The Australian Government

Department of Health and Ageing

Medicare Benefits Schedule
Allied Health and Dental Care Services

1 November 2006

At the time of printing, the relevant legislation giving authority for the changes included in this edition of the book may 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 the payment of Medicare benefits.

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INTRODUCTION

This supplement provides information about the payment of Medicare benefits for services provided by allied health professionals, dentists and dental specialists under various Australian Government initiatives.

Structure

Section 1 - Overview of the Medicare program.

Section 2 - M.3 Allied Health Services. Overview of the Medicare Allied Health and Dental Care initiative introduced on 1 July 2004, which applies to patients with chronic conditions and complex care needs who are being managed by their GP under an Enhanced Primary Care (EPC) plan. This section also contains specific information about the Medicare Benefits Schedule (MBS) allied health items (10950 to 10970) under the Medicare Allied Health and Dental Care initiative.

Section 3 – M.4 Dental Care Services. Overview of the Medicare Allied Health and Dental Care initiative and specific information about the MBS dental care items (10975 to 10977) under the Medicare Allied Health and Dental Care initiative.

Section 4 – M.6 Provision of Psychological Therapy Services by Clinical Psychologists and M.7 Provision of Focussed Psychological Strategies Services by Allied Health Providers. Overview of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Scheme initiative introduced on 1 November 2006, and specific information about the MBS items (80000 to 80170) under this initiative.

Section 5 – M.8 Pregnancy Support Counselling initiative. Overview of the Pregnancy Support Counselling initiative introduced on 1 November 2006, and specific information about the MBS items (81000 to 81010) under this initiative.

The numbers of M.3, M.4, M.6, M.7 and M.8 refer to the numbering of the explanatory notes in the Medicare Benefits Schedule Book.

Schedule of Services

Each professional service has been allocated a unique item number.

Schedule Interpretations

The day-to-day administration and payment of benefits under the Medicare arrangements is the responsibility of Medicare Australia. Inquiries concerning matters of interpretation of Schedule items should be directed to Medicare Australia and not to the Department of Health and Ageing. The following telephone numbers have been reserved by Medicare Australia exclusively for inquiries relating to the Schedule:

NSW –	132 150	WA –	132 150
VIC –	03 9605 7964	TAS –	03 6215 5740
QLD –	07 3004 5450	ACT –	02 6124 6362
SA –	08 8274 9788	NT –	use South Australia number

Changes to Provider Details

Please notify Medicare Australia on 132 150 of changes to mailing details to ensure receipt of the MBS Allied Health and Dental Services supplement and updates.

Additional Copies

This supplement is available on the Department of Health and Ageing's Internet site at **www.health.gov.au/mbsonline.** Alternatively, additional copies can also be obtained by emailing the Department of Health and Ageing at:
allied health mbs book@health.gov.au or by telephoning (02) 6289 4297.

What's New

Summary of changes included in this Edition

This supplement has been expanded to include information about new Australian Government initiatives relating to Medicare services by allied health professionals.

Introduction of New Items
From 1 November 2006, new Medicare items will be introduced through two initiatives:
The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Scheme initiative introduces MBS items for psychological therapy services provided by eligible clinical psychologists and focussed psychological strategies provided by eligible psychiatrists, psychologists, general practitioners (GPs) and other eligible allied mental health professionals to people with mental disorders.

The Pregnancy Support Counselling initiative introduces MBS items for non-directive pregnancy support counselling services provided by GPs and other eligible allied health mental health professionals to women who are concerned about a current pregnancy or a pregnancy that occurred in the preceding 12 months.

Administrative Change
Allied health professionals, dentists and dental specialists, or the patient, may contact Medicare Australia on 132 011 to ascertain eligibility for allied health or dental care services. The patient is no longer required to be present if the allied health professional, dentist or dental specialist directly contacts Medicare Australia.

General Fee increase for items 10950 to 10977 – 1 November 2006

MBS Items	Schedule Fee From 1 Nov 2006	Medicare Rebate From 1 Nov 2006
Allied Health items 10950 – 10970 inclusive	**$55.05**	**$46.80**
Dental Care items 10975 – 10977 inclusive	**$91.70**	**$77.95**

SECTION 1

AUSTRALIAN MEDICARE PROGRAM

1.1 OVERVIEW

The Australian Medicare Program provides access to medical and hospital services for all Australian residents and certain categories of visitors to Australia. Legislation covering the major elements of the Program is contained in the *Health Insurance Act 1973* (as amended).

With regard to medical expenses, the basic aim of the Medicare program is to provide:

- automatic entitlement to benefits in respect of professional services (other than professional services to which the following dot points apply) equal to 85% of the Medicare benefits Schedule (MBS) fee, with a maximum payment of $63.90 (indexed annually) by the patient for any one service where the Schedule fee is charged;
- for professional services rendered while hospital treatment (ie accommodation and nursing care) is provided to a patient who has been admitted to a hospital (other than public patients), a flat rate of benefit of 75% of the Schedule fee, that is, there is no limit to the maximum amount of gap between the benefit and the Schedule fee;
- benefits equal to 100% of the Schedule fee for non-referred attendances by a general practitioner to non-admitted patients and for services provided by a practice nurse on behalf of a general practitioner; and
- access to public hospital services for eligible persons who choose to be treated free of charge as public patients in accordance with the provisions of the 2003-2008 Australian Health Care Agreements.

Patients may insure with private health insurance organisations for the gap between the 75% Medicare benefit and the Schedule fee, or for amounts in excess of the Schedule fee where the patient has an arrangement with their health fund. For out-of-hospital services the maximum amount of 'gap' (ie the difference between the Medicare rebate and the Schedule fee) payable by a family group or an individual in any one calendar year is $345.50 (indexed annually from 1 January). Thereafter, patients are reimbursed 100% of the Schedule fee. Under the extended safety net, Medicare will meet 80% of the out-of-pocket costs (ie the difference between the fees charged and the Medicare benefits paid) for out-of-hospital medical services, once an annual threshold of $500 (indexed annually from 1 January) for families in receipt of the Family Tax Benefit Part A and concession card holders, or $1000 (indexed annually from 1 January) for all other individuals and families is reached. A family group includes a spouse and dependent children under 16 years of age or dependent students under the age of 25. Individuals do not need to register with Medicare for the safety net threshold. However, families are required to register with Medicare to be eligible. Registration forms can be obtained from Medicare offices or completed online at www.health.gov.au or www.medicareaustralia.gov.au .

Medicare Australia is responsible for the operation of Medicare and the payment of Medicare benefits. Listed below are the locations of Medicare offices:

Postal: Medicare, GPO Box 9822, in the Capital City in each State
Telephone: 132 150 - Australia wide at the cost of a local call.

NEW SOUTH WALES
The Colonial State Bank Tower
150 George Street
PARRAMATTA NSW 2165

VICTORIA
State Headquarters
460 Bourke Street
MELBOURNE VIC 3000

QUEENSLAND
State Headquarters
444 Queen Street
BRISBANE QLD 4000

SOUTH AUSTRALIA
State Headquarters
209 Greenhill Road
EASTWOOD SA 5063

WESTERN AUSTRALIA
State Headquarters
Bank West Tower
108 St. George's Terrace
PERTH WA 6000

TASMANIA
242 Liverpool Street
HOBART TAS 7000

AUSTRALIAN CAPITAL TERRITORY
134 Reed Street
TUGGERANONG ACT 2901

NORTHERN TERRITORY
As per South Australia

Clinically relevant professional service

Where an eligible person incurs medical expenses in respect of a professional service, Medicare will pay benefits for that service as outlined in these notes. The definition of professional service as contained in the Health Insurance Act provides that such a service must be "clinically relevant". A clinically relevant service means a service rendered by a medical or dental practitioner, an optometrist or an eligible allied health professional that is generally accepted in the medical, dental, optometric or allied health profession (as the case may be) as being necessary for the appropriate treatment of the patient to whom it is rendered.

It is recognised that allied health professionals and dentists will sometimes be called upon to provide services which cannot be considered as being medically necessary. Accounts for these services should not be itemised as attracting Medicare benefits. The fee charged for such services is a private matter between the practitioner and the patient.

For any service listed in the Schedule to be eligible for a Medicare rebate, the service must be rendered in accordance with the provisions of the relevant Commonwealth and State and Territory laws. Practitioners have the responsibility to ensure that the supply of medicines or medical devices used in the provision of medical services is strictly in accordance with the provisions of the *Therapeutic Goods Act 1989*.

Where a Medicare benefit has been inappropriately paid, Medicare Australia may request recovery of that benefit from the practitioner concerned.

Payment of Medicare benefits

Specific information must be included in an account or receipt for a professional service for a Medicare benefit to be payable for that service.

This information includes the fee the allied health professional, dentist or dental specialist has charged for providing the service set out in the MBS.

Allied health professionals, dentists and dental specialists are free to determine their own fees for professional services. However, the amount that is specified in the account must be the amount charged for the service that is specified. The fee cannot include any component for other goods or services that are not part of the specified MBS item.

Billing practices contrary to the Act

The following illustrate billing practices that are not permissible under the *Health Insurance Act 1973.*

1. Including the cost of a non-clinically relevant service in a consultation charge.

    - Medicare benefits can only be paid in respect of clinically relevant services. A clinically relevant service is one that is generally regarded by the relevant profession as being necessary for the appropriate treatment of the patient receiving the service.
    - If an allied health professional, dentist or dental specialist chooses to use a procedure that is not generally accepted in their profession as necessary for the treatment of the patient, then the cost of this procedure cannot be included in the fee for a Medicare item.
    - Any charge for this procedure must be separately listed on the account and not billed to Medicare.

2. Including an amount for goods supplied for the patient to use at home in the consultation charge (eg. Wheelchairs, oxygen tanks, continence pads).

    - Medicare benefits are paid in respect of specific services provided by an allied health professional, dentist or dental specialist at the time of the consultation.
    - The provision of goods, such as wheelchairs and oxygen tanks, for later use is not part of the consultation and cannot be charged to Medicare.
    - Charges can be levied for these items but must be separately listed on the account and not billed to Medicare.

3. Charging part or all of an in-patient procedure to an out-patient consultation.

    - If an allied health professional, dentist or dental specialist charges part or all of an in-hospital procedure to an out-patient consultation, then the account issued by the practitioner is not an accurate statement of the services provided and would constitute a false or misleading statement.
    - No Medicare benefits would be payable in respect of the services provided.

4. Re-issuing modified accounts to include other charges and out of pocket expenses not previously included in the account.

    - The account issued to a patient by an allied health professional, dentist or dental specialist must state the amount charged for the service provided and truly reflect what occurred between the patient and practitioner.
    - Re-issuing an account to correct a genuine error is legitimate.
    - However, if an account is re-issued to increase the fee or load additional components to the fee, the account is not a true statement of the fee charged for the service and would constitute a false or misleading statement.
    - No Medicare benefits would be payable in respect of the services provided.

Multiple consultations on the same day

Generally, consultations that run longer than the minimum time specified in the item should be billed as a single consultation.

Payment of a benefit may be made for more than one (1) consultation on a patient on the same day by the same allied health professional provided the subsequent consultation is not a continuation of the initial consultation. However, there should be a reasonable lapse of time between such consultations before they can be regarded as separate consultations.

For some services (for example, diabetes education, psychology or mental health), it is likely that a subsequent service provided on the same day would be a continuation of the initial consultation. It is also likely that providing, for example, two diabetes education or psychology services on the same day does not provided a 'reasonable time lapse between consultations' as patients need adequate time to absorb and synthesise information before more information is provided. This is especially important for patients with complex conditions.

Where two consultations are made on the one day by the same allied health professional the time of each consultation should be stated on the account (eg 10.30am and 3.15pm) in order to assist in the assessment of benefits.

For information on multiple attendances by a dentist or dental specialist, please see Section M.4.5, Dental Assessment.

1.2 CLAIMING FROM MEDICARE

Paid Accounts

The patient may pay the account provided by an allied health professional, dentist or dental specialist and subsequently present the itemised receipt at a Medicare office for assessment and payment of the Medicare benefit in cash. The claimant is not required to complete a Medicare Patient Claim Form (PC-1).

A Medicare Patient Claim Form (PC-1) is required to be completed where the claimant is mailing his or her claim for a cheque or EFT payment of Medicare benefits or arranging for an agent to collect cash on the claimant's behalf at a Medicare office.

The particulars that are required to be on the account/receipt are:

- patient's name and date of service;
- MBS item number and/or description of service;
- name and practice address or name and provider No. of servicing allied health professional;
- name and practice address or name and provider No. of referring practitioner and date of referral; and

- amount charged, total amount paid, and any amount outstanding in relation to the service.

Unpaid accounts

Where the patient has not paid the account, the itemised unpaid account may be presented to Medicare (in person or by mail) with a Medicare patient claim form. In this case, Medicare will forward to the claimant a benefit cheque made payable to the allied health professional, dentist or dental specialist.

It will be the patient's responsibility to forward the cheque to the allied health professional, dentist or dental specialist and make arrangements for payment of the balance of the account, if any.

When issuing a receipt to a patient in respect of an amount that is being paid wholly or in part by a Medicare 'pay allied health professional/dentist/dental specialist' cheque, the allied health professional, dentist or dental specialist should indicate on the receipt that a 'Medicare' cheque for $…. was involved in the payment of the account.

Assignment of benefit arrangements

Where an allied health professional, dentist or dental specialist accepts the Medicare rebate as full payment for the service, s/he undertakes to accept the relevant Medicare benefit as full payment for the service. Additional charges for that service (irrespective of the purpose or title of the charge) cannot be raised against the patient. The allied health professional, dentist or dental specialist would submit:

- the assignment of benefit (direct-payment) form (form DB2-AH); and
- a DB1N-AH claim form

to Medicare (note that direct-payment forms DB1N-AH should be used to claim assigned Medicare benefits for allied health or dental care services rendered through an EPC plan, by one provider from a single practice location. Up to 50 DB2-AH forms can be included under the one DB1N-AH form). Under these arrangements –

- the patient's Medicare number must be quoted on all direct-payment assignment forms for that patient;

- the allied health professional, dentist or dental specialist must cause the particulars relating to the professional service to be set out on the assignment form before the patient signs the form and cause the patient to receive 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 allied health professional, dentist, dental specialist or their staff) is acceptable. The reason the patient is unable to sign should also be stated. In the absence of a 'responsible person' the patient signature section should be left blank and in the section headed 'Allied Health Professional's/Dentist's/Dental Specialist's Use', an explanation should be given as to why the patient was unable to sign (e.g. injured hand etc.) and this note should be signed or initialled by the allied health professional, dentist or dental specialist. If in the opinion of the allied health professional, dentist or dental specialist the reason is of such a 'sensitive' nature that revealing it would constitute an unacceptable breach of patient confidentiality or unduly embarrass or distress the recipient of the patient's copy of the assignment of benefits form, a concessional reason 'due to medical condition' to signify that such a situation exists may be substituted for the actual reason. However, this should not be used routinely and in most cases it is expected that the reason given will be more specific.

Claims should be posted to Medicare, GPO Box 9822, in the Capital City in each state.

Use of Medicare cards in direct payment

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

Assignment of benefit forms

To meet varying requirements, different types of stationery are available from Medicare Australia. Note that these are approved forms under the Health Insurance Act, and no other forms can be used to assign benefits without the approval of Medicare Australia.

Form DB2-AH is used to assign benefits for professional services rendered by allied health professionals, dentists and dental specialists. The form may not be used for services other than services rendered under the allied health and dental care initiative.

Direct payment stationery

Allied health professionals, dentists or dental specialists wishing to use the direct-payment method may order direct-payment stationery by telephoning 1800 067 307.

Time limits applicable to lodgement of claims for assigned benefits

A time limit of six months applies to the lodgement of claims with Medicare under the direct-payment (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. Provision exists whereby in certain circumstances (eg hardship cases, third party workers compensation cases), the Minister may waive the time limits.

SECTION 2

M.3 ALLIED HEALTH SERVICES (ITEMS 10950 TO 10970)

M.3.1 OVERVIEW OF THE MEDICARE ALLIED HEALTH AND DENTAL CARE INITIATIVE

Medicare Allied Health and Dental Care Initiative
The Medicare Allied Health and Dental Care initiative commenced on 1 July 2004. It provides for Medicare benefits to be paid for certain services provided by eligible allied health professionals, dentists and dental specialists to people with chronic conditions and complex care needs who are being managed by a GP under an Enhanced Primary Care (EPC) plan. The term 'GP' is used in this section as a generic reference to medical practitioners (including a general practitioner, but not including a specialist or consultant physician) able to refer patients for eligible allied health and dental care services.

EPC plan
The term 'EPC plan' is a generic one. Patients are considered to be managed under an EPC plan, if during the last two years:

- their GP has prepared an EPC plan for them and claimed:
  - MBS items 721 and 723 together – Chronic Disease Management (CDM) items for the preparation of a GP Management Plan (GPMP) and coordination of Team Care Arrangements (TCA); or
  - MBS item 720 – preparation of an EPC multidisciplinary care plan; or
  - MBS item 722 – preparation of an EPC multidisciplinary discharge care plan; or
- their GP has contributed to a plan prepared for them as a resident of an aged care facility and claimed item 730 or 731; or
- their GP has reviewed their existing EPC plan and claimed MBS item 724, 725 or 727.

For more information on the Chronic Disease Management items, refer to the explanatory notes for these items.

Before a rebate can be paid for the allied health service on referral from a GP, either the patient must have already claimed a rebate for the relevant EPC planning item/s, or the GP must have lodged a direct bill (bulk billing) claim with Medicare Australia for the relevant EPC planning item/s and received payment for that claim from Medicare Australia.

M.3.2 ALLIED HEALTH SERVICES ATTRACTING MEDICARE BENEFITS

Eligible allied health services
The following groups of allied health professionals are eligible to provide services under the Medicare Allied Health and Dental Care initiative. Allied health professionals must meet the provider eligibility requirements set out below at paragraph M.3.4 and be registered with Medicare Australia.

- Aboriginal health workers
- Audiologists
- Chiropractors
- Diabetes Educators
- Dietitians
- Exercise Physiologists
- Mental health workers
- Occupational Therapists
- Osteopaths
- Physiotherapists
- Podiatrists
- Psychologists
- Speech Pathologists

Number of services per year
Medicare benefits are available for up to five (5) allied health services per eligible patient, per calendar year. The Medicare rebate for each allied health service is $46.80.

The five allied health services can be made up of one type of service (eg five physiotherapy services) or a combination of different types of services (eg one dietetic and four podiatry services).

In addition, people whose dental problems are exacerbating their chronic condition, may be eligible to receive a Medicare rebate for up to three (3) eligible dental care services per calendar year. There are separate explanatory notes for the dental care items at M.4.

Out-of-pocket expenses and Medicare Safety Net
Allied health professionals are free to determine their own fees for the professional service. Charges in excess of the Medicare benefit for the allied health items are the responsibility of the patient. However, such out-of-pocket costs will count toward the Medicare safety net for that patient. Allied health services in excess of five (5) in a calendar year will not attract a Medicare benefit and the safety net arrangements will not apply to costs incurred by the patient for such services.

Eligible patients
The allied health items only apply to patients with chronic conditions and complex care needs being managed under an EPC plan (described above), and where the patient is referred to an eligible allied health professional by their GP. The allied health services must be recommended in the patient's EPC plan as part of the management of their chronic and complex condition.

A chronic medical condition is one that has been or is likely to be present for at least six (6) months including, but not limited to, asthma, cancer, cardiovascular illness, diabetes mellitus, mental disorders, arthritis and musculoskeletal conditions. A patient is considered to have complex care needs if they require ongoing care from a multidisciplinary team consisting of their GP and at least two (2) other health or care providers.

Allied health professionals providing the service may be part of the EPC planning team convened by the GP to manage a patient's chronic and complex condition. However, the service may also be provided by an allied health professional who is not part of the EPC planning team, where the service has been identified as necessary by the patient's GP.

Checking patient eligibility for allied health services
Patients seeking Medicare rebates for allied health services will need to have an *EPC program referral form for allied health services under Medicare* signed by their GP. If there is any doubt about a patient's eligibility, Medicare Australia will be able to confirm whether there is an EPC plan in place and the number of allied health services already claimed by the patient during the calendar year. Allied health professionals or the patient can call Medicare Australia on 132 011 to check this information.

Publicly funded services
The allied health items (10950-10970) do not apply for services that are provided by any Commonwealth or State funded services or provided to an admitted patient of a hospital.

However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or State/Territory Government health clinic, items 10950-10970 can be claimed for services provided by eligible allied health professionals salaried by, or contracted to, the Service or health clinic. All requirements of the relevant item must be met, including registration of the allied health professional with Medicare Australia. These services must also be direct billed (that is, the Medicare rebate is accepted as full payment for services).

Private health insurance
Patients need to decide if they will use Medicare or their private health insurance ancillary cover to pay for these services. Patients cannot use their private health insurance ancillary cover to 'top up' the Medicare rebate paid for the services.

M.3.3 REFERRAL REQUIREMENTS (GPs TO ALLIED HEALTH PROFESSIONALS)

Referral form
For Medicare benefits to be payable, the patient must be referred to an eligible allied health professional by their GP using an *EPC program referral form for allied health services under Medicare* (the referral form). GPs are encouraged to attach a copy of the relevant part of the patient's care plan to the referral form.

GPs may use one referral form to refer patients for single or multiple services of the same service type (eg five chiropractic services). If referring a patient for single or multiple services of different service types (eg two dietetic services and three podiatry services), a separate referral form will be needed for each service type.

The patient will need to present the referral form to the allied health professional at the first consultation, unless the GP has previously provided it directly to the allied health professional.

Allied health professionals are required to retain the referral form for 24 months from the date the service was rendered (for Medicare Australia auditing purposes).

A copy of the referral form is **not** required to accompany Medicare claims, and allied health professionals do not need to attach a signed copy of the form to patients' itemised accounts/receipts or assignment of benefit forms.

The referral form may be downloaded from the Department of Health and Ageing website at www.health.gov.au/epc or ordered by faxing (02) 6289 7120. GPs may modify the relevant referral form to suit their practice needs (for example, relevant software packages) as long as the information contained therein is substantially retained.

Referral validity
Medicare benefits are available for up to five (5) allied health services per patient per calendar year. If a patient has not used all of their allied health services under a referral in a calendar year, it is not necessary to obtain a new referral for the "unused" services. However, any "unused" services received from 1 January in the following year under that referral will count as part of the total of five services for which the patient is eligible in that calendar year.

When patients have used all of their referred services, or require a referral for a different type of allied health service recommended in their EPC plan, they will need to obtain a new referral from their GP. GPs may choose to use this visit to undertake a review of the patient's EPC plan or, where appropriate, to manage the process using a GP consultation item.

It is not necessary to have a new EPC plan prepared each calendar year in order to access a new referral(s) for eligible allied health services. Patients continue to be eligible for rebates for allied health services while they are being managed under an EPC plan as long as the need for eligible services continues to be recommended in their plan.

M.3.4 ALLIED HEALTH PROFESSIONAL ELIGIBILITY

Eligible allied health professionals
The allied health items can only be claimed for services provided by: Aboriginal health workers; audiologists; diabetes educators; dietitians; exercise physiologists; mental health workers; occupational therapists; physiotherapists; podiatrists; chiropractors; osteopaths; psychologists; and speech pathologists, who are registered with Medicare Australia.

To be eligible to register with Medicare Australia to provide these services, an allied health professional needs to be:

a) a recognised professional who is registered under relevant State or Territory law; or
b) where there is no such State or Territory law, a practitioner who is a member of a professional association with uniform national registration requirements.

Specific eligibility requirements
Specific eligibility requirements for allied health professionals providing services under these items are as follows:

Aboriginal Health Workers practising in the Northern Territory must be registered with the Aboriginal Health Workers Board of the NT; in other States and the Australian Capital Territory they must have been awarded a Certificate Level III (or higher) in Aboriginal and Torres Strait Islander Health from a Registered Training Organisation that meets training standards of the Australian National Training Authority's Australian Quality Training Framework.

Audiologists must be either a 'Full Member' of the Audiological Society of Australia Inc (ASA), who holds a 'Certificate of Clinical Practice' issued by the ASA; or an 'Ordinary Member – Audiologist' or 'Fellow Audiologist' of the Australian College of Audiology (ACAud).

Diabetes Educators must be a Credentialled Diabetes Educator (CDE) as credentialled by the Australian Diabetes Educators Association (ADEA).

Chiropractors must be registered with the Chiropractors (or Chiropractors and Osteopaths) Registration Board in the State or Territory in which they are practising.

Dietitians must be an 'Accredited Practising Dietitian' as recognised by the Dietitians Association of Australia (DAA).

Exercise Physiologists must be an 'Accredited Exercise Physiologist' as accredited by the Australian Association for Exercise and Sports Science (AAESS).

Mental Health Workers
'Mental health' can include services provided by members of five different allied health professional groups. 'Mental health workers' are drawn from the following:

- psychologists;
- mental health nurses;
- occupational therapists;
- social workers; and
- Aboriginal health workers.

Psychologists, occupational therapists and Aboriginal health workers are eligible in separate categories for these items.

A **mental health nurse** may qualify if they are –

- a registered mental health nurse in Tasmania or the Australian Capital Territory (ACT), if providing mental health services in Tasmania or the ACT; or
- a 'Credentialled Mental Health Nurse' as certified by the Australian College of Mental Health Nurses, if providing mental health services in other States or the Northern Territory.

A **social worker** must be a 'Member' of the Australian Association of Social Workers (AASW) and be certified by AASW as meeting the standards for mental health set out in AASW's 'Standards for Mental Health Social Workers 1999', as in force on 1 November 2006.

Occupational therapists in Queensland, Western Australia, South Australia and the Northern Territory must be registered with the Occupational Therapists Board in the State or Territory in which they are practising; in other States and the Australian Capital Territory, they must be a 'Full-time Member' or 'Part-time Member' of OT AUSTRALIA, the national body of the Australian Association of Occupational Therapists.

Osteopaths must be registered with the Osteopaths (or Chiropractors and Osteopaths) Registration Board in the State or Territory in which they are practising.

Physiotherapists must be registered with the Physiotherapists Registration Board in the State or Territory in which they are practising.

Podiatrists in all States and the Australian Capital Territory must be registered with the Podiatrists Registration Board in the State or Territory in which they are practising. If practising in the Northern Territory, Podiatrists must be registered with the Podiatrists Registration Board in any other State or the Australian Capital Territory, or be a "Full Member" of the Australian Podiatry Association (ApodA) in any other State or the Australian Capital Territory.

Psychologists must be registered, without limitation, with the Psychologists Registration Board in the State or Territory in which they are practising.

Speech Pathologists in Queensland must be registered with the Speech Pathologist Board of Queensland. In all other States, the Australian Capital Territory and the Northern Territory, they must be a 'Practising Member' of Speech Pathology Australia.

A copy of these eligibility requirements may be obtained from Medicare Australia by calling 132 150 or at www.medicareaustralia.gov.au or www.health.gov.au/epc.

Registering with Medicare Australia
Provider registration forms may be obtained from Medicare Australia on 132 150 or at www.medicareaustralia.gov.au.

Chiropractors, osteopaths, physiotherapists and podiatrists who were already registered with Medicare Australia on 1 July 2004 to order diagnostic imaging under Medicare, do not need to re-register to provide services under this initiative. Allied health professionals registering with Medicare Australia for the first time only need to fill in one application form which will give them rights to provide services under this initiative and order diagnostic imaging tests etc., where appropriate, under Medicare.

M.3.5 ADDITIONAL REQUIREMENTS OF THE ALLIED HEALTH SERVICE

Service length and type
Services provided under the allied health items must be of at least 20 minutes duration and provided to an individual patient, not to a group. The allied health professional must personally attend the patient.

Reporting back to the GP
Where an allied health professional provides a single service to the patient under a referral, they must provide a written report back to the referring GP after each service.

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

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

M.3.6 FURTHER INFORMATION

Further information about Medicare Benefits Schedule items is available on the Department of Health and Ageing's website at www.health.gov.au/mbsonline.

For providers, further information is also available from the Medicare Australia provider inquiry line on 132 150.

	GROUP M3 - ALLIED HEALTH SERVICES
10950	**ABORIGINAL HEALTH WORKER SERVICE** Aboriginal or Torres Strait Islander health service provided to a person by an eligible Aboriginal health worker if: (a) the service is provided to a person who has a chronic condition, and complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under an EPC plan; and (b) the service is recommended in the person's EPC plan as part of the management of the person's chronic condition and complex care needs; and (c) the person is referred to the eligible Aboriginal health worker by the medical practitioner using a referral form that has been issued by the Department (of Health and Ageing) or a referral form that substantially complies with the form issued by the Department; and (d) the person is not an admitted patient of a hospital; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible Aboriginal health worker gives a written report to the referring medical practitioner mentioned in paragraph (c): (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagragh (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters; and (h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit; - to a maximum of 5 services (including services to which items 10950 to 10970 inclusive apply) in a calendar year *(see para M.3 of explanatory notes to this Category)* **Fee:** $55.05 **Benefit:** 85% = $46.80
10951	**DIABETES EDUCATION SERVICE** Diabetes education health service provided to a person by an eligible diabetes educator if: (a) the service is provided to a person who has a chronic condition, and complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under an EPC plan; and (b) the service is recommended in the person's EPC plan as part of the management of the person's chronic condition and complex care needs; and (c) the person is referred to the eligible diabetes educator by the medical practitioner using a referral form that has been issued by the Department (of Health and Ageing) or a referral form that substantially complies with the form issued by the Department; and (d) the person is not an admitted patient of a hospital; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible diabetes educator gives a written report to the referring medical practitioner mentioned in paragraph (c): (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagragh (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters; and (h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit; - to a maximum of 5 services (including services to which items 10950 to 10970 inclusive apply) in a calendar year *(see para M.3 of explanatory notes to this Category)* **Fee:** $55.05 **Benefit:** 85% = $46.80

	AUDIOLOGY Audiology health service provided to a person by an eligible audiologist if: (a) the service is provided to a person who has a chronic condition, and complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under an EPC plan; and (b) the service is recommended in the person's EPC plan as part of the management of the person's chronic condition and complex care needs; and (c) the person is referred to the eligible audiologist by the medical practitioner using a referral form that has been issued by the Department (of Health and Ageing) or a referral form that substantially complies with the form issued by the Department; and (d) the person is not an admitted patient of a hospital; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible audiologist gives a written report to the referring medical practitioner mentioned in paragraph (c): (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagragh (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters; and (h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit; - to a maximum of 5 services (including services to which items 10950 to 10970 inclusive apply) in a calendar year *(see para M.3 of explanatory notes to this Category)*
10952	**Fee:** $55.05 **Benefit:** 85% = $46.80
	EXERCISE PHYSIOLOGY Exercise Physiology service provided to a person by an eligible exercise physiologist if: (a) the service is provided to a person who has a chronic condition, and complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under an EPC plan; and (b) the service is recommended in the person's EPC plan as part of the management of the person's chronic condition and complex care needs; and (c) the person is referred to the eligible exercise physiologist by the medical practitioner using a referral form that has been issued by the Department (of Health and Ageing) or a referral form that substantially complies with the form issued by the Department; and (d) the person is not an admitted patient of a hospital; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible exercise physiologist gives a written report to the referring medical practitioner mentioned in paragraph (c): (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagragh (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters; and (h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit; - to a maximum of 5 services (including services to which items 10950 to 10970 inclusive apply) in a calendar year *(see para M.3 of explanatory notes to this Category)*
10953	**Fee:** $55.05 **Benefit:** 85% = $46.80

10954	**DIETETICS SERVICE** Dietetics health service provided to a person by an eligible dietitian if: (a) the service is provided to a person who has a chronic condition, and complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under an EPC plan; and (b) the service is recommended in the person's EPC plan as part of the management of the person's chronic condition and complex care needs; and (c) the person is referred to the eligible dietitian by the medical practitioner using a referral form that has been issued by the Department (of Health and Ageing) or a referral form that substantially complies with the form issued by the Department; and (d) the person is not an admitted patient of a hospital; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible dietitian gives a written report to the referring medical practitioner mentioned in paragraph (c): (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagragh (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters; and (h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit; - to a maximum of 5 services (including services to which items 10950 to 10970 inclusive apply) in a calendar year *(see para M.3 of explanatory notes to this Category)* **Fee:** $55.05 **Benefit:** 85% = $46.80
10956	**MENTAL HEALTH SERVICE** Mental health service provided to a person by an eligible mental health worker if: (a) the service is provided to a person who has a chronic condition, and complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under an EPC plan; and (b) the service is recommended in the person's EPC plan as part of the management of the person's chronic condition and complex care needs; and (c) the person is referred to the eligible mental health worker by the medical practitioner using a referral form that has been issued by the Department (of Health and Ageing) or a referral form that substantially complies with the form issued by the Department; and (d) the person is not an admitted patient of a hospital; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible mental health worker gives a written report to the referring medical practitioner mentioned in paragraph (c): (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagragh (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters; and (h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit; - to a maximum of 5 services (including services to which items 10950 to 10970 inclusive apply) in a calendar year *(see para M.3 of explanatory notes to this Category)* **Fee:** $55.05 **Benefit:** 85% = $46.80

	OCCUPATIONAL THERAPY Occupational therapy health service provided to a person by an eligible occupational therapist if: (a) the service is provided to a person who has a chronic condition, and complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under an EPC plan; and (b) the service is recommended in the person's EPC plan as part of the management of the person's chronic condition and complex care needs; and (c) the person is referred to the eligible occupational therapist by the medical practitioner using a referral form that has been issued by the Department (of Health and Ageing) or a referral form that substantially complies with the form issued by the Department; and (d) the person is not an admitted patient of a hospital; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible occupational therapist gives a written report to the referring medical practitioner mentioned in paragraph (c): (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagragh (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters; and (h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit; - to a maximum of 5 services (including services to which items 10950 to 10970 inclusive apply) in a calendar year *(see para M.3 of explanatory notes to this Category)*
10958	**Fee:** $55.05 **Benefit:** 85% = $46.80
	PHYSIOTHERAPY Physiotherapy health service provided to a person by an eligible physiotherapist if: (a) the service is provided to a person who has a chronic condition, and complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under an EPC plan; and (b) the service is recommended in the person's EPC plan as part of the management of the person's chronic condition and complex care needs; and (c) the person is referred to the eligible physiotherapist by the medical practitioner using a referral form that has been issued by the Department (of Health and Ageing) or a referral form that substantially complies with the form issued by the Department; and (d) the person is not an admitted patient of a hospital; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible physiotherapist gives a written report to the referring medical practitioner mentioned in paragraph (c): (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagragh (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters; and (h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit; - to a maximum of 5 services (including services to which items 10950 to 10970 inclusive apply) in a calendar year *(see para M.3 of explanatory notes to this Category)*
10960	**Fee:** $55.05 **Benefit:** 85% = $46.80

10962	**PODIATRY** Podiatry health service provided to a person by an eligible podiatrist if: (a) the service is provided to a person who has a chronic condition, and complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under an EPC plan; and (b) the service is recommended in the person's EPC plan as part of the management of the person's chronic condition and complex care needs; and (c) the person is referred to the eligible chiropodist or eligible podiatrist by the medical practitioner using a referral form that has been issued by the Department (of Health and Ageing) or a referral form that substantially complies with the form issued by the Department; and (d) the person is not an admitted patient of a hospital; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible chiropodist or eligible podiatrist gives a written report to the referring medical practitioner mentioned in paragraph (c): (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagragh (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters; and (h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit; - to a maximum of 5 services (including services to which items 10950 to 10970 inclusive apply) in a calendar year *(see para M.3 of explanatory notes to this Category)* **Fee:** $55.05 **Benefit:** 85% = $46.80
10964	**CHIROPRACTIC SERVICE** Chiropractic health service provided to a person by an eligible chiropractor if: (a) the service is provided to a person who has a chronic condition, and complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under an EPC plan; and (b) the service is recommended in the person's EPC plan as part of the management of the person's chronic condition and complex care needs; and (c) the person is referred to the eligible chiropractor by the medical practitioner using a referral form that has been issued by the Department (of Health and Ageing) or a referral form that substantially complies with the form issued by the Department; and (d) the person is not an admitted patient of a hospital; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible chiropractor gives a written report to the referring medical practitioner mentioned in paragraph (c): (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagragh (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters; and (h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit; - to a maximum of 5 services (including services to which items 10950 to 10970 inclusive apply) in a calendar year *(see para M.3 of explanatory notes to this Category)* **Fee:** $55.05 **Benefit:** 85% = $46.80

	OSTEOPATHY Osteopathy health service provided to a person by an eligible osteopath if: (a) the service is provided to a person who has a chronic condition, and complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under an EPC plan; and (b) the service is recommended in the person's EPC plan as part of the management of the person's chronic condition and complex care needs; and (c) the person is referred to the eligible osteopath by the medical practitioner using a referral form that has been issued by the Department (of Health and Ageing) or a referral form that substantially complies with the form issued by the Department; and (d) the person is not an admitted patient of a hospital; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible osteopath gives a written report to the referring medical practitioner mentioned in paragraph (c): (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagragh (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters; and (h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit; - to a maximum of 5 services (including services to which items 10950 to 10970 inclusive apply) in a calendar year *(see para M.3 of explanatory notes to this Category)*
10966	**Fee:** $55.05 **Benefit:** 85% = $46.80
	PSYCHOLOGY Psychology health service provided to a person by an eligible psychologist if: (a) the service is provided to a person who has a chronic condition, and complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under an EPC plan; and (b) the service is recommended in the person's EPC plan as part of the management of the person's chronic condition and complex care needs; and (c) the person is referred to the eligible psychologist by the medical practitioner using a referral form that has been issued by the Department (of Health and Ageing) or a referral form that substantially complies with the form issued by the Department; and (d) the person is not an admitted patient of a hospital; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible psychologist gives a written report to the referring medical practitioner mentioned in paragraph (c): (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagragh (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters; and (h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit; - to a maximum of 5 services (including services to which items 10950 to 10970 inclusive apply) in a calendar year *(see para M.3 of explanatory notes to this Category)*
10968	**Fee:** $55.05 **Benefit:** 85% = $46.80

	SPEECH PATHOLOGY Speech pathology health service provided to a person by an eligible speech pathologist if: (a) the service is provided to a person who has a chronic condition, and complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under an EPC plan; and (b) the service is recommended in the person's EPC plan as part of the management of the person's chronic condition and complex care needs; and (c) the person is referred to the eligible speech pathologist by the medical practitioner using a referral form that has been issued by the Department (of Health and Ageing) or a referral form that substantially complies with the form issued by the Department; and (d) the person is not an admitted patient of a hospital; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible speech pathologist gives a written report to the referring medical practitioner mentioned in paragraph (c): (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagragh (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters; and (h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit; - to a maximum of 5 services (including services to which items 10950 to 10970 inclusive apply) in a calendar year *(see para M.3 of explanatory notes to this Category)*
10970	**Fee:** $55.05 **Benefit:** 85% = $46.80

SECTION 3

M.4 DENTAL CARE SERVICES (ITEMS 10975 TO 10977)

M.4.1 OVERVIEW OF THE MEDICARE ALLIED HEALTH AND DENTAL CARE INITIATIVE

Medicare Allied Health and Dental Care Initiative
The Medicare Allied Health and Dental Care initiative commenced on 1 July 2004. It provides for Medicare benefits to be paid for certain services provided by eligible allied health professionals, dentists and dental specialists to people with chronic conditions and complex care needs who are being managed by a GP under an Enhanced Primary Care (EPC) plan. The term 'GP' is used in this section as a generic reference to medical practitioners (including a general practitioner, but not including a specialist or consultant physician) able to refer patients for eligible allied health and dental care services.

EPC plan
The term 'EPC plan' is a generic one. Patients are considered to be managed under an EPC plan, if during the last two years:

- their GP has prepared an EPC plan for them and claimed:
  - MBS items 721 and 723 together – Chronic Disease Management (CDM) items for the preparation of a GP Management Plan (GPMP) and coordination of Team Care Arrangements (TCA); or
  - MBS item 720 – preparation of an EPC multidisciplinary care plan; or
  - MBS item 722 – preparation of an EPC multidisciplinary discharge care plan; or
- their GP has contributed to a plan prepared for them as a resident of an aged care facility and claimed item 730 or 731; or
- their GP has reviewed their existing EPC plan and claimed MBS item 724, 725 or 727.

For more information on the Chronic Disease Management items, refer to the explanatory notes for these items.

Before a rebate can be paid for the dental care service on referral from a GP, either the patient must have already claimed a rebate for the relevant EPC planning item/s, or the GP must have lodged a direct bill (bulk billing) claim with Medicare Australia for the relevant EPC planning item/s and received payment for that claim from Medicare Australia.

M.4.2 DENTAL SERVICES ATTRACTING MEDICARE BENEFITS

Number of services per year
Medicare benefits are available for up to three (3) dental care services per eligible patient, per calendar year. The Medicare rebate for each dental service is $77.95.

Out-of-pocket expenses and Medicare Safety Net
Dentists and dental specialists are free to determine their own fees for the professional service. Charges in excess of the Medicare benefit for the dental care items are the responsibility of the patient. However, such out-of-pocket costs will count toward the Medicare safety net for that patient. Dental services in excess of three (3) in a calendar year will not attract a Medicare benefit and the safety net arrangements will not apply to costs incurred by the patient for such services.

Eligible patients
The dental items only apply to patients being managed under an EPC plan (described above) and where the patient is referred to an eligible dental practitioner (dentist) by their GP for a dental condition that is exacerbating the patient's chronic and complex medical condition.

The dental care services provided must be services recommended in the patient's EPC plan as part of the management of their chronic and complex condition.

How the dental items are to be used
There are three dental care items:

- 10975 (dental assessment by an eligible dentist)
- 10976 (dental treatment by an eligible dentist)
- 10977 (dental assessment or treatment by an eligible dentist or eligible dental specialist, on referral from an eligible dentist).

Specific requirements in relation to each of these items are set out below (see note M.4.5)

The dental care services may be provided in the following combinations:

- A dental assessment (1 x item 10975) AND two dental treatments (2 x item 10976) provided by an eligible dentist; or
- A dental assessment (1 x item 10975) AND one dental treatment (1 x item 10976) provided by an eligible dentist AND one dental assessment or treatment (1 x item 10977) provided by another eligible dentist or dental specialist; or
- A dental assessment (1 x item 10975) provided by an eligible dentist AND two dental assessments or treatments (2 x item 10977) provided by another eligible dentist or dental specialist.

When a patient is first referred to a dentist under an EPC plan, the patient must receive a dental assessment (item 10975) as their first service. After the first year, these services may include a combination of one dental assessment (item 10975) and two other dental care items (10976 or 10977) in any order.

For example:

- If a GP identifies a need for dental care as part of a patient's EPC plan and refers the patient to an eligible dentist in June 2007, the patient must receive a dental assessment as their first service, and may claim a Medicare benefit for that service and for two (2) subsequent dental treatment services (see combinations above) during the remainder of the 2007 calendar year.
- Where the patient is referred to an eligible dentist during the following calendar year (2008), they may claim a Medicare benefit for two (2) dental treatment services and a subsequent dental assessment. That is, as long as the patient has a dental assessment as their first treatment under an EPC plan, they may choose the order in which they access eligible services each successive calendar year, as long as sometime during that year, they have a dental assessment.

Checking patient eligibility for dental services

Patients seeking Medicare rebates for dental services will need to have an *EPC program referral form for dental care services under Medicare* signed by their GP. If there is any doubt about a patient's eligibility, Medicare Australia will be able to confirm whether there is an EPC plan in place and the number of dental services already claimed by the patient during the calendar year. Dentists and dental specialists or the patient can call Medicare Australia on 132 011 to check this information.

Supply of prostheses

The cost of making/supplying prostheses such as, an inlay, crown, bridge, implant, denture, obturator, veneer or a combination of these are **NOT** covered by Medicare. Dentists and dental specialists should separately itemise any costs associated with the supply/making of prostheses when billing patients for a dental treatment (and not include these costs under the Medicare dental care items). Costs associated with fitting prostheses can be included under items 10976 or 10977.

Publicly funded dental services

The dental items (10975-10977) do not apply for services that are provided by any other Commonwealth or State funded services or provided to an admitted patient of a hospital.

However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or State/Territory Government health clinic, items 10975-10977 can be claimed for services provided by eligible dentists and dental specialists salaried by, or contracted to, the Service or health clinic. All requirements of the relevant item must be met, including registration of the dentist or dental specialist with Medicare Australia. These services must also be direct billed (that is, the Medicare rebate is accepted as full payment for services).

Private health insurance

Patients need to decide if they will use Medicare or their private health insurance ancillary cover to pay for these services. Patients cannot use their private health insurance ancillary cover to 'top up' the Medicare rebate paid for the services.

M.4.3 REFERRAL REQUIREMENTS (GPs TO DENTISTS)

Referral forms
For Medicare benefits to be payable, the patient must be referred to an eligible dentist by their GP using an *EPC program referral form for dental care services under Medicare* (the referral form). GPs are encouraged to attach a copy of the relevant part of the patient's EPC plan to the referral form.

The dentist/ dental specialist must be in receipt of the referral at the first dental care consultation. Dentist/dental specialists are required to retain the referral form for 24 months from the date the service was rendered (for Medicare Australia auditing purposes).

A copy of the referral form is **not** required to accompany Medicare claims and dentists/dental specialists do not need to attach a signed copy of the form to patients' itemised accounts/receipts and assignment of benefit forms.

The referral form may be downloaded from the Department of Health and Ageing website at www.health.gov.au/epc or ordered by faxing (02) 6289 7120. GPs may modify the relevant referral form to suit their practice needs (for example, relevant software packages) as long as the information contained therein is substantially retained.

Referral validity
Medicare benefits are available for up to three (3) dental care services per patient per calendar year. If a patient has not used all of their dental care services under a referral in a calendar year, it is not necessary to obtain a new referral for the "unused" services. However, any "unused" services received from 1 January in the following year under that referral will count as part of the total of three services for which the patient is eligible in that calendar year.

When patients have used all of their referred services, they will need to obtain a new referral from their GP. GPs may choose to use this visit to undertake a review of the patient's EPC plan or, where appropriate, to manage the process using a GP consultation item.

It is not necessary to have a new EPC plan prepared each calendar year in order to access a new referral(s) for eligible dental care services. Patients continue to be eligible for rebates for dental care services while they are being managed under an EPC plan as long as the need for eligible services continues to be recommended in their plan.

M.4.4 DENTIST AND DENTAL SPECIALIST ELIGIBILITY

Eligibility requirements
Eligible dentists and dental specialists are those recognised professionals who are registered under relevant State or Territory law, and who are also registered with Medicare Australia to provide dental care services under the Medicare Allied Health and Dental Care initiative.

Registering with Medicare Australia
Dentists and dental specialists who are registered with Medicare Australia to order diagnostic imaging or pathology tests, for prescribing, or for specialist referral under Medicare, are also eligible to provide services under this initiative using their current Medicare provider number. Dentists and dental specialists registering with Medicare Australia for the first time only need to fill in one application form which will give them rights to provide services under this initiative and order diagnostic imaging or pathology tests etc., under Medicare.

Provider registration forms may be obtained from Medicare Australia on 132 150 or at www.medicareaustralia.gov.au.

M.4.5 ADDITIONAL REQUIREMENTS OF THE DENTAL SERVICE

Dental assessment (item 10975) and written report
This item can only be provided on referral from a GP for a patient being managed under an EPC plan. It MUST be claimed first for all eligible patients in order for items 10976 and 10977 to be provided under a dental care plan, and then as one of the three items each calendar year where further care is being provided.

The item should not be claimed more than once per calendar year unless the condition of the patient has changed substantially. Where the patient's condition requires an additional assessment to be provided within the calendar year, the patient's invoice or Medicare voucher should be annotated to indicate this

Common examples of circumstances where a dental condition can exacerbate a chronic and complex disease might include (but are not restricted to):

(a) where the patient has valvular heart disease and poor oral hygiene and gum disease (putting them at the risk of developing bacterial endocarditis);
(b) where the patient has diabetes and oral hygiene problems (such as tooth abscesses, and where infection can compromise the management of their diabetes);
(c) where the patient has malignancies of the head and neck where surgery [or radiation] has resulted in damage to the oral cavity, or has exacerbated underlying dental disease (and affects eating); or
(d) where the patient has baseline poor oral health and experience significant worsening while undergoing chemotherapy or is immuno-suppressed.

A dental assessment means a comprehensive assessment of a patient's dental health, and whether further dental treatment should be offered to the patient.

The assessment should include:

(a) an evaluation of all teeth, their supporting tissues and the oral tissues; and
(b) a written report provided to the referring GP.

The written report should include:

- the findings of the evaluation and prognosis;
- the proposed treatment, including the likely number of visits, and an estimated cost of each visit, or the total treatment; and
- any specific investigations that would be required (such as radiology or pathology services) that would assist in the management of the dental condition as it relates to the chronic and complex medical condition.

The written report of the assessment should be provided to the referring GP and a copy should also be offered to the patient. Where the patient has a carer, a copy of the report (or relevant extracts) should be offered to the carer, with the patient's agreement.

The dental assessment item may include referral for other services attracting a Medicare benefit from MBS item category 5 (diagnostic imaging) or category 6 (pathology) services where clinically relevant, but should not take the form of a health screening service. These diagnostic and pathology services do not count towards the three (3) annual dental visits available under the Medicare Allied Health and Dental Care initiative.

Dentists can provide services under item 10976 on the same day as a dental assessment if clinically indicated. These services will count as two (2) of the three (3) annual visits available under the Medicare Allied Health and Dental Care initiative.

Dental treatment (item 10976)
Services provided under item 10976 may only be provided where the patient has been the recipient of a dental assessment (item 10975). (Note: Item 10975 MUST be claimed first for all eligible patients in order for item 10976 to be provided under a dental care plan, and then each calendar year where further dental care is being provided).

This item only applies to services provided that will improve or relieve the dental condition that is exacerbating the chronic and complex medical condition for which the EPC plan has been formed.

Some services that would be appropriate under this item may be - but **are not** restricted to:

(a) Tooth extraction and oral surgery;
(b) Treatment of acute periodontal infection;
(c) Restorative services, such as metallic or adhesive restorations, or capping;
(d) Root planning and subgingival curettage;
(e) Endodontics; and
(f) Drainage of abscesses or cysts.

Dental assessment or treatment by a registered dentist or dental specialist on referral from another dentist (item 10977)

Services provided under item 10977 may only be provided where the patient has been the recipient of a dental assessment (item 10975), where the dentist providing the service under item 10975 determined that further assessment and treatment from a dental specialist or another dentist was required. (Note: Item 10975 MUST be claimed first for all eligible patients in order for item 10977 to be provided under a dental care plan, and then each calendar year where further dental care is being provided).

A written report of the assessment must also be sent to the referring dentist as well as the original referring GP.

Dental specialist for the purposes of item 10977
A dental specialist is a person who is:
(a) registered or licensed as a periodontist, endodontist, pedeodontist, or orthodontist under a law of a State or Territory; or
(b) registered or licensed as a dental specialist under a law of a State or Territory and recognised by the registering or licensing authority as a person who practices in the speciality of periodontics, endodontics, pedeodontics, or orthodontics.

For the purposes of item 10977, 'dentist or dental specialist' includes all registered dental specialists as well as registered dentists who restrict their practice to 'special needs' dentistry.

M.4.6 FURTHER INFORMATION

Further information about Medicare Benefits Schedule items is available on the Department of Health and Ageing's website at www.health.gov.au/mbsonline.

For providers, further information is also available from the Medicare Australia provider inquiry line on 132 150.

	GROUP M4 - DENTAL SERVICES
10975	Dental assessment provided to a person by an eligible dental practitioner if: (a) the service is provided to a person whose dental condition is exacerbating a chronic condition being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under an EPC plan; and (b) the service is recommended in the person's EPC plan as part of the management of the person's chronic condition and complex care needs; and (c) the person is referred to the eligible dental practitioner by the medical practitioner using a referral form that has been issued by the Department (of Health and Ageing) or a referral form that substantially complies with the form issued by the Department; and (d) the person is not an admitted patient of a hospital; and (e) after the assessment, the eligible dental practitioner gives a written report to the referring medical practitioner; and (f) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit; - to a maximum of 3 services (including services to which this item or 10976 or 10977 applies) in a calendar year *(see para M.4 of explanatory notes to this Category)* **Fee:** $91.70 **Benefit:** 85% = $77.95
10976	Dental treatment provided to a person by an eligible dental practitioner if: (a) the service is provided to a person whose dental condition is exacerbating a chronic condition being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under an EPC plan; and (b) the service is recommended in the person's EPC plan as part of the management of the person's chronic condition and complex care needs; and (c) the service is associated with a service of the kind described in item 10975 previously provided to the person; and (d) the person is referred to the eligible dental practitioner by the medical practitioner using a referral form that has been issued by the Department (of Health and Ageing) or a referral form that substantially complies with the form issued by the Department; and (e) the person is not an admitted patient of a hospital; and (f) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit; - to a maximum of 3 services (including services to which this item or 10975 or 10977 applies) in a calendar year *(see para M.4 of explanatory notes to this Category)* **Fee:** $91.70 **Benefit:** 85% = $77.95
10977	Dental service provided to a person by an eligible dental practitioner or an eligible dental specialist (the ***providing dentist***) if: (a) the service is provided to a person whose dental condition is exacerbating a chronic condition being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under an EPC plan; and (b) the service is recommended in the person's EPC plan as part of the management of the person's chronic condition and complex care needs; and (c) the service is associated with a service of the kind described in item 10975 previously provided to the person by another eligible dental practitioner; and (d) the person is referred to the providing dentist by the eligible dental practitioner who provided the service described in item 10975 using a referral form that has been issued by the Department (of Health and Ageing) or a referral form that substantially complies with the form issued by the Department; and (e) the person is not an admitted patient of a hospital; and (f) after the service, the providing dentist gives a written report to the referring eligible dental practitioner and the medical practitioner mentioned in the paragraph (a); and (g) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit; - to a maximum of 3 services (including services to which this item or 10975 or 10976 applies) in a calendar year *(see para M.4 of explanatory notes to this Category)* **Fee:** $91.70 **Benefit:** 85% = $77.95

SECTION 4

M.6 PROVISION OF PSYCHOLOGICAL THERAPY SERVICES BY CLINICAL PSYCHOLOGISTS (ITEMS 80000 TO 80020)

M.6.1 Overview of the Medicare Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Scheme Initiative

Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Scheme Initiative
The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Scheme initiative commenced on 1 November 2006. It includes the introduction of new MBS items that provide Medicare benefits for the following allied mental health services:

- psychological therapy (items 80000 to 80020) – provided by eligible clinical psychologists; and
- focussed psychological strategies – allied mental health (items 80100 to 80170) – provided by eligible psychologists, occupational therapists and social workers.

M.6.2 PSYCHOLOGICAL THERAPY SERVICES ATTRACTING MEDICARE REBATES

Eligible psychological therapy services
There are five MBS items for the provision of psychological therapy services to eligible patients by a clinical psychologist. The clinical psychologists must meet the provider eligibility requirements set out below and be registered with Medicare Australia.

Services provided under the Psychological Therapy items will not attract a Medicare rebate unless:

- the patient is being managed under a GP Mental Health Care Plan (item 2710 or 2712);
- the patient is being managed under a psychiatrist assessment and management plan (item 291 or 293); or
- an eligible psychiatric or paediatric service has been provided and claimed.

Number of services per year
Medicare rebates are available for up to twelve allied mental health services in a calendar year. The twelve services may consist of: psychological therapy services (items 80000 to 80015); and/or focussed psychological strategies – allied mental health services (items 80100 to 80115; 80125 to 80140; 80150 to 80165 and/or Access to Allied Psychological Services (ATAPS) consultations under the Better Outcomes in Mental Health Care Program. After an initial group of six services, the practitioner managing the patient will conduct a review of the need for further services, before a further six may be provided. In addition, the referring practitioner may consider that in exceptional circumstances the patient may require an additional six services above that already provided (to a maximum total of 18 services per patient per calendar year). In these cases a new referral should be provided, and exceptional circumstances noted in that referral.

Patients will also be eligible to claim up to 12 separate services within a calendar year for group psychotherapy with 6-10 patients to which items 80020 (psychological therapy – clinical psychologist), 80120 (focussed psychological strategies – psychologist), 80145 (focussed psychological strategies – occupational therapist) and 80170 (focussed psychological strategies - social worker) apply. These group services are separate from the individual services and do not count towards the 12 service calendar year maximum associated with those items.

Out-of-pocket expenses and Medicare Safety Net
Charges in excess of the Medicare benefit for these items are the responsibility of the patient. However, such out-of-pocket costs will count toward the Medicare safety net for that patient. Psychological therapy services and/or focussed psychological strategies services in excess of the maximum annual allowance of twelve individual services (apart from where exceptional circumstances apply) and twelve group sessions will not attract a Medicare benefit and the safety net arrangements will not apply to costs incurred by the patient for such services.

Eligible patients
Items 80000 to 80020 (inclusive) apply to people with an assessed mental disorder and where the patient is referred by a medical practitioner who is managing the patient under a GP Mental Health Care Plan (item 2710

or 2712); and/or a psychiatrist assessment and management plan (item 291 or 293); or on referral from an eligible psychiatrist or paediatrician.

The conditions classified as mental disorders for the purposes of these services are informed by the World Health Organisation, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care: ICD-10 Chapter V Primary Care Version. For the purposes of these items, dementia, delirium, tobacco use disorder and mental retardation are not regarded as a mental disorder.

Checking patient eligibility for psychological therapy services
Patients seeking Medicare rebates for psychological therapy services will need to have a referral from a GP, psychiatrist or paediatrician. If there is any doubt about a patient's eligibility, Medicare Australia will be able to confirm whether a GP Mental Health Care Plan; and/or a psychiatrist assessment and management plan is in place and claimed; or an eligible psychiatric or paediatric service has been claimed, as well as the number of allied health services already claimed by the patient during the calendar year.

Clinical psychologists can call Medicare Australia on 132 150 to check this information, while unsure patients can seek clarification by calling 132 011.

Publicly funded services
Psychological therapy items 80000 to 80020 do not apply for services that are provided by any other Commonwealth or State funded services or provided to an admitted patient of a hospital. However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or State/Territory clinic, the items apply for services that are provided by eligible clinical psychologists salaried by, or contracted to, the service as long as all requirements of the items are met, including registration with Medicare Australia. These services must be direct billed (that is, the Medicare rebate is accepted as full payment for services.

Private health insurance
Patients need to decide if they will use Medicare or their private health insurance ancillary cover to pay for these services. Patients cannot use their private health insurance ancillary cover to 'top up' the Medicare rebate paid for the services.

For further information about Medicare and the MBS, please go to the Department of Health and Ageing's website at www.health.gov.au/mbsonline.

M.6.3 REFERRAL REQUIREMENTS (GPs, PSYCHIATRISTS OR PAEDIATRICIANS TO ALLIED MENTAL HEALTH PROFESSIONALS)

Referrals
Patients must be referred for psychological therapy services by a GP managing the patient under a GP Mental Health Care Plan (item 2710 or 2712); and/or a psychiatrist assessment and management plan (item 291 or 293); or on referral from a psychiatrist or a paediatrician. Referring practitioners are **not** required to use a specific form to refer patients for these services. The referral may be a letter or note to an eligible clinical psychologist signed and dated by the referring practitioner.

The clinical psychologist must be in receipt of the referral at the first allied mental health consultation. A clinical psychologist is required to retain the referral form for 24 months from the date the service was rendered for Medicare Australia auditing purposes.

Referral validity
Medicare benefits are available for up to twelve (12) psychological therapy services and/or focussed psychological strategies services per patient per calendar year. If a patient has not used all of their psychological therapy services and/or focussed psychological strategies services under a referral in a calendar year, it is not necessary to obtain a new referral for the "unused" services. However, any "unused" services received from 1 January in the following year under that referral will count as part of the total of twelve services for which the patient is eligible in that calendar year.

When patients have used all of their referred services they will need to obtain a new referral from their GP. GPs may choose to use this visit to undertake a review of the patient's Mental Health Care plan and/or a psychiatrist assessment and management plan.

It is not necessary to have a new Mental Health Care plan and/or a psychiatrist assessment and management plan prepared each calendar year in order to access a new referral(s) for eligible psychological therapy services and/or focussed psychological strategies services. Patients continue to be eligible for rebates for psychological therapy services and/or focussed psychological strategies services while they are being managed under an Mental Health Care plan and/or a psychiatrist assessment and management plan as long as the need for eligible services continues to be recommended in their plan.

M.6.4 ALLIED MENTAL HEALTH PROFESSIONAL ELIGIBILITY

Eligible allied health professionals
All consultations providing psychological therapy services must be rendered by a clinical psychologist with membership of the Australian Psychological Society's College of Clinical Psychology or equivalent, and who is registered with Medicare Australia.

Registering with Medicare Australia
Advice about registering with Medicare Australia to provide psychological therapy services using items 80000-80020 inclusive is available from the Medicare Australia provider inquiry line on 132 150.

M.6.5 ADDITIONAL REQUIREMENTS OF THE PSYCHOLOGICAL THERAPY SERVICES

Service length and type
Services provided by eligible allied health professionals under these items must be within the specified time period within the item descriptor. The allied health professional must personally attend the patient.

It is expected that professional attendances at places other than consulting rooms would be provided where treatment in other environments is necessary to achieve therapeutic outcomes.

In addition to psycho-education, it is recommended that cognitive-behaviour therapy be provided. However, other evidence-based therapies ─ such as interpersonal therapy ─ may be used if considered clinically relevant.

Reporting back to the referring medical practitioner
Patients are eligible to receive up to twelve individual services (up to eighteen in exceptional circumstances) and up to twelve group sessions in a calendar year.

Within this maximum service allocation, the allied mental health professional can provide one or more courses of treatment. For the purposes of the allied mental health items, a course of treatment consists of up to six services (but may involve less than six depending on the referral). This enables the referring medical practitioner to consider a report from the allied mental health professional on the services provided to the patient, and the need for further treatment.

On completion of the initial course of treatment, the allied mental health professional must provide a written report to the referring medical practitioner, which includes information on:

- assessments carried out on the patient;
- treatment provided; and
- recommendations on future management of the patient's disorder

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

Further information
Further information about Medicare Benefits Schedule items is available on the Department of Health and Ageing's website at www.health.gov.au/mbsonline.

For providers, further information is also available from the Medicare Australia provider inquiry line on 132 150.

	GROUP M6 - PSYCHOLOGICAL THERAPY SERVICES
80000	Professional attendance for the purpose of providing psychological assessment and therapy for a mental disorder by a clinical psychologist registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting more than 30 minutes but less than 50 minutes, where the patient is referred by a medical practitioner, as part of a GP Mental Health Care Plan and/or a psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These therapies are time limited, being deliverable, in general, in up to 12 planned sessions in a calendar year (including services to which items 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 and the Better Outcomes in Mental Health Access To Allied Psychological Services apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply. (Professional attendance at consulting rooms) *(See para M.6 of explanatory notes to this Category)* **Fee:** $88.20 **Benefit:** 85% = $75.00
80005	Professional attendance at a place other than consulting rooms. As per the service requirements outlined for item 80000. *(See para M.6 of explanatory notes to this Category)* **Fee:** $110.20 **Benefit:** 85% = $93.70
80010	Professional attendance for the purpose of providing psychological assessment and therapy for a mental disorder by a clinical psychologist registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting at least 50 minutes, where the patient is referred by a medical practitioner, as part of a GP Mental Health Care Plan; and/or a psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These therapies are time limited, being deliverable, in general, in up to 12 planned sessions in a calendar year (including services to which items 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 and the Better Outcomes in Mental Health Access To Allied Psychological Services apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply. (Professional attendance at consulting rooms) *(See para M.6 of explanatory notes to this Category)* **Fee:** $129.40 **Benefit:** 85% = $110.00
80015	Professional attendance at a place other than consulting rooms As per the service requirements outlined for item 80010. *(See para M.6 of explanatory notes to this Category)* **Fee:** $151.40 **Benefit:** 85% = $128.70
80020	Professional attendance for the purpose of providing psychological therapy for a mental disorder by a clinical psychologist registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting for at least 60 minutes duration where the patients are referred by a medical practitioner, as part of a GP Mental Health Care Plan; and/or a psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These therapies are time limited, being deliverable, in general, in up to 12 planned sessions in a calendar year (including services to which items 80120, 80145 and 80170 apply). - GROUP PSYCHOTHERAPY with a group of 6 to 10 patients, EACH PATIENT *(See para M.6 of explanatory notes to this Category)* **Fee:** $32.90 **Benefit:** 85% = $28.00

M.7 PROVISION OF FOCUSSED PSYCHOLOGICAL STRATEGIES SERVICES BY ALLIED HEALTH PROVIDERS (ITEMS 80100 TO 80170)

M.7.1 Overview of the Medicare Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Scheme Initiative

Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Scheme Initiative

The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Scheme initiative commenced on 1 November 2006. It includes the introduction of new MBS items that provide Medicare benefits for the following allied mental health services:

- psychological therapy (items 80000 to 80020) – provided by eligible clinical psychologists; and
- focussed psychological strategies – allied mental health (items 80100 to 80170) – provided by eligible psychologists, occupational therapists and social workers.

M.7.2 FOCUSSED PSYCHOLOGICAL STRATEGIES – ALLIED MENTAL HEALTH SERVICES ATTRACTING MEDICARE REBATES

Eligible focussed psychological strategies services

There are fifteen MBS items for the provision of focussed psychological strategies (FPS) – allied mental health services to eligible patients by allied health professionals:

- 80100, 80105, 80110, 80115 and 80120 for provision of FPS services by a psychologist;
- 80125, 80130, 80135, 80140 and 80145 for provision of FPS services by an occupational therapist; and
- 80150, 80155, 80160, 80165 and 80170 for provision of FPS services by a social worker.

The allied health professional must meet the provider eligibility requirements set out below and be registered with Medicare Australia.

Services provided under the focussed psychological strategies – allied mental health items will not attract a Medicare rebate unless:

- the patient is being managed under a GP Mental Health Care Plan (item 2710 or 2712);
- the patient is being managed under a psychiatrist assessment and management plan (item 291 or 293); or
- an eligible psychiatric or paediatric service has been provided and claimed.

Number of services per year

Patients will be eligible to claim Medicare rebates for up to twelve allied mental health services in a calendar year. These twelve services may consist of: psychological therapy services (items 80000 to 80015); and/or focussed psychological strategies – allied mental health services (items 80100 to 80115; 80125 to 80140; 80150 to 80165 and/or Access to Allied Psychological Services (ATAPS) consultations under the Better Outcomes in Mental Health Care Program. After an initial group of six services, the practitioner managing the patient will conduct a review of the need for further services, before a further six may be provided. In addition, the referring practitioner may consider that in exceptional circumstances the patient may require an additional six services above that already provided (to a maximum total of 18 services per patient per calendar year). In these cases a new referral should be provided, and exceptional circumstances noted in that referral.

Patients will also be eligible to claim up to 12 separate services within a calendar year for group psychotherapy with 6-10 patients to which items 80020 (psychological therapy – clinical psychologist), 80120 (focussed psychological strategies – psychologist), 80145 (focussed psychological strategies – occupational therapist) and 80170 (focussed psychological strategies - social worker) apply. These group services are separate from the individual services and do not count towards the 12 service calendar year maximum associated with those items.

Out-of-pocket expenses and Medicare Safety Net

Charges in excess of the Medicare benefit for these items are the responsibility of the patient. However, such out-of-pocket costs will count toward the Medicare safety net for that patient. Psychological therapy services and/or focussed psychological strategies services in excess of the maximum annual allowance of twelve individual services (apart from where exceptional circumstances apply) and twelve group sessions will not

attract a Medicare benefit and the safety net arrangements will not apply to costs incurred by the patient for such services.

Eligible patients
Items 80100 to 80170 (inclusive) apply to people with an assessed mental disorder and where the patient is referred by a medical practitioner who is managing the patient under a GP Mental Health Care Plan; and/or a psychiatrist assessment and management plan; or from an eligible psychiatrist or paediatrician.

The conditions classified as mental disorders for the purposes of these services are informed by the World Health Organisation, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care: ICD-10 Chapter V Primary Care Version. For the purposes of these items, dementia, delirium, tobacco use disorder and mental retardation are not regarded as a mental disorder.

Checking patient eligibility for focussed psychological strategies – allied mental health services
Patients seeking Medicare rebates for focussed psychological strategies – allied mental health services will need to have a referral from a GP, psychiatrist or paediatrician. If there is any doubt about a patient's eligibility, Medicare Australia will be able to confirm whether a GP Mental Health Care Plan; and/or a psychiatrist assessment and management plan is in place and claimed; or an eligible psychiatric or paediatric service has been claimed, as well as the number of allied health services already claimed by the patient during the calendar year.

Clinical psychologists can call Medicare Australia on 132 150 to check this information, while unsure patients can seek clarification by calling 132 011.

Publicly funded services
FPS items 80100 to 80170 do not apply for services that are provided by any other Commonwealth or State funded services or provided to an admitted patient of a hospital. However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or State/Territory clinic, the FPS items apply for services that are provided by eligible allied mental health professionals salaried by, or contracted to, the service as long as all requirements of the items are met, including registration with Medicare Australia. These services must be direct billed (that is, the Medicare rebate is accepted as full payment for services).

Private health insurance
Patients need to decide if they will use Medicare or their private health insurance ancillary cover to pay for these services. Patients cannot use their private health insurance ancillary cover to 'top up' the Medicare rebate paid for the services.

For further information about Medicare and the MBS, please go to the Department of Health and Ageing's website at www.health.gov.au/mbsonline.

M.7.3 REFERRAL REQUIREMENTS (GPs, PSYCHIATRISTS OR PAEDIATRICIANS TO ALLIED MENTAL HEALTH PROFESSIONALS)

Referrals
Patients must be referred for FPS services by a GP managing the patient under a GP Mental Health Care Plan (item 2710 or 2712); and/or a psychiatrist assessment and management plan (item 291 or 293); or on referral from a psychiatrist or a paediatrician. Referring practitioners are **not** required to use a specific form to refer patients for these services. The referral may be a letter or note to an eligible allied mental health professional signed and dated by the referring practitioner.

The allied mental health professional must be in receipt of the referral at the first allied mental health consultation. An allied mental health professional is required to retain the referral form for 24 months from the date the service was rendered for Medicare Australia auditing purposes.

Referral validity
The referral remains valid for the stated number of services. If the services are not used during the calendar year in which the patient is referred, the unused services may be used in the next calendar year. However, they will be counted as part of the twelve (12) rebates for psychological therapy services and/or focussed psychological strategies – allied mental health services available to the patient during that calendar year (that is, the patient may only claim up to twelve (12) rebates in total each year).

Subsequent referrals
Where patients wish to access Medicare benefits for eligible psychological therapy services or focussed psychological strategies during their next period of eligibility for rebates (that is, the next calendar year), they should see their GP to obtain a new referral when they have used up their current referral.

M.7.4 ALLIED MENTAL HEALTH PROFESSIONAL ELIGIBILITY

Eligible allied health professionals
Allied health professionals providing services under the items must be registered with Medicare Australia. To be eligible to register with Medicare Australia to provide these services, an allied health professional must be:

- A psychologist registered with the Psychologists Registration Board in the State or Territory in which they are practising. (Psychologists whose State/Territory registration includes any limitation, for example, where marked 'provisional registration', are not eligible to register with Medicare Australia to use the FPS item); or
- A full or part-time member of OT AUSTRALIA with a minimum of two years of experience in mental health and an undertaking to abide by The Australian Competency Standards for Occupational Therapists in Mental Health; or
- A member of the Australian Association of Social Workers (AASW), including certification by the AASW as meeting the standards for mental health set out in the AASW's 'Standards for Mental Health Social Workers 1999', as in force on 1 November 2006.

Registering with Medicare Australia
Advice about registering with Medicare Australia to provide focussed psychological strategies – allied mental health services using items 80100-80170 inclusive is available from the Medicare Australia provider inquiry line on 132 150.

M.7.5 ADDITIONAL REQUIREMENTS OF THE FOCUSSED PSYCHOLOGICAL STRATEGIES SERVICES

Service length and type
Services provided by eligible allied health professionals under these items must be within the specified time period within the item descriptor. The allied health professional must personally attend the patient.

It is expected that professional attendances at places other than consulting rooms would be provided where treatment in other environments is necessary to achieve therapeutic outcomes.

A range of acceptable strategies has been approved for use by allied health professionals utilising the FPS items. These are:

1. **Psycho-education**
   (including motivational interviewing)
2. **Cognitive-behavioural Therapy including:**
   - **Behavioural interventions**
     - Behaviour modification
     - Exposure techniques
     - Activity scheduling
   - **Cognitive interventions**
     - Cognitive therapy
3. **Relaxation strategies**
   - Progressive muscle relaxation
   - Controlled breathing
4. **Skills training**
   - Problem solving skills and training
   - Anger management
   - Social skills training
   - Communication training
   - Stress management
   - Parent management training

5. **Interpersonal Therapy** (especially for depression)

There is flexibility to include narrative therapy for Aboriginal and Torres Strait Islander people.

Reporting back to the referring medical practitioner
Patients are eligible to receive up to twelve individual services (up to eighteen in exceptional circumstances) and up to twelve group sessions in a calendar year.

Within this maximum service allocation, the allied mental health professional can provide one or more courses of treatment. For the purposes of the allied mental health items, a course of treatment consists of up to six services (but may involve less than six depending on the referral). This enables the referring medical practitioner to consider a report from the allied mental health professional on the services provided to the patient, and the need for further treatment.

On completion of the initial course of treatment, the allied mental health professional must provide a written report to the referring medical practitioner, which includes information on:

- assessments carried out on the patient;
- treatment provided; and
- recommendations on future management of the patient's disorder

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

Further information
Further information about Medicare Benefits Schedule items is available on the Department of Health and Ageing's website at www.health.gov.au/mbsonline.

For providers, further information is also available from the Medicare Australia provider inquiry line on 132 150.

	GROUP M7 - FOCUSSED PSYCHOLOGICAL STRATEGIES (ALLIED MENTAL HEALTH)
80100	Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a psychologist registered with Medicare Australia as meeting the credentialing requirements for provision of this service - lasting more than 20 minutes, but not more than 50 minutes - where the patient is referred by a medical practitioner, as part of a GP Mental Health Care Plan; and/or a psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These services are time limited, being deliverable, in general, in up to 12 planned sessions in a calendar year (including services to which items 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 and the Better Outcomes in Mental Health Access To Allied Psychological Services apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply. *(See para M.7 of explanatory notes to this Category)* **Fee:** $62.50 **Benefit:** 85% = $53.15
80105	Professional attendance at a place other than consulting rooms. As per the psychologist service requirements outlined for item 80100. *(See para M.7 of explanatory notes to this Category)* **Fee:** $84.95 **Benefit:** 85% = $72.25
80110	Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a psychologist registered with Medicare Australia as meeting the credentialing requirements for provision of this service - lasting more than 50 minutes - where the patient is referred by a medical practitioner, as part of a GP Mental Health Care Plan; and/or a psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These services are time limited, being deliverable, in general, in up to 12 planned sessions in a calendar year (including services to which items 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 and the Better Outcomes in Mental Health Access To Allied Psychological Services apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply. *(See para M.7 of explanatory notes to this Category)* **Fee:** $88.20 **Benefit:** 85% = $75.00
80115	Professional attendance at a place other than consulting rooms. As per the psychologist service requirements outlined for item 80110. *(See para M.7 of explanatory notes to this Category)* **Fee:** $110.70 **Benefit:** 85% = $94.10
80120	Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a psychologist registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting for at least 60 minutes duration where the patients are referred by a medical practitioner, as part of a GP Mental Health Care Plan; and/or a psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These therapies are time limited, being deliverable, in general, in up to 12 planned sessions in a calendar year (including services to which items 80020, 80145 and 80170 apply). GROUP THERAPY with a group of 6 to 10 patients, EACH PATIENT *(See para M.7 of explanatory notes to this Category)* **Fee:** $22.45 **Benefit:** 85% = $19.10

80125	Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by an occupational therapist registered with Medicare Australia as meeting the credentialing requirements for provision of this service - lasting more than 20 minutes, but not more than 50 minutes - where the patient is referred by a medical practitioner, as part of a GP Mental Health Care Plan; and/or a psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These services are time limited, being deliverable, in general, in up to 12 planned sessions in a calendar year (including services to which items 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 and the Better Outcomes in Mental Health Access To Allied Psychological Services apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply. *(See para M.7 of explanatory notes to this Category)* **Fee:** $55.05 **Benefit:** 85% = $46.80
80130	Professional attendance at a place other than consulting rooms. As per the occupational therapist service requirements outlined for item 80125. *(See para M.7 of explanatory notes to this Category)* **Fee:** $77.50 **Benefit:** 85% = $65.90
80135	Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by an occupational therapist registered with Medicare Australia as meeting the credentialing requirements for provision of this service - lasting more than 50 minutes - where the patient is referred by a medical practitioner, as part of a GP Mental Health Care Plan; and/or a psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These services are time limited, being deliverable, in general, in up to 12 planned sessions in a calendar year (including services to which items 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 and the Better Outcomes in Mental Health Access To Allied Psychological Services apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply. *(See para M.7 of explanatory notes to this Category)* **Fee:** $77.70 **Benefit:** 85% = $66.05
80140	Professional attendance at a place other than consulting rooms. As per the occupational therapist service requirements outlined for item 80135. *(See para M.7 of explanatory notes to this Category)* **Fee:** $100.15 **Benefit:** 85% = $85.15
80145	Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by an occupational therapist registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting for at least 60 minutes duration where the patients are referred by a medical practitioner, as part of a GP Mental Health Care Plan; and/or a psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These therapies are time limited, being deliverable, in general, in up to 12 planned sessions in a calendar year (including services to which items 80020, 80120 and 80170 apply). GROUP THERAPY with a group of 6 to 10 patients, EACH PATIENT *(See para M.7 of explanatory notes to this Category)* **Fee:** $19.75 **Benefit:** 85% = $16.80

80150	Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a social worker registered with Medicare Australia as meeting the credentialing requirements for provision of this service - lasting more than 20 minutes, but not more than 50 minutes - where the patient is referred by a medical practitioner, as part of a GP Mental Health Care Plan; and/or a psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These services are time limited, being deliverable, in general, in up to 12 planned sessions in a calendar year (including services to which items 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 and the Better Outcomes in Mental Health Access To Allied Psychological Services apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply. *(See para M.7 of explanatory notes to this Category)* **Fee:** $55.05 **Benefit:** 85% = $46.80
80155	Professional attendance at a place other than consulting rooms. As per the social worker service requirements outlined for item 80150. *(See para M.7 of explanatory notes to this Category)* **Fee:** $77.50 **Benefit:** 85% = $65.90
80160	Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a social worker registered with Medicare Australia as meeting the credentialing requirements for provision of this service - lasting more than 50 minutes - where the patient is referred by a medical practitioner, as part of a GP Mental Health Care Plan; and/or a psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These services are time limited, being deliverable, in general, in up to 12 planned sessions in a calendar year (including services to which items 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 and the Better Outcomes in Mental Health Access To Allied Psychological Services apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply. *(See para M.7 of explanatory notes to this Category)* **Fee:** $77.70 **Benefit:** 85% = $66.05
80165	Professional attendance at a place other than consulting rooms. As per the social worker service requirements outlined for item 80160. *(See para M.7 of explanatory notes to this Category)* **Fee:** $100.15 **Benefit:** 85% = $85.15
80170	Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a social worker registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting for at least 60 minutes duration where the patients are referred by a medical practitioner, as part of a GP Mental Health Care Plan; and/or a psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These therapies are time limited, being deliverable, in general, in up to 12 planned sessions in a calendar year (including services to which items 80020, 80120 and 80145 apply*).* GROUP THERAPY with a group of 6 to 10 patients, EACH PATIENT *(See para M.7 of explanatory notes to this Category)* **Fee:** $19.75 **Benefit:** 85% = $16.80

SECTION 5

M.8 PREGNANCY SUPPORT COUNSELLING SERVICES (ITEMS 81000 TO 81010)

M.8.1 Overview of the Pregnancy Support Counselling Initiative

The Pregnancy Support Counselling initiative commenced on 1 November 2006. It provides for Medicare benefits to be paid for non-directive pregnancy support counselling services provided to women who are concerned about a current pregnancy, or a pregnancy that occurred in the preceding 12 months, by an eligible medical practitioner (including a general practitioner, but not including a specialist or consultant physician) or allied health professional on referral from a medical practitioner. The term 'GP' is used hereafter as a generic reference to medical practitioners (including a general practitioner, but not including a specialist or consultant physician).

M.8.2 NON-DIRECTIVE PREGNANCY SUPPORT COUNSELLING SERVICES ATTRACTING MEDICARE REBATES

Eligible pregnancy support counselling services
There are four new MBS items for the provision of non-directive pregnancy support counselling services:

- Item 4001 – services provided by an eligible GP;
- Item 81000 – services provided by an eligible psychologist;
- Item 81005 – services provided by an eligible social worker; and
- Item 81010 – services provided by an eligible mental health nurse.

These notes relate to items 81000-81010. Explanatory notes relating to item 4001 are available at note A.43.

Each individual allied health professional must meet the provider eligibility requirements set out below and be registered with Medicare Australia.

Number of services per year
Medicare benefits are available for up to three (3) eligible non-directive pregnancy support counselling services per patient, per pregnancy, provided using items 81000, 81005, 81010 and 4001 (see Explanatory notes A.43). The Medicare benefit payable for an eligible service provided using item 81000, 81005 or 81010 is $55.00.

Partners of eligible patients may attend each or any counselling session, however, only one fee applies to each service.

Out-of-pocket expenses and Medicare Safety Net
Charges in excess of the Medicare benefit for these items are the responsibility of the patient. However, such out-of-pocket costs will count toward the Medicare safety net for that patient. Non-directive pregnancy support counselling services in excess of three (3) per pregnancy will not attract a Medicare benefit and the safety net arrangements will not apply to costs incurred by the patient for such services.

Eligible patients
Items 81000-81010 inclusive are available to women who are concerned about a current pregnancy or a pregnancy that occurred in the preceding 12 months, and where the patient is referred to an eligible allied health professional by a GP.

The items may be used to address any pregnancy related issues for which non-directive counselling is appropriate.

Publicly funded services
Items 81000, 81005 and 81010 do not apply for services that are provided by any other Commonwealth or State funded services or provided to an admitted patient of a hospital.

However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or State/Territory clinic, items 81000, 81005 and 81010 can be claimed for services provided by an eligible psychologist, social worker or mental health nurse salaried by or contracted to the service, where all requirements of the relevant item are met, including registration with Medicare Australia. These services must be direct billed (that is, the Medicare rebate is accepted as full payment for services).

Private health insurance
Patients need to decide if they will use Medicare or their private health insurance ancillary cover to pay for these services. Patients cannot use their private health insurance ancillary cover to 'top up' the Medicare rebate paid for the services.

M.8.3 REFERRAL REQUIREMENTS (GPs TO ALLIED HEALTH PROFESSIONALS)

Patients must be referred for non-directive pregnancy support counselling services by a GP. GPs are **not** required to use a specific form to refer patients for these services. The referral may be a letter or note to an eligible allied health professional signed and dated by the referring GP.

Patients may be referred by a GP to more than one eligible allied health professional for eligible non-directive pregnancy support counselling services (for example, where a patient does not wish to continue receiving services from the provider they were referred to in the first instance). However, Medicare benefits are only available for a maximum of three (3) non-directive pregnancy support counselling services to which items 4001, 81000, 81005 and 81010 apply, per patient, per pregnancy.

Where the patient is unsure of the number of Medicare rebated non-directive pregnancy support counselling services they have already accessed, the patient may check with Medicare Australia on 132 011. Alternatively, the psychologist, social worker or mental health nurse may check with Medicare Australia.

The relevant allied health professional must be in receipt of the referral at the first non-directive pregnancy support counselling service and must retain the referral for 2 years from the date the service was rendered, for Medicare Australia auditing purposes.

A copy of the referral is **not** required to accompany Medicare claims. However, referral details are required to be included on patients' itemised accounts/receipts or Medicare assignment of benefit forms.

Referral validity
The referral is valid for up to three (3) non-directive pregnancy support counselling services, per patient, per pregnancy.

Subsequent referrals
A new referral is required where the patient seeks to access non-directive pregnancy support counselling in relation to a different pregnancy or where the patient wishes to be referred to a different allied health professional than the one they were referred to in the first instance.

M.8.4 ALLIED HEALTH PROFESSIONAL ELIGIBILITY

Eligible allied health professionals
Items 81000, 81005 and 81010 can only be claimed for services provided by psychologists, social workers and mental health nurses who are registered with Medicare Australia. To be eligible to register with Medicare Australia to provide these services, a psychologist, social worker or mental health nurse needs to be:
(a) a recognised professional who is registered under relevant State or Territory law; or
(b) where there is no such State or Territory law, a practitioner who is a member of a professional association with uniform national registration requirements.

Specific eligibility requirements
Specific eligibility requirements for psychologists, social workers and mental health nurses providing services under these items are as follows:

- To be eligible to provide services using MBS Item 81000, a **psychologist** must be registered with the Psychologists Registration Board in the State or Territory in which they are practising (psychologists whose State/Territory registration includes any limitation, for example, where marked 'provisional registration', are not eligible to register with Medicare Australia to use item 81000), and have completed appropriate non-directive pregnancy counselling training;

- To be eligible to provide services using MBS Item 81005, a **social worker** must be:
  - a 'Member' of the Australian Association of Social Workers (AASW),

- be certified by AASW either as meeting the standards for mental health set out in AASW's 'Standards for Mental Health Social Workers 1999' (as in force on 1 November 2006) or as an Accredited Social Worker,
- and have completed appropriate non-directive pregnancy counselling training;

- To be eligible to provide services using MBS Item 81010, a **mental health nurse** must be a 'Credentialled Mental Health Nurse' as certified by the Australian College of Mental Health Nurses, and have completed appropriate non-directive pregnancy counselling training.

Registering with Medicare Australia
Advice about registering with Medicare Australia to provide non-directive pregnancy support counselling services using items 81000-81010 inclusive is available from the Medicare Australia provider inquiry line on 132 150.

M.8.5 ADDITIONAL REQUIREMENTS OF THE NON-DIRECTIVE PREGNANCY SUPPORT COUNSELLING SERVICE

Service length and type
Non-directive pregnancy support counselling services provided by eligible psychologists, social workers and mental health nurses using items 81000-81010 inclusive must be of at least 30 minutes duration and provided to an individual patient. The allied health professional must personally attend the patient.

The service involves the psychologist, social worker or mental health nurse undertaking a safe, confidential process that helps the patient explore concerns they have about a current pregnancy or a pregnancy that occurred in the preceding 12 months. This includes providing, on request, unbiased, evidence-based information about all options and services available to the patient.

Non-directive counselling is a form of counselling which is based on the understanding that, in many situations, people can resolve their own problems without being provided with a solution by the counsellor. The counsellor's role is to encourage the person to express their feelings but not suggest what decision the person should make. By listening and reflecting back what the person reveals to them, the counsellor helps them to explore and understand their feelings. With this understanding, the person is able to make the decision that is best for them.

Further information
For further information about Medicare Benefits Schedule items, please go to the Department of Health and Ageing's website at www.health.gov.au/mbsonline.

For providers, further information is also available from the Medicare Australia provider inquiry line on 132 150.

	GROUP M8 - PREGNANCY SUPPORT COUNSELLING
81000	Provision of a non-directive pregnancy support counselling service to a woman who is concerned about a current pregnancy or a pregnancy that occurred in the preceding 12 months, by an eligible psychologist, where the patient is referred to the psychologist by a medical practitioner (including a general practitioner, but not a specialist or consultant physician), and lasting at least 30 minutes. The service may be used to address any pregnancy related issues for which non-directive counselling is appropriate. This service may be provided by a psychologist who is registered with Medicare Australia as meeting the credentialling requirements for provision of this service. It may not be provided by a psychologist who has a direct pecuniary interest in a health service that has as its primary purpose the provision of services for pregnancy termination. To a maximum of three non-directive pregnancy support counselling services per patient, per pregnancy from any of the following items –81000, 81005, 81010 and 4001 *(See para M.8 of explanatory notes to this Category)* **Fee:** $64.70 **Benefit:** 85% = $55.00
81005	Provision of a non-directive pregnancy support counselling service to a woman who is concerned about a current pregnancy or a pregnancy that occurred in the preceding 12 months, by an eligible social worker, where the patient is referred to the social worker by a medical practitioner (including a general practitioner, but not a specialist or consultant physician), and lasting at least 30 minutes. The service may be used to address any pregnancy related issues for which non-directive counselling is appropriate. This service may be provided by a social worker who is registered with Medicare Australia as meeting the credentialling requirements for provision of this service. It may not be provided by a social worker who has a direct pecuniary interest in a health service that has as its primary purpose the provision of services for pregnancy termination. To a maximum of three non-directive pregnancy support counselling services per patient, per pregnancy from any of the following items –81000, 81005, 81010 and 4001 *(See para M.8 of explanatory notes to this Category)* **Fee:** $64.70 **Benefit:** 85% = $55.00
81010	Provision of a non-directive pregnancy support counselling service to a woman who is concerned about a current pregnancy or a pregnancy that occurred in the preceding 12 months, by an eligible mental health nurse, where the patient is referred to the mental health nurse by a medical practitioner (including a general practitioner, but not a specialist or consultant physician), and lasting at least 30 minutes. The service may be used to address any pregnancy related issues for which non-directive counselling is appropriate. This service may be provided by a mental health nurse who is registered with Medicare Australia as meeting the credentialling requirements for provision of this service. It may not be provided by a mental health nurse who has a direct pecuniary interest in a health service that has as its primary purpose the provision of services for pregnancy termination. To a maximum of three non-directive pregnancy support counselling services per patient, per pregnancy from any of the following items - 81000, 81005, 81010 and 4001 *(See para M.8 of explanatory notes to this Category)* **Fee:** $64.70 **Benefit:** 85% = $55.00