Listing of Repetitive Transcranial Magnetic Stimulation (rTMS) on the Medicare Benefits Schedule (MBS)

Frequently Asked Questions

Last updated: 29 October 2021

- For a summary of the new MBS items for rTMS, please refer to the Fact Sheets available on the MBS Online website at MBS Online. Providers should also refer to the item descriptors and explanatory notes on the website.
- The information in this document is to be read in conjunction with the other resources.
- These Frequently Asked Questions will be updated from time to time in response to questions from patients, providers and other stakeholders.

Why are Medicare rebates not available for patients who have previously received rTMS treatment, or for ongoing maintenance treatment?

The Government has followed the advice of the Medical Services Advisory Committee (MSAC) on these issues. MSAC is an independent, expert advisory group which provides advice to Government on whether new medical services should be publicly funded, based on an assessment of comparative safety, clinical effectiveness and cost-effectiveness, using the best available evidence.

Based on MSAC's advice to Government, Medicare rebates will be available for the initial course of treatment and one course of retreatment services over a patient's lifetime. MSAC supported the listing of rTMS for patients who have not previously received rTMS treatment.

MSAC also considered the use of rTMS as a maintenance treatment for major depressive disorder. MSAC found that, compared to initial treatment and retreatment courses, there was a limited evidence base for maintenance treatment.

Is there any discretion to increase the number of Medicare-funded rTMS treatment services to a patient?

No, the Medicare regulations allow a maximum of 50 treatment services (35 services initially and a further 15 services if clinically appropriate) over a person's lifetime.

How will the treating psychiatrist ascertain if a patient has received any prior rTMS treatment before?

Before commencing Medicare-funded rTMS services, the treating psychiatrist should make reasonable inquiries as to whether the patient has previously received any rTMS treatment. This includes considering any clinical records or referrals available to the psychiatrist regarding the patient's treatment history and asking the patient whether they have previously received any rTMS treatment (either through Medicare, privately funded or in a public setting). In the future, the patient will also be able to contact Services Australia to check whether they have previously received Medicare-funded rTMS treatment. The psychiatrist may rely on information provided to them by the patient in good faith about their treatment history.

In providing informed financial consent, the psychiatrist should explain to the patient that they will not be eligible for Medicare-funded rTMS services (and may incur additional out-of-pocket costs) if they have previously received rTMS treatment.

Will patients be eligible to claim a Medicare rebate for the balance of a partially completed course of self-funded rTMS treatment that commenced prior to 1 November 2021?

No, Medicare-funded rTMS services are only available to patients who have not previously received rTMS therapy in either a public or private setting. Therefore, if a patient has commenced a course of treatment privately, before 1 November 2021, they will not be eligible for Medicare-funded rTMS services to complete the course of treatment. This treatment should continue to be funded privately.

If a patient has commenced Medicare-funded rTMS with one provider (psychiatrist), must they complete all their Medicare-funded treatments with that one provider?

No, while it is expected that most patients would receive treatment from a single provider, this is not a requirement.

Is there a 'grandparenting' pathway for psychiatrists already trained in rTMS to use the MBS items?

Yes, from 1 November 2021, those providers (psychiatrists) who meet the RANZCP's 'grandparenting' criteria for rTMS will be eligible to use the MBS items. The MBS Explanatory Note TN.1.28 (available on the MBS Online website) details the requirements for the grandparenting pathway which will be available for a time-limited period. This is a self-declaration process, which requires providers to individually assess whether or not they meet the criteria. If providers meet the criteria, no further action is required and the rTMS item numbers can be used from 1 November 2021. Documentation confirming that the provider has met the grandparenting criteria may be requested by the Department as part of MBS compliance processes and activities. The grandparenting criteria are applicable for psychiatrists only. Providers should contact the RANZCP if they require clarification about the grandparenting criteria. Records must also be kept to demonstrate that all health care professionals providing rTMS services are appropriately trained.

Can another health care professional (other than a psychiatrist trained in the provision of rTMS) bill the MBS items?

No, while treatment and re-treatment services (covered by items 14217 and 14220) may be provided by an appropriately trained health care professional on behalf of a psychiatrist, the items can only be claimed by a psychiatrist. The health care professional may include a nurse practitioner, practice nurse, registered nurse, enrolled nurse or allied health professional trained in the provision of rTMS.

Prescription and mapping services (covered by items 14216 and 14219) can only be provided and claimed by a psychiatrist.

Where rTMS services are provided in a private hospital, the MBS items must still be claimed by a medical practitioner (psychiatrist) – the items cannot be claimed by the hospital itself.

Does a patient have to receive a prescription and mapping service (item 14216) before treatment services (item 14217) can be billed to Medicare?

Yes, although both services can be provided on the same day.

For a course of retreatment, item 14219 must be provided before item 14220, although both services can be provided on the same day.

Can a presciption and mapping service (item 14216) be provided more than once for the same patient?

For most patients, it is expected that item 14216 would only be claimed once, prior to commencing a course of treatment. However, item 14216 may be claimed more than once if there is a clinical need (e.g. for the purposes of re-establishing threshold for treatment), or if the patient's rTMS treatment is to be continued by another psychiatrist and prescription and mapping with the new practitioner is necessary in order to complete the treatment.

The same arrangements apply to prescription and mapping for a course of retreatment (item 14219).

Can the Medicare items be used for rTMS services provided as part of hospital treatment?

Yes. While it is expected that the majority of rTMS services will be provided as out-of-hospital treatment, there will be circumstances where some patients may require hospital treatment.

For private health insurance benefits purposes, procedures are defined in the *Private Health Insurance (Benefit Requirements) Rules 2011* (the Rules) by categorising MBS items into one of three categories:

- Type A procedures – performed in hospital and include part of an overnight stay (higher accommodation benefits);
- Type B procedures – performed in hospital but do not include part of an overnight stay (lower accommodation benefits); or
- Type C procedures – procedures not normally requiring hospital treatment and therefore hospital treatment benefits are not payable (no insurance benefits).

The rTMS MBS items have a Type C private health insurance procedure classification. Type C procedures are those not normally requiring hospital treatment under the *Private Health Insurance (Benefit Requirements) Rules 2011* (the Rules). However, the Rules allow for hospital accommodation and other private health insurance benefits to be paid for Type C procedures if certification is provided.

The medical practitioner (psychiatrist) providing the professional service must certify in writing that, because of the medical condition of the patient or because of the special circumstances specified, it would be contrary to accepted medical practice to provide the procedure to the patient except as hospital treatment in a hospital.

To assist psychiatrists, the Royal Australian and New Zealand College of Psychiatrists (RANZCP) and the Department will publish further guidance on the type of information required in a Type C certification. This guidance is currently being developed and will be available on the RANZCP and MBS Online websites soon.

Is a Type C certification required to provide rTMS as part of hospital treatment to patients not eligible for Medicare-funded rTMS services?

No, this is not required if the patient is not eligible to receive Medicare-funded rTMS services. If the patient is not eligible to receive Medicare-funded rTMS services, private health insurers are not required to pay benefits for the MBS services. Type C certification is only required if the psychiatrist claims one or more of the MBS items for rTMS in relation to treatment provided during an inpatient admission at a private hospital.

The certification must be undertaken each time a Medicare-funded rTMS service is provided as hospital treatment.

Can a patient who has been admitted to a private hospital for psychiatric care or another purpose receive rTMS outside of the private hospital environment (e.g from a private psychiatrist or another rTMS community based clinic)?

Yes, as long as the requirements of the MBS items are met. In this scenario, the patient would not be receiving rTMS as part of hospital treatment.

Can patients receive privately-funded treatment after 1 November 2021 if they are not eligible for Medicare-funded rTMS services?

Yes, patients can continue to access privately-funded treatment. Patients with private health insurance should speak to their health fund about what private health benefits would apply under their individual policy.

Does the Extended Medicare Safety Net apply to the rTMS items?

Yes, if a patient has reached their annual threshold for the Extended Medicare Safety Net (EMSN), they may be eligible to receive a higher Medicare rebate for out-of-hospital treatment, depending on what the psychiatrist charges for the service. Further information about the EMSN is available from the Services Australia website.

It is intended that the new rTMS items will have EMSN caps – these specify the maximum amount payable in safety net benefits for each service. The proposed EMSN caps are $500 per service under items 14216 and 14219, and $316.65 per service under items 14217 and 14220. EMSN caps will commence once the legislative instrument has been approved by resolution of both houses of Parliament. The Department will publish updated information on the MBS Online website and advise stakeholders and peak bodies once this occurs.

Where can I find more information?

Further information regarding MSAC and the recommendation to list rTMS on the MBS can be found on MSAC's website at www.msac.gov.au under applications 1196.2 - Repetitive Transcranial Magnetic Stimulation (rTMS) for the treatment of depression (Resubmission) and 1196.3 - Repetitive Transcranial Magnetic Stimulation (rTMS) for the treatment of depression (Resubmission).

The full item descriptors and information on other changes to the MBS are available on the MBS Online website at MBS Online. You can also subscribe to future MBS updates by visiting MBS Online and clicking 'Subscribe' at the bottom of the page.

The Department of Health provides an email advice service for providers seeking advice on interpretation of the MBS items and rules and the Health Insurance Act and associated regulations. If you have a query relating exclusively to interpretation of the Schedule, you can email askMBS.

Subscribe to 'News for Health Professionals' on the Services Australia website and you will receive regular news highlights.

If you are seeking advice in relation to Medicare billing, claiming, payments, or obtaining a provider number, please go to the Health Professionals page on the Services Australia website or contact Services Australia on the Provider Enquiry Line – 13 21 50.

Please note that the information provided is a general guide only. It is ultimately the responsibility of treating practitioners to use their professional judgment to determine the most clinically appropriate services to provide, and then to ensure that any services billed to Medicare fully meet the eligibility requirements outlined in the legislation. This sheet is current as of the Last updated date shown above and does not account for MBS changes since that date.