Difference between requests for diagnostic imaging services and referrals for other services under Medicare

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The terms ‘request’ and ‘referral’ are often used interchangeably within the diagnostic imaging sector and by requesters and the general public when discussing the forms patients need to take to a provider of diagnostic imaging services.

There are four distinct legislative differences between requests and referrals. These are:

Request	Referral
Applies to diagnostic imaging services	Applies to specialist and consultant physician referred consultations
Needs only to provide sufficient information to identify the item that relates to the service being requested (although it is best practice to provide clinical information to the provider).	Needs to explain the reasons for referring the patient, including any information about the patient’s condition that the referring practitioner considers necessary to give to the specialist or consultant physician.
The requesting provider determines that the diagnostic imaging service is necessary	The referring practitioner determines that a specialist or consultant physician should consult with the patient.
No general time limit on validity	Has defined validity periods

The significant differentiating feature of a request and referral is that a request is a demand for one or more diagnostic imaging services, whereas as a referral is a call for a specialist or consultant physician to consult with the patient.

Issues

From time to time the Department of Health and Aged Care receives enquiries about the:

- differences between requests for diagnostic imaging services for the purposes of claiming Medicare benefits and referrals to specialists or consultant physicians for claiming the relevant referred consultation items, for example, item 104; and
- validity dates of requests and referrals for Medicare claiming purposes.

The Department of Health and Aged Care also understands that there may be occasions when diagnostic imaging practices seek further updated requests when these are not necessary, for example, when a request from a specialist is older than three months.

Discussion

The terms ‘request’ and ‘referral’ are often used interchangeably within the diagnostic imaging sector and by requesters and the general public. However, requests apply specifically to diagnostic imaging (and pathology) services. Referrals apply to specialist and consultant physician consultation items in the *Health Insurance (General Medical Services Table) Regulations 2021* (GMST).

Where a provider refers a patient to a specialist for a consultation and at the same time requests a diagnostic imaging service from the same specialist, this can be done on the same form as long as all the elements of both a referral and request as required by the legislation (discussed below) are present.

However, the matter can become clouded when request forms supplied by diagnostic imaging providers contain references to referrals.

Legislative requirements

Requests for Medicare funded diagnostic imaging services

Section 16B of the *Health Insurance Act 1973* (HIA) provides the framework for requesting R-type (requested) diagnostic imaging services. Requirements regarding the information that must be included in a request are set out in Section 70 of the *Health Insurance Regulations 2018* (HI Regs).

In summary, Medicare benefits are not payable for diagnostic imaging services that are classified as R-type services unless, prior to commencing the relevant service, the providing practitioner receives a request from a practitioner who is eligible to request the service and who determined the service was necessary.

A written request for a R-type service is not required when the diagnostic imaging service is provided by or on behalf of a consultant physician or a specialist (other than a specialist in diagnostic radiology) practicing in his or her specialty and after clinical assessment he/she determines that the service was necessary. An assessment that the patient needs an imaging service need not be done at a consultation with the specialist, for example, a specialist can determine from information provided in a referral that an imaging service is needed prior to a consultation.

When this occurs, the service is considered a self-determined service and must be designated as such on the account for the service, through wording such as ‘self-determined’ or ‘SD’, to differentiate it from a service that has been requested by another practitioner.

There are other exemptions to the request requirements that relate to: additional services; substituted services; remote areas; emergencies; lost requests and pre-existing diagnostic imaging practices.

Medicare request requirements

There is no standard form for a request for a diagnostic imaging service. However, requests must be in writing (manual or electronic) and contain sufficient information to clearly identify the services being requested. Responsibility for determining the clinical need for the service and the adequacy of requesting details rests with the requesting practitioner.

The request must also be dated and contain the name and practice address or name and provider number of the requesting practitioner. There is no requirement for a diagnostic imaging request to be signed. Guidance on the information that should be provided on a request for a diagnostic imaging service is provided in note IN.0.6 of the MBS Online Notes.

There is no specific timeframe in which a request for a diagnostic imaging test is valid. However, if a single request orders more than one diagnostic imaging service, all services provided under the request must be rendered within seven days of the date the first service was rendered for Medicare benefits to be payable for the subsequent services. This requirement is specified in subsection 16B(5) of the Act and was introduced in 1990. It does not prevent requesting practitioners issuing more than one request form if it is anticipated that all the services will not be rendered within 7 days of each other, for example, requests for periodic ultrasound services during a pregnancy.

Medicare referrals to specialists and consultant physicians

Section 132A of the HIA provides that a referral by a practitioner can be required for some services. The manner of the referral is provided for in Part 11, Division 4 of the HI Regs. As noted earlier, the provisions are specific to GMST items.

Note GN.6.16 in the MBS says that a referral for the purposes of the GMST does not mean a written request for diagnostic imaging or pathology services. It goes on to express that a referral for the purposes of the GMST is a request to a specialist or a consultant physician for investigation, opinion, treatment and/or management of a condition or problem of a patient or for the performance of a specific examination(s) or test(s).

Subject to some exceptions, for a valid referral to take place:

i. the referring practitioner must have undertaken a professional attendance with the patient and turned their mind to the patient's need for a referral and have communicated relevant information about the patient to the specialist or consultant physician (this need not mean an attendance on the occasion of the referral);

ii. the instrument of referral must be in writing as a letter or note to a specialist or to a consultant physician and must be signed and dated by the referring practitioner; and

iii. the specialist or consultant physician to whom the patient is referred must have received the instrument of referral on or prior to the occasion of the professional service to which the referral relates.

Where a referral originates from a specialist or a consultant physician, the referral is valid for 3 months from the date of the consultation with the specialist or consultant physician to whom the patients has been referred, except where the referred patient is an admitted

patient. For admitted patients, the referral is valid for 3 months or the duration of the admission whichever is the longer.

Where the referral originates from a practitioner other than a specialist or consultant physician, the referral is valid for a period of 12 months, unless the referring practitioner indicates that the referral is for a period more or less than 12 months (e.g. 3, 6 or 18 months or valid indefinitely). Referrals for longer than 12 months should only be used where the patient's clinical condition requires continuing care and management of a specialist or a consultant physician for a specific condition or specific conditions. Again, the validity period starts from the date of the first consultation with the specialist or consultant physician to whom the patient has been referred, not the date of the referral.

When claiming specialist referred consultation items, such as item 104, an initial attendance can only be billed once in a single course of treatment, which includes:

- the initial attendance on the patient by a specialist;
- the continuing management or treatment up to and including the stage when the patient is referred back to the care of the referring practitioner; and
- any subsequent review of the patient's condition by the specialist that may be necessary, whether the review is initiated by the referring practitioner or by the specialist.

The receipt by a specialist of a new referral, following the expiration of a previous referral for the same condition(s), does not necessarily indicate the commencement of a new course of treatment allowing the billing of an initial attendance. In the continuing management/treatment situation the new referral is to facilitate the payment of benefits at the referred rate rather than the non-referred rate.

Another initial attendance may be billed, and another single course of treatment commenced, if:

- the patient develops a new or unrelated condition, and there is a new referral in place related to that condition; or
- the patient's condition remains substantially the same but a significant period of time (more than 9 months) has elapsed since the previous attendance, so as to warrant a new history and assessment, and a new valid referral is in place for the new attendance.

When consultations may be billed by diagnostic imaging providers

Diagnostic imaging service other than magnetic resonance imaging (MRI)

Since 1 May 2020, specialist radiologists have not been able to claim a consultation in conjunction with one of the following diagnostic imaging services:

- All musculoskeletal ultrasound – Group I1, Subgroup 6 (items 55812 – 55895)

- Diagnostic radiology items as follows:
  - Group I3, Subgroup 1 – Radiographic Examination of the Extremities - items 57506 to 57527
  - Group I3, Subgroup 2 – Radiographic Examination of Shoulder and Pelvis - items 57700 to 57721
  - Group I3, Subgroup 3 – Radiographic Examination of the Head - items 57901 to 57969
  - Group I3, Subgroup 4 – Radiographic Examination of the Spine - items 58100 to 58121
  - Group I3, Subgroup 5 – Bone Age Study and Skeletal Survey - items 58300 to 58306
  - Group I3, Subgroup 6 – Radiographic Examination of Thoracic Region - items - 58500 to 58527
  - Group I3, Subgroup 7 – Radiographic Examination of Urinary Tract - items 58700 to 58721
  - Group I3, Subgroup 8 – Radiographic Examination of Alimentary Tract and Biliary System - items 58900 and 58939
  - Group I3, Subgroup 9 – Radiographic Examination of Localisation of Foreign Bodies - item 59103

Radiologists may claim consultations when they attend the patient before, during or after the rendering of diagnostic imaging services other than those listed above.

While the restriction on co-claiming of consultations with the items mentioned above does not apply to other diagnostic imaging providers, a consultation should only be claimed by **any provider** where the attendance on the patient is meaningful and is clinically relevant. That would be where:

- the provider utilises their medical knowledge, clinical acumen, technical skills and personal experience in their relevant profession to determine, alter, or potentially alter, the course of the patient's management in the best interests of the patient.
- the provider takes primary clinical responsibility for the management decisions made during the consultation (even if the decision is to proceed with a planned course of management).
- the consultation itself includes components of history taking; physical examination; discussion with the patient; formulation of management plans; and may include referral for additional opinion or tests.

Not all the components need be present in any one consultation, but the presence of at least some would indicate that a meaningful consultation occurred.

To claim a specialist or consultant physician referred consultation, the specialist or consultant physician must have received a valid referral (not simply a request for a diagnostic imaging service) from a medical practitioner in accordance with the requirements noted earlier in this paper.

A request for the provision of a diagnostic imaging service, in the absence of the other elements of a referral as noted above, does not constitute a valid referral for a specialist referred consultation.

A consultation should not be claimed where a specialist or consultant physician receives a request for diagnostic imaging service only, for example, a request to a cardiologist to do an echocardiogram.

MRI services

Since 1 November 2021, providers are only able to claim a consultation rendered in association with an MRI service when the consultation is necessary for the treatment of management of the patient's conditions.

Again, any consultation has to be meaningful as described earlier and needs to meet the relevant referral requirements.

Where can I find more information?

The full item descriptor(s) and information on other changes to the MBS can be found on the MBS Online website at www.mbsonline.gov.au. You can also subscribe to future MBS updates by visiting MBS Online and clicking 'Subscribe'.

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

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

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

The data file for software vendors when available can be accessed via the Downloads page.

The Services Australia website also provides summary information about referring and requesting[1] Medicare services.

> *Please note that the information provided is a general guide only. It is ultimately the responsibility of treating practitioners to use their professional judgment to determine the most clinically appropriate services to provide, and then to ensure that any services billed to Medicare fully meet the eligibility requirements outlined in the legislation.*

[1] https://www.servicesaustralia.gov.au/organisations/health-professionals/subjects/referring-and-requesting-medicare-services

This sheet is current as of the Last updated date shown above and does not account for MBS changes since that date.