



QUESTIONS AND ANSWERS: WEBINAR - NEW AND REVISED ITEMS FOR RESPIRATORY AND SLEEP STUDIES

Webinar date: 29 November 2018 **Time:** 11:30 am (Australia/Sydney UTC+11:00)

The webinar can be viewed online [here](#).

QUESTIONS

During and immediately following the webinar, a number of questions were received in regards to new and revised Medicare Benefits Schedule (MBS) items for respiratory and sleep studies. Some questions covered the same content and have been answered in one question.

Question No#	Question
RESPIRATORY	
1	Is billing overnight oximetry study for item 11503 still available?
2	Why can only consultant respiratory physicians report on tests under items 11503, 11508 and 11512? Were other professional organisations consulted?
3	Can item 11503 still be used for cardiopulmonary exercise testing (CPET)?
4	What is the evidence based reason for the rebate of item 11505 (diagnosis) at a fee of \$41.10, and a repeat spirometry item 11506 at only a fee of \$20.55 when the cost to deliver the service and clinical value is the same?
5	For item 11503, what tests does (c)(iii) 'measurement of airway or pulmonary resistance by any method' include? Does this include rhinomanometry?
6	When can a six minute walk test be reimbursed by Medicare?
7	Can item 11512 be billed if a patient has had a bronchodilator prior to performing spirometry, and a post spirometry is not required?
8	Why were the providers of pulmonary function tests not notified of the changes? The first notification I received after performing the tests for many years was when Medicare benefits were refused on November 1st.
9	Can item 11508 for CPET be performed by an anaesthetist?
10	Can fractional exhaled nitric oxide (FeNO) spirometry be performed at a physician's desk under the supervision of a specialist or consultant physician with a nurse present instead of a respiratory scientist?
11	Is it possible to claim item 11503 for a DLCO and also item 11507 for a spirometry and FeNO during the same attendance for a patient?
12	How do we know if another medical practitioner has billed an item 11505 for spirometry (as it is a one off payment per patient in a 12 month period) - do we have to contact Medicare before billing?

Question No#	Question
SLEEP STUDIES	
13	Does a sleep physician consult overrule the explanatory notes for the contraindications of a home-based sleep study (HBSS) that is, as long as the patient has a consult they can have a laboratory-based sleep study (LBSS)?
14	The split between HBSS & LBSS is currently 50/50. What is the government expectations following the implementation of the new guidelines?
15	Why was the Clinical Committee comprised only of city based specialists? Was any consideration given to rural and regional communities, especially where access to consultant respiratory physicians is very limited?
16	Patients that have a high probability for moderate to severe obstructive sleep apnoea must have an unattended study NOT an attended study unless contraindications for an unattended sleep are met. Yes/No?
17	Item 12204 states that the patient cannot be on positive airway pressure (PAP) therapy for 6 months prior. Can a patient's initial AutoPAP trial (to acclimatise before their CPAP sleep study) be considered as part of the initiation period?
18	With the sleep screening questionnaires, how much detail must be obtained from the referrer (i.e. copy of the questionnaires or simply the patient scores)?
19	What steps has the NPS taken to disperse info to GP's and referrers? Where/who can we direct our referrers to as very few seem to be aware of the screening requirements.
20	Item 12205 refers only to changes in weight or co morbid conditions etc but clarification notes refer to assessment of mandibular advancement splint (MAS). Is this code used to assess efficacy of MAS/oxygen therapy? as 12204 CPAP only
21	For item 12250, once criteria are met do records need to be kept that the sleep physician approval the sleep study?
22	For the purposes of billing for a sleep study, does the referral need to be addressed to a specific physician?
23	For item 12250, if it is not possible for the equipment to be fitted by a trained technician, is it possible for the patient to fit the equipment themselves?
24	Is there any option for a home treatment review study if 12250 is just to confirm diagnosis?
25	For item 12250, if a specialist is named on the referral, does there need to be a specialist to specialist referral if a different specialist is used for the entire process.
26	Item 12203/12250 requires referral from medical practitioner or professional attendance with a physician. Implications for dentist referrals seen by physician and non-referred, off-Medicare consults? Can they have an item 12203/12250?
27	Can ENT (Ear Nose Throat Specialist)/Cardiologists refer directly to sleep laboratory studies or does the patient now have to see a sleep physician in order to meet the new criteria? Previously they could refer directly.

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28	Can a video conference call between a patient and GP and billed privately to the patient constitute a valid referral (to a sleep physician for 12250)?
29	For item 12250, if the GP has referred the patient with the completed questionnaires, can the patient be referred directly for the home study or do they need to see a sleep physician first?
30	Are laboratory sleep studies performed as inpatient or outpatient settings?
31	Item 12207 specifically states ' if the patient has severe cardio-respiratory failure'. Can this item be billed for patient who has central apnoeas without cardio-respiratory failure or a patient who does not have severe cardio-respiratory failure?
32	What item number should be used for split studies, having both a diagnostic and PAP component in one night?
33	Can a home-based sleep test be used the night prior to Multiple Sleep Latency Resting (MSLT) and Maintenance of Wakefulness Testing (MWT)? (rather than in-lab)
34	It is not clear on the requirements for GP referrals to investigate other sleep disorders, for example periodic limb movement disorder (PLM), insomnia, narcolepsy. Can you please explain?
35	In order to bill for item 12250 & 12203 by a physician, receiving a referral from a GP, is that original referral required to be named?
36	What is the correct item now for a standalone MWT (no diagnostic beforehand)?
37	If a GP directly referred a patient for a home-based sleep study and the sleep physician has confirmed the necessity, does the sleep centre need to notify the referring doctor of this approval before conducting the home-based sleep study?
38	If there is a failed home study (for example a lead detaches from a patient because their dog jumps on them!) - What are our options? Can we perform a lab study on this patient? If not, this patient then runs the risk of remaining undiagnosed for a year until they can have another sleep study.
39	Following a sleep physician consultation (as specified in paragraph (a) ii) of item 12203), can the sleep physician choose for the patient to have a laboratory-based study (and not a home-based study)?
40	Does the new item number wording mean that a home study (rather than a lab study) should be the default investigation for suspected obstructive sleep apnoea (OSA)? Is physician preference (that lab study is a better test) enough for a patient to have a lab study over a home study?
41	When it states 'only once a year' in the sleep study item numbers, does this refer to once in a calendar year? Or does the year start from the date of the initial attendance.
42	Where a specialist has been billed with Medicare 12250 but then goes away and doesn't get to report it prior to leave, can another physician report it in his absence (if unplanned leave)?

Question No#	Question
43	My reading of the updated Medicare guidelines is that as a consultant respiratory physician I can order a home sleep study in appropriate patients (selected using a validated tool plus Epworth Sleepiness Scale). If I then report that study I am able to utilise the new 12250 item number. Is that correct?
44	Where a specialist approves a study but it has not yet been billed, can another specialist report and item 12250 gets billed to them?
45	Billing scenario – Item 12205
46	Item 12254 - MSLT, says an overnight diagnostic assessment like item 12203. What if the patient is on PAP and still unexplained hyper somnolence? Can a CPAP overnight study happen followed by the naps trials?
47	Which sleep item number can be used for initial oxygen titration therapy?
48	Is there a way of claiming TcCO2 separately, in addition to item 12203 for a patient having an in-lab PSG for suspected hypoventilation?
49	Clarification on item 12250 for home-based sleep tests.

RESPIRATORY

1. Is billing overnight oximetry study for item 11503 still available?

A. No, in line with the recommendations of the MBS Review Taskforce, item 11503 has been revised to provide rebates for a range of common complex lung function tests that are supported by clinical evidence and are performed in a respiratory laboratory.

Oximetry is not generally performed in a laboratory-based setting and has therefore been excluded as an eligible test for the purposes of item 11503. Before a new MBS item could be listed for oximetry, the service would need to be assessed and recommended for public funding by the independent Medical Services Advisory Committee (MSAC). The MSAC process would include an assessment of which patients would benefit the most from this test. Further information on the [MSAC website](#).

2. Why can only consultant respiratory physicians report on tests under items 11503, 11508 and 11512? Were other professional organisations consulted?

A. The MBS Review Taskforce considered that tests billed to items 11503, 11508 and 11512 should be reported on by respiratory physicians. The Thoracic Medicine Clinical Committee's (TMCC) proposed recommendations for the thoracic medicine items (including items 11503, 11508 and 11512) consisted of a broad public consultation process where any organisation could make a submission and the outcomes of the consultation process were included in the TMCC report which was published on the MBS Reviews website in late 2016. Following public consultation, the TMCC retained its key recommendations for items 11503, 11508 and 11512, including that tests billed to these items be reported on by respiratory physicians.

3. Can item 11503 still be used for cardiopulmonary exercise testing (CPET)?

A. No, the tests which attract a rebate under item 11503 are listed in the item descriptor. From 1 November 2018, a new item has been listed for CPET (item 11508). The requirements for performing CPET under the MBS are outlined in the descriptor for item 11508. Professor Christine Jenkins spoke to this question during the webinar (see 46.40 minute mark).

4. What is the evidence based reason for the rebate of item 11505 (diagnosis) at a fee of \$41.10, and a repeat spirometry item 11506 at \$20.55 when the cost to deliver the service and clinical value is the same?

A. A higher fee was allocated to 11505 (\$41.10) to encourage the use of initial appropriately performed spirometry for the diagnosis of asthma, COPD and other causes of lung flow limitation in the primary care setting. The fee for item 11505 was informed by a rapid evidence review. Item 11505 has a higher fee as it is intended for initial diagnosis and is only available once per patient in a 12 month period. Item 11506 is intended for ongoing monitoring and has the same level of rebate as previously available for office-based spirometry. Professor Christine Jenkins spoke to this question during the webinar (see 49.10 minute mark)

5. For item 11503, what tests does (c)(iii) 'measurement of airway or pulmonary resistance by any method' include? Does this include rhinomanometry?

A. The wording of paragraph (c)(iii) is based on the recommendations of the MBS Review Taskforce and is intended to refer to a set of validated tests of airflow in the intra-thoracic airways, measured by several different techniques. The Taskforce did not intend for rhinomanometry to attract a rebate under item 11503.

However, given the nares are anatomically part of the upper airways, the service would appear to meet the criteria as per the current wording of (c)(iii). However, a rhinomanometry service billed to the item would need to satisfy the other requirements of the descriptor including that it be performed in a respiratory laboratory and the test reported on by a consultant respiratory physician.

6. When can a six minute walk test be reimbursed by Medicare?

A. The 6 minute walk test attracts a rebate under item 11503. The requirements for performing the test under item 11503 are outlined in the item descriptor.

7. Can item 11512 be billed if a patient has had a bronchodilator prior to performing spirometry, and a post spirometry is not required?

A. A service billed to Medicare must meet all the requirements as outlined within the relevant item descriptor. For item 11512, it is a requirement that the measurement of spirometry be performed before and after inhalation of a bronchodilator for the service to be eligible for a Medicare rebate.

8. Why were the providers of pulmonary function tests not notified of the changes?

A. The proposed changes were subject to a broad public consultation process as part of the MBS Review process. Reports and recommendations of the Taskforce were published on the [Department of Health website](#).

The Department notified peak professional groups about the changes following the release of the Budget on 8 May 2018. Communication materials, including fact sheets about the changes were circulated to relevant professional groups in late September 2018 for dissemination to members and fellows.

Information about the changes was published on the [MBS Online website](#). This website has a range of materials available, including latest news, downloadable files, fact sheets and Q and A documents. MBS Online has an email subscription service and subscribers would have been informed of the changes prior to any changes to the MBS.

9. Can item 11508 for CPET be performed by an anaesthetist?

A. The descriptor for item 11508 does not preclude an anaesthetist (or other specialists) from performing the test as long as a respiratory scientist and a medical practitioner are in constant attendance during the testing as per paragraph (c). However, as specified in paragraph (f), only a consultant respiratory physician (i.e. specialist in respiratory medicine) can report on the test (a requirement in line with the recommendations of the MBS Review Taskforce).

10. Can fractional exhaled nitric oxide (FeNO) spirometry be performed at a physician's desk under the supervision of a specialist or consultant physician with a nurse present instead of a respiratory scientist?

A. No, given the descriptor for item 11507 specifies "with continuous attendance by a respiratory scientist" and "in a respiratory laboratory equipped to perform complex lung function tests", these requirements must be met when performing the FeNO service. These requirements are based on the recommendations of the MBS Review Taskforce.

11. Is it possible to claim item 11503 for a DLCO and also item 11507 for a spirometry and FeNO during the same attendance for a patient?

A. Both 11503 and 11507 cannot be claimed during the same attendance. This is because from 1 November 2018, item 11503 will specify "Not applicable to a service performed in association with a spirometry or sleep study service to which item 11505, 11506, 11507, 11508, 11512, 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies".

This requirement means that if item 11503 is provided to the patient at the same attendance as an item 11507, benefits would be payable for the service under item 11507, but not item 11503.

12 How do we know if another medical practitioner has billed an item 11505 for spirometry (as it is a one off payment per patient in a 12 month period) - do we have to contact Medicare before billing?

A. If there is any uncertainty on whether the patient is eligible for another rebate for a service under item 11505, the Department of Human Services Medicare Provider Enquiry Line can be contacted on **132 150**.

Information on patient Medicare item numbers is also available through Health Professional Online Services (HPOS). Further information on HPOS is available at the [Department of Human Services Medicare website](#).

SLEEP STUDIES

13. Does a sleep physician consult overrule the explanatory notes for the contraindications of a home-based sleep study (HBSS) that is, as long as the patient has a consult they can have a laboratory-based sleep study (LBSS)?

A. No, regardless of whether the patient has a consultation with a consultant respiratory physician or qualified sleep medicine practitioner, there needs to be reason as to why the patient requires a laboratory-based study rather than a home-based (or unattended) study. The reason must be documented. Dr Maree Barnes provides further information on this issue during the webinar (see 33.30 and 43.10 minute marks).

14. The split between HBSS & LBSS is currently 50/50. What is the government expectations following the implementation of the new guidelines?

A. The decision on whether a patient should receive a laboratory-based study versus a home-based study should be based on clinical need. Given the new triage arrangements for sleep studies, there will likely be an increase in home-based studies. There is no ratio of home-based studies to laboratory-based studies which the sleep service needs to meet or for which the department is aiming for.

15. Why was the Clinical Committee comprised only of city based specialists? Was any consideration given to rural and regional communities, especially where access to consultant respiratory physicians is very limited?

A. While the membership of the TMCC of the MBS Review Taskforce did not include a specialist from a rural and regional community, the TMCC did take into account considerations around rural and remote medicine, such as obtaining feedback on the proposed recommendations from rural and remote-based physicians. Professor Christine Jenkins provides further information on this issue during the webinar (see 59.35 minute mark).

16. Patients that have a high probability for moderate to severe obstructive sleep apnoea must have an unattended study NOT an attended study unless contraindications for an unattended sleep are met. Yes/No?

A. Yes, noting that the list of contraindications for an unattended study as outlined in the MBS Explanatory Note [DN.1.17](#) is not an exhaustive list. It is the decision of the referring practitioner, qualified sleep medicine practitioner or consultant respiratory physician as to whether the patient has a contraindication for a HBSS. However, it is important that the reason why the patient is unsuitable for a HBSS is documented. Dr Maree Barnes provides further information on this issue during the webinar (see 33.30 and 43.10 minute marks).

17. Item 12204 states that the patient cannot be on positive airway pressure (PAP) therapy for 6 months prior. Can a patient's initial AutoPAP trial (to acclimatise before their CPAP sleep study) be considered as part of the initiation period?

A. Yes, the requirement in the descriptor for item 12204 that "the patient has not undergone positive airway pressure therapy in the previous 6 months" is deemed to be from the date of the professional attendance before the study (not the date which the service was performed).

18. With the sleep screening questionnaires, how much detail must be obtained from the referrer (i.e. copy of the questionnaires or simply the patient scores)?

A. While it is not mandatory, the department recommends a copy of the full screening questionnaires are provided with the referral and not just the patient scores from the screening questionnaires. However, it is still possible to proceed if just the score is provided by the referring practitioner. For auditing purposes, the referrer should keep documentation to demonstrate the questionnaires were administered to the patient in full.

19. What steps has the NPS taken to disperse info to GP's and referrers? Where/who can we direct our referrers to as very few seem to be aware of the screening requirements.

A. Referrers can view information on the new referral arrangements for sleep studies on the Royal Australian College of General Practitioners (RACGP) website at: www1.racgp.org.au/news/gp/professional/changes-to-the-medicare-benefits-schedule-what-gps.

Information on the new referral arrangements is also available on the [fact sheets](#) page of the [MBS Online website](#).

20. Item 12205 refers only to changes in weight or co morbid conditions etc but clarification notes refer to assessment of mandibular advancement splint (MAS). Is this code used to assess efficacy of MAS/oxygen therapy? as 12204 CPAP only

A. The availability of item 12205 to assess treatment effectiveness of a number of therapies is in line with the recommendations of the MBS Review Taskforce.

21. For item 12250, once criteria are met do records need to be kept that the sleep physician approval the sleep study?

A. Yes, the approval for the necessity for the sleep study by the consultant respiratory physician or qualified sleep medicine practitioner must be documented.

22. For the purposes of billing for a sleep study, does the referral need to be addressed to a specific physician?

A. No, the referral can be to the service and not to a specific physician. Referrers should let patients choose where to present the referral (this also applies to electronic referrals). Further information on referrals is outlined at questions 25 and 35.

23. For item 12250, if it is not possible for the equipment to be fitted by a trained technician, is it possible for the patient to fit the equipment themselves?

A. Yes, where circumstances do not permit the fitting the equipment to the patient by a sleep technician, the patient can be shown how to correctly apply the equipment by a sleep technician and be provided with written instructions. It is a requirement that the reason for not fitting the equipment to the patient in the clinic be documented.

24. Is there any option for a home treatment review study if 12250 is just to confirm diagnosis?

A. The revised structure of items does not include an item for a home-based treatment review study. Before a new MBS item could be listed for this type of service, assessment and recommendation for public funding by the independent MSAC may be required. Further information on the MSAC is available on the [MSAC website](#). Dr Maree Barnes spoke to this question during the webinar (see 59:00 minute mark).

25. For item 12250, if a specialist is named on the referral, does there need to be a specialist to specialist referral if a different specialist is used for the entire process.

A. A referral does not need to be named. There is no requirement for referrals to be made out to a certain specialist or consultant physician (see question 35 for further information). However, if a named referral has been received by a practitioner who is not the practitioner who will determine the necessity for the sleep study, the practitioner can write a specialist to specialist referral to the relevant practitioner who will be determining the necessity for the sleep study. The report on the study does not need to be provided by the same qualified sleep medicine practitioner who determined the necessity for the study. It is a requirement that the qualified sleep practitioner who reported on the study bill the item.

Alternatively, if a named referral has been received by a practitioner who is not the practitioner who will determine the necessity for the sleep study, the referrer could be contacted to discuss the possibility of re-issuing the referral as appropriate.

26. Item 12203/12250 requires referral from medical practitioner or professional attendance with a physician. Implications for dentist referrals seen by physician and non-referred, off-Medicare consults? Can they have an item 12203/12250?

A. From 1 November 2018, a patient can receive a service under item 12203/12250 via two pathways – either:

- Pathway 1: referral directly for testing by a medical practitioner (without a consultation with a qualified sleep medicine practitioner or a consultant respiratory physician) where approved screening tools suggest a high pre-test probability for the diagnosis of symptomatic, moderate to severe obstructive sleep apnoea (OSA); or
- Pathway 2: professional attendance (either face-to-face or by video conference) with a qualified sleep medicine practitioner or a consultant respiratory physician to determine if the investigation is necessary to confirm the diagnosis of OSA.

Pathway 1: If a dental practitioner is also a licensed medical practitioner, they would be able to directly refer a patient for a sleep study under item 12203/12250 using the approved screening tools.

Pathway 2: If a dental practitioner is able to claim the oral and maxillofacial items in Category 4 of the MBS, this dental practitioner could refer the patient to a consultant physician (qualified sleep medicine practitioner or a consultant respiratory physician). Further information on the dental practitioners with access to Category 4 is available [here](#).

In regards to the professional attendance in Pathway 2, this does not need to be billed to Medicare (see Question 28). Dental practitioners who are not medical practitioners and cannot refer may wish to contact the patient's GP to discuss the need for referral (the GP could then refer the patient directly for testing if required).

27. Can ENT (Ear Nose Throat Specialist)/Cardiologists refer directly to sleep laboratory studies or does the patient now have to see a sleep physician in order to meet the new criteria? Previously they could refer directly.

A. Under the new arrangements, patients referred directly for sleep studies by ENT or cardiologists would still need to meet the relevant criteria using the screening questionnaires (as per direct referral from a GP). Dr Maree Barnes spoke to this question during the webinar (see 53.00 minute mark).

28. Can a video conference call between a patient and GP and billed privately to the patient constitute a valid referral (to a sleep physician for 12250)?

A. It would be acceptable for a GP to assess a patient via telehealth if this is deemed to be clinically appropriate. There would be no need for the consultation to be billed to Medicare.

If the patient is directly referred to the sleep physician using the screening questions, the patient would require a valid referral. A referral would be considered valid if it includes the following information:

- relevant clinical information about the patient's condition for investigation, opinion, treatment and/or management
- the date of the referral, and
- the signature of the referring practitioner

In relation to the second pathway (paragraph a)(ii) of the item descriptor), there is no requirement for the professional attendance with the qualified sleep medicine practitioner or consultant respiratory physician to be billed to Medicare. The professional attendance can be billed privately to the patient and could also be performed via telehealth should this be considered clinically appropriate. Practitioners should keep an appropriate clinical record of the professional attendance.

For further clarification, the Department of Human Services Medicare Provider Enquiry Line can be contacted on **132 150**.

29. For item 12250, if the GP has referred the patient with the completed questionnaires, can the patient be referred directly for the home study or do they need to see a sleep physician first?

A. If the patient has been referred via the direct pathway (paragraph (a)(i) of the item descriptor and meets the score criteria of the screening questionnaires), the patient does not need to have a consultation (either face to face or via telehealth) with the consultant respiratory physician or qualified sleep medicine practitioner. However, the qualified sleep medicine practitioner or consultant respiratory physician still needs to determine the necessity for the study (based on the results of the screening questionnaires) but this does not need to occur during a consultation.

30. Are laboratory sleep studies performed as inpatient or outpatient settings?

A. Items 12203, 12204, 12205, 12207 and 12208 for laboratory-based sleep studies have both a 75% and 85% rebate.

31. Item 12207 specifically states 'if the patient has severe cardio-respiratory failure'. Can this item be billed for patient who has central apnoeas without cardio-respiratory failure or a patient who does not have severe cardio-respiratory failure?

A. Services billed to Medicare must meet all the requirements as outlined within the relevant item descriptors. Given item 12207 specifies 'if the patient has severe cardio-respiratory failure', the item would not apply where the patient does not have cardio-respiratory failure or non-severe cardio-respiratory failure. It is for the clinical judgement of the practitioner to determine the severity of the cardio-respiratory failure (severe versus non severe).

32. What item number should be used for split studies, having both a diagnostic and PAP component in one night?

A. Currently, there is not a specific item listed for a split diagnostic-treatment study. Before an MBS item could be listed for this type of service, assessment and recommendation for public funding by the independent MSAC may be required. Further information on the MSAC is available on the [MSAC website](#).

33. Can a home-based sleep test be used the night prior to Multiple Sleep Latency Resting (MSLT) and Maintenance of Wakefulness Testing (MWT)? (rather than in-lab)

A. No, the new set of items for MSLT and MWT in adult and paediatric patients require a laboratory-based study be performed. Further information on these new items is available [here](#) on the MBS Online website.

34. It is not clear on the requirements for GP referrals to investigate other sleep disorders, for example periodic limb movement disorder (PLM), insomnia, narcolepsy. Can you please explain?

A. Items 12254 to 12272 for MSLT or MWT do not require a referral by a medical practitioner. However, these items require that a qualified sleep medicine practitioner (or neurologist in the case of items 12254 and 12258) determines that testing is necessary, either through face to face consultation or via telehealth.

GPs can refer patients to a sleep medicine practitioner for other sleep disorders such as narcolepsy, insomnia and PLMs. However, they cannot have a sleep study unless this is deemed appropriate during the consultation. The direct referral pathway of item 12203 and 12250 is for the investigation of obstructive sleep apnoea only.

35. In order to bill for item 12203 & 12250 by a physician, receiving a referral from a GP, is that original referral required to be named?

A. No, the referral does not need to be named. There is no requirement for referrals to be made out to a certain specialist or consultant physician. There is also nothing to preclude a referral being addressed to a non-named specialist such as a business, as long as the referral includes the following information:

- relevant clinical information about the patient's condition for investigation, opinion, treatment and/or management
- the date of the referral, and
- the signature of the referring practitioner

However, in the event that a referral has been specifically addressed to a named specialist but a locum is covering, the patient does not have to be seen by the named specialist – they can be seen under that referral by the locum. A new referral is not required as it is accepted medical practice that the original referral applies to the locum. Additional information on referrals is available on the [Department of Human Services Website](#).

36. What is the correct item now for a standalone MWT (no diagnostic beforehand)?

A. There is no item available for a MWT that does not contain an overnight sleep study as part of the service. Before a new MBS item could be listed for this type of service, assessment and recommendation for public funding by the independent MSAC may be required. Further information on the [MSAC website](#).

From 1 November 2018, new items for MSLT/MWT were listed on the MBS (items 12254 to 12272). These items include both the overnight laboratory-based study component and the daytime component. Further information on the new items is available [here](#) of the MBS Online website.

37. If a GP directly referred a patient for a home-based sleep study and the sleep physician has confirmed the necessity, does the sleep centre need to notify the referring doctor of this approval before conducting the home-based sleep study?

A. For item 12250 (home-based sleep studies), it is no longer a requirement that the necessity for the investigation be communicated back to the referring practitioner. However, it is appropriate practice for treating practitioners to provide feedback to referring practitioners on the patient's condition and treatment.

38. If there is a failed home study (for example a lead detaches from a patient because their dog jumps on them!) - What are our options? Can we perform a lab study on this patient? If not, this patient then runs the risk of remaining undiagnosed for a year until they can have another sleep study.

A. If all the requirements of item 12250 are not met, the failed study could not be billed to item 12250. Therefore, the patient could receive another HBSS under item 12250 if the practitioner considers this appropriate. If the second study meets all the requirements within the descriptor of item 12250 the service would then be eligible for a rebate.

It is the decision of the referring practitioner, qualified sleep medicine practitioner or consultant respiratory physician on whether the patient is not suitable for another home-based study. If the practitioner is of the view that the patient's home environment is not suitable for a home-based study, then this would be a valid reason for the patient to receive a laboratory-based study.

39. Following a sleep physician consultation (as specified in paragraph (a) ii of item 12203), can the sleep physician choose for the patient to have a laboratory-based study (and not a home-based study)?

A. Following an assessment of the patient, a qualified sleep medicine practitioner or consultant respiratory physician can deem a patient unsuitable for a home-based study. The reason why the patient is unsuitable for a home-based sleep study must be documented. Contraindications for a home-based study are listed in MBS Explanatory Note [DN.1.17](#), noting that it is not an exhaustive list of contraindications. Dr Maree Barnes provides further information on this issue during the webinar (see 33.30 and 43.10 minute marks).

40. Does the new item number wording mean that a home study (rather than a lab study) should be the default investigation for suspected OSA? Is physician preference (that lab study is a better test) enough for a patient to have a lab study over a home study?

A. In the scenario where a patient is referred for testing but has no contraindications for a home-based sleep study, then it would be appropriate for the patient to receive a home-based study. It is the decision of the referring practitioner, qualified sleep medicine practitioner or consultant respiratory physician on whether the patient is not suitable for a home-based study. The reason why the patient is not suitable for a home-based sleep study must be documented, but physician belief that a laboratory study test is better is not a valid reason. Contraindications for a home-based study are listed in MBS Explanatory Note [DN.1.17](#), noting that the list is not exhaustive.

41. When it states 'only once a year' in the sleep study item numbers, does this refer to once in a calendar year? Or does the year start from the date of the initial attendance.

A. For the sleep study items, each item is applicable to a patient in any 12 month period. For example, if a patient receives an item 12203 in February 2019, the patient can only receive another item 12203 from February 2020. The 12 period starts from the date on which the service under item 12203 was performed.

42. Where a specialist has been billed with Medicare 12250 but then goes away and doesn't get to report it prior to leave, can another physician report it in his absence (if unplanned leave)?

A. MBS item (e.g. 12250) should be billed once all the requirements of the item have been fulfilled (i.e. once the interpretation and preparation of a permanent report has been provided by a qualified sleep medicine practitioner).

Individual components of the sleep study service do not need to be performed by the same qualified sleep medicine practitioner.

The qualified sleep medicine practitioner who prepared the report on the results of the investigation must bill the relevant item.

43. My reading of the updated Medicare guidelines is that as a consultant respiratory physician I can order a home sleep study in appropriate patients (selected using a validated tool plus Epworth Sleepiness Scale). If I then report that study I am able to utilise the new 12250 item number. Is that correct?

A. Consultant respiratory physicians can order the home-based sleep study, either via the questionnaires or through face-to-face assessment. However the report must be provided by a qualified sleep medicine practitioner.

44. Where a specialist approves a study but it has not yet been billed, can another specialist report and item 12250 gets billed to them?

A. Yes, providing the qualified sleep medicine practitioner who prepares the report on the results of the investigation bills the item. From 1 November 2018, item 12250 also enables a 'consultant respiratory physician' to determine the necessity for the investigation, so if this occurs then the report on the investigation would need to be provided by a different practitioner anyway (given only a 'qualified adult sleep medicine practitioner' is only permitted to report on the test). Noting of course that 12250 can only be billed once per service.

45. Patient has been well-treated with CPAP for a number of years. They then develop recurrence of symptoms (EDS, snoring) and attend to sort this out. Pump download shows good adherence (4-6 hours/night, same as previously), minimal leak and AHI 2. No other obvious reason detected in a clinical consultation for recurrence of symptoms. Can the patient have a review CPAP billed with 12205?

A. Yes, the above scenario would be eligible for a rebate under item 12205. However, as per paragraph (a)(i) of the descriptor, if the recurrence of symptoms were due to inadequate usage of treatment, sleep duration or significant recent illness then item 12205 would not apply.

46. Item 12254 - MSLT, says an overnight diagnostic assessment like item 12203. What if the patient is on PAP and still unexplained hyper somnolence? Can a CPAP overnight study happen followed by the naps trials?

A. The study under item 12254 can be performed with PAP but not as a titration study. Item 12254 is applicable once per patient in a 12 month period.

47. Which sleep item number can be used for initial oxygen titration therapy?

A. Based on the information provided, this study may meet the requirements for an item 12205 (treatment initiation sleep study). It is for the clinical judgement of the practitioner to determine if the service meets the requirements set out in the item descriptor.

48. Is there a way of claiming TcCO₂ separately, in addition to item 12203 for a patient having an in-lab PSG for suspected hypoventilation?

A. No, it is not possible to claim a TcCO₂ separately for a patient having an in-lab PSG for suspected hypoventilation.

49. Item 12250 – where a patient is on CPAP treatment but has symptoms of OSA (i.e. meets ESS & StopBang/OSA50 etc criteria) are they eligible for a home sleep study on CPAP (if they have not had a study in the last 12 months) or do they need to have a prior Telehealth? (If a patient doesn't have symptoms but they have requested a follow up CPAP review or a MAS review? We understand this is no longer covered.)

A. There is currently no item number for home CPAP titration through the use of an auto-titrating machine. If the patient has recurrent symptoms and the download from the CPAP pump is ambiguous, then following either face to face review or telehealth, a CPAP effectiveness study (12205) could be performed in a laboratory. However, a treatment effectiveness study could not be performed if there is no clinical indication.