The Australian Government

Department of Health and Ageing

Medicare Benefits Schedule
Allied Health Services

1 November 2007

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The information in this book is based on the relevant legislation and in the event of any discrepancy the relevant legislation is the authoritative source document.

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INTRODUCTION

This booklet provides information for allied health professionals who are eligible to provide services under Medicare. To provide services under Medicare, allied health professionals must meet the eligibility requirements for the particular Medicare item, as set out in the relevant Part of this document, and be registered with Medicare Australia.

Medicare benefits are available for a range of specified allied health services for certain patients, as summarised below. To receive allied health services, patients must be referred by their GP, or in the case of some patients with an assessed mental disorder, by a psychiatrist or paediatrician. The term 'GP' is used in this book as a generic reference to medical practitioners (including a general practitioner, but not including a specialist or consultant physician).

Eligible Patients	**No. of Services Per Patient Per Calendar Year**	**Allied Health Professionals Eligible to Provide Services**
Patients who have a chronic medical condition and complex care needs (refer **Part 1**)	Up to 5 individual services	Aboriginal Health Worker Audiologist Chiropractor Diabetes Educator Dietitian Exercise Physiologist Mental Health Worker Occupational Therapist Osteopath Physiotherapist Podiatrist Psychologist Speech Pathologist
Patients who have type 2 diabetes (refer **Part 2**)	1 individual assessment AND up to 8 group sessions (NB: these services are in addition to the five individual services for patients with a chronic medical condition and complex care needs)	Diabetes Educator Dietitian Exercise Physiologist
Patients with an assessed mental disorder (refer **Parts 3 and 4**)	Up to 12 individual services AND up to 12 group therapy services	Clinical Psychologist Psychologist Occupational Therapist Social Worker (NB: services can also be provided by a qualified medical practitioner)
Women who are concerned about either a current pregnancy, or one that occurred in the previous 12 months (refer **Part 5**)	Up to 3 services per pregnancy (not per calendar year)	Psychologist Social Worker Mental Health Nurse (NB: services can also be provided by a medical practitioner)

A summary of Medicare rebateable services sorted by eligible allied health professional is provided at Appendix 1.

Clinically relevant professional service
The *Health Insurance Act 1973* requires that for a Medicare benefit to be payable, a professional service must be 'clinically relevant'. A clinically relevant service means a service that is generally accepted by the profession as being necessary for the appropriate treatment of the patient.

Item descriptions
The service requirements for individual item numbers are contained in the Item Descriptions provided at the end of each Part. These requirements are contained in the *Health Insurance (Allied Health and Dental Services) Determination 2007*.

Multiple consultations on the same day
Generally, consultations that run longer than the minimum time specified in the Item Description should be billed as a single consultation. For payment of a benefit for more than one (1) consultation with a patient on the same day by the same allied health professional, the subsequent consultation must not be a continuation of the initial consultation. There should be a reasonable lapse of time between such consultations before they can be regarded as separate consultations.

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. Where in doubt, the allied health professional can contact Medicare Australia on 132 150.

However, in the case of group services for patients with type 2 diabetes (items 81105, 81115 and 81125), where clinically relevant, up to two group services may be provided consecutively on the same day by the same allied health provider – refer part 2.

Commonwealth and State and Territory laws
For any service listed in the Medicare Benefits Schedule to be eligible for a Medicare rebate, the service must be provided in accordance with the provisions of the relevant Commonwealth and State and Territory laws.

Medicare benefits (rebate)
The Medicare benefit (rebate) level for each item is provided in the Item Description. The amounts of these rebates are indexed in November each year.

WHAT'S NEW

Separate dental schedule
The dental items previously listed in this schedule are now listed in a separate Medicare Benefits Schedule.

Introduction of new items
On 1 May 2007, new items for group services for patients with type 2 diabetes, provided by dietitians, diabetes educators and exercise physiologists, were added to the Medicare Benefits Schedule (refer Part 2).

General fee increase
The new Medicare rebate level for each item is provided in the Item Description at the end of each Part.

USEFUL CONTACT INFORMATION

Department of Health and Ageing

Telephone:	02 6289 4297
Facsimile:	02 6289 7120
Email:	epc.items@health.gov.au
Internet:	www.health.gov.au/epc

This supplement is also available on the Department of Health and Ageing Internet site at www.health.gov.au/mbsonline. Alternatively, additional hard copies can be obtained by calling 02 6289 4297 or emailing **alliedhealth.items@health.gov.au**

Medicare Australia

Provider Information:	132 150
Patient Eligibility:	132 011
Direct Payment (Bulk Billing)	
Stationery	1800 067 307
Internet:	www.medicareaustralia.gov.au

PART 1

SERVICES FOR PATIENTS WHO HAVE A CHRONIC CONDITION AND COMPLEX CARE NEEDS

INDIVIDUAL ALLIED HEALTH SERVICES (ITEMS 10950 TO 10970)

ELIGIBLE PATIENTS

Medicare benefits are available for certain services provided by eligible allied health professionals to people with chronic conditions and complex care needs who are being managed by a GP under an Enhanced Primary Care (EPC) plan. The allied health services must be recommended in the patient's EPC plan as part of the management of their chronic condition.

Chronic conditions and complex care needs

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 care providers.

EPC plan

Patients are considered to be managed under an EPC plan if, during the last two years:

- their GP has put in place a GP Management Plan (MBS Chronic Disease Management (CDM) item 721) **and** Team Care Arrangements (MBS Chronic Disease Management (CDM) item 723); or
- their GP has reviewed their existing EPC plan and claimed MBS item 725 and 727; or
- their GP has contributed to or reviewed a multidisciplinary care plan prepared for them as a resident of an aged care facility and claimed item 731.

For more information on the CDM EPC planning items, refer to the explanatory notes for these items in the general Medicare Benefits Schedule which can be found at www.health.gov.au/mbsonline.

> **Important note**: Before a Medicare rebate can be paid for the allied health service, 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 that claim must have been processed. 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. The allied health professional or the patient can call Medicare Australia on 132 011 to check this information.

EPC planning team

The allied health professional providing the service may be part of the EPC planning team convened by the GP to manage a patient's chronic condition and complex care needs. However, the service may also be provided by an allied health professional who is not part of the EPC planning team, provided that the service has been identified as necessary by the patient's GP and recommended in their EPC plan.

Group services
In addition to individual services, patients who have type 2 diabetes may also access MBS items 81100 to 81125 which provide allied health group services – refer Part 2.

ELIGIBLE ALLIED HEALTH SERVICES

Eligible allied health professionals
The following groups of allied health professionals are eligible to provide individual services under Medicare for patients with a chronic condition and complex care needs:

- 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. If more than five services are provided in a calendar year, the subsequent service/s will not attract a Medicare rebate and the MBS Safety Net Arrangements will not apply to costs incurred by the patient for the service/s.

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).

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 in the calendar year. The allied health professional or the patient can call Medicare Australia on 132 011 to check this information.

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

Reporting requirements
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 that service.

Where multiple services are provided to the same patient under the one referral, the allied health professional 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.

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 are the responsibility of the patient. However, 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.

Publicly funded services

Items 10950 to 10970 do not apply for services that are provided by any Commonwealth or State or Territory 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 to 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.

REFERRAL REQUIREMENTS

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* - refer Appendix 2. 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 direct.

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 can be downloaded from the Department of Health and Ageing website at www.health.gov.au/epc or ordered by faxing (02) 6289 7120 or phoning (02) 6289 4297. GPs may modify the referral form to suit their practice needs (for example, relevant software packages) as long as the information is substantially retained.

Referral validity

A referral is valid for the stated number of services. If all services are not used during the calendar year in which the patient was referred, the unused services can be used in the next calendar year. However, those services will be counted as part of the five rebates for allied health services available to the patient during that calendar year.

When all referred services have been used, or a referral for a different type of allied health service is required, patients 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.

ALLIED HEALTH PROFESSIONAL ELIGIBILITY

The allied health items (10950 to 10970) can only be claimed for services provided by eligible allied health professionals who are registered with Medicare Australia. To be eligible to register with Medicare Australia to provide these services, allied health professionals must meet the specific eligibility requirements detailed below:

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 in Aboriginal and Torres Strait Islander Health (or an equivalent or higher qualification) from a Registered Training Organisation that meets training standards of the Australian National Training Authority's Australian Quality Training Framework.

> **Note:** Where individuals consider their qualification to be equivalent to or higher than a Certificate Level III in Aboriginal and Torres Strait Islander Health, they will need to contact a Registered Training Organisation in their State to have the qualification assessed as such before they can register with Medicare Australia.

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. Psychologists whose State or Territory registration includes any limitation, for example, where marked 'provisional registration', are not eligible to register with Medicare Australia to use item 10968.

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 can 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 can be obtained from Medicare Australia on 132 150 or at www.medicareaustralia.gov.au.

Chiropractors, osteopaths, physiotherapists and podiatrists who are already registered with Medicare Australia 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.

Changes to provider details
Allied health providers must notify Medicare Australia in writing of all changes to mailing details to ensure that they continue to receive this book and any updates about Medicare rebateable allied health services.

ITEM DESCRIPTIONS

	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 (i) a chronic condition; and (ii) 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 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 subparagraph (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) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of 5 services (including any services to which items 10950 to 10970 inclusive apply) in a calendar year **Benefit:** = $47.85
10951	**DIABETES EDUCATION** Diabetes education health service provided to a person by an eligible diabetes educator if: (a) the service is provided to a person who has (i) a chronic condition; and (ii) 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 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 subparagraph (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) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of 5 services (including any services to which items 10950 to 10970 inclusive apply) in a calendar year **Benefit:** = $47.85

10952	**AUDIOLOGY** Audiology health service provided to a person by an eligible audiologist if: (a) the service is provided to a person who has (i) a chronic condition; and (ii) 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 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 subparagraph (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) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of 5 services (including any services to which items 10950 to 10970 inclusive apply) in a calendar year **Benefit:** = $47.85
10953	**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 (i) a chronic condition; and (ii) 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 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 subparagraph (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) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of 5 services (including any services to which items 10950 to 10970 inclusive apply) in a calendar year **Benefit:** = $47.85

10954	**DIETETICS** Dietetics health service provided to a person by an eligible dietitian if: (a) the service is provided to a person who has (i) a chronic condition; and (ii) 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 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 subparagraph (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) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of 5 services (including any services to which items 10950 to 10970 inclusive apply) in a calendar year **Benefit:** = $47.85
10956	**MENTAL HEALTH** Mental health service provided to a person by an eligible mental health worker if: (a) the service is provided to a person who has (i) a chronic condition; and (ii) 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 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 subparagraph (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) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of 5 services (including any services to which items 10950 to 10970 inclusive apply) in a calendar year **Benefit:** = $47.85

10958	**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 (i) a chronic condition; and (ii) 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 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 subparagraph (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) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of 5 services (including any services to which items 10950 to 10970 inclusive apply) in a calendar year **Benefit:** = $47.85
10960	**PHYSIOTHERAPY** Physiotherapy health service provided to a person by an eligible physiotherapist if: (a) the service is provided to a person who has (i) a chronic condition; and (ii) 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 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 subparagraph (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) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of 5 services (including any services to which items 10950 to 10970 inclusive apply) in a calendar year **Benefit:** = $47.85

10962	**PODIATRY** Podiatry health service provided to a person by an eligible podiatrist if: (a) the service is provided to a person who has (i) a chronic condition; and (ii) 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 podiatrist by the medical practitioner using a referral form that has been issued by the Department 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 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 subparagraph (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) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of 5 services (including any services to which items 10950 to 10970 inclusive apply) in a calendar year **Benefit:** = $47.85
10964	**CHIROPRACTIC** Chiropractic health service provided to a person by an eligible chiropractor if: (a) the service is provided to a person who has (i) a chronic condition; and (ii) 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 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 subparagraph (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) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of 5 services (including any services to which items 10950 to 10970 inclusive apply) in a calendar year **Benefit:** = $47.85

10966	**OSTEOPATHY** Osteopathy health service provided to a person by an eligible osteopath if: (a) the service is provided to a person who has (i) a chronic condition; and (ii) 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 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 subparagraph (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) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of 5 services (including any services to which items 10950 to 10970 inclusive apply) in a calendar year **Benefit:** = $47.85
10968	**PSYCHOLOGY** Psychology health service provided to a person by an eligible psychologist if: (a) the service is provided to a person who has (i) a chronic condition; and (ii) 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 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 subparagraph (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) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of 5 services (including any services to which items 10950 to 10970 inclusive apply) in a calendar year **Benefit:** = $47.85

	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 (i) a chronic condition; and (ii) 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 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 subparagraph (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) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of 5 services (including any services to which items 10950 to 10970 inclusive apply) in a calendar year
10970	**Benefit:** = $47.85

PART 2

SERVICES FOR PATIENTS WITH TYPE 2 DIABETES

GROUP ALLIED HEALTH SERVICES (ITEMS 81100 TO 81125)

ELIGIBLE PATIENTS

Medicare benefits are available for allied health group services for patients with type 2 diabetes. These items (81100 to 81125) apply to services provided by eligible diabetes educators, exercise physiologists and dietitians, on referral from a GP.

Services available under these items are in addition to the five individual allied health services available to patients each calendar year – refer Part 1.

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

- a GP Management Plan (GPMP) – item 721; or
- where a patient has an existing GP Management Plan, the GP has reviewed that plan (item 725); or
- for a resident of a residential aged care facility, the GP must have contributed to, or reviewed, a care plan prepared for them by the facility (item 731). [Note: Generally, residents of an aged care facility rely on the facility for assistance to manage their type 2 diabetes. Therefore, the resident may not need to be referred for allied health group services under these items, as the self management approach offered in group services may not be appropriate.]

Unlike the existing individual allied health services under items 10950 to 10970, there is no additional requirement for a Team Care Arrangement (item 723) in order for the patient to be referred for allied health group services.

Once the patient has been referred by their GP, a diabetes educator, exercise physiologist or dietitian will conduct an individual assessment. A maximum of one (1) assessment service is available per calendar year. After assessment, the patient may receive up to eight (8) group services per calendar year from an eligible diabetes educator, exercise physiologist and/or dietitian. A collaborative approach, where diabetes educators, exercise physiologists and dietitians work together to develop group service programs in their local area, is encouraged.

It is important to note that:

- before a Medicare rebate can be paid for the allied health assessment item either the patient or the GP must have lodged a claim with Medicare Australia for the relevant GP care planning item and received payment for that claim; and
- before a Medicare rebate can be paid for the allied health group items either the patient or the allied health professional must have lodged a claim with Medicare Australia for the assessment item and received payment for that claim.

ASSESSMENT FOR GROUP SERVICES (ITEMS 81100, 81110 AND 81120)

An assessment service is provided by a diabetes educator, an exercise physiologist or a dietitian, on referral from a GP. The purpose of this service is to undertake an individual assessment of the patient preparing him/her for an appropriate group services program. It involves taking a comprehensive patient history, identification of individual goals and preparing the patient for the group service. This may also provide an opportunity to identify any patient who is likely to be unsuitable for group services.

Number of services per year

Patients are eligible for a maximum of one assessment for group services (item 81100 **or** 81110 **or** 81120) per calendar year. If more than one assessment service is provided in a calendar year, the subsequent service/s will not attract a Medicare rebate and the MBS Safety Net arrangements will not apply to costs incurred by the patient for the service/s.

If there is any doubt about a patient's eligibility, Medicare Australia will be able to confirm whether the appropriate care planning item is in place and the number of assessment services already claimed by the patient during the calendar year. The allied health professionals or the patient can call Medicare Australia on 132 011 to check this information.

Referral form

The GP must refer the patient using the *Referral form for allied health group services under Medicare* – refer Appendix 3. The allied health professional undertaking the assessment service will need to complete Part B of this form, and the patient will then need to present this form to the provider/s of group services.

Service length and type

This service must be of at least 45 minutes duration and provided to an individual patient. The allied health professional must personally attend the patient.

Reporting requirements

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

GROUP SERVICES (ITEMS 81105, 81115 AND 81125)

These services are provided in a group setting to assist with the management of type 2 diabetes.

Number of services per year

Patients are eligible for up to eight (8) allied health group services in total per calendar year. Each separate group service must be provided to the patient by only one type of allied health professional (ie either a diabetes educator, exercise physiologist or dietitian). However, the overall group services program provided for the patient could be comprised of one type of service only (eg 8 diabetes education services) or a combination of services (eg 3 diabetes education services, 3 dietitian services and 2 exercise physiology services). An eligible allied health professional with more than one Medicare provider number (eg for the provision of diabetes education and dietetics) may provide separate services under each of these provider numbers.

Allied health group service providers are strongly encouraged to deliver multidisciplinary group services programs that allow patients to benefit from a range of interventions designed to assist in the management of their type 2 diabetes.

Where a patient receives more than the limit of 8 group services in a calendar year, the additional service/s will not attract a Medicare benefit and the MBS Safety Net arrangements will not apply to costs incurred by the patient for the service/s.

If there is any doubt about a patient's eligibility for group services, Medicare Australia will be able to confirm the number of group services already claimed by the patient in the calendar year. The allied health professional or the patient can call Medicare Australia on 132 011 to check this information.

Multiple services on the same day
Where clinically relevant, up to two group services may be provided consecutively on the same day by the same allied health professional.

Referral form
The allied health professional/s undertaking the group services will need to receive the *Referral form for allied health group services under Medicare*, for which Part B has been completed by the provider who has undertaken the assessment service.

Group size
The service must be provided to a person who is part of a group of between 2 and 12 persons.

Service length
Each group service must be of at least 60 minutes duration.

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

REFERRAL REQUIREMENTS

The patient must be referred by their GP to an eligible allied health professional (diabetes educator, exercise physiologist or dietitian) who will undertake an individual assessment, preparing him/her for an appropriate group services program (under item 81100, 81110 or 81120).

When referring patients, GPs need to use the *Referral form for allied health group services under Medicare* (refer Appendix 3) provided by the Commonwealth Department of Health and Ageing. The referral form can be downloaded from the Department of Health and Ageing website at www.health.gov.au/epc or ordered by faxing (02) 6289 7120. The form can be modified to suit practice needs (for example, relevant software packages) as long as the information is substantially retained.

GPs are also encouraged to provide a copy of the relevant part of the patient's care plan to the allied health professional.

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

ALLIED HEALTH PROFESSIONAL ELIGIBILITY

Items 81100 to 81125 only apply to services provided by eligible diabetes educators, exercise physiologists and dietitians who are registered with Medicare Australia. If providers are already registered with Medicare Australia to use item 10951, 10953 or 10954, they do not need to register separately for items 81100 to 81125. Eligibility criteria are as follows:

Diabetes Educator: must be a 'Credentialed Diabetes Educator' (CDE) as credentialed by the Australian Diabetes Educators Association (ADEA).

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

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

Registering with Medicare Australia

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

Changes to provider details

Allied health providers must notify Medicare Australia in writing of all changes to mailing details to ensure that they continue to receive this book and any updates about Medicare rebateable allied health services.

ADDITIONAL INFORMATION

Out-of-pocket expenses and Medicare Safety Net

Allied health professionals are free to determine their own fees for both the assessment and group professional services. Charges in excess of the Medicare benefit are the responsibility of the patient. However, such out of pocket costs will count toward the Medicare Safety Net for that patient.

Publicly funded services

Items 81100 – 81125 do not apply for services that are provided by any other Commonwealth or State or Territory 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 81100-81125 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 bulk billed.

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.

ITEM DESCRIPTIONS

	ALLIED HEALTH GROUP SERVICES
81100	**DIABETES EDUCATION – ASSESSMENT FOR GROUP SERVICES** Diabetes education health service provided to a person by an eligible diabetes educator for the purposes of ASSESSING a person's suitability for group services for the management of type 2 diabetes, including taking a comprehensive patient history, identifying an appropriate group services program based on the patient's needs, and preparing the person for the group services, if: (a) the service is provided to a person who has type 2 diabetes; and (b) the person is being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under a GP Management Plan [ie item 721 or 725], or if the person is a resident of an aged care facility, their medical practitioner has contributed to a multidisciplinary care plan [ie item 731]; and (c) the person is referred to an 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 45 minutes duration; and (g) after the service, the eligible diabetes educator gives a written report to the referring medical practitioner mentioned in paragraph (c); and (h) for a service for which a private health insurance benefit is payable - the person has elected to claim the Medicare for the service, and not the private health insurance benefit. Benefits are payable **once** only in a calendar year for this or any other Assessment for Group Services item (including services in items 81100, 81110 and 81120). **Benefit:** = $61.30
81105	**DIABETES EDUCATION – GROUP SERVICE** Diabetes education health service provided to a person by an eligible diabetes educator, as a GROUP SERVICE for the management of type 2 diabetes if: (a) the person has been assessed as suitable for a type 2 diabetes group service under assessment item 81100, 81110 or 81120; and (b) the service is provided to a person who is part of a group of between 2 and 12 patients; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to a person involving the personal attendance by an eligible diabetes educator; and (e) the service is of at least 60 minutes duration; and (f) after the last service in the group services program provided to the person under items 81105, 81115 or 81125, the eligible diabetes educator prepares, or contribute to, a written report to be provided to the referring medical practitioner; and (g) an attendance record for the group is maintained by the eligible diabetes educator; and (h) for a service for which a private health insurance benefit is payable - the person has elected to claim the Medicare for the service, and not the private health insurance benefit. - to a maximum of eight (8) GROUP SERVICES (including services in items 81105, 81115 and 81125) in a calendar year. **Benefit:** = $15.30

81110	**EXERCISE PHYSIOLOGY – ASSESSMENT FOR GROUP SERVICES** Exercise physiology health service provided to a person by an eligible exercise physiologist for the purposes of ASSESSING a person's suitability for group services for the management of type 2 diabetes, including taking a comprehensive patient history, identifying an appropriate group services program based on the patient's needs, and preparing the person for the group services, if: (a) the service is provided to a person who has type 2 diabetes; and (b) the person is being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under a GP Management Plan [ie item 721 or 725], or if the person is a resident of an aged care facility, their medical practitioner has contributed to a multidisciplinary care plan [ie item 731]; and (c) the person is referred to an 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 45 minutes duration; and (g) after the service, the eligible exercise physiologist gives a written report to the referring medical practitioner mentioned in paragraph (c); and (h) for a service for which a private health insurance benefit is payable - the person has elected to claim the Medicare for the service, and not the private health insurance benefit. Benefits are payable **once** only in a calendar year for this or any other Assessment for Group Services item (including services in items 81100, 81110 and 81120). **Benefit:** = $61.30
81115	**EXERCISE PHYSIOLOGY – GROUP SERVICE** Exercise physiology health service provided to a person by an eligible exercise physiologist, as a GROUP SERVICE for the management of type 2 diabetes if: (a) the person has been assessed as suitable for a type 2 diabetes group service under assessment item 81100, 81110 or 81120; and (b) the service is provided to a person who is part of a group of between 2 and 12 patients; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to a person involving the personal attendance by an eligible exercise physiologist; and (e) the service is of at least 60 minutes duration; and (f) after the last service in the group services program provided to the person under items 81105, 81115 or 81125, the eligible exercise physiologist prepares, or contribute to, a written report to be provided to the referring medical practitioner; and (g) an attendance record for the group is maintained by the eligible exercise physiologist; and (h) for a service for which a private health insurance benefit is payable - the person has elected to claim the Medicare for the service, and not the private health insurance benefit. - to a maximum of eight (8) GROUP SERVICES (including services in items 81105, 81115 and 81125) in a calendar year. **Benefit:** = $15.30

81120	**DIETETICS – ASSESSMENT FOR GROUP SERVICES** Dietetics health service provided to a person by an eligible dietitian for the purposes of ASSESSING a person's suitability for group services for the management of type 2 diabetes, including taking a comprehensive patient history, identifying an appropriate group services program based on the patient's needs, and preparing the person for the group services, if: (a) the service is provided to a person who has type 2 diabetes; and (b) the person is being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under a GP Management Plan [ie item 721 or 725], or if the person is a resident of an aged care facility, their medical practitioner has contributed to a multidisciplinary care plan [ie item 731]; and (c) the person is referred to an 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 45 minutes duration; and (g) after the service, the eligible dietitian gives a written report to the referring medical practitioner mentioned in paragraph (c); and (h) for a service for which a private health insurance benefit is payable - the person has elected to claim the Medicare for the service, and not the private health insurance benefit. Benefits are payable **once** only in a calendar year for this or any other Assessment for Group Services item (including services in items 81100, 81110 and 81120). **Benefit:** = $61.30
81125	**DIETETICS – GROUP SERVICE** Dietetics health service provided to a person by an eligible dietitian, as a GROUP SERVICE for the management of type 2 diabetes if: (a) the person has been assessed as suitable for a type 2 diabetes group service under assessment item 81100, 81110 or 81120; and (b) the service is provided to a person who is part of a group of between 2 and 12 patients; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to a person involving the personal attendance by an eligible dietitian; and (e) the service is of at least 60 minutes duration; and (f) after the last service in the group services program provided to the person under items 81105, 81115 or 81125, the eligible dietitian prepares, or contribute to, a written report to be provided to the referring medical practitioner; and (g) an attendance record for the group is maintained by the eligible dietitian; and (h) (h) for a service for which a private health insurance benefit is payable - the person has elected to claim the Medicare for the service, and not the private health insurance benefit. - to a maximum of eight (8) GROUP SERVICES (including services in items 81105, 81115 and 81125) in a calendar year. **Benefit:** = $15.30

PART 3

PSYCHOLOGICAL THERAPY SERVICES FOR PATIENTS WITH AN ASSESSED MENTAL DISORDER

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

OVERVIEW

The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative commenced on 1 November 2006. Under the Better Access initiative MBS items 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 (refer to Part 4).

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.

In these notes, 'GP' means a medical practitioner, including a general practitioner, but not including a specialist or consultant physician.

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

- a referral has been made by a GP who is managing the patient under a GP Mental Health Care Plan (item 2710);
- a referral has been made by a GP who is managing the patient under a referred psychiatrist assessment and management plan (item 291); or
- a referral has been made by a psychiatrist or paediatrician from an eligible psychiatric or paediatric service (see Referral Requirements for further details regarding psychiatrist and paediatrician referrals).

Number of services per year

Medicare rebates are available for up to twelve individual allied mental health services in a calendar year. These twelve services may consist of: GP focussed psychological strategies services (items 2721 to 2727); and/or 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. Referrals should be provided, as required, in one or more groups of up to six sessions.

In addition, the referring practitioner may consider that in exceptional circumstances the patient may require an additional six individual psychological therapy or focused psychological strategies services above those already provided (to a maximum total of 18 individual services per patient per calendar year). Exceptional circumstances are defined as a significant change in the patient's clinical condition or care circumstances which make it appropriate and necessary to increase the maximum number of services. It is up to the referring practitioner to determine that the patient meets these requirements. In these cases a new referral should be provided, and exceptional circumstances noted in that referral. Invoices for services provided under exceptional circumstances must state that exceptional circumstances apply.

Patients will also be eligible to claim up to 12 separate services within a calendar year for group therapy services involving 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 services per calendar year maximum associated with those items.

Service length and type
Services provided by eligible clinical psychologists under these items must be within the specified time period within the item descriptor. The clinical psychologist 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.

Course of treatment and 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 clinical psychologist 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 clinical psychologist on the services provided to the patient, and the need for further treatment.

On completion of the initial course of treatment, the clinical psychologist 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.
Following receipt of this report, the referring practitioner will consider the need for further treatment, before further allied mental health services may be provided.

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. Any psychological therapy services and/or focussed psychological strategies – allied mental health services that are in excess of the entitlement of twelve (12) individual services (apart from where exceptional circumstances apply) and twelve (12) group sessions 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
Items 80000 to 80020 (inclusive) apply to people with an assessed mental disorder and where the patient is referred by a GP who is managing the patient under a GP Mental Health Care Plan (item 2710), or under a referred psychiatrist assessment and management plan (item 291); or on referral by a psychiatrist or paediatrician from an eligible service.

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 mental 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 patients can seek clarification by calling 132 011.

The patient will not be eligible if they have not been appropriately referred and a relevant Medicare service provided to them. If the referring service has not yet been claimed, Medicare Australia will not be aware of the patient's eligibility. In this case the patient or the clinical psychologist (with the patient's permission) should contact the referring practitioner to ensure the relevant service has been provided to the patient.

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.

REFERRAL REQUIREMENTS (GPs, PSYCHIATRISTS OR PAEDIATRICIANS TO CLINICAL PSYCHOLOGISTS FOR PSYCHOLOGICAL THERAPY)

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 a referred psychiatrist assessment and management plan (item 291); or on referral from a psychiatrist or a paediatrician from an eligible service.

Referrals from psychiatrists and paediatricians must be made from eligible Medicare services. For specialist psychiatrists and paediatricians these services include any of the specialist attendance items 104 through 109. For consultant physician psychiatrists the relevant eligible Medicare services cover any of the consultant psychiatrist items 293 through 370; while for consultant physician paediatricians the eligible services are consultant physician attendance items 110 through 131.

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 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) individual (up to 18 services where exceptional circumstances apply) and/or twelve (12) group psychological therapy services and/or focussed psychological strategies services per patient per calendar year. Referrals should be made in one or more groups of up to six sessions. 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 the referring practitioner if they are eligible for further services. Where the patient's care is being managed by a GP, the GP may choose to use this visit to undertake a review of the patient's GP Mental Health Care Plan and/or psychiatrist assessment and management plan.

It is not necessary to have a new GP Mental Health Care Plan and/or 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 a GP 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.

CLINICAL PSYCHOLOGIST PROFESSIONAL ELIGIBILITY

Eligible clinical psychologists

All consultations providing psychological therapy services must be rendered by a clinical psychologist who is a member of the Australian Psychological Society's College of Clinical Psychologists or meets the requirements for such membership, based on assessment by the Australian Psychological Society; 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.

Further information

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.

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

ITEM DESCRIPTIONS

	PSYCHOLOGICAL THERAPY SERVICES
80000	**CLINICAL PSYCHOLOGY** 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 or a referred 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 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 and the Better Outcomes in Mental Health Care Program 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) **Benefit:** = $76.65
80005	**CLINICAL PSYCHOLOGY** Professional attendance at a place other than consulting rooms. As per the service requirements outlined for item 80000. **Benefit:** = $95.75
80010	**CLINICAL PSYCHOLOGY** 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; or a referred 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 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 and the Better Outcomes in Mental Health Care Program 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) **Benefit:** = $112.45
80015	**CLINICAL PSYCHOLOGY** Professional attendance at a place other than consulting rooms As per the service requirements outlined for item 80010. **Benefit:** = $131.55
80020	**CLINICAL PSYCHOLOGY** 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; or a referred 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 THERAPY with a group of 6 to 10 patients, EACH PATIENT **Benefit:** = $28.60

PART 4

FOCUSSED PSYCHOLOGICAL STRATEGY SERVICES FOR PATIENTS WITH AN ASSESSED MENTAL DISORDER

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

OVERVIEW

The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative commenced on 1 November 2006. Under the Better Access initiative MBS items provide Medicare benefits for the following allied mental health services:

- psychological therapy (items 80000 to 80020) – provided by eligible clinical psychologists (refer to Part 3); and
- focussed psychological strategies – allied mental health (items 80100 to 80170) – provided by eligible psychologists, occupational therapists and social workers.

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

In these notes, ‘GP’ means a medical practitioner, including a general practitioner, but not including a specialist or consultant physician.

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

- a referral has been made by a GP who is managing the patient under a GP Mental Health Care Plan (item 2710);
- a referral has been made by a GP who is managing the patient under a referred psychiatrist assessment and management plan (item 291); or
- a referral has been made by a psychiatrist or paediatrician from an eligible psychiatric or paediatric service (see Referral Requirements for further details regarding psychiatrist and paediatrician referrals).

Number of services per year
Medicare rebates are available for up to twelve individual allied mental health services in a calendar year. These twelve services may consist of: GP focussed psychological strategies services (items 2721 to 2727); and/or 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. Referrals should be provided, as required, in one or more groups of up to six sessions.

In addition, the referring practitioner may consider that in exceptional circumstances the patient may require an additional six services above those already provided (to a maximum total of 18 individual services per patient per calendar year). Exceptional circumstances are defined as a significant change in the patient's clinical condition or care circumstances which make it appropriate and necessary to increase the maximum number of services. It is up to the referring practitioner to determine that the patient meets these requirements. In these cases a new referral should be provided, and exceptional circumstances noted in that referral. Invoices for services provided under exceptional circumstances must state that exceptional circumstances apply.

Patients will also be eligible to claim up to 12 separate services within a calendar year for group therapy services involving 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 per calendar year maximum associated with those items.

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 mental 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 mental 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.

Course of treatment and 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.

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. Any psychological therapy services and/or focussed psychological strategies services that are in excess of the entitlement of twelve (12) individual services (apart from where exceptional circumstances apply) and twelve group sessions 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
Items 80100 to 80170 (inclusive) apply to people with an assessed mental disorder and where the patient is referred by a GP who is managing the patient under a GP Mental Health Care Plan (item 2710), or under a referred psychiatrist assessment and management plan (item 291); 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 mental health services already claimed by the patient during the calendar year.

Allied Mental Health Professionals can call Medicare Australia on 132 150 to check this information, while patients can seek clarification by calling 132 011.

The patient will not be eligible if they have not been appropriately referred and a relevant Medicare service provided to them. If the referring service has not yet been claimed, Medicare Australia will not be aware of the patient's eligibility. In this case the allied health professional (with the patient's permission) or patient should contact the referring practitioner to ensure the relevant service has been provided to the patient.

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.

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

Referrals

Patients must be referred for focussed psychological strategies – allied mental health services by a GP managing the patient under a GP Mental Health Care Plan (item 2710), or a referred psychiatrist assessment and management plan (item 291); or on referral from a psychiatrist or a paediatrician.

Referrals from psychiatrists and paediatricians must be made from eligible Medicare services. For specialist psychiatrists and paediatricians these services include any of the specialist attendance items 104 through 109. For consultant physician psychiatrists the relevant eligible Medicare services cover any of the consultant psychiatrist items 293 through 370; while for consultant physician paediatricians the eligible services are consultant physician attendance items 110 through 131.

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 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) individual (up to 18 services where exceptional circumstances apply) and/or twelve (12) group psychological therapy services and/or focussed psychological strategies services per patient per calendar year. Referrals should be made in one or more groups of up to six sessions. 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 the referring practitioner if they are eligible for further services. Where the patient’s care is being managed by a GP, the GP may choose to use this visit to undertake a review of the patient's GP Mental Health Care Plan and/or psychiatrist assessment and management plan.

It is not necessary to have a new GP Mental Health Care Plan and/or 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 a GP 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.

ALLIED MENTAL HEALTH PROFESSIONAL ELIGIBILITY

Eligible allied health professionals

Allied mental 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 mental 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'.

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.

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.

ITEM DESCRIPTIONS

	FOCUSSED PSYCHOLOGICAL STRATEGIES (ALLIED MENTAL HEALTH)
80100	**PSYCHOLOGY** 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; or a referred 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 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 and the Better Outcomes in Mental Health Care Program 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) **Benefit:** = $54.35
80105	**PSYCHOLOGY** Professional attendance at a place other than consulting rooms. As per the psychologist service requirements outlined for item 80100. **Benefit:** = $73.80
80110	**PSYCHOLOGY** 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; or a referred 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 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 and the Better Outcomes in Mental Health Care Program 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) **Benefit:** = $76.65
80115	**PSYCHOLOGY** Professional attendance at a place other than consulting rooms. As per the psychologist service requirements outlined for item 80110. **Benefit:** = $96.20
80120	**PSYCHOLOGY** 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; or a referred 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 **Benefit:** = $19.55

80125	**OCCUPATIONAL THERAPY** 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; or a referred 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 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 and the Better Outcomes in Mental Health Care Program 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) **Benefit:** = $47.85
80130	**OCCUPATIONAL THERAPY** Professional attendance at a place other than consulting rooms. As per the occupational therapist service requirements outlined for item 80125. **Benefit:** = $67.35
80135	**OCCUPATIONAL THERAPY** 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; or a referred 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 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 and the Better Outcomes in Mental Health Care Program 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) **Benefit:** = $67.50
80140	**OCCUPATIONAL THERAPY** Professional attendance at a place other than consulting rooms. As per the occupational therapist service requirements outlined for item 80135. **Benefit:** = $87.00
80145	**OCCUPATIONAL THERAPY** 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; or a referred 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 **Benefit:** = $17.20

80150	**SOCIAL WORKER** 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; or a referred 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 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 and the Better Outcomes in Mental Health Care Program 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) **Benefit:** = $47.85
80155	**SOCIAL WORKER** Professional attendance at a place other than consulting rooms. As per the social worker service requirements outlined for item 80150. **Benefit:** = $67.35
80160	**SOCIAL WORKER** 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 referred 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 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 and the Better Outcomes in Mental Health Care Program 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) **Benefit:** = $67.50
80165	**SOCIAL WORKER** Professional attendance at a place other than consulting rooms. As per the social worker service requirements outlined for item 80160. **Benefit:** = $87.00
80170	**SOCIAL WORKER** 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; or a referred 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 **Benefit:** = $17.20

PART 5

SERVICES FOR WOMEN WHO ARE CONCERNED ABOUT A PREGNANCY

PREGNANCY SUPPORT COUNSELLING SERVICES (ITEMS 81000 TO 81010)

ELIGIBLE PATIENTS

Medicare benefits are available 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. Services can be provided either by an eligible GP or by an eligible psychologist, social worker or mental health nurse on referral from a GP.

ELIGIBLE SERVICES

There are four 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 in the general Medicare Benefits Schedule which can be found at www.health.gov.au/mbsonline.

Service length and type
Non-directive pregnancy support counselling services provided by eligible psychologists, social workers and mental health nurses using items 81000 to 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 items may be used to address any pregnancy related issues for which non-directive counselling is appropriate.

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.

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.

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.

Publicly funded services
Items 81000, 81005 and 81010 do not apply for services that are provided by any other Commonwealth or State or Territory 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.

REFERRAL REQUIREMENTS

Patients must be referred by a GP for non-directive pregnancy support counselling services. 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.

ALLIED HEALTH PROFESSIONAL ELIGIBILITY

Items 81000, 81005 and 81010 can only be claimed for services provided by psychologists, social workers and mental health nurses who meet the following specific eligibility requirements, and are registered with Medicare Australia.

- 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;

- a **social worker** must be a 'Member' of the Australian Association of Social Workers (AASW), 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;

- 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.

Changes to provider details

Allied health providers must notify Medicare Australia in writing of all changes to mailing details to ensure that they continue to receive this book and any updates about Medicare rebateable allied health services.

ITEM DESCRIPTIONS

	PREGNANCY SUPPORT COUNSELLING
81000	**PSYCHOLOGY** 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 credentialing 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 **Benefit:** = $56.20
81005	**SOCIAL WORKER** 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 credentialing 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 **Benefit:** = $56.20
81010	**MENTAL HEALTH NURSE** 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 credentialing 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 **Benefit:** = $56.20

PART 6

CLAIMING FROM MEDICARE

Account/Receipt Requirements

For a Medicare payment to be made the account/receipt must include the following information:

- patient's name;
- date of service;
- MBS item number;
- allied health professional's name and provider number, or name and practice address;
- referring medical practitioners name and provider number, or name and practice address;
- date of referral; and
- amount charged, total amount paid, and any amount outstanding in relation to the service.

PAID ACCOUNTS

The patient can pay the account provided by the allied health professional and present the itemised receipt (see above) at a Medicare office for assessment and payment of the Medicare benefit in cash. From 1 November 2007, patients may also be able to lodge Medicare claims electronically with their provider.

If the patient chooses to mail the claim to Medicare, a Medicare Patient Claim Form (PC-1) must be completed. This also applies when the patient is arranging for an agent to collect cash on his/her behalf at a Medicare office.

UNPAID ACCOUNTS

Cheque from Medicare

If the patient has not paid the account, the itemised unpaid account can be presented to Medicare (in person or by mail) with a Medicare Patient Claim Form (PC-1). In this case Medicare will forward to the patient a benefit cheque made payable to the allied health professional. It is the patient's responsibility to forward the cheque to the allied health professional and make arrangements for payment of the balance of the account, if any.

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

Assignment of benefit (bulk billing or direct payment) arrangements

Where an allied health professional chooses to bulk bill for the service, s/he undertakes to accept the 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.

When bulk billing, the allied health professional will need to submit the approved forms (DB2-AH and DBIN-AH) to Medicare. These forms are approved forms under the Health Insurance Act, and no other forms can be used to assign benefits without the approval of Medicare Australia. They can be ordered by telephoning 1800 067 307.

To bulk bill, the allied health professional will need to complete:

a) An assignment of benefit (direct-payment) form (Medicare form DB2-AH) for each patient

This form contains the patient's details. Under these arrangements:

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

- the allied health professional must set out on the assignment form the details relating to the professional service before the patient signs the form. The patient must then receive a copy of the form;

- 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 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 Use' an explanation should be given as to why the patient was unable to sign (e.g. injured hand etc.). This note should be signed or initialled by the allied health professional. If in the opinion of the allied health professional, the reason is of such a 'sensitive' nature that revealing it would constitute an unacceptable breach of patient confidentiality 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.

b) A claim for assignment of benefit form (Medicare claim form DB1N-AH)

To claim the Medicare benefit, the allied health professional then forwards the individual assignment of benefit forms (DB2-AH) to Medicare using a claim for assignment of benefit form DB1N-AH. Up to 50 individual assignment of benefit (direct-payment) forms may be submitted with each claim form.

The claim for assignment of benefits form must relate to assigned Medicare benefits for allied health services by one provider from a single practice location.

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

From 1 November 2007, Medicare Australia is also rolling out electronic claiming to enable bulk billing claims to be submitted online. For more information please contact Medicare Australia on 1800 700 199.

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. Medicare benefits are not payable for any service where the service was provided more than six months earlier than the date the claim was lodged with Medicare. In certain circumstances (eg hardship cases, third party workers compensation cases), the Minister may waive the time limits.

Billing practices contrary to the Act
Under the *Health Insurance Act 1973* (as amended), it is not permissible to:

1. Include the cost of a non-clinically relevant service in a consultation charge. Medicare benefits can only be paid for clinically relevant services. If an allied health professional chooses to use a procedure that is not generally accepted in their profession as necessary for the treatment of the patient, the cost of this procedure cannot be included in the fee for a Medicare item. Any charge for non-clinically relevant services must be separately listed on the account and not included in the fee billed to Medicare.

2. Include an amount for goods supplied for the patient to use at home in the consultation charge (eg. wheelchairs, oxygen tanks, continence pads). Charges can be levied for these items, but they must be listed separately on the account and not billed to Medicare.

3. Charge part or all of an in-patient procedure to an out-patient consultation. If an allied health professional charges part or all of an in-patient procedure to an out-patient consultation, the account issued by the practitioner is not an accurate statement of the services provided and would constitute a false or misleading statement.

4. Re-issue 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 must state the amount charged for the service provided and truly reflect what occurred between the patient and practitioner. While re-issuing an account to correct a genuine error is legitimate, 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.

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

Medicare Australia
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.

AUSTRALIAN CAPITAL TERRITORY
134 Reed Street
TUGGERANONG ACT 2901

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

NORTHERN TERRITORY
As per South Australia

QUEENSLAND
State Headquarters
444 Queen Street
BRISBANE QLD 4000

SOUTH AUSTRALIA
State Headquarters
209 Greenhill Road
EASTWOOD SA 5063

TASMANIA
242 Liverpool Street
HOBART TAS 7000

VICTORIA
State Headquarters
460 Bourke Street
MELBOURNE VIC 3000

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

The day-to-day administration and payment of benefits under the Medicare arrangement is the responsibility of Medicare Australia. Inquiries concerning payment of benefits 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:

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

Appendix 1
MBS Item Numbers by Profession

AHP Group*	Item Number	Item Rebate	Service Provided	Eligible Patients	Prerequisite for Claiming
Aboriginal Health Worker	10950	$47.85 (min 20 mins)	Aboriginal Health Worker Service	Patients who have a chronic condition and complex care needs	• GP must have claimed GP Management Plan (item 721) and Team Care Arrangement (item 723), or a review (item 727) in past 2 years. • GPs must refer using an approved referral form.
Audiologist	10952	$47.85 (min 20 mins)	Audiology	Patients who have a chronic condition and complex care needs	• GP must have claimed GP Management Plan (item 721) and Team Care Arrangement (item 723), or a review (item 727) in past 2 years. • GPs must refer using an approved referral form.
Chiropractor	10964	$47.85 (min 20 mins)	Chiropractic Service	Patients who have a chronic condition and complex care needs	• GP must have claimed GP Management Plan (item 721) and Team Care Arrangement (item 723), or a review (item 727) in past 2 years. • GPs must refer using an approved referral form.

AHP Group*	Item Number	Item Rebate	Service Provided	Eligible Patients	Prerequisite for claiming
Clinical Psychologist (see also Psychologist)	80000	$76.65 (30-50 mins) $112.45 (min 50 mins) $95.75 (30-50 mins) for consultations outside of consulting rooms $131.55 (min 50 mins) for consultations outside of consulting rooms $28.60 per patient for group sessions	Psychological Therapy Services	Patients with an assessed mental disorder	• GP Mental Health Care Plan (items 2710 or 2712), referred psychiatrist assessment management plan (items 291 or 293), and/or relevant psychiatrist or paediatrician item must have been claimed. • No specific referral form, just a note or a letter.
	80005				
	80010				
	80015				
	80020				
Diabetes Educator	10951	$47.85 (min 20 mins)	Diabetes Education Service	Patients who have a chronic condition and complex care needs	• GP must have claimed GP Management Plan (item 721) and Team Care Arrangement (item 723), or a review (item 727) in past 2 years. • GPs must refer using an approved referral form.
	81100	$61.30 (min 45 mins)	Diabetes Education Service - Assessment for Group Services	Patients with type 2 diabetes	• GP must have claimed GP Management Plan (item 721). • GPs must refer using an approved referral form.
	81105	$15.30 (min 60 mins)	Diabetes Education Service - Group Service		• Assessed as suitable by Assessment for Group Services (item 81100, 81110 or 81120).

AHP Group*	Item Number	Item Rebate	Service Provided	Eligible Patients	Prerequisite for claiming
Dietitian	10954	$47.85 (min 20 mins)	Dietetics Service	Patients who have a chronic condition and complex care needs	• GP must have claimed GP Management Plan (item 721) and Team Care Arrangement (item 723), or a review (item 727) in past 2 years. • GPs must refer using an approved referral form.
	81120	$61.30 (min 45 mins)	Dietetics Service - Assessment for Group Services	Patients with type 2 diabetes	• GP must have claimed GP Management Plan (item 721). • GPs must refer using an approved referral form.
	81125	$15.30 (min 60 mins)	Dietetics Service - Group Service		• Assessed as suitable by Assessment for Group Services (item 81100, 81110 or 81120).
Exercise Physiologist	10953	$47.85 (min 20 mins)	Exercise Physiology Service	Patients who have a chronic condition and complex care needs	• GP must have claimed GP Management Plan (item 721) and Team Care Arrangement (item 723), or a review (item 727) in past 2 years. • GPs must refer using an approved referral form.
	81110	$61.30 (min 45 mins)	Exercise Physiology Service - Assessment for Group Services	Patients with type 2 diabetes	• GP must have claimed GP Management Plan (item 721). • GPs must refer using an approved referral form.
	81115	$15.30 (min 60 mins)	Exercise Physiology Service - Group Service		• Assessed as suitable by Assessment for Group Services (item 81100, 81110 or 81120).

AHP Group*	Item Number	Item Rebate	Service Provided	Eligible Patients	Prerequisite for claiming
Mental Health Nurse	81010	$56.25 (min 30 mins)	Non-directive pregnancy support counselling	Women who are concerned about a pregnancy	• A referral (no specific form, just note or letter) from GP.
Mental Health Workers (psychologist, mental health nurse, occupational therapist, social worker and Aboriginal health worker)	10956	$47.85 (min 20 mins)	Mental Health Service	Patients who have a chronic condition and complex care needs	• GP must have claimed GP Management Plan (item 721) and Team Care Arrangement (item 723), or a review (item 727) in past 2 years. • GPs must refer using an approved referral form.
Occupational Therapist	10958	$47.85 (min 20 mins)	Occupational Therapy	Patients who have a chronic condition and complex care needs	• GP must have claimed GP Management Plan (item 721) and Team Care Arrangement (item 723), or a review (item 727) in past 2 years. • GPs must refer using an approved referral form.
	80125	$47.85 (20-50 mins) $67.50 (min 50 mins) $67.35 (20-50 mins) for consultations outside of consulting rooms $87.05 (min 50 mins) for consultations outside of consulting rooms $17.20 per patient for group sessions	Focussed psychological strategies - allied mental health	Patients with an assessed mental disorder	• GP Mental Health Care Plan (items 2710 or 2712), referred psychiatrist assessment management plan (items 291 or 293), and/or relevant psychiatrist or paediatrician item must have been claimed. • No specific referral form, just a note or a letter.
	80130				
	80135				
	80140				
	80145				

AHP Group*	Item Number	Item Rebate	Service Provided	Eligible Patients	Prerequisite for claiming
Osteopath	10966	$47.85 (min 20 mins)	Osteopathy	Patients who have a chronic condition and complex care needs	• GP must have claimed GP Management Plan (item 721) and Team Care Arrangement (item 723), or a review (item 727) in past 2 years. • GPs must refer using an approved referral form.
Physiotherapist	10960	$47.85 (min 20 mins)	Physiotherapy	Patients who have a chronic condition and complex care needs	• GP must have claimed GP Management Plan (item 721) and Team Care Arrangement (item 723), or a review (item 727) in past 2 years. • GPs must refer using an approved referral form.
Podiatrist	10962	$47.85 (min 20 mins)	Podiatry	Patients who have a chronic condition and complex care needs	• GP must have claimed GP Management Plan (item 721) and Team Care Arrangement (item 723), or a review (item 727) in past 2 years. • GPs must refer using an approved referral form.

AHP Group*	Item Number	Item Rebate	Service Provided	Eligible Patients	Prerequisite for claiming
Psychologist (see also Clinical Psychologist)	10968	$47.85 (min 20 mins)	Psychology	Patients who have a chronic condition and complex care needs	• GP must have claimed GP Management Plan (item 721) and Team Care Arrangement (item 723), or a review (item 727) in past 2 years. • GPs must refer using an approved referral form.
	80100 80105 80110 80115 80120	$54.30 (20-50 mins) $76.65 (min 50 mins) $73.80 (20-50 mins) for consultations outside of consulting rooms $96.20 (min 50 mins) for consultations outside of consulting rooms $19.55 per patient for group sessions	Focussed psychological strategies - allied mental health	Patients with an assessed mental disorder	• GP Mental Health Care Plan (items 2710 or 2712), referred psychiatrist assessment management plan (items 291 or 293), and/or relevant psychiatrist or paediatrician item must have been claimed. • No specific referral form, just a note or a letter.
	81000	$56.25 (min 30 mins)	Non-directive pregnancy support counselling	Women who are concerned about a pregnancy	• A referral (no specific form, just note or letter) from GP.
Social Worker	80150 80155 80160 80165 80170	$47.85 (20-50 mins) $67.50 (min 50 mins) $67.35 (20-50 mins) for consultations outside of consulting rooms $87.05 (min 50 mins) for consultations outside of consulting rooms $16.80 per patient for group sessions	Focussed psychological strategies - allied mental health	Patients with an assessed mental disorder	• GP Mental Health Care Plan (items 2710 or 2712), referred psychiatrist assessment management plan (items 291 or 293), and/or relevant psychiatrist or paediatrician item must have been claimed. • No specific referral form, just a note or a letter.
	81005	$56.25 (min 30 mins)	Non-directive pregnancy support counselling	Women who are concerned about a pregnancy	• A referral (no specific form, just note or letter) from GP.

AHP Group*	Item Number	Item Rebate	Service Provided	Eligible Patients	Prerequisite for claiming
Speech Pathologist	10970	$47.85 (min 20 mins)	Speech Pathology	Patients who have a chronic condition and complex care needs	• GP must have claimed GP Management Plan (item 721) and Team Care Arrangement (item 723), or a review (item 727) in past 2 years. • GPs must refer using an approved referral form.

* All allied health providers must be registered with Medicare Australia as meeting eligibility for relevant service prior to providing services.

Appendix 2
Enhanced Primary Care (EPC) Program
Referral form for individual Allied Health Services under Medicare

To be completed by referring GP:

Please tick the relevant box below:

Patient has a GP Management Plan and Team Care Arrangements in place (new CDM MBS items 721 AND 723 or 731) OR

Patient has an EPC Multidisciplinary Care Plan in place (former MBS items 720, 722 or 730)

Note: GPs are encouraged to attach a copy of the relevant part of the patient's care plan to this form.

Medicare rebates and Private Health Insurance benefits cannot both be claimed for these services.
Patients should be advised that they must choose whether to access one or the other.

GP details

Provider Number

Name

Address Postcode

Patient details

Medicare Number Patient's ref no.

First Name Surname

Address Postcode

Allied Health Professional (AHP) patient referred to: (Please specify name or type of AHP)

Name

Address Postcode

Referral details – Please use a separate copy of the referral form for each type of service

Eligible patients may access Medicare rebates for up to 5 allied health services (total) in a calendar year. Please indicate the number of services required by writing the number in the 'No. of services' column next to the relevant AHP.

No of services	AHP Type	Item Number
	Aboriginal Health Worker	10950
	Audiologist	10952
	Chiropractor	10964
	Diabetes Educator	10951
	Dietitian	10954

No of services	AHP Type	Item Number
	Exercise Physiologists	10953
	Mental Health Worker	10956
	Occupational Therapist	10958
	Osteopath	10966
	Physiotherapist	10960

No of services	AHP Type	Item Number
	Podiatrist	10962
	Psychologist	10968
	Speech Pathologist	10970

Referring General Practitioner's signature

Date signed

AHP must provide a written report to patient's GP after each service – except where the AHP provides multiple services to a patient under the one referral. In this case, the AHP must provide a written report to the patient's GP after the first and last service, and more often if clinically necessary.

Allied health professionals should retain this referral form for record keeping and Medicare Australia audit purposes.

Allied health services funded by other Commonwealth or State/Territory programs are not eligible for Medicare rebates under this initiative.

This 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 or by phoning (02) 6289 4297.

THE FORM DOES NOT HAVE TO ACCOMPANY MEDICARE CLAIMS

Appendix 3
Enhanced Primary Care (EPC) Program
Referral form for Allied Health Group Services under Medicare for patients with type 2 diabetes

PART A – To be completed by referring GP (tick relevant boxes):

☐ Patient has type 2 diabetes AND either

☐ GP has prepared a new GP Management Plan (MBS item 721) OR

☐ GP has reviewed an existing GP Management Plan (MBS item 725) OR

☐ for a resident of an aged care facility, GP has contributed to or reviewed a care plan prepared by the facility (MBS item 731)

[Note: Generally, residents of an aged care facility rely on the facility for assistance to manage their type 2 diabetes. Therefore, residents may not need to be referred for allied health group services as the self management approach may not be appropriate.]

Note: GPs are encouraged to attach a copy of the relevant part of the patient's care plan to this form.

Please advise patients that Medicare rebates and Private Health Insurance benefits cannot both be claimed for this service

GP details

Provider ☐☐☐☐☐☐☐☐

Name

Address Postcode

Patient details

First Name Surname

Address Postcode

Note: Eligible patients may access Medicare rebates for **one** assessment for group services item in a calendar year. Indicate the name of the practitioner (diabetes educator, exercise physiologist or dietitian), or the allied health practice, you wish to refer the patient to for this assessment. The assessment must be done before the patient can access group services.

Allied Health Practitioner (or practice) the patient is referred to for Assessment:

Name of AHP or practice

Address Postcode

Referring GP's signature **Date**

PART B – To be completed by Allied Health Professional who undertakes Assessment service:

Eligible patients may access Medicare rebates for **up to 8** allied health group services in a calendar year. Group size must be between 2 and 12 persons.

Indicate the name of the provider/s, and details of the group service program.

Name of provider/s:

Name of program:

No. of sessions in the program:

Venue (if known):

Name of Referring AHP: **Signature and date**

AHPs must provide, or contribute to, **a written report** to the patient's GP after the Assessment service and at completion of the group services program.

AHPs should retain a copy of the referral form for record keeping and Medicare Australia audit purposes.

Allied health services funded by other Commonwealth or State/Territory programs are not eligible for Medicare rebates under these items, except where the service is operating under sub-section 19(2) arrangements.

This form may be downloaded from the Department of Health and Ageing website at www.health.gov.au/epc or ordered by phoning (02) 6289 4297 or faxing (02) 6289 7120.

THIS FORM DOES NOT HAVE TO ACCOMPANY MEDICARE CLAIMS