

**Australian Government**  
**Department of Health and Aged Care**

**Medicare Benefits Schedule Book**

**Category 7**

**Operating from 1 July 2024**

Title: Medicare Benefits Schedule Book

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**The latest Medicare Benefits Schedule information is available from *MBS Online* at <https://www.health.gov.au/mbsonline>**

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# GENERAL EXPLANATORY NOTES

## **GENERAL EXPLANATORY NOTES**

### **GN.0.1 AskMBS Email Advice Service**

If you are a patient seeking advice about Medicare services, benefits or your Medicare claims, please contact Services Australia on the Medicare general enquiry line - 132 011.

AskMBS responds to enquiries from providers of services listed on the Medicare Benefits Schedule (MBS) seeking advice on interpretation of MBS items (including those for dental, pathology and diagnostic imaging), explanatory notes and associated legislation. This advice is intended primarily to assist health professionals, practice managers and others to understand and comply with MBS billing requirements. AskMBS works closely with policy areas within the Department of Health and Aged Care, and with Services Australia, to ensure enquirers receive accurate, authoritative and up-to-date information.

If you have a query relating exclusively to interpretation of the Schedule, you should email [askMBS@health.gov.au](mailto:askMBS@health.gov.au).

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

AskMBS issues advisories summarising responses to frequently asked questions on specific subject areas. [AskMBS Email Advice Service](#)

### **GN.1.1 The Medicare Benefits Schedule - Introduction Schedules of Services**

Each professional service contained in the Schedule has been allocated a unique item number. Located with the item number and description for each service is the Schedule fee and Medicare benefit, together with a reference to an explanatory note relating to the item (if applicable).

If the service attracts an anaesthetic, the word (Anaes.) appears following the description. Where an operation qualifies for the payment of benefits for an assistant, the relevant items are identified by the inclusion of the word (Assist.) in the item description. Medicare benefits are not payable for surgical assistance associated with procedures which have not been so identified.

Higher rates of benefits are provided for consultations by a recognised consultant physician where the patient has been referred by another medical practitioner or an approved dental practitioner (oral surgeons).

Differential fees and benefits also apply to services listed in Category 5 (Diagnostic Imaging Services). The conditions relating to these services are set out in Category 5.

#### **Explanatory Notes**

Explanatory notes relating to the Medicare benefit arrangements and notes that have general application to services are located at the beginning of the schedule, while notes relating to specific items are located at the beginning of each Category. While there may be a reference following the description of an item to specific notes relating to that item, there may also be general notes relating to each Group of items.

### **GN.1.2 Medicare - an outline**

The Medicare Program ('Medicare') provides access to medical and hospital services for all Australian residents and certain categories of visitors to Australia. Services Australia administers Medicare and the payment of Medicare benefits. The major elements of Medicare are contained in the *Health Insurance Act 1973*, as amended, and include the following:

- a. Free treatment for public patients in public hospitals.
- b. The payment of 'benefits', or rebates, for professional services listed in the Medicare Benefits Schedule (MBS). The relevant benefit rates are:

- i. 100% of the Schedule fee for services provided by a general practitioner to non-referred, non-admitted patients, or for general practitioner attendances specified as not being hospital treatments - see note below;
- ii. 100% of the Schedule fee for services provided on behalf of a general practitioner by a practice nurse or Aboriginal and Torres Strait Islander health practitioner\*;
- iii. 75% of the Schedule fee for professional services rendered to a patient as part of an episode of hospital treatment (other than services provided to public patients), including services provided in hospital outpatient settings but not generally including services set out in the note below. Medical practitioners must indicate on their accounts if a medical service is rendered in these circumstances by placing an asterisk '\*' or the letter 'H' directly after an item number where used; or a description of the professional service and an indication the service was rendered as an episode of hospital treatment (for example, 'in hospital', 'hospital outpatient service', 'admitted' or 'in patient');
- iv. 75% of the Schedule fee for professional services rendered as part of a privately insured episode of hospital-substitute treatment such as 'hospital in the home', but generally not including certain services listed below. Medical practitioners must indicate on their accounts if a medical service is rendered in these circumstances by placing the words 'hospital-substitute treatment' directly after an item number where used; or a description of the professional service, preceded by the words 'hospital-substitute treatment';
- v. 85% of the Schedule fee for all other services.

Note: while hospital treatments and hospital-substitute treatments attract a 75% rebate, most attendances, services provided to private patients in emergency departments, pathology services and diagnostic imaging services do not generally require hospital treatment and therefore do not attract a rebate of 75% of the Schedule fee unless certified as a 'Type C' treatment. A list of most MBS items in scope of this exception, and the requirements around certifying a treatment as 'Type C' can be found in the Private Health Insurance (Benefit Requirement) Rules 2011. Services provided to a private patient in an emergency department are exempted under the Private Health Insurance (Health Insurance Business) Rules 2018.

Medicare benefits are claimable only for 'clinically relevant' services rendered by an appropriate health practitioner. A 'clinically relevant' service is one which is generally accepted by the relevant profession as necessary for the appropriate treatment of the patient.

When a service is not clinically relevant, the fee and payment arrangements are a private matter between the practitioner and the patient.

Services listed in the MBS must be rendered according to the provisions of the relevant Commonwealth, State and Territory laws. For example, medical practitioners must ensure that the medicines and medical devices they use have been supplied to them in strict accordance with the provisions of the Therapeutic Goods Act 1989.

Where a Medicare benefit has been inappropriately paid, Services Australia may request its return from the practitioner concerned.

\* MBS items 10988 and 10989 generally attract a 100% rebate but can be specified as 'Type C' treatments and attract a 75% rebate.

### **GN.1.3 Medicare benefits and billing practices**

#### **Key information on Medicare benefits and billing practices**

The *Health Insurance Act 1973* stipulates that Medicare benefits are payable for professional services. A professional service is a clinically relevant service which is listed in the MBS. A medical service is clinically relevant if it is generally accepted in the medical profession as necessary for the appropriate treatment of the patient.

Medical practitioners are free to set their fees for their professional service. However, the amount specified in the patient's account must be the amount charged for the service specified. The fee may not include a cost of goods or services which are not part of the MBS service specified on the account.

### **Billing practices contrary to the Act**

A *non-clinically relevant service* must not be included in the charge for a Medicare item. The non-clinically relevant service must be separately listed on the account and not billed to Medicare.

Goods supplied for the patient's home use (such as wheelchairs, oxygen tanks, continence pads) must not be included in the consultation charge. Medicare benefits are limited to services which the medical practitioner provides at the time of the consultation - any other services must be separately listed on the account and must not be billed to Medicare.

Charging part of all of an episode of hospital treatment or a hospital substitute treatment to a non-admitted consultation is prohibited. This would constitute a false or misleading statement on behalf of the medical practitioner and no Medicare benefits would be payable.

An account may not be re-issued to include charges and out-of-pocket expenses excluded in the original account. The account can only be reissued to correct a genuine error.

### **Potential consequence of improperly issuing an account**

The potential consequences for improperly issuing an account are

- (a) No Medicare benefits will be paid for the service;
- (b) The medical practitioner who issued the account, or authorised its issue, may face charges under sections 128A or 128B of the *Health Insurance Act 1973*.
- (c) Medicare benefits paid as a result of a false or misleading statement will be recoverable from the doctor under section 129AC of the *Health Insurance Act 1973*.

Providers should be aware that Services Australia is legally obliged to investigate doctors suspected of making false or misleading statements, and may refer them for prosecution if the evidence indicates fraudulent charging to Medicare. If Medicare benefits have been paid inappropriately or incorrectly, Services Australia will take recovery action.

Services Australia (SA), in consultation with the Department of Health and Aged Care, has developed a [Health Practitioner Guideline for responding to a request to substantiate that a patient attended a service](#). There is also a [Health Practitioner Guideline for substantiating that a specific treatment was performed](#). These guidelines are located on the Department of Health and Aged Care's website.

### **GN.2.4 Provider eligibility for Medicare**

To be eligible to provide medical service which will attract Medicare benefits, or to provide services for or on behalf of another practitioner, practitioners must meet one of the following criteria:

- (a) be a recognised specialist, consultant physician or general practitioner; or
- (b) be in an approved placement under section 3GA of the *Health Insurance Act 1973*; or
- (c) be a temporary resident doctor with an exemption under section 19AB of the *Health Insurance Act 1973*, and working in accord with that exemption.

Any practitioner who does not satisfy the requirements outlined above may still practice medicine but their services will not be eligible for Medicare benefits.



**NOTE:** New Zealand citizens entering Australia do so under a special temporary entry visa and are regarded as temporary resident doctors.

**NOTE:** It is an offence under Section 19CC of the *Health Insurance Act 1973* to provide a service without first informing a patient where a Medicare benefit is not payable for that service (i.e. the service is not listed in the MBS).

### **Non-medical practitioners**

To be eligible to provide services which will attract Medicare benefits under MBS items 10950-10977 and MBS items 80000-88000 and 82100-82140 and 82200-82215, allied health professionals, dentists, and dental specialists, participating midwives and participating nurse practitioners must be

(a) registered according to State or Territory law or, absent such law, be members of a professional association with uniform national registration requirements; and

(b) registered with the Services Australia to provide these services.

### **GN.2.5 Provider Numbers**

Practitioners eligible to have Medicare benefits payable for their services and/or who for Medicare purposes wish to raise referrals for specialist services and requests for pathology or diagnostic imaging services, may apply *in writing* to Services Australia for a Medicare provider number for the locations where these services/referrals/requests will be provided. The form may be downloaded from the [Services Australia website](#).

For Medicare purposes, an account/receipt issued by a practitioner must include the practitioner's name and *either* the provider number for the location where the service was provided *or* the address where the services were provided.

Medicare provider number information is released in accord with the secrecy provisions of the *Health Insurance Act 1973* (section 130) to authorized external organizations including private health insurers, the Department of Veterans' Affairs and the Department of Health and Aged Care.

When a practitioner ceases to practice at a given location they must inform Medicare promptly. Failure to do so can lead to the misdirection of Medicare cheques and Medicare information.

### **GN.2.6 Locum tenens**

Where a locum tenens will be in a practice for more than two weeks *or* in a practice for less than two weeks but on a regular basis, the locum should apply for a provider number for the relevant location. If the locum will be in a practice for less than two weeks and will not be returning there, they should contact Services Australia (provider liaison - 132 150) to discuss their options (for example, use one of the locum's other provider numbers).

A locum must use the provider number allocated to the location if

(a) they are an approved general practice or specialist trainee with a provider number issued for an approved training placement; or

(b) they are associated with an approved rural placement under Section 3GA of the *Health Insurance Act 1973*; or

(c) they have access to Medicare benefits as a result of the issue of an exemption under section 19AB of the *Health Insurance Act 1973* (i.e. they have access to Medicare benefits at specific practice locations); or

(d) they will be at a practice which is participating in the Practice Incentives Program; or

(e) they are associated with a placement on the MedicarePlus for Other Medical Practitioners (OMPs) program, the After Hours OMPs program, the Rural OMPs program or Outer Metropolitan OMPs program.

### **GN.2.7 Overseas trained doctor**

Ten year moratorium

Section 19AB of the *Health Insurance Act 1973* states that services provided by overseas trained doctors (including New Zealand trained doctors) and former overseas medical students trained in Australia, will not attract Medicare benefits for 10 years from either

- a. their date of registration as a medical practitioner for the purposes of the *Health Insurance Act 1973*; or
- b. their date of permanent residency (the reference date will vary from case to case).

Exclusions - Practitioners who before 1 January 1997 had

- a. registered with a State or Territory medical board and retained a continuing right to remain in Australia; or
- b. lodged a valid application with the Australian Medical Council (AMC) to undertake examinations whose successful completion would normally entitle the candidate to become a medical practitioner.

The Minister of Health and Ageing may grant an overseas trained doctor (OTD) or occupational trainee (OT) an exemption to the requirements of the ten year moratorium, with or without conditions. When applying for a Medicare provider number, the OTD or OT must

- a. demonstrate that they need a provider number and that their employer supports their request; and
- b. provide the following documentation:
  - i. Australian medical registration papers; and
  - ii. a copy of their personal details in their passport and all Australian visas and entry stamps; and
  - iii. a letter from the employer stating why the person requires a Medicare provider number and/or prescriber number is required; and
  - iv. a copy of the employment contract.

### **GN.2.8 Contact details for Services Australia**

The day-to-day administration and payment of benefits under the Medicare arrangements is the responsibility of Services Australia.

#### **Changes to Provider Contact Details**

It is important that you contact Services Australia promptly of any changes to your preferred contact details. Your preferred mailing address is used to contact you about Medicare provider matters. We require requests for changes to your preferred contact details to be made by the provider in writing to Services Australia at:

Medicare

GPO Box 9822

in your capital city

or

the Medicare Provider telephone line on 132 150.

You may also be able to update some provider details through HPOS <http://www.servicesaustralia.gov.au/hpos>

### **GN.3.9 Patient eligibility for Medicare services**

This note sets out who can access Medicare services.

#### **ELIGIBLE GROUPS**

To be eligible for Medicare, a person must ordinarily live in Australia, be located in Australia at the time of the service, and be:

- an Australian citizen
- an Australian permanent resident
- a New Zealand citizen
- a Resident Return visa holder
- an applicant for permanent residency ([conditions apply](#)) or
- a temporary visa holder covered by a [Ministerial Order](#).

Ministerial Orders made under Section 6(1) of the [Health Insurance Act 1973](#) grant eligibility to groups including Australian citizens who have been absent from Australia for up to five years and holders of particular temporary visa types.

**Note:** access to Medicare by visitors to Australia who are covered by a Reciprocal Health Care Agreement is subject to the specific conditions of each Agreement (see below).

### **ENROLLING IN MEDICARE**

The patient must enrol with Medicare before receiving Medicare benefits. Once enrolled, they will receive a Medicare Card. There are three types of Medicare cards, in the following colours:

**Green** – this is the standard Medicare card for Australian citizens, permanent residents and New Zealand citizens living in Australia and Resident Return visa holders.

**Blue** – this is the card for people who have applied for permanent residence or who hold a temporary visa covered by a Ministerial Order.

**Yellow** – this is the card for visitors to Australia from a country with a Reciprocal Health Care Agreement.

More information about enrolling in Medicare and the different Medicare cards is available from [Services Australia](#).

### **RECIPROCAL HEALTH CARE AGREEMENTS**

Under Section 7 of the [Health Insurance Act 1973](#), the Australian Government has agreements with 11 other governments to cover the cost of certain medical care when Australians and overseas residents visit each other's countries.

Eligible overseas visitors from these countries generally receive:

- inpatient/outpatient services as a public patient in a public hospital
- out of hospital care
- Pharmaceutical Benefits Scheme (PBS) prescription medicines

**Exceptions:** Visitors from New Zealand and Ireland are entitled to public hospital care and PBS drugs only (not MBS services).

Reciprocal Health Care Agreements do not cover the cost of treatment as a private patient in a public or private hospital.

People visiting Australia for the specific purpose of receiving medical treatment are not covered.

**Eligible Countries:**

As at 1 February 2024, Australia has Reciprocal Health Care Agreements with the following countries:

- Belgium
- Finland
- Italy (eligibility limited to six months from date of arrival)
- Malta (eligibility limited to six months from date of arrival)
- Netherlands
- New Zealand (public hospital care and PBS medicines only, not MBS services)
- Norway
- Ireland (public hospital care and PBS medicines only, not MBS services)
- Slovenia
- Sweden
- United Kingdom

Eligible patients from these countries need to enrol in Medicare to access MBS services. Once enrolled they will have a yellow Medicare card.

- Visitors from New Zealand and Ireland do not need to enrol in Medicare to access public hospital services and PBS medicines under the Reciprocal Health Care Agreements. They are not eligible for MBS services unless they hold a green Medicare card.

More information about access to medical care under each Reciprocal Health Care Agreement is available from [Services Australia](#).

**OTHER VISITORS AND TEMPORARY RESIDENTS**

Other visitors and temporary residents are not eligible for Medicare and should arrange private health insurance cover.

**RELEVANT LEGISLATION**

Information about the legislative arrangements applying to Medicare and the Reciprocal Health Care Agreements is set out in the [Health Insurance Act 1973](#), which can be found on the [Federal Register of Legislation](#).

**GN.4.13 Who can use the Medicare Benefits Schedule GP items?**

**SUMMARY**

This general note sets out which medical practitioners can use the MBS general practitioner (GP) items.

Medical practitioners that are eligible to provide Medicare services who are not GPs but provide services in a general practice setting can use the medical practitioner and [prescribed medical practitioner](#) (explanatory note [AN.7.1](#)) MBS items.

## **WHO CAN USE THE MBS GP ITEMS?**

The [Health Insurance Act 1973](#) (the Act), and legal instruments made under the Act, set out which medical practitioners can claim MBS GP items. The four categories of medical practitioner that can access MBS GP items are those that are:

1. Fellows of a General Practice College
2. On an approved placement in a general practice training program
3. Listed on the Vocational Register of GPs (closed to new participants)
4. Eligible non-VR GPs (closed to new participants)

Before you can claim MBS GP items you must have a Medicare provider number for the location at which you are practising. You can apply for a Medicare provider number through [Services Australia](#).

### **1. Medical practitioners who are fellows of a General Practice College**

Medical practitioners that are fellows of either the:

- Australian College of Rural and Remote Medicine (ACRRM), or
- Royal Australian College of GPs (RACGP)

are GPs for MBS purposes.

Services Australia uses the Australian Health Practitioner Regulation Agency (Ahpra) [Register of Medical Practitioners](#) to determine practitioners' access to the GP items. Fellows of the RACGP and ACRRM must hold specialist registration as a GP with the [Medical Board of Australia](#) to access the GP items. The Ahpra registration for these medical practitioners will indicate that they are a specialist in the field of general practice.

### **2. Medical practitioners on an Approved Placement in a general practice training program**

Section 1.1.3 of the [Health Insurance \(General Medical Services Table\) Regulations 2021](#) provides access to the MBS GP items to medical practitioners undertaking an approved training placement. That is, a training placement that will lead to fellowship with the RACGP or ACCRM.

- For more information on approved training placements see the [General Practice Fellowship Program Placement Guidelines](#).

Your placement organisation must advise [Services Australia](#) of the placement before MBS GP items can be accessed.

### **3. Medical practitioners on the Vocational Register of GPs**

The Vocational Register of GPs closed to new participants on 16 June 2021.

Section 16 of the [Health Insurance Regulation 2018](#) allows medical practitioners whose names are entered onto the Vocational Register of GPs to access MBS GP items provided they continue to be registered with Ahpra.

### **4. Eligible non-vocationally recognised medical practitioners**

The programs below closed to new participants on 1 January 2019.

Section 1.1.2 of the [Health Insurance \(General Medical Services Table\) Regulations 2021](#) specifies which non-vocationally recognised medical practitioners can access MBS GP items:

1. Medical practitioners who have been notified by the Chief Executive of Medicare that they have completed the requirements of the MedicarePlus for Other Medical Practitioners Program before 31 December 2023.
2. Participants in the [Other Medical Practitioners Extension Program](#) who were enrolled in one of the following programs as at 30 June 2023:
  - a. After Hours Other Medical Practitioner Program
  - b. Outer Metropolitan Other Medical Practitioner Program
  - c. Rural Other Medical Practitioner Program

## **RELEVANT LEGISLATION**

Details of the legislative arrangements applying to the categories of medical practitioners able to use the MBS GP items can be found on the [Federal Register of Legislation](#), and are set out in three regulatory instruments:

- [Health Insurance Act 1973](#)
- [Health Insurance \(General Medical Services Table\) Regulations 2021](#)
- [Health Insurance Regulations 2018](#)

### **GN.5.14 Recognition as a Specialist or Consultant Physician**

A medical practitioner who:

- is registered as a specialist under State or Territory law; or
- holds a fellowship of a specified specialist College and has obtained, after successfully completing an appropriate course of study, a relevant qualification from a relevant College

and has formally applied and paid the prescribed fee, may be recognised by the Minister as a specialist or consultant physician for the purposes of the *Health Insurance Act 1973*.

A relevant specialist College may also give Services Australia's Chief Executive Officer a written notice stating that a medical practitioner meets the criteria for recognition.

A medical practitioner who is training for a fellowship of a specified specialist College and is undertaking training placements in a private hospital or in general practice, may provide services which attract Medicare benefits. Specialist trainees should consult the information available at [Services Australia's Medicare website](#).

Once the practitioner is recognised as a specialist or consultant physician for the purposes of the *Health Insurance Act 1973*, Medicare benefits will be payable at the appropriate higher rate for services rendered in the relevant speciality, provided the patient has been appropriately referred to them.

Further information about applying for recognition is available at [Services Australia Medicare website](#).

Services Australia (SA), in consultation with the Department of Health and Aged Care, has developed a [Health Practitioner Guideline to substantiate that a valid referral existed \(specialist or consultant physician\)](#) which is located on the Department of Health and Aged Care website.

### **GN.5.15 Emergency Medicine**

A practitioner will be acting as an emergency medicine specialist when treating a patient within 30 minutes of the patient's presentation, and that patient is

- (a) at risk of serious morbidity or mortality requiring urgent assessment and resuscitation; or

- (b) suffering from suspected acute organ or system failure; or
- (c) suffering from an illness or injury where the viability or function of a body part or organ is acutely threatened; or
- (d) suffering from a drug overdose, toxic substance or toxin effect; or
- (e) experiencing severe psychiatric disturbance whereby the health of the patient or other people is at immediate risk; or
- (f) suffering acute severe pain where the viability or function of a body part or organ is suspected to be acutely threatened; or
- (g) suffering acute significant haemorrhage requiring urgent assessment and treatment; and
- (h) treated in, or via, a bona fide emergency department in a hospital.

Benefits are not payable where such services are rendered in the accident and emergency departments or outpatient departments of public hospitals.

#### **GN.5.16 Conjoint Committee for recognising training in Micro Bypass Glaucoma Surgery (MBGS)**

The Conjoint Committee comprises representatives from the Australian and New Zealand Glaucoma Society (ANZGS) and the Royal Australian and New Zealand College of Ophthalmologists (RANZCO). For the purposes of MBS item 42504, specialists performing this procedure must have certification and training recognised by the Conjoint Committee for the Recognition of Training in Micro-Bypass Glaucoma Surgery, and Services Australia notified of that recognition.

#### **GN.6.16 Referral Of Patients To Specialists Or Consultant Physicians**

For certain services provided by specialists and consultant physicians, the Medicare benefit payable is dependent on acceptable evidence that the service has been provided following referral from another practitioner.

A reference to a referral in this Section does not refer to written requests made for pathology services or diagnostic imaging services. Information about the form of a diagnostic imaging request can be found in **Note IN.0.6** of the Diagnostic Imaging Services Table (Category 5) and information about the form of a pathology request can be found in **Note PN.2.1** of the Pathology Services Table (Category 6).

#### **What is a Referral?**

A "referral" 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 the exceptions in the paragraph below, 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 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.

The exceptions to the requirements in paragraph above are that

(a) sub-paragraphs (i), (ii) and (iii) do not apply to

- a pre-anaesthesia consultation by a specialist anaesthetist (items 16710-17625);

(b) sub-paragraphs (ii) and (iii) do not apply to

- a referral generated during an episode of hospital treatment, for a service provided or arranged by that hospital, where the hospital records provide evidence of a referral (including the referring practitioner's signature); or
- an emergency where the referring practitioner or the specialist or the consultant physician was of the opinion that the service be rendered as quickly as possible; and

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

### **Examination by Specialist Anaesthetists**

A referral is not required in the case of pre-anaesthesia consultation items 17610-17625. However, for benefits to be payable at the specialist rate for consultations, other than pre-anaesthesia consultations by specialist anaesthetists (items 17640 -17655) a referral is required.

### **Who can Refer?**

The general practitioner is regarded as the primary source of referrals. Cross-referrals between specialists and/or consultant physicians should usually occur in consultation with the patient's general practitioner.

### **Referrals by Dentists or Optometrists or Participating Midwives or Participating Nurse Practitioners**

For Medicare benefit purposes, a referral may be made to

(i) a recognised specialist:

(a) by a registered dental practitioner, where the referral arises from a dental service; or

(b) by a registered optometrist where the specialist is an ophthalmologist; or

(c) by a participating midwife where the specialist is an obstetrician or a paediatrician, as clinical needs dictate. A referral given by a participating midwife is valid until 12 months after the first service given in accordance with the referral and for I pregnancy only or

(d) by a participating nurse practitioner to specialists and consultant physicians. A referral given by a participating nurse practitioner is valid until 12 months after the first service given in accordance with the referral.

(ii) a consultant physician, by an approved dental practitioner (oral surgeon), where the referral arises out of a dental service.

In any other circumstances (i.e. a referral to a consultant physician by a dentist, other than an approved oral surgeon, or an optometrist, or a referral by an optometrist to a specialist other than a specialist ophthalmologist), it is not a valid referral. Any resulting consultant physician or specialist attendances will attract Medicare benefits at unreferred rates.

Registered dentists and registered optometrists may refer themselves to specialists in accordance with the criteria above, and Medicare benefits are payable at the levels which apply to their referred patients.

### **Billing**

#### ***Routine Referrals***



In addition to providing the usual information required to be shown on accounts, receipts or assignment forms, specialists and consultant physicians must provide the following details (unless there are special circumstances as indicated in paragraph below):-

- name and either practice address or provider number of the referring practitioner;
- date of referral; and
- period of referral (when other than for 12 months) expressed in months, eg "3", "6" or "18" months, or "indefinitely" should be shown.

### ***Special Circumstances***

#### *(i) Lost, stolen or destroyed referrals.*

If a referral has been made but the letter or note of referral has been lost, stolen or destroyed, benefits will be payable at the referred rate if the account, receipt or the assignment form shows the name of the referring medical practitioner, the practice address or provider number of the referring practitioner (if either of these are known to the consultant physician or specialist) and the words 'Lost referral'. This provision only applies to the initial attendance. For subsequent attendances to attract Medicare benefits at the referred rate a duplicate or replacement letter of referral must be obtained by the specialist or the consultant physician.

#### *(ii) Emergencies*

If the referral occurred in an emergency, benefit will be payable at the referred rate if the account, receipt or assignment form is endorsed 'Emergency referral'. This provision only applies to the initial attendance. For subsequent attendances to attract Medicare benefits at the referred rate the specialist/consultant physician must obtain a letter of referral.

#### *(iii) Hospital referrals.*

Private Patients - Where a referral is generated during an episode of hospital treatment for a service provided or arranged by that hospital, benefits will be payable at the referred rate if the account, receipt or assignment form is endorsed 'Referral within (name of hospital)' and the patient's hospital records show evidence of the referral (including the referring practitioner's signature). However, in other instances where a medical practitioner within a hospital is involved in referring a patient (e.g. to a specialist or a consultant physician in private rooms) the normal referral arrangements apply, including the requirement for a referral letter or note and its retention by the specialist or the consultant physician billing for the service.

### ***Public Hospital Patients***

State and Territory Governments are responsible for the provision of public hospital services to eligible persons in accordance with the National Healthcare Agreement.

### ***Bulk Billing***

Bulk billing assignment forms should show the same information as detailed above. However, faster processing of the claim will be facilitated where the provider number (rather than the practice address) of the referring practitioner is shown.

### ***Period for which Referral is Valid***

The referral is valid for the period specified in the referral which is taken to commence on the date of the specialist's or consultant physician's first service covered by that referral.

### ***Specialist Referrals***

Where a referral originates from a specialist or a consultant physician, the referral is valid for 3 months, 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 and ceases when the patient is discharged.

A referral for a specialist professional service to a patient in a hospital who is not a public patient is valid until the patient ceases to be a patient in the hospital.

As it is expected that the patient's general practitioner will be kept informed of the patient's progress, a referral from a specialist or a consultant physician must include the name of the patient's general practitioners and/or practice. Where a patient is unable or unwilling to nominate a general practitioner or practice this must be stated in the referral.

### ***Referrals by other Practitioners***

Where the referral originates from a practitioner other than those listed in *Specialist Referrals*, 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 (eg. 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.

### **Definition of a Single Course of Treatment**

A single course of treatment involves an initial attendance by a specialist or consultant physician and the continuing management/treatment up to the stage where the patient is referred back to the care of the referring practitioner. It also includes any subsequent review of the patient's condition by the specialist or the consultant physician that may be necessary. Such a review may be initiated by either the referring practitioner or the specialist/consultant physician.

The presentation of an unrelated illness, requiring the referral of the patient to the specialist's or the consultant physician's care would initiate a new course of treatment in which case a new referral would be required.

The receipt by a specialist or consultant physician 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 involving the itemisation of an initial consultation. In the continuing management/treatment situation the new referral is to facilitate the payment of benefits at the specialist or the consultant physician referred rates rather than the unreferral rates.

However, where the referring practitioner:-

- (a) deems it necessary for the patient's condition to be reviewed; and
- (b) the patient is seen by the specialist or the consultant physician outside the currency of the last referral; and
- (c) the patient was last seen by the specialist or the consultant physician more than 9 months earlier

the attendance following the new referral initiates a new course of treatment for which Medicare benefit would be payable at the initial consultation rates.

### **Retention of Referral Letters**

The prima facie evidence that a valid referral exists is the provision of the referral particulars on the specialist's or the consultant physician's account.

A specialist or a consultant physician is required to retain the instrument of referral (and a hospital is required to retain the patient's hospital records which show evidence of a referral) for 2 years from the date the service was rendered.

A specialist or a consultant physician is required, if requested by the Services Australia CEO, to produce to a medical practitioner who is an employee of Services Australia, the instrument of referral within seven days after the request is received. Where the referral originates in an emergency situation or in a hospital, the specialist or consultant physician is required to produce such information as is in his or her possession or control relating to whether the patient was so treated.

### **Attendance for Issuing of a Referral**

Medicare benefit is attracted for an attendance on a patient even where the attendance is solely for the purpose of issuing a referral letter or note. However, if a medical practitioner issues a referral without an attendance on the patient, no benefit is payable for any charge raised for issuing the referral.

### **Locum-tenens Arrangements**

It should be noted that where a non-specialist medical practitioner acts as a locum-tenens for a specialist or consultant physician, or where a specialist acts as a locum-tenens for a consultant physician, Medicare benefit is only payable at the level appropriate for the particular locum-tenens, eg, general practitioner level for a general practitioner locum-tenens and specialist level for a referred service rendered by a specialist locum tenens.

Medicare benefits are not payable where a practitioner is not eligible to provide services attracting Medicare benefits acts as a locum-tenens for any practitioner who is eligible to provide services attracting Medicare benefits.

Fresh referrals are not required for locum-tenens acting according to accepted medical practice for the principal of a practice ie referrals to the latter are accepted as applying to the former and benefit is not payable at the initial attendance rate for an attendance by a locum-tenens if the principal has already performed an initial attendance in respect of the particular instrument of referral.

### **Self Referral**

Medical practitioners may refer themselves to consultant physicians and specialists and Medicare benefits are payable at referred rates.

### **GN.7.17 Billing procedures**

The Services Australia website contains information on Medicare billing and claiming options. Please visit the [Services Australia](#) website for further information.

#### Bulk billing

Under the *Health Insurance Act 1973*, a bulk billing facility for professional services is available to all persons in Australia who are eligible for a benefit under the Medicare program. If a practitioner bulk bills for a service the practitioner undertakes to accept the relevant Medicare benefit as full payment for the service. Additional charges for that service cannot be raised. This includes but is not limited to:

- any consumables that would be reasonably necessary to perform the service, including bandages and/or dressings;
- record keeping fees;
- a booking fee to be paid before each service, or;
- an annual administration or registration fee.

Where the patient is bulk billed, an additional charge can **only** be raised against the patient by the practitioner where the patient is provided with a vaccine or vaccines from the practitioner's own supply held on the practitioner's premises. This exemption only applies to general practitioners and other non-specialist practitioners in association with attendance items **3 to 96, 179 to 212, 733 to 789 and 5000 to 5267** (inclusive) and only relates to vaccines that are not available to the patient free of charge through Commonwealth or State funding arrangements or available through the Pharmaceutical Benefits Scheme. The additional charge must only be to cover the supply of the vaccine.

Where a practitioner provides a number of services (excluding operations) on the one occasion, they can choose to bulk bill some or all of those services and privately charge a fee for the other service (or services), in excess of the Medicare rebate. The privately charged fee can only be charged in relation to said service (or services). Where two or more operations are provided on the one occasion, all services must be either bulk billed or privately charged.

It should be noted that, where a service is not bulk billed, a practitioner may privately raise an additional charge against a patient, such as for a consumable. An additional charge can also be raised where a practitioner does not bulk bill a patient but instead charges a fee that is equal to the rebate for the Medicare service. For example, where a general practitioner provides a professional service to which item 23 relates the practitioner could, in place of bulk billing the patient, charge the rebate for the service and then also raise an additional charge (such as for a consumable).

### **GN.8.18 Provision for review of individual health professionals**

The Professional Services Review (PSR) reviews and investigates service provision by health practitioners to determine if they have engaged in inappropriate practice when rendering or initiating Medicare services, or when prescribing or dispensing under the PBS.

Section 82 of the *Health Insurance Act 1973* defines inappropriate practice as conduct that is such that a PSR Committee could reasonably conclude that it would be unacceptable to the general body of the members of the profession in which the practitioner was practicing when they rendered or initiated the services under review. It is also an offence under Section 82 for a person or officer of a body corporate to knowingly, recklessly or negligently cause or permit a practitioner employed by the person to engage in such conduct.

Services Australia monitors health practitioners' claiming patterns. Where Services Australia detects an anomaly, it may request the Director of PSR to review the practitioner's service provision. On receiving the request, the Director must decide whether to conduct a review and in which manner the review will be conducted. The Director is authorized to require that documents and information be provided.

Following a review, the Director must:

decide to take no further action; or

enter into an agreement with the person under review (which must then be ratified by an independent Determining Authority); or

refer the matter to a PSR Committee.

A PSR Committee normally comprises three medically qualified members, two of whom must be members of the same profession as the practitioner under review. However, up to two additional Committee members may be appointed to provide wider range of clinical expertise.

The Committee is authorized to:

investigate any aspect of the provision of the referred services, and without being limited by the reasons given in the review request or by a Director's report following the review;

hold hearings and require the person under review to attend and give evidence;

require the production of documents (including clinical notes).

The methods available to a PSR Committee to investigate and quantify inappropriate practice are specified in legislation:

**(a) Patterns of Services** - The *Health Insurance (Professional Services Review) Regulations 1999* specify that when a general practitioner or other medical practitioner reaches or exceeds 80 or more attendances on each of 20 or more days in a 12-month period, they are deemed to have practiced inappropriately.

A professional attendance means a service of a kind mentioned in group A1, A2, A5, A6, A7, A9, A11, A13, A14, A15, A16, A17, A18, A19, A20, A21, A22 or A23 of Part 3 of the General Medical Services Table.

If the practitioner can satisfy the PSR Committee that their pattern of service was as a result of exceptional circumstances, the quantum of inappropriate practice is reduced accordingly. Exceptional circumstances include, but are not limited to, those set out in the *Regulations*. These include:

an unusual occurrence;

the absence of other medical services for the practitioner's patients (having regard to the practice location); and

the characteristics of the patients.

**(b) Sampling** - A PSR Committee may use statistically valid methods to sample the clinical or practice records.

**(c) Generic findings** - If a PSR Committee cannot use patterns of service or sampling (for example, there are insufficient medical records), it can make a 'generic' finding of inappropriate practice.

#### **Additional Information**

A PSR Committee may not make a finding of inappropriate practice unless it has given the person under review notice of its intention to review them, the reasons for its findings, and an opportunity to respond. In reaching their decision, a PSR Committee is required to consider whether or not the practitioner has kept adequate and contemporaneous patient records (See general explanatory note G15.1 for more information on adequate and contemporaneous patient records).

The practitioner under review is permitted to make submissions to the PSR Committee before key decisions or a final report is made.

If a PSR Committee finds that the person under review has engaged in inappropriate practice, the findings will be reported to the Determining Authority to decide what action should be taken:

**(i)** a reprimand;

**(ii)** counselling;

**(iii)** repayment of Medicare benefits; and/or

**(iv)** complete or partial disqualification from Medicare benefit arrangements for up to three years.

Further information is available from the PSR website - [www.psr.gov.au](http://www.psr.gov.au)

#### **GN.8.19 Medicare Participation Review Committee**

The Medicare Participation Review Committee determines what administrative action should be taken against a practitioner who:

(a) has been successfully prosecuted for relevant criminal offences;

(b) has breached an Approved Pathology Practitioner undertaking;

(c) has engaged in prohibited diagnostic imaging practices; or

(d) has been found to have engaged in inappropriate practice under the Professional Services Review scheme and has received Final Determinations on two (or more) occasions.

The Committee can take no further action, counsel or reprimand the practitioner, or determine that the practitioner be disqualified from Medicare for a particular period or in relation to particular services for up to five years.

Medicare benefits are not payable in respect of services rendered by a practitioner who has been fully disqualified, or partly disqualified in relation to relevant services under the *Health Insurance Act 1973* (Section 19B applies).

#### **GN.8.20 Referral of professional issues to regulatory and other bodies**

The *Health Insurance Act 1973* provides for the following referral, to an appropriate regulatory body:

- i. a significant threat to a person's life or health, when caused or is being caused or is likely to be caused by the conduct of the practitioner under review; or
- ii. a statement of concerns of non-compliance by a practitioner with 'professional standards'.

#### **GN.8.21 Comprehensive Management Framework for the MBS**

The Government announced the Comprehensive Management Framework for the MBS in the 2011-12 Budget to improve MBS management and governance into the future. As part of this framework, the Medical Services Advisory Committee (MSAC) Terms of Reference and membership have been expanded to provide the Government with independent expert advice on all new proposed services to be funded through the MBS, as well as on all proposed amendments to existing MBS items. Processes developed under the previously funded MBS Quality Framework are now being integrated with MSAC processes under the Comprehensive Management Framework for the MBS.

#### **GN.8.22 Medical Services Advisory Committee**

The Medical Services Advisory Committee (MSAC) advises the Minister on the strength of evidence relating to the safety, effectiveness and cost effectiveness of new and emerging medical services and technologies and under what circumstances public funding, including listing on the MBS, should be supported.

MSAC members are appointed by the Minister and include specialist practitioners, general practitioners, health economists, a health consumer representative, health planning and administration experts and epidemiologists.

For more information on the MSAC refer to their website - [www.msac.gov.au](http://www.msac.gov.au) or email on [msac.secretariat@health.gov.au](mailto:msac.secretariat@health.gov.au) or by phoning the MSAC secretariat on (02) 6289 7550.

#### **GN.8.23 Pathology Services Table Committee**

This Pathology Services Table Committee comprises six representatives from the interested professions and six from the Australian Government. Its primary role is to advise the Minister on the need for changes to the structure and content of the Pathology Services Table (except new medical services and technologies) including the level of fees.

#### **GN.9.25 Penalties and Liabilities**

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

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

#### **GN.10.26 Schedule fees and Medicare benefits**

Medicare benefits are based on fees determined for each medical service. The fee is referred to in these notes as the "Schedule fee". The fee for any item listed in the MBS is that which is regarded as being reasonable on average for

that service having regard to usual and reasonable variations in the time involved in performing the service on different occasions and to reasonable ranges of complexity and technical difficulty encountered.

The Schedule fee and Medicare benefit levels for the medical services contained in the MBS are located with the item descriptions. Where appropriate, the calculated benefit has been rounded to the nearest higher 5 cents. However, in no circumstances will the Medicare benefit payable exceed the fee actually charged.

There are presently three levels of Medicare benefit payable:

- a. 75% of the Schedule fee:
  - i. for professional services rendered to a patient as part of an episode of hospital treatment (other than services provided to public patients). Medical practitioners must indicate on their accounts if a medical service is rendered in these circumstances by placing an asterisk '\*' or the letter 'H' directly after an item number where used; or a description of the professional service and an indication the service was rendered as an episode of hospital treatment (for example, 'in hospital', 'hospital outpatient service', 'admitted' or 'in patient'). Certain services are not generally considered hospital treatments – see GN1.2;
  - ii. for professional services rendered as part of an episode of hospital-substitute treatment, and the patient who receives the treatment chooses to receive a benefit from a private health insurer. Medical practitioners must indicate on their accounts if a medical service is rendered in these circumstances by placing the words 'hospital-substitute treatment' directly after an item number where used; or a description of the professional service, preceded by the words 'hospital-substitute treatment'. Certain services are not generally considered hospital treatments – see GN1.2.
- b. 100% of the Schedule fee for non-referred attendances by general practitioners to non-admitted patients and services provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner on behalf of a general practitioner – see GN1.2 for exceptions.
- c. 85% of the Schedule fee, or the Schedule fee less \$98.70 (indexed annually in November), whichever is the greater, for all other professional services.

Public hospital services are to be provided free of charge to eligible persons who choose to be treated as public patients in accordance with the 2020-2025 Addendum to the National Health Reform Agreement.

Where a Medicare item with multiple components is provided, and some components are provided in the hospital and the remainder outside of the hospital (e.g. aftercare), the 75% benefit level applies. With regard to obstetric items, benefits would be attracted at the 75% level where the confinement takes place in hospital.

Pathology tests performed after discharge from hospital on bodily specimens taken during hospitalisation also attract the 75% level of benefits if not a type of item specified in GN1.2 as not generally being a hospital treatment.

It should be noted that private health insurers can cover the "patient gap" (that is, the difference between the Medicare rebate and the Schedule fee) for services attracting benefits at the 75% level. Patients may insure with private health insurers for the gap between the 75% Medicare benefits and the Schedule fee or for amounts in excess of the Schedule fee where the doctor has an arrangement with their health insurer.

### **GN.10.27 Medicare Safety Nets**

The Medicare Safety Nets provide families and individuals with an additional rebate for out-of-hospital Medicare services, once annual thresholds are reached. There are two safety nets: the Original Medicare Safety Net (OMSN) and the Extended Medicare Safety Net (EMSN).

Original Medicare Safety Net:

Under the OMSN, the Medicare benefit for out-of-hospital services is increased to 100% of the Schedule Fee (up from 85%) once an annual threshold in gap costs is reached. Gap costs refer to the difference between the Medicare benefit (85%) and the Schedule Fee. The threshold from 1 January 2024 is \$560.40. This threshold applies to all Medicare-eligible individuals and families.

### Extended Medicare Safety Net:

Under the EMSN, once an annual threshold in out-of-pocket costs for out-of-hospital Medicare services is reached, Medicare will pay for up to 80% of any future out-of-pocket costs for out-of-hospital Medicare services for the remainder of the calendar year. However, where the item has an EMSN benefit cap, there is a maximum limit on the EMSN benefit that will be paid for that item. Further explanation about EMSN benefit caps is provided below. Out-of-pocket costs refer to the difference between the Medicare benefit and the fee charged by the practitioner.

In 2024, the threshold for concessional individuals and families, including families that received Family Tax Benefit Part (A), is \$811.80. The threshold for all other (non-concessional) individuals and families in 2024 is \$2544.30.

The thresholds for both safety nets are indexed on 1 January each year in line with the Consumer Price Index (CPI).

Individuals are automatically registered with Services Australia for the safety nets. Families (including couples) are required to register in order to be recognised as a family for the purposes of the safety nets. In most cases, registered families have their expenses combined to reach the safety net thresholds. This may help to qualify for safety net benefits more quickly. Registration forms can be completed online at <https://www.servicesaustralia.gov.au/individuals/services/medicare/medicare-safety-nets>.

### EMSN Benefit Caps:

The EMSN benefit cap is the maximum EMSN benefit payable for that item and is paid in addition to the standard Medicare rebate. Where there is an EMSN benefit cap in place for the item, the amount of the EMSN cap is displayed in the item descriptor. Once the EMSN threshold is reached, each time the item is claimed the patient is eligible to receive up to the EMSN benefit cap. In other words, once the patient reaches the EMSN threshold, they will receive either 80% of their out-of-pocket costs back or the EMSN cap amount, whichever is the lower amount.

For example: Item A has a Schedule fee of \$100, the out-of-hospital benefit is \$85 (85% of the Schedule fee). The EMSN benefit cap is \$30. Assuming that the patient has reached the EMSN threshold:

- o If the fee charged by the doctor for Item A is \$125, the standard Medicare rebate is \$85, with an out-of-pocket cost of \$40. The EMSN benefit is calculated as  $\$40 \times 80\% = \$32$ . However, as the EMSN benefit cap is \$30, only \$30 will be paid.
- o If the fee charged by the doctor for Item A is \$110, the standard Medicare rebate is \$85, with an out-of-pocket cost of \$25. The EMSN benefit is calculated as  $\$25 \times 80\% = \$20$ . As this is less than the EMSN benefit cap, the full \$20 is paid.

### **GN.11.28 Services not listed in the MBS**

Benefits are not generally payable for services not listed in the MBS. However, there are some procedural services which are not specifically listed because they are regarded as forming part of a consultation or else attract benefits on an attendance basis. For example, intramuscular injections, aspiration needle biopsy, treatment of sebhorreic keratoses and less than 10 solar keratoses by ablative techniques and closed reduction of the toe (other than the great toe).

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

If you have a query relating exclusively to interpretation of the Schedule, you should email <mailto:askmbs@health.gov.au>



### **GN.11.29 Ministerial Determinations**

Section 3C of the *Health Insurance Act 1973* empowers the Minister to determine an item and Schedule fee (for the purposes of the Medicare benefits arrangements) for a service not included in the health insurance legislation. This provision may be used to facilitate payment of benefits for new developed procedures or techniques where close monitoring is desirable. Services which have received section 3C approval are located in their relevant Groups in the MBS with the notation "**(Ministerial Determination)**".

### **GN.12.30 Professional services**

Professional services which attract Medicare benefits include medical services rendered by or "on behalf of" a medical practitioner. The latter include services where a part of the service is performed by a technician employed by or, in accordance with accepted medical practice, acting under the supervision of the medical practitioner.

The following medical services will attract benefits only if they have been personally performed by a medical practitioner on not more than one patient on the one occasion (i.e. two or more patients cannot be attended simultaneously, although patients may be seen consecutively), unless a group session is involved (i.e. Items 170-172). The requirement of "personal performance" is met whether or not essential assistance is provided, according to accepted medical practice:-

- (a) Category 1 (Professional Attendances) items except 170-172, 342-346, 820-880, 6029-6042, 6064-6075;
- (b) Each of the following items in Group D1 (Miscellaneous Diagnostic):- 11012, 11015, 11018, 11021, 11304, 11600, 11627, 11705, 11724, 11728, 11729, 11730, 11731, 11921, 12000, 12003;
- (c) All Group T1 (Miscellaneous Therapeutic) items (except 13020, 13025, 13200-13206, 13212-13221, 13703, 13706, 13750-13760, 13950, 14050, 14221 and 14245);
- (d) Item 15600 in Group T2 (Radiation Oncology);
- (e) All Group T3 (Therapeutic Nuclear Medicine) items;
- (f) All Group T4 (Obstetrics) items (except 16400 and 16514);
- (g) All Group T6 (Anaesthetics) items;
- (h) All Group T7 (Regional or Field Nerve Block) items;
- (i) All Group T8 (Operations) items;
- (j) All Group T9 (Assistance at Operations) items;
- (k) All Group T10 (Relative Value Guide for Anaesthetics) items.

For the group psychotherapy and family group therapy services covered by Items 170, 171, 172, 342, 344 and 346, benefits are payable only if the services have been conducted personally by the medical practitioner.

Medicare benefits are not payable for these group items or any of the items listed in (a) - (k) above when the service is rendered by a medical practitioner employed by the proprietor of a hospital (not being a private hospital), except where the practitioner is exercising their right of private practice, or is performing a medical service outside the hospital. For example, benefits are not paid when a hospital intern or registrar performs a service at the request of a staff specialist or visiting medical officer.

Medicare benefits are only payable for items 12306 - 12322 (Bone Densitometry) when the service is performed by a specialist or consultant physician in the practice of the specialist's or consultant physician's speciality where the patient is referred by another medical practitioner.

### **GN.12.31 Services rendered on behalf of medical practitioners**

Medical services in Categories 2 and 3 not included in GN.12.30 and Category 5 (Diagnostic Imaging) services continue to attract Medicare benefits if the service is rendered by:-

- (a) the medical practitioner in whose name the service is being claimed;
- (b) a person, other than a medical practitioner, who is employed by a medical practitioner or, in accordance with accepted medical practice, acts under the supervision of a medical practitioner.

See Category 6 Notes for Guidance for arrangements relating to Pathology services.

So that a service rendered by an employee or under the supervision of a medical practitioner may attract a Medicare rebate, the service must be billed in the name of the practitioner who must accept full responsibility for the service. All practitioners should ensure they maintain adequate and contemporaneous records. All elements of the service must be performed in accordance with accepted medical practice.

Supervision from outside of Australia is not acceptable.

While the supervising medical practitioner need not be present for the entire service, they must have a direct involvement in at least part of the service. Although the supervision requirements will vary according to the service in question, they will, as a general rule, be satisfied where the medical practitioner has:-

- (a) established consistent quality assurance procedures for the data acquisition; and
- (b) personally analysed the data and written the report.

Benefits are not payable for these services when a medical practitioner refers patients to self-employed medical or paramedical personnel, such as radiographers and audiologists, who either bill the patient or the practitioner requesting the service.

### **GN.12.32 Medicare benefits and vaccinations**

Where a medical practitioner administers an injection for immunisation purposes on the medical practitioner's own patient, Medicare benefits for that service would be payable on a consultation basis, that is, for the attendance at which the injection is given. However, the cost of the vaccine itself does not attract a Medicare rebate. The Medicare benefits arrangements cover only the professional component of the medical practitioner's service. There are some circumstances where a Medicare benefit is not payable when a medical practitioner administers an injection for immunisation purposes – please refer to example 3 below for further details.

#### **Example 1**

A patient presents to a GP to receive the influenza vaccination. The patient is not in the cohort of patients which is covered for the influenza vaccine under the NIP.

After taking a short patient history, the GP administers the vaccine to the patient. The GP has met the requirements of a level A consultation and claims item 3. The GP can bulk bill the patient for the cost of the MBS service and can charge a separate amount for the cost of the vaccine, which is not covered under the NIP.

If a patient presented to a GP to receive a vaccine and to enquire about a medical condition, the GP may claim the appropriate item (such as item 23).

#### **Example 2**

A patient presents to a GP to receive the influenza vaccination. The patient is in the cohort of patients which is covered for the influenza vaccine under the NIP.

After taking a short patient history, the GP administers the vaccine to the patient. The GP has met the requirements of a level A consultation and claims item 3. The GP can bulk bill the patient but does not need to charge a separate amount for the cost of the vaccine, which is covered under the NIP.

If a patient presented to a GP to receive a vaccine and to enquire about a medical condition, the GP may claim the appropriate item (such as item 23).

### **Example 3**

A GP is employed by a State or Territory community health centre to administer vaccines and provides no additional medical services.

A Medicare benefit is not payable as the GP is providing the service under an arrangement with the State or Territory, which is prohibited under subsection 19(2) of the *Health Insurance Act 1973*. The service is also prohibited on the basis that it is a mass immunisation which is prohibited under subsection 19(4).

A mass immunisation is a program to inoculate people that is funded by the Commonwealth or State Government, or through an international or private organisation.

## **GN.13.33 Services which do not attract Medicare benefits**

### **Medical services that do not attract Medicare benefits**

- (a) issue of repeat prescriptions when the patient does not attend the surgery in person;
- (b) group attendances (unless otherwise specified in the item, such as items 170, 171, 172, 342, 344 and 346);
- (c) non-therapeutic cosmetic surgery;
- (d) euthanasia and any service directly related to the procedure. However, services rendered for counselling/assessment about euthanasia will attract benefits.

### **Medicare benefits are not payable where the medical expenses for the service**

- (a) are paid/payable to a public hospital;
- (b) are for a compensable injury or illness for which the patient's insurer or compensation agency has accepted liability. (Please note that if the medical expenses relate to a compensable injury/illness for which the insurer/compensation agency is disputing liability, then Medicare benefits are payable until the liability is accepted.);
- (c) are for a medical examination for the purposes of life insurance, superannuation, a provident account scheme, or admission to membership of a friendly society;
- (d) are incurred in mass immunisation (see General Explanatory Note 12.3 for further explanation).

### **Unless the Minister otherwise directs**

Medicare benefits are not payable where:

- (a) the service is rendered by or on behalf of, or under an arrangement with the Australian Government, a State or Territory, a local government body or an authority established under Commonwealth, State or Territory law;
- (b) the medical expenses are incurred by the employer of the person to whom the service is rendered;
- (c) the person to whom the service is rendered is employed in an industrial undertaking and that service is rendered for the purposes related to the operation of the undertaking; or
- (d) the service is a health screening service.

(e) the service is a pre-employment screening service

**Current regulations preclude the payment of Medicare benefits** for professional services rendered in relation to or in association with:

(a) chelation therapy (that is, the intravenous administration of ethylenediamine tetra-acetic acid or any of its salts) other than for the treatment of heavy-metal poisoning;

(b) the injection of human chorionic gonadotrophin in the management of obesity;

(c) the use of hyperbaric oxygen therapy in the treatment of multiple sclerosis;

(d) the removal of tattoos;

(e) the transplantation of a thoracic or abdominal organ, other than a kidney, or of a part of an organ of that kind; or the transplantation of a kidney in conjunction with the transplantation of a thoracic or other abdominal organ, or part of an organ of that kind;

(f) the removal from a cadaver of kidneys for transplantation;

(g) the administration of microwave (UHF radio wave) cancer therapy, including the intravenous injection of drugs used in the therapy.

#### **Pain pumps for post-operative pain management**

The cannulation and/or catheterisation of surgical sites associated with pain pumps for post-operative pain management cannot be billed under any MBS item.

The filling or re-filling of drug reservoirs of ambulatory pain pumps for post-operative pain management cannot be billed under any MBS items.

#### **Non Medicare Services**

No MBS item applies to a service mentioned in the item if the service is provided to a patient at the same time as, or in connection with, an injection of blood or a blood product that is autologous.

No MBS item applies to a service mentioned in the item if the service is provided to a patient at the same time as, or in connection with, the harvesting, storage, in vitro processing or injection of non-haematopoietic stem cells.

An item in the range 1 to 10943 does not apply to the service described in that item if the service is provided at the same time as, or in connection with, any of the services specified below:

(a) endoluminal gastroplication, for the treatment of gastro-oesophageal reflux disease;

(b) gamma knife surgery;

(c) intradiscal electro thermal arthroplasty;

(d) intravascular ultrasound (except where used in conjunction with intravascular brachytherapy);

(e) intro-articular viscosupplementation, for the treatment of osteoarthritis of the knee;

(f) low intensity ultrasound treatment, for the acceleration of bone fracture healing, using a bone growth stimulator;

(g) lung volume reduction surgery, for advanced emphysema;

(h) photodynamic therapy, for skin and mucosal cancer;

(i) placement of artificial bowel sphincters, in the management of faecal incontinence;

- (j) selective internal radiation therapy for any condition other than hepatic metastases that are secondary to colorectal cancer;
- (k) specific mass measurement of bone alkaline phosphatase;
- (l) transmyocardial laser revascularisation;
- (m) vertebral axial decompression therapy, for chronic back pain;
- (n) autologous chondrocyte implantation and matrix-induced autologous chondrocyte implantation;
- (o) extracorporeal magnetic innervation.

### **Health Screening Services**

Unless the Minister otherwise directs Medicare benefits are not payable for health screening services. A health screening service is defined as a medical examination or test that is not reasonably required for the management of the medical condition of the patient. Services covered by this proscription include such items as:

- (a) multiphasic health screening;
- (b) mammography screening (except as provided for in Items 59300/59303);
- (c) testing of fitness to undergo physical training program, vocational activities or weight reduction programs;
- (d) compulsory examinations and tests to obtain a flying, commercial driving or other licence;
- (e) entrance to schools and other educational facilities;
- (f) for the purposes of legal proceedings;
- (g) compulsory examinations for admission to aged persons' accommodation and pathology services associated with clinical ecology.

The Minister has directed that Medicare benefits be paid for the following categories of health screening:

- (a) a medical examination or test on a symptomless patient by that patient's own medical practitioner in the course of normal medical practice, to ensure the patient receives any medical advice or treatment necessary to maintain their state of health. Benefits would be payable for the attendance and tests which are considered reasonably necessary according to patients individual circumstances (such as age, physical condition, past personal and family history). For example, a cervical screening test in a person (see General Explanatory note 12.3 for more information), blood lipid estimation where a person has a family history of lipid disorder. However, such routine check-up should not necessarily be accompanied by an extensive battery of diagnostic investigations;
- (b) a pathology service requested by the National Heart Foundation of Australia, Risk Evaluation Service;
- (c) age or health related medical examinations to obtain or renew a licence to drive a private motor vehicle;
- (d) a medical examination of, and/or blood collection from persons occupationally exposed to sexual transmission of disease, in line with conditions determined by the relevant State or Territory health authority, (one examination or collection per person per week). Benefits are not paid for pathology tests resulting from the examination or collection;
- (e) a medical examination for a person as a prerequisite of that person becoming eligible to foster a child or children;
- (f) a medical or optometrical examination provided to a person who is an unemployed person (as defined by the Social Security Act 1991), as the request of a prospective employer.

The National Policy for the National Cervical Screening Program (NCSP) is as follows:

- (a) Cervical screening should be undertaken every five years in asymptomatic persons, using a primary human papillomavirus (HPV) test with partial genotyping and reflex liquid based cytology (LBC) triage;
- (b) Persons who have ever been sexually active should commence cervical screening at 25 years of age;
- (c) Persons aged 25 years or older and less than 70 years will receive invitations and reminders to participate in the program;
- (d) Persons will be invited to exit the program by having a HPV test between 70 years or older and less than 75 years of age and may cease cervical screening if their test result is low risk;
- (e) Persons 75 years of age or older who have either never had a cervical screening test or have not had one in the previous five years, may request a cervical screening test and can be screened;
- (f) All persons, both HPV vaccinated and unvaccinated, are included in the program;
- (g) Self collection of a sample for testing is available for persons who are aged 30 years and over and has never participated in the NCSP; or is overdue for cervical screening by two years or longer.

- Self collection must be facilitated and requested by a healthcare professional who also routinely offers cervical screening services;

- The self collection device and the HPV test, when used together, must meet the requirements of the National Pathology Accreditation Advisory Council (NPAAC) Requirements for Laboratories Reporting Tests for the NCSP; and

- (h) Persons with intermediate and higher risk screening test results should be followed up in accordance with the cervical screening pathway and the NCSP: Guidelines for the management of screen detected abnormalities, screening women in specific populations and investigation of women with abnormal vaginal bleeding (2016 Guidelines) – endorsed by the Royal Australian College of General Practitioners, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, the Royal College of Pathologists of Australasia, the Australian Society of Gynaecologic Oncologists and the Australian Society for Colposcopy and Cervical Pathology.

Note 1: As separate items exist for routine screening, screening in specific population and investigation of persons with abnormal vaginal bleeding, treating practitioners are asked to clearly identify on the request form, if the sample is collected as part of routine screening or for another purpose (see paragraph PP.16.11 of Pathology Services Explanatory Notes in Category 6).

Note 2: Where reflex cytology is performed following the detection of HPV in routine screening, the HPV test and the LBC test results must be issued as a combined report with the overall risk rating.

Note 3: See items 2501 to 2509, and 2600 to 2616 in Group A18 and A19 of Category 1 - Professional Attendances and the associated explanatory notes for these items in Category 1 - Professional Attendances.

### **Services rendered to a doctor's dependants, practice partner, or practice partner's dependants**

Medicare benefits are not paid for professional services rendered by a medical practitioner to dependants or partners or a partner's dependants.

A 'dependant' person is a spouse or a child. The following provides definitions of these dependant persons:

- (a) a spouse, in relation to a dependant person means:
  - a. a person who is legally married to, and is not living, on a permanent basis, separately and apart from, that person; and
  - b. a de facto spouse of that person.

(b) a child, in relation to a dependant person means:

a. a child under the age of 16 years who is in the custody, care and control of the person or the spouse of the person; and

b. a person who:

(i) has attained the age of 16 years who is in the custody, care and control of the person or the spouse of the person; or

(ii) is receiving full time education at a school, college or university; and

(iii) is not being paid a disability support pension under the Social Security Act 1991; and

(iv) is wholly or substantially dependent on the person or on the spouse of the person.

#### **GN.14.34 Principles of interpretation of the MBS**

Each professional service listed in the MBS is a complete medical service. Where a listed service is also a component of a more comprehensive service covered by another item, the benefit for the latter service will cover the former.

Where a service is rendered partly by one medical practitioner and partly by another, only the one amount of benefit is payable. For example, where a radiographic examination is started by one medical practitioner and finalised by another.

#### **GN.14.35 Services attracting benefits on an attendance basis**

Some services are not listed in the MBS because they are regarded as forming part of a consultation or they attract benefits on an attendance basis.

#### **GN.14.36 Consultation and procedures rendered at the one attendance**

Where, during a single attendance, a consultation (under Category 1 of the MBS) and another medical service (under any other Category of the Schedule) occur, benefits are payable subject to certain exceptions, for both the consultation and the other service. Benefits are not payable for the consultation in addition to an item rendered on the same occasion where the item is qualified by words such as "each attendance", "attendance at which", "including associated attendances/consultations", and all items in Group T6 and T9. In the case of radiotherapy treatment (Group T2 of Category 3) benefits are payable for both the radiotherapy and an initial referred consultation.

Where the level of benefit for an attendance depends upon the consultation time (for example, in psychiatry), the time spent in carrying out a procedure which is covered by another item in the MBS, may not be included in the consultation time.

A consultation fee may only be charged if a consultation occurs; that is, it is not expected that consultation fee will be charged on every occasion a procedure is performed.

#### **GN.14.37 Aggregate items**

The MBS includes a number of items which apply only in conjunction with another specified service listed in the MBS. These items provide for the application of a fixed loading or factor to the fee and benefit for the service with which they are rendered.

When these particular procedures are rendered in conjunction, the legislation provides for the procedures to be regarded as one service and for a single patient gap to apply. The Schedule fee for the service will be ascertained in accordance with the particular rules shown in the relevant items.

#### **GN.14.38 Residential aged care facility**

A residential aged care facility is defined in the *Aged Care Act 1997*; the definition includes facilities formerly known as nursing homes and hostels.

#### **GN.15.39 Practitioners should maintain adequate and contemporaneous records**

All practitioners who provide, or initiate, a service for which a Medicare benefit is payable, should ensure they maintain **adequate** and **contemporaneous** records.

**Note:** 'Practitioner' is defined in Section 81 of the *Health Insurance Act 1973* and includes: medical practitioners, dentists, optometrists, chiropractors, physiotherapists, podiatrists and osteopaths.

Since 1 November 1999 PSR Committees determining issues of inappropriate practice have been obliged to consider if the practitioner kept adequate and contemporaneous records. It will be up to the peer judgement of the PSR Committee to decide if a practitioner's records meet the prescribed standards.

The standards which determine if a record is adequate and contemporaneous are prescribed in the *Health Insurance (Professional Services Review) Regulations 1999*.

To be **adequate**, the patient or clinical record needs to:

clearly identify the name of the patient; and

contain a separate entry for each attendance by the patient for a service and the date on which the service was rendered or initiated; and

each entry needs to provide clinical information adequate to explain the type of service rendered or initiated; and

each entry needs to be sufficiently comprehensible that another practitioner, relying on the record, can effectively undertake the patient's ongoing care.

To be **contemporaneous**, the patient or clinical record should be completed at the time that the service was rendered or initiated or as soon as practicable afterwards. Records for hospital patients are usually kept by the hospital and the practitioner could rely on these records to document in-patient care.

Services Australia (SA), in consultation with the Department of Health and Aged Care, has developed a [Health Practitioner Guideline to substantiate that a specific treatment was performed](#) which is located on the Department of Health and Aged Care's website.



# **CATEGORY 7: CLEFT AND CRANIOFACIAL SERVICES**

# SUMMARY OF CHANGES FROM 01/07/2024

The 01/07/2024 changes to the MBS are summarised below and are identified in the Schedule pages by one or more of the following words appearing above the item number:

- |                         |       |
|-------------------------|-------|
| (a) new item            | New   |
| (b) amended description | Amend |
| (c) fee amended         | Fee   |
| (d) item number changed | Renum |
| (e) EMSN changed        | EMSN  |

**Fee Amended**

|       |       |       |       |       |       |       |       |       |       |       |       |       |
|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 75002 | 75005 | 75007 | 75009 | 75012 | 75015 | 75023 | 75024 | 75027 | 75030 | 75032 | 75034 | 75039 |
| 75042 | 75045 | 75048 | 75049 | 75050 | 75051 | 75200 | 75203 | 75206 | 75400 | 75402 | 75405 | 75600 |
| 75603 | 75606 | 75609 | 75610 | 75618 | 75621 | 75800 | 75802 | 75815 | 75818 | 75820 | 75833 | 75836 |
| 75842 | 75845 | 75848 | 75851 | 75854 |       |       |       |       |       |       |       |       |

**Indexation**

From 1 July 2024, annual fee indexation will be applied to most of the general medical services items. The MBS indexation factor for 1 July 2024 is 3.5 per cent.

## CLEFT AND CRANIOFACIAL SERVICES NOTES

### CN.0.1 Schedule Fees and Medicare Benefits

Medicare benefits are based on fees determined for each Schedule service. The fee is referred to in these notes as the "Schedule fee". The fee for any item listed in the Schedule is that which is regarded as being reasonable on average for that service having regard to usual and reasonable variations in the time involved in performing the service on different occasions and to reasonable ranges of complexity and technical difficulty encountered.

The Schedule fee and Medicare benefit levels for the medical services contained in the Schedule are located with the item descriptions. Where appropriate, the calculated benefit has been rounded to the nearest higher 5 cents. However, in no circumstances will the Medicare benefit payable exceed the fee actually charged.

There are presently two levels of Medicare benefit payable for cleft lip and cleft palate services:

(a) **75% of the Schedule fee:**

for professional services rendered to a patient as part of an episode of hospital treatment (other than public patients). Medical practitioners must indicate on their accounts if a medical service is rendered in these circumstances by placing an asterisk '\*' or the letter 'H' directly after an item number where used; or a description of the professional service and an indication the service was rendered as an episode of hospital treatment (for example, 'in hospital', 'hospital outpatient service', 'admitted' or 'in patient'). Certain services are not generally considered hospital treatments - see GN.1.2;

for professional services rendered as part of an episode of hospital-substitute treatment, and the patient who receives the treatment chooses to receive a benefit from a private health insurer. Medical practitioners must indicate on their accounts if a medical service is rendered in these circumstances by placing the words 'hospital-substitute treatment' directly after an item number where used; or a description of the professional service, preceded by the words 'hospital-substitute treatment'.

(b) **85% of the Schedule fee**, or the Schedule fee less \$98.70 (indexed annually), whichever is the greater, for all other professional services.

It should be noted that the *Health Insurance Act 1973* makes provision for private medical insurance to cover the "patient gap" (ie, the difference between the Medicare benefit and the Schedule fee) for services attracting benefit at the 75% level. Patients may insure with private health insurance organisations for the gap between the 75% Medicare benefit and the Schedule fee or for amounts in excess of the Schedule fee where the patient has an agreement with their health fund.

### CN.0.2 Where Medicare Benefits are not Payable

Medicare benefits are not payable in respect of a professional service where the medical expenses for the service:-

- (a) are paid/payable to a public hospital;
- (b) are for a compensable injury or illness for which the patient's insurer or compensation agency has accepted liability. (Please note that if the medical expenses relate to a compensable injury/illness for which the insurer/compensation agency is disputing liability, then Medicare benefits are payable until the liability is accepted);
- (c) are for a medical examination for the purposes of life insurance, superannuation, a provident account scheme, or admission to membership of a friendly society; or
- (d) are incurred in mass immunisation.

Unless the Minister otherwise directs, Medicare benefits are not payable where:

- (a) the service is rendered by or on behalf of, or under an arrangement with the Australian Government, a State or Territory, a local government body or an authority established under Commonwealth, State or Territory law;

- (b) the medical expenses are incurred by the employer of the person to whom the service is rendered;
- (c) the person to whom the service is rendered is employed in an industrial undertaking and that service is rendered for the purposes related to the operation of the undertaking; or
- (d) the services is a health screening service.

Benefits are not payable for items 75150 to 75621 unless the patient was referred by letter of Referral by an eligible orthodontist.

### **CN.0.3 Limiting Rule**

In no circumstances will the benefit payable for a professional service exceed the fee charged for the service.

### **CN.0.4 Penalties**

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

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

### **CN.0.5 Billing of the Patient**

#### **CN.0.5 Billing of the Patient**

Where the practitioner bills the patient for medical services rendered, the patient needs a properly itemised account/receipt to enable a claim to be made for Medicare benefits.

Under the provisions of the *Health Insurance Act 1973* and Regulations, Medicare benefits are not payable in respect of a professional service unless there is recorded on the account setting out the fee for the service or on the receipt for the fee in respect of the service, the following particulars:-

- (a) Patient's name;
- (b) The date on which the professional service was rendered;
- (c) A description of the professional service sufficient to identify the item that relates to that service, including an indication where the service is rendered to a person while hospital treatment is provided in a hospital or day-hospital facility (other than a Medicare hospital patient), that is, the words (ie, accommodation and nursing care) "admitted patient" immediately preceding the description of the service or an asterisk "\*" directly after an item number where used;
- (d) The name and practice address or name and provider number of the practitioner who actually rendered the service; (Where the practitioner has more than one practice location recorded with Services Australia, the provider number used should be that which is applicable to the practice location at or from which the service was given).

A medical or dental practitioner must notate 'certified dental patient' on the patient's account or include 'certified dental patient' in the text field when submitting a Medicare claim for benefits.

Where a practitioner wishes to apportion the total fee between the appropriate professional fee for the particular service and any balance outstanding in respect of services rendered previously, the practitioner should ensure that

the balance is described in such a way (eg balance of account) that it cannot be mistaken as being a separate service. In particular no item number should be shown against the balance.

Only one original itemised account should be issued in respect of any one medical service and any duplicates of accounts or receipts should be clearly marked "duplicate" and should be issued only where the original has been lost. Duplicates should not be issued as a routine system for "accounts rendered".

## **CN.0.6 Claiming of Benefits**

### **Claiming Benefits**

The patient, upon receipt of a practitioner's account, has two courses open for paying the account and receiving benefits as outlined below.

### **Unpaid and Partially Paid Accounts**

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

It will be the patient's responsibility to forward the cheque to the practitioner and make arrangements for payment of the balance of the account if any. "Pay doctor" cheques involving Medicare benefits cannot be sent direct to practitioners or to patients at a practitioner's address (even if requested by the patient to do so). "Pay doctor" cheques will be forwarded to the claimant's last known address.

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

### **Assignment of Benefits (Direct-Billing) Arrangements**

Under the *Health Insurance Act 1973* the Assignment of Benefit (direct-billing) facility for professional services is available to all persons in Australia who are eligible for benefit under the Medicare program. This facility is NOT confined to pensioners or people in special need. If a practitioner direct-bills, the practitioner undertakes to accept the relevant Medicare benefit as full payment for the service. Additional charges for that service (irrespective of the purpose or title of the charge) cannot be raised against the patient. Under these arrangements:-

- The patient's Medicare card number must be quoted on all direct-bill forms for that patient.
- The basic forms provided are loose leaf to enable the patient details to be imprinted from the Medicare card.
- The forms include information required by Regulations under Subsection 19(6) of the *Health Insurance Act 1973*.
- The practitioner must cause the particulars relating to the professional service to be set out on the assignment form before the patient signs the form and cause the patient to receive a copy of the form as soon as practicable after the patient signs it.

Where a patient is unable to sign the assignment form:

- the signature of the patient's parent, guardian or other responsible person (other than the doctor, doctor's staff, hospital proprietor, hospital staff, residential aged care facility proprietor or residential aged care facility staff) is acceptable; or
- In the absence of a "responsible person" the patient signature section should be left blank.

Where the signature space is either left blank or another person signs on the patient's behalf, the form must include:

- the notation "Patient unable to sign" and
- in the section headed 'Practitioner's Use', an explanation should be given as to why the patient was unable to sign (e.g. unconscious, injured hand etc.) and this note should be signed or initialled by the doctor. If in the opinion of the practitioner the reason is of such a "sensitive" nature that revealing it would constitute an unacceptable breach of patient confidentiality or unduly embarrass or distress the recipient of the patient's copy of the assignment of benefits form, a concessional reason "due to medical condition" to signify that such a situation exists may be substituted for the actual reason. However, this should not be used routinely and in most cases it is expected that the reason given will be more specific.

The administration of the direct-billing arrangements under Medicare as well as the payment of Medicare benefits on patient claims is the responsibility of Services Australia. Any enquiries in regard to these matters should therefore be directed to Medicare offices or enquiry points.

Under Medicare any eligible dental practitioner can accept assignment of benefit and direct-bill for any eligible person.

### **Use of Medicare Cards in Direct Billing**

An eligible person who applies to enrol for Medicare benefits (using a Medicare Enrolment/Amendment Application) will be issued with a uniquely numbered Medicare card which shows the Medicare card number, the patient identification number (reference number), the applicant's first given name, initial of second given name, surname and an effective "valid to" date. These cards may be issued on an individual or family basis. Up to 5 persons may be listed on the one Medicare card, and up to 9 persons may be listed under the one Medicare card number.

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

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

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

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

### **Assignment of Benefit Forms**

To meet varying requirements the following types of stationery are available from Medicare. Note that these forms are approved forms under the *Health Insurance Act 1973*, and no other forms can be used to assign benefits without the approval of Services Australia.

(a) *Form DB2*. This form is used to assign benefits for services other than requested pathology. It is loose leaf for imprinting and comprises a throw away cover sheet (after imprinting), a Medicare copy, a Patient copy and a Practitioner copy.

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

### **The Claim for Assigned Benefits (Form DB1N, DB1H)**

Practitioners who accept assigned benefits must claim from Medicare using either Claim for Assigned Benefits form DB1N or DB1H. The DB1N form should be used where services are rendered to persons for treatment provided out

of hospital or day hospital treatment. The DB1H form should be used where services are rendered to persons while hospital treatment is provided in a hospital or day hospital facility (other than public patients). Both forms have been designed to enable benefit for a claim to be directed to a practitioner other than the one who rendered the services. The facility is intended for use in situations such as where a short term locum is acting on behalf of the principal doctor and setting the locum up with a provider number and pay-group link for the principal doctor's practice is impractical. Practitioners should note that this facility cannot be used to generate payments to or through a person who does not have a provider number.

The DB1N and DB1H are also loose leaf to enable imprinting of practitioner details using the special Medicare imprinter. For this purpose, practitioner cards, showing the practitioner's name, practice address and provider numbers are available from Medicare on request.

### **Direct-Bill Stationery**

Medical practitioners and eligible dental practitioners wishing to direct-bill may obtain information on direct-bill stationery by telephoning **132150**. Information on the completion of the forms and direct-bill procedures are provided with the forms. Information on direct-billing is available from any Medicare office.

### **Time Limits Applicable to Lodgement of Claims for Assigned Benefits**

A time limit of two years applies to the lodgement of claims with Medicare under the direct-billing (assignment of benefit) arrangements. This means that Medicare benefits are not payable for any service where the service was rendered more than two years earlier than the date the claim was lodged with Medicare.

Provision exists whereby in certain circumstances (e.g. hardship cases), the Minister may waive the time limits. Special forms for this purpose are available, if required, from the processing centre to which assigned claims are directed.

### **CN.0.7 Interpretation of the Cleft and Craniofacial Services**

Each professional service listed in the Schedule is a complete medical service in itself. Where a service is rendered partly by one practitioner and partly by another, only the one amount of benefit is payable.

### **CN.0.8 Multiple Operation Rule**

The Schedule fee for two or more operations performed on a patient on the one occasion is calculated by the following rule:

· 100% for the item with the greatest Schedule fee, plus 50% for the item with the next greatest Schedule fee, plus 25% for each other item.

NOTE:

1. Fees so calculated which result in a sum which is not a multiple of 5 cents are taken to the next higher multiple of 5 cents.
2. Where two or more operations performed on the one occasion have fees which are equal, one of these amounts shall be treated as being greater than the other or others of those amounts.
3. The Schedule fee for benefits purposes is the aggregate of the fees calculated in accordance with the above formula.

The above rule does not apply to an operation which is one of two or more operations performed under the one anaesthetic on the same patient by different dental practitioners unless either practitioner assists the other. In this case, the fees and benefits specified in the Schedule apply. For these purposes the term "operation" includes items 75200 to 75610.

If the operation comprises a combination of procedures which are commonly performed together and for which a specific combined item is provided in the Schedule, it is regarded as the one item and service in applying the multiple operation rule.

### **CN.0.9 Administration of Anaesthetics**

When a medical practitioner administers an anaesthetic in connection with a dental procedure prescribed for the payment of Medicare benefits (and the procedure has been performed by an eligible dental practitioner), Medicare benefits are payable for the administration of the anaesthetic on the same basis as if the procedure had been rendered by a medical practitioner.

To ascertain the Schedule fee for the anaesthetic, medical practitioners should refer to Group T10 - Relative Value Guide for Anaesthesia - of the Medicare Benefits Schedule Book.

### **CN.0.10 Definitions**

#### ***Orthodontic treatment planning***

Orthodontic treatment planning is defined as the measurement and analysis of the face and jaws and occlusion providing a diagnosis and planned prescription of appliances and treatment required.

#### ***Study models***

Study models are defined as physical or virtual models of the upper and lower teeth and alveolar processes. This does not include working models.

### **CN.0.11 Referral of Oral and Maxillofacial Surgical Services**

Benefits are payable for items 75002 to 75621 only where the service has been rendered to a patient who has been referred by letter of referral by a medical practitioner or referring dentist.

Item 75621 may be claimed in association with items 46150 to 46161 where the service is performed by a practitioner holding a FRACDS (OMS) qualification.

### **CN.0.12 General and Prosthodontic Services - (Item 75800)**

Item number 75800 refers to an attendance by a dental practitioner for the management, prevention, and prophylaxis of the patient's eligible condition, and includes such services as dietary advice, oral hygiene, and fluoride treatment.

### **CN.0.13 Over-servicing**

Over-servicing must be avoided. In the case of denture services, examples of over-servicing might be:-

- Unjustifiably frequent replacement of dentures;
- Provision of new dentures when relining or re-modelling of an existing prosthesis would meet the clinical need;
- Provision of metal dentures where an acrylic denture would meet the clinical need.

The Schedule includes an item for metal dentures to allow for the provision of a precise, long-term prosthesis. The item is not intended for use during the period of growth, where prostheses must be replaced or altered frequently, unless there is some definite and extraordinary clinical requirement.

### **CN.0.14 Commonwealth Department of Health and Aged Care Addresses**

Postal : GPO Box 9848 in each Capital City

Contact details: please visit [www.health.gov.au](http://www.health.gov.au)



### **CN.1.1 Introduction - Medicare Benefits**

The Medicare Benefits Schedule includes certain professional services in respect of the treatment of cleft lip and craniofacial conditions for which Medicare benefits are payable. These services are normally described as dental services. However, for the purposes of these Notes the word "medical" is to be interpreted to include "dental". The definition of professional service as contained in the *Health Insurance Act 1973* provides that such a service must be "clinically relevant". A clinically relevant service means a service rendered by a medical or dental practitioner or optometrist that is generally accepted in the medical, dental or optometrical profession (as the case may be) as being necessary for the appropriate treatment of the patient to whom it is rendered.

Medicare benefits are payable in respect of services listed in Schedule 2 of the *Health Insurance (Section 3C General Medical Services - Cleft and Craniofacial Services) Determination 2024*, when the services are rendered by an eligible dental practitioner to patients who have been diagnosed with an eligible cleft or craniofacial condition.

### **CN.2.1 Dental Practitioner Eligibility**

In order to attract Medicare benefits, all treatment must be carried out by eligible medical practitioners or eligible dental practitioners in Australia. For the purposes of cleft and craniofacial services, groupings for eligible practitioners include:

- Dental practitioner: all registered dental practitioners, including practitioners who hold qualifications and are registered in the specialty of orthodontics, paediatric dentistry, oral and maxillofacial surgery, and prosthodontics.
- Eligible orthodontist: dental practitioners who are registered in the specialty of orthodontics and who hold qualifications as an orthodontic specialist can provide relevant Medicare Benefits Schedule (MBS) cleft and craniofacial services.
- Eligible prosthodontist: dental practitioners who are registered in the specialty of prosthodontics and who hold qualifications as a prosthodontic specialist can provide relevant MBS cleft and craniofacial services.
- Eligible paediatric dentist: dental practitioners who hold qualifications as a paediatric dentist and are registered in the specialty of paediatric dentistry can provide relevant MBS cleft and craniofacial services.
- Eligible oral and maxillofacial surgeon: oral and maxillofacial services may be performed, following a referral from a medical practitioner or referring dentist, by:
  - medical practitioners who are specialists in the practice of their specialty of oral and maxillofacial surgery; or
  - dental practitioners who were approved by the Minister prior to 1 November 2004 for the purposes of subsection 3 (1) of the *Health Insurance Act 1973* (the Act) to carry out prescribed medical services (oral and maxillofacial surgery) contained in the MBS.

Dental practitioners who were previously accredited to provide cleft and craniofacial services who do not meet the registration requirements as a dental practitioner will be grandfathered under legislative arrangements that came into force on 1 November 2012.

All eligible dental practitioners are entitled to perform services covered by items 75009, 75023, 75200, 75203, 75206, 75400, 75402, 75800, 75802, 75815, 75818, 75820, 75833, 75836, 75842, 75845, 75848, 75851 and 75854.

All eligible orthodontists are entitled to perform services covered by items 75002, 75005, 75007, 75012, 75015, 75024, 75027, 75030, 75032, 75034, 75039, 75042, 75045, 75048, 75049, 75050, 75051, 75618 and 75621.

All eligible prosthodontists are entitled to perform services covered by items 75002, 75005, 75007, 75618 and 75621.

All eligible paediatric dentists are entitled to perform services covered by items 75002, 75005, 75007, 75024, 75027, 75600 and 75603.

All eligible oral and maxillofacial surgeons and dental practitioners who, immediately prior to 1 November 2012, held an approval granted by the Minister for the purposes of the definition of professional service in subsection 3(1) of the Act, are entitled to perform services covered by items 75002, 75005, 75007, 75012, 75015, 75405, 75600, 75603, 75606, 75609, 75610, 75618 and 75621.

Items 75002, 75005, 75200, 75203, 75206, 75400, 75402, 75600, 75603, 75618 and 75621 apply only to a service provided by an eligible oral and maxillofacial surgeon if the patient has been referred by a referring dentist or medical practitioner.

### **CN.3.1 Patient Eligibility**

To be eligible to claim benefits for cleft and dental services performed by eligible medical and registered dental practitioners, a patient must satisfy the following criteria:

- a. The patient must be an Australian resident or any other person or class of persons whom the Minister declares to be eligible. All eligible persons will be issued with a Medicare card on application as evidence of their eligibility; and
- b. The patient must be diagnosed with an eligible cleft or craniofacial condition specified in the *Health Insurance (Section 3C General Medical Services - Cleft and Craniofacial Services) Determination 2024*.

The *Health Insurance (Section 3C General Medical Services - Cleft and Craniofacial Services) Determination 2024* specifies the eligible cleft or craniofacial conditions listed below:

| <b>1. Oral and/or facial clefting</b>   |  |
|---|--|
| <i>Limited to</i>   | Cleft lip, alveolus and/or palate  |
|   | Tessier facial cleft   |
| <b>2. Congenital or hereditary craniofacial malformation, deformation or disruption</b> |  |
| <i>Limited to</i>   | Achondroplasia   |
|   | Branchial arch disorders including:<br>Hemifacial/craniofacial microsomia, Goldenhar syndrome, DiGeorge syndrome, Velocardiofacial syndrome, Auriculo-condylar syndrome      |
|   | CHARGE syndrome  |
|   | Congenital hemifacial hyperplasia  |
|   | Congenital lymphatic and/or vascular malformations of the head & neck, cystic hygroma, Sturge-Weber syndrome, excluding haemangiomas, birth marks and naevi                  |
|   | Craniofacial Neurofibromatosis Type 1  |
|   | Craniometaphyseal dysplasia  |
|   | Congenital lymphatic and vascular malformations and segmental haemangiomas involving the jaws and associated soft tissues including cystic hygroma and Sturge-Weber syndrome |
|   | Ectodermal dysplasia   |
|   | Hemifacial atrophy (Parry Romberg syndrome)  |
|   | Mandibulofacial dysostosis (Treacher Collins syndrome)   |
|   | Maxillonasal dysplasia (Binder syndrome)   |
|   | Oral-facial digital syndrome Type 1  |
|   | Osteogenesis imperfecta  |
|   | Pierre Robin sequence  |
|   | Rubinstein-Taybi syndrome  |

|  |  |
|--|--|
|  | Shprintzen-Goldberg syndrome   |
|  | Solitary median maxillary central incisor syndrome   |
|  | Stickler syndrome  |
|  | Syndromic craniosynostoses including:<br>Apert, Crouzon, Pfeiffer, Saethre Chotzen, and Muenke syndromes |
|  | Trichorhinophalangeal syndrome Type 1  |
| <b>3. Hereditary conditions</b> presenting with the absence of 6 (six) or more permanent teeth, excluding 3rd molars |  |
| <b>4. Hereditary conditions</b> where the presence of supernumerary teeth is a major feature                         |  |
| <i>Limited to</i>  | Cleidocranial dysplasia  |
|  | Gardner's syndrome   |
| <b>5. Development or hereditary conditions</b> affecting the formation of enamel and/or dentine of all teeth         |  |
| <i>Limited to</i>  | Amelogenesis imperfecta  |
|  | Dentinogenesis imperfecta  |
|  | Regional odontodysplasia   |

### **CN.3.3 Visitors to Australia**

Medicare benefits for the Cleft and Craniofacial Scheme are generally not payable to visitors to Australia or temporary residents.

### **CN.3.4 Health Care Expenses Incurred Overseas**

Medicare does not cover medical or hospital expenses incurred outside Australia.

**CLEFT AND CRANIOFACIAL SERVICES ITEMS**

| <b>C1. CLEFT AND CRANIOFACIAL SERVICES</b> |  |
|--|--|
|  | <b>Group C1. Cleft and Craniofacial Services</b>   |
| <b>Fee</b><br>75002                        | Initial professional attendance, in a single course of treatment (other than a service associated with a service to which item 75009, 75012, 75015 or 75023 applies)<br><br>(See para CN.2.1 of explanatory notes to this Category)<br><b>Fee:</b> \$97.40 <b>Benefit:</b> 75% = \$73.05    85% = \$82.80  |
| <b>Fee</b><br>75005                        | Subsequent professional attendance in a single course of treatment (other than a service associated with a service to which item 75009, 75012, 75015 or 75023 applies)<br><br>(See para CN.2.1 of explanatory notes to this Category)<br><b>Fee:</b> \$49.00 <b>Benefit:</b> 75% = \$36.75    85% = \$41.65  |
| <b>Fee</b><br>75007                        | Production of dental study models (other than a service associated with a service to which item 75002 or 75005 applies) prior to provision of a service to which:<br><br>(a) item 75030, 75032, 75039, 75045 or 75051 apply; or<br>(b) an item in Group T8 or Groups O3 to O9 apply; or<br>(c) item 52321, 53212 or 75618 apply; or<br>(d) any of items 52330 to 52382, 52600 to 52630, 53400 to 53409 or 53415 to 53429 apply;<br><br>in a single treatment<br><br>(See para CN.2.1, CN.0.10 of explanatory notes to this Category)<br><b>Fee:</b> \$86.80 <b>Benefit:</b> 75% = \$65.10    85% = \$73.80 |
| <b>Fee</b><br>75009                        | Orthodontic radiography—orthopantomography (panoramic radiography), including any consultation on the same occasion<br><br>(See para CN.2.1 of explanatory notes to this Category)<br><b>Fee:</b> \$77.70 <b>Benefit:</b> 75% = \$58.30    85% = \$66.05   |
| <b>Fee</b><br>75012                        | Orthodontic anteroposterior cephalometric radiography with cephalometric tracings or lateral cephalometric radiography with cephalometric tracings, including any consultation on the same occasion<br><br>(See para CN.2.1 of explanatory notes to this Category)<br><b>Fee:</b> \$123.10 <b>Benefit:</b> 75% = \$92.35    85% = \$104.65   |
| <b>Fee</b><br>75015                        | Radiography anteroposterior and lateral cephalometric radiography with cephalometric tracings, including any consultation on the same occasion<br><br>(See para CN.2.1 of explanatory notes to this Category)<br><b>Fee:</b> \$169.20 <b>Benefit:</b> 75% = \$126.90    85% = \$143.85   |
| <b>Fee</b><br>75023                        | Intraoral radiography—single area, periapical or bitewing film<br><br>(See para CN.2.1 of explanatory notes to this Category)<br><b>Fee:</b> \$52.90 <b>Benefit:</b> 75% = \$39.70    85% = \$45.00  |
| <b>Fee</b><br>75024                        | Pre-surgical infant maxillary arch repositioning including nasoalveolar moulding, supply of appliances and all adjustments of appliances, and supervision of all components of the service—if 1 appliance is used<br><br>(See para CN.2.1 of explanatory notes to this Category)<br><b>Fee:</b> \$683.65 <b>Benefit:</b> 75% = \$512.75    85% = \$584.95  |

## C1. CLEFT AND CRANIOFACIAL SERVICES

|                     |   |
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| <b>Fee</b><br>75027 | <p>Pre-surgical infant maxillary arch repositioning including nasoalveolar moulding, supply of appliances and all adjustments of appliances, and supervision of all components of the service—if 2 appliances are used</p> <p>(See para CN.2.1 of explanatory notes to this Category)<br/> <b>Fee:</b> \$937.45      <b>Benefit:</b> 75% = \$703.10    85% = \$838.75</p>   |
| <b>Fee</b><br>75030 | <p>Maxillary arch expansion (other than a service associated with a service to which item 75039, 75042, 75045 or 75048 applies), including supply of appliances and all adjustments of appliances, removal of appliances and retention</p> <p>(See para CN.2.1 of explanatory notes to this Category)<br/> <b>Fee:</b> \$834.70      <b>Benefit:</b> 75% = \$626.05    85% = \$736.00</p>   |
| <b>Fee</b><br>75032 | <p>Mixed dentition treatment including incisor alignment (mandibular and/or maxillary) lateral arch expansion, including supply of appliances and all adjustments of appliances, removal of appliances and retention</p> <p>(See para CN.2.1 of explanatory notes to this Category)<br/> <b>Fee:</b> \$1,879.35      <b>Benefit:</b> 75% = \$1409.55    85% = \$1780.65</p>   |
| <b>Fee</b><br>75034 | <p>Mixed dentition treatment—incisor alignment with or without lateral arch expansion using a removable appliance in the maxillary arch, including supply of all appliances, and associated adjustments and retention</p> <p>(See para CN.2.1 of explanatory notes to this Category)<br/> <b>Fee:</b> \$696.35      <b>Benefit:</b> 75% = \$522.30    85% = \$597.65</p>  |
| <b>Fee</b><br>75039 | <p>Permanent dentition treatment—single arch (mandibular or maxillary) treatment (correction and alignment) using orthodontic fixed appliances or aligners, including supply of appliances and aligners—initial 3 months of active treatment</p> <p>(See para CN.2.1 of explanatory notes to this Category)<br/> <b>Fee:</b> \$632.60      <b>Benefit:</b> 75% = \$474.45    85% = \$537.75</p>   |
| <b>Fee</b><br>75042 | <p>Permanent dentition treatment—single arch (mandibular or maxillary) treatment (correction and alignment) using orthodontic fixed appliances or aligners, including supply of appliances and aligners—each subsequent 3 months of active treatment (including all adjustments and maintenance and removal of the appliances) after the initial three months of active treatment for a maximum of a further 33 months</p> <p>(See para CN.2.1 of explanatory notes to this Category)<br/> <b>Fee:</b> \$236.45      <b>Benefit:</b> 75% = \$177.35    85% = \$201.00</p> |
| <b>Fee</b><br>75045 | <p>Permanent dentition treatment—2 arch (mandibular and maxillary) treatment (correction and alignment) using orthodontic fixed appliances or aligners, including supply of appliances or aligners—initial 3 months of active treatment</p> <p>(See para CN.2.1 of explanatory notes to this Category)<br/> <b>Fee:</b> \$1,266.30      <b>Benefit:</b> 75% = \$949.75    85% = \$1167.60</p>   |
| <b>Fee</b><br>75048 | <p>Permanent dentition treatment—2 arch (mandibular and maxillary) treatment (correction and alignment) using orthodontic fixed appliances or aligners, including supply of appliances or aligners—each subsequent 3 months of active treatment (including all adjustments and maintenance, and removal of the appliances) after the initial three months of active treatment for a maximum of a further 33 months</p> <p>(See para CN.2.1 of explanatory notes to this Category)<br/> <b>Fee:</b> \$324.75      <b>Benefit:</b> 75% = \$243.60    85% = \$276.05</p>     |
| <b>Fee</b><br>75049 | <p>Retention, fixed or removable, single arch (mandibular or maxillary)—supply of retainer and supervision of retention</p>   |

| <b>C1. CLEFT AND CRANIOFACIAL SERVICES</b> |  |
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|  | (See para CN.2.1 of explanatory notes to this Category)<br><b>Fee:</b> \$380.10 <b>Benefit:</b> 75% = \$285.10    85% = \$323.10   |
| <b>Fee</b><br>75050                        | Retention, fixed or removable, 2-arch (mandibular and maxillary)—supply of retainers and supervision of retention<br><br>(See para CN.2.1 of explanatory notes to this Category)<br><b>Fee:</b> \$733.70 <b>Benefit:</b> 75% = \$550.30    85% = \$635.00  |
| <b>Fee</b><br>75051                        | Jaw growth guidance using removable or functional appliances, including supply of appliances and all adjustments to appliances<br><br>(See para CN.2.1 of explanatory notes to this Category)<br><b>Fee:</b> \$1,126.30 <b>Benefit:</b> 75% = \$844.75    85% = \$1027.60                            |
| <b>Fee</b><br>75200                        | Removal of tooth or tooth fragment (other than treatment to which item 75402 or 75405 applies)<br><br>(See para CN.2.1, CN.0.8 of explanatory notes to this Category)<br><b>Fee:</b> \$62.55 <b>Benefit:</b> 75% = \$46.95    85% = \$53.20  |
| <b>Fee</b><br>75203                        | Removal of tooth or tooth fragment under general anaesthesia<br><br>(See para CN.2.1, CN.0.8 of explanatory notes to this Category)<br><b>Fee:</b> \$93.85 <b>Benefit:</b> 75% = \$70.40    85% = \$79.80  |
| <b>Fee</b><br>75206                        | Removal of each additional tooth or tooth fragment if provided in association with a service to which item 75200 or 75203 applies<br><br>(See para CN.2.1, CN.0.8 of explanatory notes to this Category)<br><b>Fee:</b> \$31.15 <b>Benefit:</b> 75% = \$23.40    85% = \$26.50                       |
| <b>Fee</b><br>75400                        | Surgical removal of erupted tooth<br><br>(See para CN.2.1, CN.0.8 of explanatory notes to this Category)<br><b>Fee:</b> \$187.70 <b>Benefit:</b> 75% = \$140.80    85% = \$159.55  |
| <b>Fee</b><br>75402                        | Surgical removal of tooth, or tooth fragment requiring incision of soft tissue only<br><br>(See para CN.2.1, CN.0.8 of explanatory notes to this Category)<br><b>Fee:</b> \$185.50 <b>Benefit:</b> 75% = \$139.15    85% = \$157.70  |
| <b>Fee</b><br>75405                        | Surgical removal of tooth, or tooth fragment requiring removal of bone, where the patient is referred by a referring dentist or medical practitioner<br><br>(See para CN.2.1, CN.0.8 of explanatory notes to this Category)<br><b>Fee:</b> \$237.20 <b>Benefit:</b> 75% = \$177.90    85% = \$201.65 |
| <b>Fee</b><br>75600                        | Surgical exposure and packing of unerupted tooth<br><br>(See para CN.2.1, CN.0.8 of explanatory notes to this Category)<br><b>Fee:</b> \$264.35 <b>Benefit:</b> 75% = \$198.30    85% = \$224.70   |
| <b>Fee</b><br>75603                        | Surgical exposure of unerupted tooth for the purpose of fitting a traction device or placement of a temporary anchorage device<br><br>(See para CN.2.1, CN.0.8 of explanatory notes to this Category)<br><b>Fee:</b> \$310.75 <b>Benefit:</b> 75% = \$233.10    85% = \$264.15                       |
| <b>Fee</b><br>75606                        | Surgical repositioning of unerupted tooth where the patient is referred by a referring dentist or medical practitioner<br><br>(See para CN.2.1, CN.0.8 of explanatory notes to this Category)<br><b>Fee:</b> \$310.75 <b>Benefit:</b> 75% = \$233.10    85% = \$264.15                               |
| <b>Fee</b><br>75609                        | Transplantation of tooth bud where the patient is referred by a referring dentist or medical practitioner  |

## C1. CLEFT AND CRANIOFACIAL SERVICES

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|                     | (See para CN.2.1, CN.0.8 of explanatory notes to this Category)<br><b>Fee:</b> \$463.90 <b>Benefit:</b> 75% = \$347.95    85% = \$394.35   |
| <b>Fee</b><br>75610 | Surgical procedure for intraoral implantation of an osseointegrated fixture and placement of transmucosal abutments where the patient is referred by a referring dentist or medical practitioner<br><br>(See para CN.2.1, CN.0.8 of explanatory notes to this Category)<br><b>Fee:</b> \$393.30 <b>Benefit:</b> 75% = \$295.00    85% = \$334.35   |
| <b>Fee</b><br>75618 | Fabrication and fitting of a bite rising appliance or dental splint for the management of temporomandibular joint dysfunction syndrome<br><br>(See para CN.2.1 of explanatory notes to this Category)<br><b>Fee:</b> \$263.80 <b>Benefit:</b> 75% = \$197.85    85% = \$224.25   |
| <b>Fee</b><br>75621 | The fabrication and fitting of surgical splint or guide in conjunction with orthognathic surgical procedures and implant treatment, if provided in association with a service to which:<br><br>(a) any item in the following series applies:<br><br>(i) any of items 46150 to 46161 apply; or<br>(ii) any of items 52342 to 52375 apply; or<br><br>(b) item 52380 or 52382 applies;<br><br>(c) item 75610 applies<br><br>(See para CN.0.11, CN.2.1 of explanatory notes to this Category)<br><b>Fee:</b> \$263.80 <b>Benefit:</b> 75% = \$197.85    85% = \$224.25 |
| <b>Fee</b><br>75800 | Attendance involving consultation, preventive treatment and prophylaxis, of not less than 30 minutes in duration for each attendance to a maximum of 3 attendances in any 12 month period (other than a service associated with a service to which item 75009, 75012, 75015 or 75023 applies)<br><br>(See para CN.0.12, CN.2.1 of explanatory notes to this Category)<br><b>Fee:</b> \$93.85 <b>Benefit:</b> 75% = \$70.40    85% = \$79.80  |
| <b>Fee</b><br>75802 | Fabrication and fitting of acrylic base partial denture, including retainers—1 to 4 teeth<br><br>(See para CN.2.1 of explanatory notes to this Category)<br><b>Fee:</b> \$479.40 <b>Benefit:</b> 75% = \$359.55    85% = \$407.50  |
| <b>Fee</b><br>75815 | Fabrication and fitting of acrylic base partial denture, including retainers—5 to 9 teeth<br><br>(See para CN.2.1 of explanatory notes to this Category)<br><b>Fee:</b> \$707.35 <b>Benefit:</b> 75% = \$530.55    85% = \$608.65  |
| <b>Fee</b><br>75818 | Fabrication and fitting of acrylic base partial denture or complete denture or overdenture, including retainers—10 to 12 teeth<br><br>(See para CN.2.1 of explanatory notes to this Category)<br><b>Fee:</b> \$834.70 <b>Benefit:</b> 75% = \$626.05    85% = \$736.00   |
| <b>Fee</b><br>75820 | Fabrication and fitting of metal framework partial denture, including all components—1 to 4 teeth<br><br>(See para CN.2.1 of explanatory notes to this Category)<br><b>Fee:</b> \$831.95 <b>Benefit:</b> 75% = \$624.00    85% = \$733.25  |
| <b>Fee</b><br>75833 | Fabrication and fitting of metal framework partial denture including all components—5 to 9 teeth<br><br>(See para CN.2.1 of explanatory notes to this Category)<br><b>Fee:</b> \$1,205.70 <b>Benefit:</b> 75% = \$904.30    85% = \$1107.00  |

**C1. CLEFT AND CRANIOFACIAL SERVICES**

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| <b>Fee</b><br>75836 | Fabrication and fitting of metal framework partial denture or complete denture or overdenture including all components—10 to 12 teeth<br><br>(See para CN.2.1 of explanatory notes to this Category)<br><b>Fee:</b> \$1,379.70 <b>Benefit:</b> 75% = \$1034.80    85% = \$1281.00 |
| <b>Fee</b><br>75842 | Adjustment of denture (other than a service associated with a service to which item 75802, 75815, 75818, 75820, 75833 or 75836 applies)<br><br>(See para CN.2.1 of explanatory notes to this Category)<br><b>Fee:</b> \$46.40 <b>Benefit:</b> 75% = \$34.80    85% = \$39.45      |
| <b>Fee</b><br>75845 | Relining of denture by laboratory process and associated fitting<br><br>(See para CN.2.1 of explanatory notes to this Category)<br><b>Fee:</b> \$232.00 <b>Benefit:</b> 75% = \$174.00    85% = \$197.20  |
| <b>Fee</b><br>75848 | Remodelling and fitting of denture of more than 4 teeth<br><br>(See para CN.2.1 of explanatory notes to this Category)<br><b>Fee:</b> \$278.20 <b>Benefit:</b> 75% = \$208.65    85% = \$236.50   |
| <b>Fee</b><br>75851 | Repair to metal framework of denture—1 or more points<br><br>(See para CN.2.1 of explanatory notes to this Category)<br><b>Fee:</b> \$139.15 <b>Benefit:</b> 75% = \$104.40    85% = \$118.30   |
| <b>Fee</b><br>75854 | Addition of a tooth or teeth to a denture to replace extracted tooth or teeth, including taking of necessary impression<br><br>(See para CN.2.1 of explanatory notes to this Category)<br><b>Fee:</b> \$139.15 <b>Benefit:</b> 75% = \$104.40    85% = \$118.30                   |