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Commonwealth Department of
Health and
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Medicare benefits for consultations by optometrists

1 November 1999

Commonwealth Department of Health and Aged Care

MEDICARE BENEFITS FOR CONSULTATIONS BY OPTOMETRISTS

Effective 1 November 1999

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At the time of printing, the relevant legislation giving authority for changes included in this edition of the book may still be subject to the approval of Executive Council and Parliamentary scrutiny. This book is not a legal document, and, in cases of discrepancy, the legislation will be the source document for payment of Medicare benefits.

INTRODUCTION

This book provides information on the arrangements for the payment of Medicare benefits for optometric consultations by optometrists who undertake to participate in the benefits arrangements and by optometrists acting on their behalf. These arrangements operate under the Health Insurance Act 1973 (as amended).

Section 1 of this book contains an outline of the arrangements for optometric consultation benefits and notes for the guidance of participating optometrists, including addresses of the Department and the Health Insurance Commission.

The Schedule in Section 2 shows the item number, description of service, Schedule fee and Medicare benefit payable in respect of the optometric items.

Section 3 contains a copy of the "Common Form of Undertaking" which optometrists are required to sign to participate in the arrangements.

This edition of the book has been printed for use by participating optometrists, the Health Insurance Commission and other interested authorities.

CHANGES INCLUDED IN THIS EDITION

General Fee Increase

Schedule fees for optometric consultation items have increased by 1.5% from 1 November 1999. For Items 10921 to 10930 covering contact lens consultations, agreement with the profession has resulted in the three more complex contact lens items (10924, 10927 and 10929) receiving the aggregate increase for the contact lens section of the Schedule. Other less complex contact lens items have not been increased. The new fees and benefits have been included in this book.

Fee Changes

Fees amended within this Schedule are identified by the following symbol "+"

Fees Amended

10900 10905 10907 10912 10913 10914 10916 10918 10924 10927 10929

Special Arrangements - Transitional Period

These arrangements cover Items 10921 - 10930 - Contact Lenses (Bulk Items for all subsequent consultations). During the transitional period, the date of service of Items 10921 - 10930 will be deemed to be the day on which the first attendance occurs subsequent to the initial consultation covered by Item 10900 to 10916. Thus, benefits would be payable for Items 10921 - 10930 as follows:

(i) where the first attendance covered by Items 10921 - 10930 occurs before 1 November 1999, at the 1 November 1998 level of benefits; or

(ii) where the first attendance covered by Items 10921 - 10930 occurs on or after 1 November 1999, at the 1 November 1999 level of benefits.

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SECTION 1

OUTLINE OF ARRANGEMENTS AND NOTES FOR GUIDANCE

OUTLINE OF PROVISIONS FOR MEDICARE BENEFITS FOR OPTOMETRIC CONSULTATIONS AND NOTES FOR GUIDANCE

O1. INTRODUCTION

O1.1 All Australian residents and certain categories of visitors to Australia can claim Medicare benefits for consultations with participating optometrists. The Health Insurance Act contains legislation covering the major elements of the Medicare program.

O1.2 Responsibility for regulating the Medicare program lies with the Commonwealth Government through the Department of Health and Aged Care. The Health Insurance Commission (HIC) is responsible for consideration of applications for the acceptance of optometric undertakings and for the day to day operation of Medicare and the payment of benefits. Addresses of the Department and the HIC (Medicare offices) are located at the end of these Notes.

O2. PARTICIPATION BY OPTOMETRISTS

O2.1 Medicare pays benefits for consultations with optometrists who have signed an agreement to participate in arrangements with the Commonwealth Government. This agreement is formally known as the "Common Form of Undertaking - Participating Optometrists" and is often referred to as the Participating Agreement. A copy of the Undertaking is contained in Section 3 of this book.

O2.2 An optometrist registered or licensed under a law in any State or Territory of Australia, who wishes to become a participating optometrist, is required to sign the Common Form of Undertaking and an employer of optometrists must sign a separate common form of undertaking except where the optometrist and the owner of the business are the same person.

O2.3 Where the optometric practice is conducted in a corporate form, such as a company or partnership, it is necessary for the corporation to become a "participating optometrist", and an additional undertaking must be signed by a person who has authority to give the undertaking on behalf of the organisation.

O2.4 The undertaking sets out the obligations to be met under the arrangements. Copies of the undertaking may be obtained from the Provider Liaison Section, Health Insurance Commission at the addresses listed at the end of these Notes.

O2.5 Where an employer of optometrists completes an undertaking, that undertaking must identify premises owned by them or in their possession. The relevant details are to be included in schedules 2 and 3 of the undertaking. An undertaking completed by an individual optometrist does not need to identify the premises from which services are to be provided as the Common Form of Undertaking applies to all premises from which the optometrists will provide services.

O2.6 When completed, the undertaking should be returned to the Manager (Eligibility), Health Insurance Commission, PO Box 1001, Tuggeranong, ACT 2901.

O2.7 The Minister may refuse to accept an undertaking given by an optometrist. In these circumstances the optometrist will be notified in writing of the refusal and is given 30 days to forward a written request to the Minister, to have the matter referred to the Professional Services Review Tribunal.

02.8 After acceptance by the Minister, or his delegate, of the completed undertaking, a letter of acceptance of the undertaking will be forwarded to the optometrist. At the same time, the HIC will send the optometrist a supply of assignment forms and claim forms for assignment of Medicare benefits, together with the necessary instructions for direct-billing purposes.

O2.9 The Manager (Eligibility) must be notified in writing of any changes to the details furnished by an optometrist in schedule 2 and schedule 3 of the undertaking.

O2.10 Participating optometrists may at any time terminate undertakings either wholly or as they relate to particular premises, by notifying the Manager (Eligibility), Health Insurance Commission, PO Box 1001, Tuggeranong ACT 2901. The date of termination may not be earlier than 30 days after the date on which the notice is served.

O2.11 The names and addresses of participating optometrists may be obtained from the Manager (Eligibility), Health Insurance Commission, PO Box 1001, Tuggeranong ACT 2901, if the Minister or the Minister's delegate certifies in writing that this is necessary in the public interest.

O3. PROVIDER NUMBERS

O3.1 To ensure that benefits are paid only for services provided by optometrists registered in a State or Territory of Australia, each optometrist providing consultations for which a Medicare benefit is payable requires an individual provider number.

O3.2 Provider numbers will be issued only to individual participating optometrists registered in a State or Territory of Australia. Corporations, other business entities and individuals who are not registered optometrists will not be issued

with provider numbers.

O3.3 Provider numbers are allocated to practitioners to enable claims for Medicare benefits to be processed and cheques to be correctly drawn in favour of the practitioner where applicable. The number may be up to eight characters. The second last character identifies the practice location, the last being a check character.

O3.4 Optometrists can obtain a provider number from Medicare. A separate provider number is issued for each location at which an optometrist practices. Provider numbers for other or additional practice locations may also be obtained from Medicare.

O3.5 If a practitioner wishes Medicare benefits cheques, which would normally be drawn in favour of the practitioner, to be made payable to another payee and/or another address, written authority can be given to Medicare to do this. This payment to another party is known as a pay group link. There can only be one pay group link for an individual practice location but multiple practitioners and practice locations can be linked to one pay group. Further information on pay group links may be obtained from Medicare (addresses at the end of the Notes).

Locum Tenens

O3.6 Where a locum is to provide services at a practice location for more than 2 weeks or will return to the practice on a regular basis for short periods, the locum should apply for a provider number for that location. If the locum is to provide services at a practice for less than 2 weeks, the locum can use an existing provider number, however, a provider number can be issued for a shorter period if required.

O3.7 Locums can direct Medicare payments to the principal of the practice by either arranging a pay group link and/or by nominating the principal as the payee provider on direct bill stationery.

O4. PATIENT ELIGIBILITY

Eligible persons

O4.1 For the purpose of the optometric arrangements, an eligible person is:

a person who holds the normal Medicare card as issued to Australian residents; or

a person who holds a Medicare card which shows "Visitor" and the period of eligibility.

O4.2 Medicare benefits are not payable for optometric consultations for persons holding a Medicare card which is endorsed "Reciprocal Health Care" on the face of the card.

O4.3 See paragraph O4.5 below for details on the various types of Medicare cards issued.

Medicare cards

O4.4 An eligible person who applies to enrol for Medicare benefits (using a Medicare Enrolment/ Amendment Application) will be issued with a uniquely numbered Medicare card which shows the Medicare Card number, the patient identification number (reference number), the applicant's first given name, initial of second given name, surname and an effective "valid to" date. These cards may be individual or family based. Up to five persons may be listed on the one Medicare card, and up to nine persons may be listed under the one Medicare card number.

O4.5 Currently, there are three types of Medicare cards issued

- the normal card for Australian residents which has only the month and year to which the card is valid at the bottom right hand side of the card and entitles the bearer to unrestricted access to Medicare benefits.
- a visitor card which entitles the bearer to unrestricted access to Medicare benefits. Persons who would be issued with this type of card are persons who have come to Australia under various longer term Government schemes which have special Government approval. The Medicare card shows "VISITOR" and an expiry date at the bottom of the card.

a Reciprocal Health Care Agreement card for persons from countries which have an Agreement with Australia to provide access to Medicare for services that are "immediately necessary" medical and hospital treatment but NOT optometric consultations. The Medicare card differs in colour to the usual Medicare card, is endorsed "RECIPROCAL HEALTH CARE" and includes a "valid to" date.

Note: A Reciprocal Health Care Agreement card is NOT valid for optometric consultations.

Optometric expenses overseas

O4.6 Medicare benefits under the Health Insurance Act are not available in respect of services rendered outside Australia. It is recommended that Australian residents travelling overseas take out private traveller's or health insurance which offers adequate coverage for the countries to be visited.

O5. BENEFITS FOR SERVICES BY PARTICIPATING OPTOMETRISTS

What services are covered

O5.1 The services coming within the scope of the optometric consultation benefit arrangements are those clinically relevant services ordinarily rendered by the optometrist in relation to consultation on ocular or vision problems.

O5.2 Benefits may only be claimed when:

(a) a procedure has been performed and a clinical record of the consultation has been made;
(b) a significant consultation or examination procedure has been carried out;
(c) the consultation has been performed at premises listed in an undertaking;
(d) the consultation has involved the personal attendance of both the patient and the optometrist; and
(e) the service is "clinically relevant", (as defined in the Health Insurance Act,) i.e., a service rendered by an optometrist that is generally accepted in the optometric profession as being necessary for the appropriate treatment of the patient to whom it is rendered.

Where Medicare benefits are not payable

O5.3 Medicare benefits may not be claimed for attendances for:

(a) delivery, dispensing, adjustment or repairs of visual aids;
(b) filling of prescriptions written by other practitioners; or
(c) vision screenings.

O5.4 Medicare benefits are not payable for services in the following circumstances:

(a) where the expenses for the service are paid or payable to a recognised (public) hospital;
(b) where the service is provided by teaching institutions to patients of supervised students;
(c) where the service is not "clinically relevant" (as described in the Health Insurance Act, i.e. a service rendered by an optometrist that is generally accepted in the optometric profession as being necessary for the appropriate treatment of the patient to whom it is rendered).

O5.5 Unless the Minister otherwise directs, a benefit is not payable in respect of an optometric consultation where:

(a) the consultation has been rendered by or on behalf of, or under an arrangement with, the Commonwealth, a State or a local governing body or an authority established by a law of the Commonwealth, a law of a State or a law of an internal Territory; or
(b) the expenses were incurred by the employer of the person to whom the consultation was rendered; or
(c) the attendance was at the patient's workplace or in a mobile consulting room at the patient's workplace. Benefits are payable for consultations at the optometrist's practice which are a consequence of a workplace consultation only when such attendances are a private arrangement between the patient and the optometrist. Consultations arranged or required by the employer do not attract a benefit.

Services rendered to an optometrist's dependants, employer or practice partner or dependants

O5.6 A condition of the participating arrangement is that the optometrist agrees not to submit an account or a claim for services rendered to any dependants of the optometrist, to his or her employer or practice partner or any dependants of that employer or partner.

Workers' compensation, third party insurance, damages, etc.

O5.7 From 1 February 1996, Medicare benefits are payable for optometric expenses for professional services that are wholly covered by workers compensation or damages under a Commonwealth or State or Territory law.

O5.8 The only exception to this is where a person has entered into a reimbursement arrangement with a compensation insurer. In such cases, a Medicare benefit is not payable. (A reimbursement arrangement is an agreement between a compensation claimant and the insurer stating that the optometric expenses of the person will be paid by the insurer as and when they arise.)

O5.9 The practitioner has the option to either bulk-bill Medicare or give the patient a private account as would normally occur with any other consultation.

O5.10 There are arrangements in place to recover any Medicare benefits paid as a result of the injury once a settlement or judgement is made on the compensation claim. The recovery is done between the insurer or compensation payer, the compensable person and Medicare. These recovery arrangements do not impact on practitioners.

O6. SCHEDULE FEES AND MEDICARE BENEFITS

Schedule fees and Medicare benefits

O6.1 Optometrists participating in the scheme agree not to charge more than the Schedule fees for services covered by Medicare, and also, that charges for appliances shall not include any amount related to consultation procedures for which benefits are payable. The only exceptions are for Item 10907 and in relation to domiciliary visits - see paragraphs O6.13 and O6.18.

O6.2 The services provided by participating optometrists which attract benefits are set out in the Health Insurance Regulations. Details of the services, including the Schedule fee and Medicare benefits for each service are contained in Section 2 of this book.

O6.3 Medicare benefits are payable at 85% of the Schedule fee for services rendered with a maximum gap payment for any one service of $50.90 (indexed annually) between the Medicare rebate and the Schedule fee.

O6.4 Where it can be established that payments of $280.30 (indexed annually from 1 January) have been made for a family group or an individual during a calendar year in respect of the difference between the Medicare benefit and the Schedule fee for services rendered, benefits will be paid for expenses incurred for professional services rendered during the rest of that year up to 100% of the Schedule fee. This does not apply to the assignment of benefit arrangements. A family group includes a spouse and dependent children under 16 years of age or dependent students under the age of 25.

Limiting rule

O6.5 Where a fee charged for a consultation is less than the Medicare benefit, the benefit will be reduced to the amount of the fee actually charged. In no case will the benefit payable exceed the fee charged.

Multiple attendances

O6.6 Payment of benefit may be made for several attendances on a patient on the same day by the same optometrist provided that the subsequent attendances are not a continuation of the initial or earlier attendances. However, there should be a reasonable lapse of time between the consultations before they can be regarded as separate attendances.

O6.7 Where two or more attendances are made on the one day by the same optometrist the time of each attendance should be stated on the account (eg. 10.30 am and 3.15 pm) in order to assist in the payment of benefits.

O6.8 In some circumstances a subsequent consultation on the same day may be judged to be a continuation of an earlier attendance and a second benefit is not payable. For example, a preliminary eye examination may be concluded with the instillation of mydriatic or cycloplegic drops and some time later additional examination procedures are undertaken. These sessions are regarded as being one attendance for benefit purposes.

Referred comprehensive initial consultations (Item 10905)

O6.9 For the purposes of Item 10905, the referring optometrist, having considered the patient's need for the referred consultation, is required to provide a written referral, dated and signed, and setting out the patient's condition and the reason for the referral.

06.10 Benefits will be paid at the level of Item 10905 providing the referral is received before the provision of the service, and providing the account, receipt or bulk-billing form contains the name and provider number of the referring optometrist.

06.11 The optometrist claiming the Item 10905 service is obliged to retain the written referral for a period of twenty-four months.

06.12 Referrals must be at "arms length". That is to say, no commercial arrangements or connections should exist between the optometrists.

Second comprehensive initial consultation within 24 months of a previous comprehensive consultation (Item 10907)

O6.13 Where a patient receives a comprehensive initial consultation within 24 months of a previous comprehensive consultation provided by another optometrist an additional fee may be charged provided that the service is <u>not</u> direct-billed. The actual additional amount charged is a matter between the optometrist and the patient but it must not exceed an amount equal to the difference between the Schedule fees for Item 10900 and Item 10907.

O6.14 In circumstances where an additional fee is charged the optometrist *must inform the patient* of the benefit payable for Item 10907 *at the time of the consultation* and that the additional fee *will not* attract benefits.

O6.15 Where it is necessary for the optometrist to seek patient information from Medicare in order to determine appropriate itemisation of accounts, receipts or bulk-billed claims, the optometrist must ensure that:-

(i) the patient is advised of the need to seek the information and the reason the information is required;
(ii) the patient's informed consent to the release of information has been obtained; and
(iii) the patient's records verify the patient's consent to the release of information.

Significant change in visual function requiring comprehensive re-evaluation (Item 10912)

O6.16 Significant changes in visual function which justify the charging of Item 10912 include documented changes of:

- vision or visual acuity of 2 lines (0.2 logMAR) or more (corrected or uncorrected)
- visual fields or previously undetected field loss
- binocular vision
- contrast sensitivity or previously undetected contrast sensitivity loss

New Signs or symptoms/progressive disorder requiring comprehensive re-evaluation (Items 10913 and 10914)

O6.17 When charging Item 10913 or Item 10914, the optometrist must document the new signs or symptoms or the nature of the progressive disorder suffered by the patient on the patient's record card.

Domiciliary visits

O6.18 A domiciliary visit is one conducted away from the optometrist's practice at the patient's place of residence, be it their home, nursing home or hospital.

O6.19 In the case of a domiciliary visit provided at the patient's request an extra fee may be charged, in addition to the Schedule fee provided the service is not direct-billed. The actual additional amount charged is a matter between the optometrist and the patient but it must not exceed an amount equal to the fee for Item 10900 - Initial Consultation.

O6.20 No Medicare benefits are payable for the additional amount that may be charged for a domiciliary visit. The patient must make up the difference between the rebate and the fee charged.

O6.21 Charges for domiciliary visits should be shown separately on accounts issued by optometrists and not included in the fee for the consultation (refer paragraph O7.11).

Release of prescription

O6.22 Where a spectacle prescription is prepared for the patient, it becomes the property of the patient, who is free to have the spectacles dispensed by a person of the patient's choice. The optometrist will ensure that the patient is made aware that he or she is entitled to a copy of the spectacle prescription.

O6.23 Contact lens prescriptions are excluded from the above provision, although the prescription remains the property of the patient and should be available to the patient at the completion of the prescription and fitting process.

Reminder notices

O6.24 The optometrist will ensure that any notice sent to a patient suggesting re-examination is sent solely on the basis of the clinical needs of the patient.

O7. BILLING PROCEDURES

O7.1 There are three ways benefits may be paid for optometric consultations:

(i) the patient may pay the optometrist's account and then claim benefits from a Medicare office by submitting the account and the receipt;
(ii) the patient may submit the unpaid account to Medicare which will then draw a cheque in favour of the optometrist; or
(iii) the optometrist may bill Medicare instead of the patient for the consultation. This mechanism is known as direct billing. If an optometrist direct-bills, he/she undertakes to accept the relevant Medicare benefit as *full payment* for the consultation. Additional charges for that service (irrespective of the purpose or title of the charge) *cannot* be raised against the patient.

Note: Additional charges must not be levied in respect of domiciliary visits and consultations covered by Item 10907 if the services are direct-billed.

Claiming of benefits

O7.2 The patient, upon receipt of an optometrist's account, has two courses open for paying the account and receiving benefits.

Paid accounts

O7.3 The patient may pay the account and subsequently present the account, supporting receipt and a covering Medicare claim form to Medicare for payment of Medicare benefit.

Unpaid accounts

O7.4 Where the patient has not paid the account the unpaid account may be presented to Medicare with a Medicare claim form. In this case Medicare will forward to the claimant a benefit cheque made payable to the optometrist.

O7.5 It is the patient's responsibility to forward the cheque to the optometrist and make arrangements for payment of the balance of the account, if any. "Pay optometrist cheques" involving Medicare benefits cannot be sent direct to optometrists, or to patients at an optometrist's address (even if requested by the patient to do so). "Pay optometrist cheques" will be forwarded to the patient's normal address.

O7.6 When issuing a receipt to a patient for an account that is being paid wholly or in part by a Medicare "pay optometrist cheque" the optometrist should indicate on the receipt that a "Medicare" cheque for $..... was involved in the payment of the account.

Itemised accounts

O7.7 When an optometrist bills a patient for a consultation, the patient should be issued with a properly itemised account and receipt to enable him/her to claim Medicare benefits.

O7.8 Medicare benefits are not payable in respect of an optometric consultation unless there is recorded on the account setting out the fee for the service or on the receipt for the fee in respect of each consultation to each patient, the following information:-

(i) patient's name;
(ii) date on which the consultation was rendered;
(iii) a description of the consultation (eg. "initial consultation, "subsequent consultation" or "contact lens consultation");
(iv) Medicare Benefits Schedule item number;
(v) the name and practice address or name and provider number of the optometrist who actually rendered the service. Where the optometrist has more than one practice location, the provider number used should be that which is applicable to the practice location where the service was given;
(vi) the fee charged for that consultation;
(vii) the time each consultation began if the optometrist attended the patient on more than one occasion on the same day and on each occasion rendered a professional service relating to an optometric item;

O7.9 The optometrist billing for the service bears responsibility for the accuracy and completeness of the information included on accounts, receipts and assignment of benefits forms even where such information has been recorded by an employee of the optometrist.

O7.10 Payment of benefits could be delayed or disallowed if the account does not clearly identify the service as one which qualifies for Medicare benefits or that the practitioner is a registered optometrist practising at the address where the service was rendered. It is important to ensure that an appropriate description of the service, the item number and the optometrist's provider number is included on accounts, receipts and assignment forms.

O7.11 Details of any charges made other than for consultations, eg. a dispensing charge, a charge for a domiciliary visit, should be shown separately either on the same account or on a separate account.

Duplicate accounts

O7.12 Only one original itemised account per consultation should be issued. Duplicates of accounts or receipts should be clearly marked "duplicate" and should be issued only where the original has been lost. Duplicates should not be issued as a routine system for "accounts rendered".

Assignment of benefit (direct billing) arrangements

O7.13 Under the Health Insurance Act an Assignment of Benefit (direct-billing) facility for professional services is available to all persons in Australia who are eligible for benefit under the Medicare program. This facility is NOT confined to pensioners or people in special need.

O7.14 If an optometrist direct-bills, he/she undertakes to accept the relevant Medicare benefit as full payment for the consultation. Additional charges for that service (irrespective of the purpose or title of the charge) cannot be raised against the patient. Under these arrangements:

- The patient's Medicare number must be quoted on all direct-bill forms for that patient.
- The basic forms provided are loose leaf to enable the patient details to be imprinted from the Medicare card.
- The optometrist must state the particulars relating to the consultation on the assignment form before the patient signs the form and give the patient a copy of the form as soon as practicable after the patient signs it.
- Where a patient is unable to sign the assignment form the signature of the patient's parent, guardian or other responsible person (other than the participating optometrist, participating optometrist's staff, hospital proprietor, hospital staff, nursing home proprietor or nursing home staff) is acceptable. The reason the patient was unable to sign should be stated.
    - In the absence of a "responsible person" the patient signature section on the form should be left blank and an explanation as to why the patient was unable to sign should be given in the section headed "Practitioner Use" or on the back of the assignment form. The Attending Optometrist should initial the explanation. If the reason for the patient being unable to sign would be an unacceptable breach of confidentiality or would be unduly embarrassing or distressing, the optometrist may explain the situation using the concessional reason "due to medical condition". This wording should not be used routinely and in most cases it is expected that the reason given would be more specific.

Use of Medicare cards in direct billing

O7.15 The Medicare card plays an important part in direct-billing as it can be used to imprint the patient details (including Medicare number) on the basic direct-billing forms. A special Medicare imprinter is used for this purpose and is available free of charge, on request, from Medicare.

O7.16 The patient details can, of course, be entered on the direct-bill forms by hand, but the use of the card to imprint patient details assists optometrists and ensures accuracy of information. The latter is essential to ensure that the processing of a claim by Medicare is expedited.

O7.17 The Medicare card number must be quoted on direct-bill forms. If the number is not available, then the assignment of benefit facility should not be used. To do so would incur a risk that the patient may not be eligible and Medicare benefits not payable.

O7.18 Where a patient presents without a Medicare card and indicates that he/she has been issued with a card but does not know the details, the optometrist may contact a Medicare telephone enquiry number to obtain the number.

O7.19 It is important for the optometrist to check the eligibility of patients for Medicare benefits by reference to the card, as entitlement is limited to the "valid to" date shown on the bottom of the card. Additionally the card will show if a person is enrolled through a Reciprocal Health Care Agreement. Benefits are not payable for this category.

Assignment of benefit forms

O7.20 Only the approved forms available from the HIC can be used to direct bill patients for optometric consultations and no other form can be used without the approval of the Commission.

(a) Form DB2
It is loose leaf for imprinting and comprises a throw away cover sheet (after imprinting), a Medicare copy, a patient copy and a practitioner copy.

(b) Form DB4
This is a continuous stationery version of Form DB2 and has been designed for use on most office accounting machines.

The claim for assigned benefits (Form DB1)

O7.21 Optometrists who accept assigned benefits i.e., who direct bill on behalf of a patient, must claim from Medicare using Claim for Assigned Benefits form DB1. The form has been designed to enable the payment to be made to an optometrist other than the one who rendered the service. This facility is intended for use in situations such as where a short term locum is acting on behalf of the principal optometrist and setting the locum up with a provider number and pay-group link is impractical. Optometrists should note that this facility cannot be used to generate payments to or through a person who does not have a provider number.

O7.22 Each claim form must be accompanied by the assignment forms to which the claim relates.

O7.23 The DB1 is also loose leaf to enable imprinting of optometrists' details using the special Medicare imprinter. For this purpose, optometrist cards, showing the optometrist's name, practice address and provider number are

available from the HIC on request.

O7.24 When an optometrist direct-bills Medicare, the assignment forms take the place of the conventional accounts and receipts. It is important therefore, that the assignment forms show for each service to each patient the information required on patient's accounts as mentioned in paragraph O7.8.

O7.25 Detailed instructions regarding requirements for completion and submission of claims for assigned benefits are included with the assignment stationery provided by the HIC.

O7.26 The assignment form should be signed by the patient. The name of the optometrist who conducted the examination should be shown in the space on the form titled "Name of practitioner who actually rendered the professional service being claimed" together with his/her provider number or address.

O7.27 The claim form must be signed and dated by the optometrist who rendered the services described on the assignment forms attached to the claim form. This claim form must also be witnessed and the witness identified.

O7.28 A claim form together with corresponding assignment forms should be forwarded to the HIC at the convenience of the optometrist. The only proviso is that there should be no more than fifty (50) assignment forms with each claim. If more than 50 are received processing may be delayed.

Time limits applicable to lodgement of claims for Medicare benefits

O7.29 A time limit of six months applies to the lodgement of claims with Medicare under the direct-billing (Assignment of Benefits) arrangements. This means that Medicare benefits are not payable for any service where the service was rendered more than six months earlier than the date the claim was lodged with Medicare.

O7.30 Provision exists whereby in certain circumstances (eg. hardship cases, third party or workers' compensation cases), the Minister may waive the time limits. Special forms for this purpose are available, if required, from the processing centre to which assigned claims are directed.

O8. LIMITATIONS ON BENEFITS

Single Course of Attention

O8.1 A reference to a single course of attention means:-

(a) In the case of Items 10900 to 10918 - a course of attention by one or more optometrists in relation to a specific episode of optometric care.

(b) In relation to Items 10921 to 10930 - a course of attention, including all associated attendances, by one or more optometrists for the purpose of prescribing and fitting of contact lenses.

Initial consultations

O8.2 The initial consultation item (Item 10900) is payable once only within 24 months of the previous standard consultation (Item 10900, 10905, 10907, 10912, 10913 or 10914). However, a benefit is payable under Item 10912, 10913 or 10914 where the patient has an ocular condition which necessitates a further course of attention being started within 24 months of the previous initial consultation. The conditions which qualify for a further course of attention are contained in the descriptions of these items (see paragraphs 06.16 and O6.17).

O8.3 Where an attendance would have been covered by Item 10900,10905, 10907, 10912, 10913, or 10914 but is of 15 minutes duration or less, Item 10916 (Short consultation) applies.

Second or subsequent consultations (Item 10918)

O8.4 Each consultation, apart from the initial consultation, in a single course of attention, other than a course of attention involving the fitting and prescription of contact lenses, is covered by Item 10918.

Contact lens consultations (Items 10921 to 10930)

O8.5 In the case of contact lens consultations, benefit is payable only where the patient is one of the prescribed classes of patient entitled to benefit for contact lens consultations as described in Items 10921 to 10929.

O8.6 Medicare benefits are not payable for Item 10929 in circumstances where patients want contact lenses for:

(a) reasons of appearance (because they do not want to wear spectacles);

(b) sporting purposes;

(c) work purposes; or

(d) psychological reasons (because they cannot cope with spectacles).

O8.7 All attendances subsequent to the initial consultation in a course of attention are collectively regarded as a single service under Items 10921 to 10929, as appropriate. The date of service is deemed to be the date on which the contact lenses are delivered to the patient.

O8.8 Any account for consultations involving the fitting and prescription of contact lenses issued to a patient who does not fall into the specified categories should be prepared in such a way that it cannot be used to obtain benefits. No Medicare item number should be attached to any service that does not attract benefits and the optometrist should annotate the account with wording such as "Medicare benefits not payable".

O8.9 Where an optometrist wishes to apportion the total fee to show the appropriate optometric consultation benefit and the balance of the fee, he or she should ensure that the balance is described in such a way (eg. balance of account) that it cannot be mistaken as being a separate consultation. In particular no Medicare item number should be shown against the balance.

O8.10 When a patient receives a course of attention involving the prescription and fitting of contact lenses an account should not be issued (or an assignment form completed) until the date on which the patient takes delivery of the lenses.

O8.11 Benefit under Items 10921-10929 is payable once only in any period of 36 consecutive months except where circumstances are met under Item 10930 within a 36 month period.

Optometrists visiting isolated areas

O8.12 Special arrangements exist under the provisions of Section 129A of the Health Insurance Act to enable optometrists who visit country areas where optometric services are not otherwise available to provide services without additional charge to patients.

O8.13 Under these arrangements, assistance may be provided in the form of per capita payments directly related to the numbers of patients attended, with individual rates approved for each applicant who meets the criteria for assistance, in respect of visits to specified locations.

O8.14 This assistance is provided because the participating nature of the benefit arrangements does not permit optometrists to charge fees higher than Medicare Schedule fees to offset the additional costs involved in visiting

remote areas.

O8.15 Visiting optometrists may obtain application forms for such assistance from the State Manager, Commonwealth Department of Health and Aged Care. Addresses of State offices are located at the end of these Notes.

O9. REFERRALS

General

O9.1 Optometrists are required to refer a patient for medical attention when it becomes apparent to them that the patient's condition is such that it would be more appropriate for treatment to be undertaken by a medical practitioner.

O9.2 Optometrists may refer patients directly to specialist ophthalmologists with the patient being able to claim benefits for the ophthalmologist's services at the referred specialist rate.

O9.3 Optometrists may refer patients directly to another optometrist, based on the clinical needs of the patient.

O9.4 A referral letter or note must have been issued by the optometrist for all such services provided by specialist ophthalmologists or optometrists in order for patients to be eligible for Medicare benefit at the referred rate. Unless such a letter or note has been provided, benefits will be paid at the unreferred rate.

O9.5 Medicare benefits at the referred rate are not paid for patients referred by optometrists to consultant physicians or to specialists other than ophthalmologists. See paragraph O9.13 regarding emergency situations.

What is a referral

O9.6 For the purposes of the optometric arrangements, a "referral" is a request to a specialist ophthalmologist or another optometrist for investigation, opinion, treatment and/or management of a condition or problem of a patient or for the performance of a specific examination(s) or test(s).

O9.7 Subject to the exceptions in paragraph O9.8 below, for a valid "referral" to take place:

(i) the referring optometrist must have turned his or her mind to the patient's need for referral and communicate relevant information about the patient to the specialist ophthalmologist or optometrist to whom the patient is referred (but this does not necessarily mean an attendance on the occasion of the referral);

(ii) the instrument of referral must be in writing by way of a letter or note and must be signed and dated by the referring optometrist; and

(iii) the practitioner to whom the patient is referred must have received the instrument of referral on or prior to the occasion of the professional service to which the referral relates.

O9.8 The exceptions to the requirements in paragraph O9.7 are that:

(a) sub-paragraphs (ii) and (iii) do not apply to an emergency situation where the specialist ophthalmologist was of the opinion that the service be rendered as quickly as possible (see para O9.13); and

(b) sub-paragraph (iii) does not apply to instances where a written referral was completed by a referring optometrist but was lost, stolen or destroyed.

Period for which referral is valid

O9.9 If a referring optometrist wishes that a referral to a specialist ophthalmologist be for a period less than or more than 12 months (eg. 3, 6 or 18 months or valid indefinitely), he/she should indicate this to the specialist ophthalmologist.

O9.10 The referral is valid for the period specified (or 12 months where not otherwise indicated) from the date of the specialist ophthalmologist's first service.

O9.11 The purpose of permitting a referral for longer than 12 months is to obviate the necessity for a chronically ill patient, who is under the continuing care and management of a specialist for a specific condition(s), to obtain a new referral at the end of each 12 months.

Self referral

O9.12 Optometrists may refer themselves to specialist ophthalmologists or other optometrists and Medicare benefits are payable at referred rates.

Emergency situations

O9.13 In an emergency situation (as defined in the regulations) where the specialist or the consultant physician is of the opinion that the service be rendered as quickly as possible and endorses the account, receipt or assignment form "Emergency referral", Medicare benefits are payable even though there is no written referral. This provision only

applies to the initial attendance. For subsequent attendances to attract benefits at the referred rate a referral must be obtained from a medical practitioner or, in the case of a specialist ophthalmologist, a medical practitioner or an optometrist.

O10. PROVISION FOR REVIEW AND INQUIRY

Optometric Benefits Consultative Committee (OBCC)

O10.1 The OBCC is an advisory committee established in 1990 by arrangement between the Minister and the Australian Optometrical Association.

O10.2 The OBCC's functions are:

(i) to consider the appropriateness of existing Medicare Benefits Schedule items, including the need to combine, delete or create items, and the need to amend item descriptions;

(ii) to undertake reviews of particular services and to report on the appropriateness of the existing structure of the Schedule, having regard to current optometric practice;

(iii) to provide a forum for the discussion on fees and fee relativities for individual optometric items in the Medicare Benefits Schedule (but not so as to involve a general review of the overall level of optometric fees);

(iv) to consider and advise on the appropriateness of the participating optometrists' arrangements and the Common Form of Undertaking (as specified in the Health Insurance Act and related legislation) and the administrative rules and interpretations which determine the payment of benefits for optometric services or the level of benefits;

(v) to investigate specific matters associated with the participating optometrists' arrangements and to advise on desirable changes.

O10.3 The OBCC comprises two representatives from the Department of Health and Aged Care, two representatives from the Health Insurance Commission, and three representatives from the Australian Optometrical Association.

Professional Services Review (PSR) Scheme

O10.4 The Professional Services Review (PSR) Scheme provides for a system of peer review to determine whether a practitioner has inappropriately rendered or initiated services which attract a Medicare benefit, or has inappropriately prescribed under the Pharmaceutical Benefits Scheme (PBS). A practitioner includes an optometrist.

O10.5 Section 82 of the *Health Insurance Act 1973* defines inappropriate practice as conduct that is such that a PSR Committee could reasonably conclude would be unacceptable to the general body of the members of the profession in which the practitioner was practising when he or she rendered or initiated the services.

O10.6 From 1 August 1999, changes were introduced to improve the administration of the PSR Scheme. These include increased investigation, case preparation and negotiation powers for the Director of PSR and greater legal support for the person under review. The PSR Tribunals have also been removed from the process whilst retaining the right of review on points of law.

O10.7 Under the PSR Scheme, the decision to establish a PSR Committee is made by the independent Director of PSR after receiving an investigative referral for the review of a practitioner's conduct from the Health Insurance Commission.

O10.8 When an investigative referral is made, the Director of PSR must conduct an investigation, in such manner as he or she thinks appropriate, into the referred services, including services not dealt with in reasons given by the Commission for the referral. The Director has the power to require the production of documents or the giving of information.

O10.9 The Director also has the power to dismiss an investigative referral, set up a PSR Committee, negotiate a written agreement with the pratitioner, or take no action.

O10.10 The various methods available to a PSR Committee to investigate and quantify inappropriate practice have been clarified. In addition to examining identified services, the legislation now provides for the following methodologies:

- Patterns of Services - Where a practitioner reaches or exceeds a volume of services specified in regulations, he or she is deemed to have practised inappropriately. The quantum of that inappropriate practice can be reduced if the PSR Committee is satisfied that the practitioner has demonstrated exceptional circumstances in respect of any day or days on which services were rendered.

- Sampling - A PSR Committee can apply a statistically valid sampling methodology to examine the conduct of a practitioner in relation to particular identifiable services and to extrapolate the results to a larger number of similar services within the referral period.

Generic findings - If a PSR Committee cannot conduct its inquiry using the patterns of services or sampling provisions, it can make a generic finding of inappropriate practice. This will apply where a PSR Committee is unable to obtain sufficient clinical or practice records from the practitioner to conduct its investigation.

O10.11 In determining whether a practitioner has engaged in inappropriate practice, from 1 November 1999 a PSR Committee is also required to have regard to whether or not the practitioner kept adequate and contemporaneous patient records. The standards which a record must meet to constitute an adequate and contemporaneous record are prescribed in regulations. A record should be completed at the time that the service was provided or as soon as practicable afterwards. It should be sufficient to contribute to the quality and continuity of the patients care. It should be clear and detailed enough to enable another practitioner to undertake the ongoing care of the patient. The record should also identify the service that was provided.

O10.12 If a professional Services Review Committee finds that an optometrist has engaged in inappropriate practice, a determination must be made that the optometrist be : reprimanded; couselled; ordered to repay to the Commonwealth the whole part of the Medicare benefits paid for the services; and/or partially or fully disqualified from Medicare.

O10.13 The new PSR arrangements apply in relation to new cases referred by the HIC to the Director of PSR after 1 August 1999. Existing cases will be dealt with under the previous arrangements.

O11. PENALTIES AND LIABILITIES

Penalties

O11.1 Penalties of up to $10,000 or imprisonment for up to five years may be imposed on any person who makes a statement (either orally or in writing) or who issues or presents a document that is false or misleading in a material particular and which is capable of being used in connection with a claim for benefits. In addition, any practitioner who is found guilty of such offences shall be subject to examination by a Medicare Participation Review Committee and may be counselled or reprimanded or may have services wholly or partially disqualified from the Medicare benefit arrangements.

O11.2 A penalty of up to $1,000 or imprisonment for up to three months, or both, may be imposed on any person who obtains a patient's signature on a direct-billing form without the necessary details having been entered on the form before the patient signs or who fails to give the patient a copy of the completed form.

Medicare Participation Review Committee (MPRC)

O11.3 The Medicare Participation Review Committee determines what administrative action should be taken against a practitioner who has been successfully prosecuted for defrauding Medicare.

O11.4 The Committees have a discretionary range of options from taking no action against the practitioner through counselling and reprimand to full or partial disqualification from participating in the Medicare benefit arrangements for up to five years.

COMMONWEALTH DEPARTMENT OF HEALTH AND AGED CARE

(Postal : GPO Box 9848 in each Capital City)

NEW SOUTH WALES

Level 6
1 Oxford Street
SYDNEY 2000 Tel (02) 9263 3555

VICTORIA

Casselden Place
2 Lonsdale Street
MELBOURNE 3000 Tel (03) 9665 8888

QUEENSLAND

5th Floor
Samuel Griffith Building
340 Adelaide Street
BRISBANE 4000 Tel (07) 3360 2555

SOUTH AUSTRALIA

Commonwealth Centre
55 Currie Street
ADELAIDE 5000 Tel (08) 8237 6111

WESTERN AUSTRALIA

152-158 St George's Terrace
PERTH 6000 Tel (08) 9346 5111

TASMANIA

Montpelier Building
21 Kirksway Place
BATTERY POINT 7004 Tel (03) 6221 1411

AUSTRALIAN CAPITAL TERRITORY

Alexander Building
Furzer Street
PHILLIP 2606 Tel (02) 6289 1555

NORTHERN TERRITORY

Cascom Centre
13 Scaturchio Street
CASUARINA 0800 Tel (08) 8946 3444

HEALTH INSURANCE COMMISSION

(Postal : Medicare, GPO Box 9822, in each Capital City, Phone Enquiries on 132150)

NEW SOUTH WALES

State Headquarters
33 Erskine Street
SYDNEY 2000 Tel (02) 9895 3346

VICTORIA

Medibank House
460 Bourke Street
MELBOURNE 3000 Tel (03) 9605 7964

QUEENSLAND

State Headquarters
444 Queen Street
BRISBANE 4000 Tel (07) 3004 5280

SOUTH AUSTRALIA

State Headquarters
209 Greenhill Road
EASTWOOD 5063 Tel (08) 8274 9788

WESTERN AUSTRALIA

State Headquarters
11th Floor
Bank West Tower
108 St. George's Terrace
PERTH 6000 Tel 13 2150

TASMANIA

State Headquarters
242 Liverpool Street
HOBART 7000 Tel (03) 6211 3011

AUSTRALIAN CAPITAL TERRITORY

134 Reed Street
TUGGERANONG 2901 Tel (02) 62146362

NORTHERN TERRITORY

As per South Australia

SECTION 2

SCHEDULE OF SERVICES

GROUP A10 - OPTOMETRIC CONSULTATIONS

SUBGROUP 1 - OPTOMETRIC CONSULTATIONS

+	**COMPREHENSIVE INITIAL CONSULTATION** Professional attendance of more than 15 minutes duration, being the first in a course of attention - not payable within 24 months of an attendance to which item 10900, 10905, 10907, 10912, 10913 or 10914 applied *(See para O1. of explanatory notes to this Category)*	
10900	**Fee:** $54.20	**Benefit:** 85% = $46.10
+	**REFERRED COMPREHENSIVE INITIAL CONSULTATION** Professional attendance of more than 15 minutes duration, being the first in a course of attention, where the patient has been **referred** by another optometrist who is not associated with the optometrist to whom the patient is referred *(See para O1. of explanatory notes to this Category)*	
10905	**Fee:** $54.20	**Benefit:** 85% = $46.10
+	**COMPREHENSIVE INITIAL CONSULTATION BY ANOTHER PRACTITIONER WITHIN 24 MONTHS OF A PREVIOUS COMPREHENSIVE CONSULTATION** Professional attendance of more than 15 minutes duration being the first in a course of attention **where the patient has attended another optometrist** within the previous 24 months for an attendance to which item 10900, 10905, 10907, 10912, 10913 or 10914 applied *(See para O1. of explanatory notes to this Category)*	
10907	**Fee:** $27.15	**Benefit:** 85% = $23.10
+	**OTHER COMPREHENSIVE CONSULTATIONS** Professional attendance of more than 15 minutes duration, being the first in a course of attention, where the patient has suffered a **significant change of visual function** requiring comprehensive reassessment within 24 months of initial consultation to which item 10900, 10905, 10907, 10912, 10913 or 10914 at the same practice applied *(See para O1. of explanatory notes to this Category)*	
10912	**Fee:** $54.20	**Benefit:** 85% = $46.10
+	Professional attendance of more than 15 minutes duration, being the first in a course of attention, where the patient has **new signs or symptoms**, unrelated to the earlier course of attention, requiring comprehensive reassessment within 24 months of initial consultation to which item 10900, 10905, 10907, 10912, 10913 or 10914 at the same practice applied *(See para O1. of explanatory notes to this Category)*	
10913	**Fee:** $54.20	**Benefit:** 85% = $46.10
+	Professional attendance of more than 15 minutes duration, being the first in a course of attention, where the patient has a **progressive disorder** (excluding presbyopia) requiring comprehensive reassessment within 24 months of initial consultation to which item 10900, 10905, 10907, 10912, 10913 or 10914 applied *(See para O1. of explanatory notes to this Category)*	
10914	**Fee:** $54.20	**Benefit:** 85% = $46.10
+	**BRIEF INITIAL CONSULTATION** Professional attendance, being the first in a course of attention, of not more than 15 minutes duration *(See para O1. of explanatory notes to this Category)*	
10916	**Fee:** $27.15	**Benefit:** 85% = $23.10
+	**SUBSEQUENT CONSULTATION** Professional attendance being the second or subsequent in a course of attention not related to the prescription and fitting of contact lenses	
10918	**Fee:** $27.15	**Benefit:** 85% = $23.10

CONTACT LENSES FOR SPECIFIED CLASSES OF PATIENTS - BULK ITEMS FOR ALL SUBSEQUENT CONSULTATIONS

Note: Benefits may not be claimed under Item 10929 where the patient wants the contact lenses for appearance, sporting, work or psychological reasons - see paragraph O8.10 of Notes for Guidance (Section 1)

All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention in respect of which the first attendance is a service to which item 10900, 10905, 10907, 10912, 10913, 10914 or 10916 applies - payable only once in a period of 36 months

10921 - patients with **myopia of 5.0 dioptres or greater** (spherical equivalent) in 1 eye
Fee: $134.50 **Benefit:** 85% = $114.35

10922 - patients with **manifest hyperopia of 5.0 dioptres or greater** (spherical equivalent) in 1 eye
Fee: $134.50 **Benefit:** 85% = $114.35

10923 - patients with **astigmatism of 3.0 dioptres or greater** in 1 eye
Fee: $134.50 **Benefit:** 85% = $114.35

\+ 10924 - patients with **irregular astigmatism** in either eye, being a condition the existence of which has been confirmed by keratometric observation, if the maximum visual acuity obtainable with spectacle correction is worse than 0.3 logMAR (6/12) and if that corrected acuity would be improved by an additional 0.1 logMAR by the use of a contact lens
Fee: $169.70 **Benefit:** 85% = $144.25

10925 - patients with **anisometropia of 3.0 dioptres or greater** (difference between spherical equivalents)
Fee: $134.50 **Benefit:** 85% = $114.35

10926 - patients with corrected **visual acuity of 0.7 logMAR (6/30) or worse** in both eyes, being patients for whom a contact lens is prescribed as part of a **telescopic system**
Fee: $134.50 **Benefit:** 85% = $114.35

\+ 10927 - patients for whom a wholly or segmentally opaque contact lens is prescribed for the alleviation of dazzle, distortion or diplopia caused by:
(i) **pathological mydriasis; or**
(ii) **aniridia; or**
(iii) **coloboma of the iris; or**
(iv) **pupillary malformation or distortion; or**
(v) **significant ocular deformity or corneal opacity**
whether congenital, traumatic or surgical in origin
Fee: $169.70 **Benefit:** 85% = $144.25

10928 - patients who, by reason of **physical deformity**, are unable to wear spectacles
Fee: $134.50 **Benefit:** 85% = $114.35

\+ 10929 - patients who have a **medical or optical condition** (other than myopia, hyperopia, astigmatism, anisometropia or a condition to which item 10926, 10927 or 10928 applies) requiring the use of a contact lens for correction, where the **condition is specified** on the patient's account
Fee: $169.70 **Benefit:** 85% = $144.25

10930 All professional attendances regarded as a single service in a single course of attention involving the prescription and fitting of contact lenses where the patient meets the requirements of an item in the range 10921-10929 and requires a **change in contact lens material or basic lens parameters**, other than a simple power change, because of a **structural or functional change in the eye or an allergic response** within 36 months of the fitting of a contact lens covered by item 10921 to 10929
Fee: $134.50 **Benefit:** 85% = $114.35

SECTION 3

COMMON FORM OF UNDERTAKING

Common Form of Undertaking

Participating Optometrists

Sections 23A and 23B
Health Insurance Act 1973

For the purposes of section 23A of the ***Health Insurance Act 1973*** ("the Act")

I, _____ (full name in BLOCK letters)

of _____ (address for correspondence)

being

__ an optometrist registered to practice optometry in a State or Territory of Australia; or

__ a person/s who employs optometrists to provide services in the course of the practice of their profession; or

__ both of the above

(Choose one of the above options by marking a cross in the appropriate box)

who wishes to become a Participating Optometrist, hereby give the following undertaking to the Minister for Health and Aged Care for and on behalf of the Commonwealth of Australia.

(Where this undertaking is made on behalf of a company or partnership which employs optometrists, it should be signed by a person who has the authority to make such undertakings on behalf of the company or, in the case of a partnership, by one of the partners on behalf of the partnership)

INTRODUCTION

1 The Minister has, pursuant to subsection 23A(1) of the Act, after consultation with the Australian Optometrical Association, drawn up a common form of Undertaking to be given by an optometrist who wishes to become a Participating Optometrist. Definitions, interpretation and other formalities relating to this Undertaking are at Schedule 1.

2 ***Date on which an Undertaking comes into force***

2.1 An Undertaking comes into force on the day on which it is accepted by the Minister.

3 ***Services to which this Undertaking relates***

3.1 This Undertaking relates to any clinically relevant service ordinarily rendered by an optometrist in relation to consultation on ocular or vision problems, but does not include:

(a) an attendance for the sole purpose of delivering a prescribed visual aid or appliance or adjusting or repairing such an aid or appliance;

(b) an attendance for the purpose of filling a prescription written by another practitioner;

(c) an attendance on behalf of teaching institutions on patients of supervised students of optometry;

(d) an attendance by an optometrist on:

(i) any dependant of the Optometrist;

(ii) a practice partner of the Optometrist or any dependants of that partner;

(iii) an employer of the Optometrist or any dependants of that employer;

(e) anything done or service provided at any premises other than those specified in this Undertaking.

4 ***Premises to which this Undertaking relates***

4.1 Where this Undertaking is signed by a person/s who employs optometrists to provide services in the course of the practice of optometry, the premises to which this Undertaking relates are those:

(a) specified in Schedule 2; and

(b) any other premises at which a domiciliary visit is made.

5 ***Termination of Undertaking***

5.1 This Undertaking shall continue to be in force until it is:

(i) terminated by the Optometrist under subsection 23B(6) of the Act; or

(ii) revoked by the Minister following a determination of fraudulent or inappropriate practice.

5.2 A Participating Optometrist may, at any time, terminate an Undertaking, either wholly or in so far as it covers particular premises, by serving, as prescribed, a notice of termination to the Managing Director, Health Insurance Commission, specifying a date of termination not earlier than 30 days after the day on which the notice is served.

6 Fees

6.1 I undertake to charge fees which do not exceed the Medicare Schedule fee for any service to which this Undertaking and a Medicare item apply, except in the case of:

(i) a domiciliary visit where an additional fee not exceeding the Medicare Schedule fee for Item 10900 may apply; and

(ii) a patient being billed an Item 10907 attendance where an additional fee not exceeding an amount equal to the difference between the Medicare Schedule fee for Item 10900 and Item 10907 may apply. The appropriate fee for patient billing purposes in such cases should not exceed the Medicare Schedule fee for Item 10900.

6.2 I undertake that when I charge an additional fee as specified in subclause 6.1(ii), I will inform the patient of the Medicare benefit payable for Item 10907, at the time of the consultation, and that the additional fee will not attract benefits.

6.3 I undertake that I will obtain the patient's informed consent to the release of information to me if it is necessary for me to seek patient information from the Health Insurance Commission in order to determine appropriate itemisation of accounts, receipts or bulk-billed claims.

6.4 I undertake that I will not include an amount that relates to a service to which this Undertaking and a Medicare item apply in any charge made for appliances.

6.5 I undertake that I will not include a fee for a visit made or a service provided which is not a service to which this Undertaking applies in any charge made in respect of a Medicare item.

7 Billing procedures

7.1 I undertake to issue a receipt, or an account and a receipt, as the case may require, for all attendances made by myself, or on my behalf, to which a Medicare item applies, except where an assignment of benefit is made in accordance with section 20A of the Act.

7.2 I undertake that any receipt or account issued as provided in subclause 7.1 will contain the details of:

(a) any additional fee for a domiciliary visit where applicable (subclause 6.1(i));

(b) any additional fee in respect of Item 10907 (subclause 6.1(ii)); and

(c) the particulars prescribed in regulations made from time to time pursuant to subsection 19(6) of the Act.

7.3 I undertake that I will ensure that no fee is charged, nor an assignment of benefit made under section 20A of the Act for an attendance to which one of Items 10921-10930 inclusive relates before the date on which the patient takes delivery of the contact lenses.

7.4 I undertake that I will ensure that in respect of each service:

(a) only one original of the receipt or account is issued; and

(b) where a duplicate receipt or account is issued it is clearly marked "duplicate".

7.5 I undertake that I will take all reasonable steps to ensure that all items are billed in accordance with

this Undertaking and the appropriate Medicare items.

7.6 I undertake to accept the relevant Medicare benefit as full payment for the consultation where an assignment of benefit is made in accordance with section 20A of the Act. I accept that additional charges for that service (irrespective of the purpose or title of the charge) ***cannot*** be raised against the patient, including the special circumstances relating to domiciliary visits and consultations covered under Item 10907.

8 Referral

8.1 I undertake that I will ensure that a patient is referred to a medical practitioner when it becomes apparent to the Attending Optometrist that the condition of the patient is such that it would be more appropriate for treatment to be undertaken by a medical practitioner.

8.2 I undertake that I will refer patients to other optometrists solely on the basis of the clinical needs of the patient.

9 Prescriptions

9.1 I undertake that I will ensure that patients are informed that they are entitled to a copy of their spectacle prescription, and that they are free to have the prescribed spectacles dispensed by any person of their choice.

9.2 I undertake that I will ensure that where a contact lens prescription is prepared for the patient, the contact lens prescription is available to the patient at the completion of the prescription and fitting process.

10 Recalls

10.1 I undertake that any notice sent to a patient by me or on my behalf suggesting re-examination will be sent solely on the basis of the clinical needs of the patient.

11 Advertising

11.1 I undertake that I will not advertise or allow any person to advertise on my behalf in a manner that would lead to claims for Medicare benefits for services that are not Clinically Relevant Services as defined in the Act.

12 Notification of changes in practice details

12.1 I/we, as an employer of optometrists, undertake that in the event of a change in, or addition to, the details of the practice, as set out in Schedule 2, I/we will provide the Health Insurance Commission with details of the change or addition within 28 days of the change or addition.

13 Supply of Information

13.1 I undertake to furnish to the Minister such information relating to the rendering of services by, or on behalf of, the Optometrist as is from time to time reasonably requested by the Minister.

[Signature]

[Date]

[Witnesses]

Schedule 1

Definitions, Interpretation and Other Formalities

1 Definitions

In this Undertaking:

(a) **"Act"** means the *Health Insurance Act 1973*;

(b) **"Attending Optometrist"** means an optometrist as defined in subsection 3(1) of the Act, who renders the service;

(c) **"Clinically Relevant Service"** means a service rendered by an optometrist that is generally accepted in the optometrical profession as being necessary for the appropriate treatment of the patient to whom it is rendered;

(d) **"Commonwealth"** means the Commonwealth of Australia;

(e) **"Department of Health and Aged Care"** means the Commonwealth Department of Health and Aged Care or, where the subject matter of the Undertaking is transferred to another Commonwealth Department or Agency, that other Department or Agency;

(f) **"Domiciliary Visit"** means a professional attendance to which an item in the General Medical Services Table relates, given at the request of patients, either at their place of residence or at a nursing home, hospital or other temporary place of residence of the patient;

(g) **"General Medical Services Table"** means a table of medical services prescribed under section 4 of the Act in the Regulations, as varied from time to time;

(h) **"Medicare benefit"** means a benefit payable by the Commonwealth in relation to a professional service to which Medicare item applies;

(i) **"Medicare item"** means an item specified in the General Medical Services Table;

(j) **"Medicare Schedule fee"** means a fee specified for a Medicare item;

(k) **"Minister"** means the Minister responsible for administering the Department of Health and Aged Care and includes:

(i) any other Minister of the Commonwealth of Australia who is for the time being acting for that Minister;

(ii) a person to whom the relevant powers or functions of the Minister are for the time being delegated;

(l) **"Optometrist"** for the purposes of sections 23A and 23B of the Act, includes a person who employs optometrists to provide services in the course of the practice of their profession;

(m) **"Participating Optometrist"** means an optometrist or other person in respect of whom there is in force an Undertaking given by that person and accepted by the Minister under section 23B of the Act;

(n) **"Person"** includes a body politic or corporation as well as an individual;

(o) **"Service"** means a professional service specified in a Medicare item that relates to an attendance by a Participating Optometrist;

(p) **"Undertaking"** means this Common Form of Undertaking and any Schedules hereto as each may be amended from time to time.

2 Interpretation

In this Undertaking, unless contrary intention appears:

(a) a reference to a clause refers to the relevant clause to this Undertaking;

(b) a reference to a Schedule is to the relevant Schedule of this Undertaking and if a Schedule is at any time varied extends to the Schedule as so varied;

(c) words in the singular include the plural and words in the plural include the singular;

(d) the terms "I" and "me" refer to the company or the body corporate where a company or a body corporate is making an undertaking; and

(e) words and expressions used in the Undertaking have the meaning given to them in Schedule 1 of the Undertaking and the Act.

3 Operation of Undertaking

If the Act or the Regulations are amended this Undertaking will be read as amended to comply with the then current form of the Act or Regulations.

Any amendments to the Undertaking will be notified in writing to the Optometrist within 28 days of their coming into force or on such earlier day specified by the Minister not being a day earlier than the day on which the amendment was received by the Health Insurance Commission.

4 Variation of Undertaking

This Undertaking is subject to variation as provided in subsections 23A(3) and 23B(5) of the Act.

5 Notices

Any notice or other communication to the Optometrist under, or for the purpose of, this Undertaking by the Minister shall be deemed to have been duly given or made if it is in writing signed by or on behalf of the Minister or in the case of a delegate signed by that delegate and is sent by prepaid post addressed to the Optometrist at the address shown in Schedule 3 for the forwarding of notices or at such other address as is notified in writing, from time to time, by the Optometrist to the Minister or his delegate for that purpose.

Any notice, or other communication to the Minister under, or for the purpose of, this Undertaking by the Optometrist shall be deemed to have been duly given or made if it is in writing, signed by or on behalf of the Optometrist, addressed to the Minister and is served personally or by being sent by prepaid post, addressed to the Manager, Health Insurance Commission in the State in which the premises to which the Undertaking applies are situated. If the premises are situated in the Australian Capital Territory or the Northern Territory, the notice is to be addressed to the General Manager, Health Insurance Commission, PO Box 1001, Tuggeranong ACT 2901.

A notice, or other communication sent by post shall be deemed to have been received by the Optometrist or the Minister as the case may be, when it would have been delivered in the ordinary course of mail delivery.

Schedule 2

Premises to which this Undertaking relates

The premises specified for the purposes of this Undertaking are located at:

[Address 1]

[Address 2]

[Address 3]

[Etc]

Schedule 3

Address for correspondence

Notices or other communications to the Optometrist relating to this Undertaking should be directed to:

[Name & Address]