an additional fee for an extended consultation or for consumables?

No. When bulk billing, a patient agrees to assign their Medicare benefit (rebate) to the provider who accepts the benefit as full payment for the service. In these circumstances the provider will receive payment directly from Medicare. If you bulk bill a patient you cannot impose additional charges for that service; for example, it is not permitted to charge for consumables such as wound dressings or to charge a 'gap fee' that results in out-of-pocket costs to the patient.

The restriction on additional charges for a bulk billed service applies even if you attempt to use a separate invoice. No matter how the arrangement is described, if the practical effect is that you require patients to pay additional charges, then the professional service cannot be bulk billed.

For allied health services subsidised through private health insurance, many practices use payment systems such as HICAPS which allow for the patient to pay the gap between their private health cover and the cost of the service. Medicare rules do not allow the same approach for bulk billed services.

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

2. Chronic disease management allied health items

Relevant items: 10950 to 10970, 93000 and 93013

Further information on MBS chronic disease management arrangements is available in a Q&A published by the Department available at: www1.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-chronicdiseasemanagement-qanda

2.1. Who is eligible for Medicare rebates for chronic disease management individual allied health services?

A patient's eligibility for a chronic disease management (CDM) service is essentially a matter for the referring GP to determine, using their clinical judgement and considering any eligibility criteria and general Medicare guidance. While an AHP may suggest that a patient discuss their chronic health condition with a GP, it would not be appropriate for an AHP to suggest to a patient that they will necessarily be eligible for a CDM service subsidised by Medicare.

Allied health services provided through CDM referrals must be directly related to the management of the patient's chronic medical condition/s, and the need for allied health services must be identified in the patient's care plan.

Patients may be referred for CDM individual allied health services if:

- their GP has put in place a GP Management Plan and Team Care Arrangements; or
- their GP has reviewed their existing care plan; or
- their GP has contributed to (or contributed to a review of) a multidisciplinary care plan prepared for them as a resident of a residential aged care facility and claimed; and
- their GP determines that the patient's chronic medical condition would benefit from CDM allied health services; or
- for patients who are enrolled with a Health Care Home, a shared-care plan that has been prepared by the medical practitioner who is leading the patient's care.

2.2. What conditions make a patient eligible for a chronic disease management service?

To be eligible for any of the chronic disease management (CDM) services, a patient must have a chronic or terminal medical condition—that is, a condition that has been, or is likely to be, present for six months or longer and includes, but is not limited to, asthma, cancer, cardiovascular illness, diabetes mellitus, musculoskeletal conditions and stroke. The MBS does not list all the medical conditions which are regarded as chronic medical conditions for the purposes of the CDM items.

Where a patient's 'condition' is not obviously covered by the MBS definition, a GP may still consider the patient's condition and circumstances require the preparation of a care plan because of such factors as non-compliance with an existing treatment plan, an inability to self-manage, or a functional disability. For example, while patients with gestational diabetes are unlikely to be eligible for a GP Management Plan and Team Care Arrangements (TCAs) based on that condition alone, the GP may consider the patient's condition and broader health circumstances are such that the preparation of a care plan is appropriate. Using this example, the GP may determine that it is appropriate to refer the patient for allied health services that address the impact of gestational diabetes on the patient's chronic condition.

Note that AHPs are not obliged to accept referrals or requests to participate in TCAs. If the AHP has concerns regarding the eligibility of the patient for their services, they can discuss these concerns with the referring GP upon receipt of the referral, or when collaborating and providing input into the patient's TCA. Where the AHP chooses to provide the service, it is their responsibility to ensure that all the requirements of the relevant MBS item, as detailed in the item descriptor and associated explanatory notes, have been met and the service provided is clinically relevant.

2.3. What are the referral and reporting requirements for chronic disease management allied health services?

For Medicare benefits to be payable, the patient must be referred to an eligible AHP by their GP or medical practitioner using a referral form that has been issued by the Australian Government Department of Health, or a form that contains all the components of this form. The form issued by the Department is available at: www1.health.gov.au/internet/main/publishing.nsf/Content/Chronic+Disease+Allied+Health+Individual+Services

Where an AHP provides a single service to the patient under a referral, they must provide a written report back to the referring GP or medical practitioner after that service.

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

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

More information on the allied health referral form and reporting requirements can be found in MBS explanatory notes MN.3.2 and MN.3.3 by searching www.mbsonline.gov.au

2.4. Can referrals be shared between providers participating in Team Care Arrangements?

Team Care Arrangements (TCAs) are for patients who have a chronic or terminal medical condition and complex needs requiring ongoing care from a multidisciplinary team. TCAs are intended for patients who require care from at least three collaborating health professionals or care providers, each of whom provides a different kind of treatment or service and at least one of whom is a medical practitioner. At least two health professionals or care providers who will be providing ongoing treatment or services to the patient must collaborate with the GP in the development of TCAs. The TCA team may be made up of a range of service providers, including:

- AHPs to whom a GP can refer patients for Medicare-rebateable CDM allied health services i.e. Aboriginal health workers, Aboriginal and Torres Strait Islander health practitioners, audiologists, chiropractors, diabetes educator, dietitians, exercise physiologists, mental health workers, occupational therapists, osteopaths, physiotherapists, podiatrists, psychologists, and speech pathologists; and/or
- other AHPs such as social workers, optometrists, pharmacists, orthoptists, orthotists or prosthetists; and/or
- other health professionals or care providers such as registered nurses and asthma educators.

A team might also include home and community service providers, or care organisers such as: education providers; 'meals on wheels' providers; personal care workers (workers who

are paid to provide care services); and probation officers where they are contributing to the plan and not simply providing a service identified in the plan.

Therefore, the TCAs team may or may not include the AHP(s) who have received a CDM referral. A GP may choose to refer all five Medicare-eligible allied health services to one provider or may distribute the five referrals as they deem appropriate for the needs and circumstances of the patient. Where the GP has referred all five eligible sessions to one provider, there must be still be a minimum of two members of the TCAs team.

2.5. Can I use a referral that has been made out to a different provider?

If the patient's referral contains the name and practice location of an AHP, the patient may see any AHP at that practice. However, if a referral contains the name of an AHP, but no practice location, they must see the AHP who is specified in the referral or obtain a new referral from their GP if they wish to see a different AHP. If the GP has only specified the type of AHP, the patient is free to see any AHP of their choosing provided they are registered with Medicare Australia to provide services.

The AHP has a responsibility to only provide services based on a valid referral. If an AHP is unsure about a referral, they should seek clarification directly from the referring practitioner.

2.6. Does a patient need a new referral at the start of each year?

CDM allied health referrals do not expire. They may be issued at any time of the year and remain open until the number of services the GP has specified in the referral have been used. Any unused services at 31 December can continue to be used in the following year, but will be subject to the maximum limit of five Medicare-rebateable CDM allied health services available in any one calendar year (i.e. 1 January – 31 December).

It is not necessary to have a new plan or review for each calendar year to access a new referral(s) for eligible allied health services. Patients continue to be eligible for rebates for allied health services while they are being managed under an existing plan whilst the need for eligible services continues to be recommended in their plan. When patients have used all their referred services, they need to obtain a new referral from their GP. This does not have to take the form of a new plan or formal review.

3. Aboriginal and Torres Strait Islander health assessment – Follow-up services

Relevant items: 81300 to 81360, 93048 and 93061

3.1. Eligibility for follow-up services of people who have received an Aboriginal and Torres Strait Islander health assessment

The aim of the health assessment follow-up items is to help ensure that Aboriginal and Torres Strait Islander people receive primary health care matched to their needs, by encouraging early detection, diagnosis and intervention for common and treatable conditions that cause morbidity and early mortality. This includes items for Aboriginal and Torres Strait Islander health services as well as follow-up services provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner, on behalf of a medical practitioner, for an Indigenous person who has received a health assessment (item 10987).

A person who identifies as Aboriginal or Torres Strait Islander may be referred by their GP for follow-up allied health services under items 81300 to 81360 (with corresponding telehealth items 93048 for video attendances and 93061 for telephone attendances), when the GP has undertaken an Aboriginal health assessment and identified a need for such services.

These items are similar to the individual allied health items (items 10950 to 10970) available to patients who have a chronic or terminal medical condition and complex care needs and have a GP Management Plan (GPMP) and Team Care Arrangements prepared by their GP. Items 81300 to 81360 and their telehealth equivalents provide an additional referral pathway for Aboriginal and Torres Strait Islander people to access allied health services. If a patient meets the eligibility criteria for individual allied health services under the GPMP and follow-up allied health services, they can access both sets of services.

3.2. What are the referral and reporting requirements for allied health follow-up services for people who have received an Aboriginal and Torres Strait Islander health assessment?

For follow-up allied health services for Aboriginal and Torres Strait Islander people, the referring practitioner must use the referral form that has been issued by the Australian Government Department of Health or a form that contains all the components of this form.

Please note that this referral form is different to the referral form required to access chronic disease management (CDM) allied health services. The form issued by the Department is available here:
www1.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare_ATSI_mbsha_resource_kit

The reporting requirements for these services are similar to the CDM items–that is, following the first and last service provided by a particular AHP. Note that the referral and reporting requirements must be separately satisfied for both follow-up and CDM items.

4. Group allied health services for patients with type 2 diabetes

Relevant items: 81100 to 81125, 93284

4.1. Eligibility of patients with type 2 diabetes for group allied health services

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

- a GP Management Plan; or
- for a resident of a residential aged care facility, the GP or medical practitioner must have contributed to, or contributed to a review of, a care plan prepared for them by the facility; or
- a Health Care Home shared care plan.

Unlike the individual allied health services under items 10950 to 10970, there is no additional requirement for Team Care Arrangements for the patient to be referred for group allied health services.

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

4.2. What are the referral and reporting requirements for group allied health services for patients with type 2 diabetes?

The GP must refer the patient using the referral form for group allied health services for patients with type 2 diabetes or a form that contains all the components of this form. The form issued by the Department is available at: www1.health.gov.au/internet/main/publishing.nsf/Content/mbsprimary-ahgs-diabetes.htm

If a patient has not used all of their group allied health services consistent with their assessment recommendation in a calendar year, any ‘unused’ services can be used in the following year as long as the total does not exceed the number of services recommended, or a maximum of eight in any one calendar year.

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

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

5. Autism, pervasive developmental disorder and disability services

Relevant items: 82000 to 82035, 93032 to 93036, 93040 to 93044

5.1. Who is eligible for autism, pervasive developmental disorder or disability services?

To access autism, pervasive developmental disorder or disability services, a child can be referred by a consultant paediatrician or psychiatrist for the following allied health services:

Up to four diagnostic / assessment services in total from psychologists, speech pathologists, occupational therapists, audiologists, optometrists, orthoptists or physiotherapists to assist the referring practitioner with diagnosis, or to contribute to a child's treatment and management plan (for a child under 13 years of age).

Up to 20 treatment services from psychologists, speech pathologists, occupational therapists, audiologists, optometrists, orthoptists or physiotherapists (for a child under 15 years of age, providing a treatment and management plan is in place before their 13th birthday).

5.2. What are the referral and reporting requirements for autism, pervasive developmental disorder or disability services?

Referring medical practitioners are not required to use a specific form to refer patients for the allied health services available through the Helping Children with Autism program. The referral may be a letter or note to an eligible AHP, making clear the type and number of services being referred, and signed and dated by the referring practitioner.

On completion of a course of treatment, the eligible audiologist, occupational therapist, optometrist, orthoptist, physiotherapist, psychologist and speech pathologist must separately provide a written report to the referring practitioner which includes information on:

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

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

6. COVID-19 allied health telehealth services

Relevant items: 93000 to 93286

Further information on the COVID-19 telehealth items is available at:
www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-TempBB

6.1. When can telehealth items for allied health services be used?

The clinical requirements for all COVID-19 telehealth services are the same as for the face-to-face service to which they correspond. A service may only be provided by telehealth where it is safe and clinically appropriate to do so. AHPs should also have regard to patient needs and preferences such as culturally safe services, privacy and IT resources. The MBS telehealth items allow people to access essential Medicare-funded health services remotely and reduce their risk of exposure to COVID-19.

Videoconference services are the preferred substitute for face-to-face attendances. However, in response to the COVID-19 pandemic, providers may also offer audio-only services via telephone if video is not a viable option. There are separate items available for video and audio-only services.

Patients, including residents of residential aged care facilities, must be present when receiving MBS services whether face-to-face, by video or by telephone.

Third parties, such as parents of young children or carers of people with communication difficulties, may need to communicate with the AHP at times during or for the entirety of telehealth and telephone consultations, and may be required to facilitate any activities at the patient end of the consultation.

As with all MBS services, where a person other than the patient is responsible for paying the account, the claim for the service should identify the patient as such and the other person as the claimant. The Medicare benefit will be paid to the claimant.

The COVID-19 items are intended to be direct substitutes for the corresponding existing item. Any administrative conditions applying to the existing item also apply to the COVID-19 items. For example, if a valid referral is required for the existing item, the COVID-19 item also requires a valid referral.

For the purposes of the COVID-19 MBS items, a telehealth attendance by videoconference means a professional attendance where the health practitioner:

- has the capacity to provide the full service through this means safely and in accordance with professional standards; and
- is satisfied that it is clinically appropriate to provide the service to the patient; and
- maintains a visual and audio link with the patient (and carers if applicable); and
- is satisfied that the software and hardware used to deliver the service meets the applicable laws for security and privacy.

For the purposes of the COVID-19 MBS items, a telehealth attendance by telephone means a professional attendance where the health practitioner:

- has the capacity to provide the full service through this means safely and in accordance with professional standards; and
- is satisfied that it is clinically appropriate to provide the service to the patient; and
- maintains an audio link with the patient (and carers if applicable).

- No specific equipment is required to provide Medicare-compliant telehealth services. Health professionals must ensure that their chosen telecommunications solution meets their clinical requirements and satisfies privacy laws.

6.2. Do I need to bulk bill patients for telehealth consultations?

No. AHPs are currently not required to bulk bill the telehealth items. However, in general all Medicare providers are expected to have regard to their patients' financial circumstances when billing, and to obtain informed financial consent from patients prior to charging private fees.

7. New items for services in residential aged care facilities

Relevant items: 93501 to 93620, 90004

7.1. What are the new MBS items for residential aged care facilities?

From 10 December 2020 until 30 June 2022, temporary MBS items allow access to multidisciplinary care for residents of residential aged care facilities (RACFs) during the COVID-19 pandemic.

This includes temporary items to support RACF residents' increased access to Medicare-subsidised allied health services. The new MBS items for patients living in a RACF replicate the existing items for allied health services for:

- chronic disease management (CDM) (face-to-face 93524 – 93536; video 93537; telephone 93538);
- Indigenous follow-up services for eligible patients (face-to-face 93579 – 93591; video 93592; telephone 93593); and
- group allied health services (face-to-face 93606 – 93620; video 93285 – 93286; telephone 93286 assessment item only).

In addition, new items support access for up to five additional services per calendar year for selected physical therapy services, provided by exercise physiology, occupational therapy and physiotherapy (CDM items 93518 – 93520; Aboriginal and Torres Strait Islander follow up items 93571 – 93573). Initially, patients were eligible for these services only when they had used their existing allocation of five allied health services, even if more than one type of AHP was involved in providing the initial five services. However, this requirement was removed on 1 October 2021 and patients can now access the physical therapy services at any point in their treatment. No new referral is required if the additional physical therapy services were already included in a patient's eligible treatment, management or care plan.

These physical therapy items are applicable to non-admitted patients who reside in a RACF and cannot be claimed as part of hospital treatment. The physical therapy services must be provided face-to-face.

RACF residents may also access temporary items for initial/long attendances with AHPs (CDM items 93501 – 93513 and Aboriginal and Torres Strait Islander follow-up items 93546 – 93558). The initial/long attendance items can only be claimed once per AHP type per calendar year.

Additionally, AHPs may claim a call-out or 'flag-fall' fee to cover their costs to travel to a RACF to provide a face-to-face service (see below for details, including restrictions on claiming flag-fall items).

Further information about the temporary COVID-19 Allied Health Support Services for Aged Care Residents can be found in the fact sheet.

7.2. How do the initial/long attendance items work?

The temporary initial/long attendance items allow AHPs to undertake an extended consultation with a RACF resident referred to them under an eligible treatment, management or care plan. They may be claimed only once per patient per calendar year for each type of service. For example, a patient may receive initial attendances once each for podiatry and physiotherapy, but not twice for a service by the same type of provider.

Initial/long attendance items are included in patients' maximum allocation of allied health services per calendar year. This means there is a maximum of ten individual services per

calendar year when the additional five physical therapy items are included. These new arrangements are also available to Aboriginal and Torres Strait Islander patients living in a RACF, who are eligible for allied health follow-up services after receiving an Aboriginal and Torres Strait Islander health assessment.

The temporary initial/long attendance allied health items must be provided face-to-face.

7.3. When can I claim the flag-fall item 90004?

The flag-fall is intended to compensate AHPs for travel costs in visiting a RACF and are to be claimed per RACF visit rather than per patient attendance. Where two or more RACFs are co-located or are adjacent to each other, and no additional travel costs are incurred in moving from one facility to another, a practitioner is not eligible for extra compensation for visiting the second facility. The flag-fall items apply to a provider's first attendance at a RACF to provide an MBS service, per visit. Once the flag-fall item is billed, providers may then bill an applicable attendance item for each of the RACF patients they see.

Note that the flag-fall must be claimed in the same manner as the corresponding attendance item. For example, if the first attendance at the RACF is privately billed then the flag fall cannot be bulk billed.

Recognising the ongoing risk of COVID-19 transmission and the vulnerable population of aged care residents, AHPs should be mindful of their attendance to multiple RACFs and take appropriate precautions to minimise spread.

AskMBS metrics: 1 January 2020 – 31 December 2020

AskMBS receives enquiries from medical practitioners and health professionals providing MBS services as well as practice managers, billing agents, professional organisations, and a range of other stakeholders.

The service averages around 200 enquiries per week. Between commencing in the Department of Health and the end of December 2020, AskMBS received 15,981 enquiries and finalised responses to 15,467. Between January 2020 and December 2020 AskMBS received 9,952 enquiries and finalised responses to 9,580. The chart below shows a monthly breakdown of enquiries received and responses sent.

The chart shows a significant increase in activity in March and April resulting from the introduction of the COVID-19 MBS telehealth items, and in August and September with the introduction of new items based on recommendations of the MBS Review.