Australian Government
Department of Health and Aged Care

Listing of Repetitive Transcranial Magnetic Stimulation (rTMS) on the Medicare Benefits Schedule (MBS)
Frequently Asked Questions

Last updated: 13 July 2022

- For a summary of the new MBS items for rTMS, please refer to the Fact Sheets available on the MBS Online website at MBS Online. Providers should also refer to the item descriptors and explanatory notes on the website.
- The information in this document is to be read in conjunction with the other resources.
- These Frequently Asked Questions will be updated from time to time in response to questions from patients, providers and other stakeholders.

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Patient Eligibility

Why are Medicare rebates not available for patients who have previously received rTMS treatment, or for ongoing maintenance treatment?

The Government has followed the advice of the Medical Services Advisory Committee (MSAC) on these issues. MSAC is an independent, expert advisory group which provides advice to Government on whether new medical services should be publicly funded, based on an assessment of comparative safety, clinical effectiveness and cost-effectiveness, using the best available evidence.

Based on MSAC's advice to Government, Medicare rebates will be available for the initial course of treatment and one course of retreatment services over a patient's lifetime. MSAC supported the listing of rTMS for patients who have not previously received rTMS treatment, and this includes where rTMS was used for treatment of disorders other than depression, such as obsessive compulsive disorder.

MSAC also considered the use of rTMS as a maintenance treatment for major depressive disorder. MSAC found that, compared to initial treatment and retreatment courses, there was a limited evidence base for maintenance treatment.

How will the treating psychiatrist ascertain if a patient has received any prior rTMS treatment before?

Before commencing Medicare-funded rTMS services, the treating psychiatrist should make reasonable inquiries as to whether the patient has previously received any rTMS treatment. This includes considering any clinical records or referrals available to the psychiatrist regarding the patient's treatment history and asking the patient whether they have previously received any rTMS treatment (either through Medicare, privately funded or in a public setting).

A provider can check if the treatment item 14217 and re-treatment item 14220 have previously been claimed via the Online Item Checker on the Services Australia website.

A patient can also contact Services Australia (13 23 07) to check whether they have previously received Medicare-funded rTMS treatment. The psychiatrist may rely on information provided to them by the patient in good faith about their treatment history.

In providing informed financial consent, the psychiatrist should explain to the patient that they will not be eligible for Medicare-funded rTMS services (and may incur additional out-of-pocket costs) if they have previously received rTMS treatment.

Is there any discretion to increase the number of Medicare-funded rTMS treatment services to a patient?

No, the Medicare regulations allow a maximum of 50 treatment services (35 services initially, claimed through item 14217 and a further 15 services, claimed through item 14220, if clinically appropriate) over a person's lifetime.

If a patient has received an initial course of rTMS therapy prior to 1 November 2021, are they eligible to claim the MBS retreatment items 14219 and 14220?

No, the patient cannot have received any previous rTMS therapy regardless of where this was provided or whether this was privately or publicly funded. The MBS re-treatment items are only claimable if the patient has received initial rTMS through the MBS items 14216 and 14217, which were introduced on 1 November 2021.

Does a patient have to receive a prescription and mapping service (item 14216) before treatment services (item 14217) can be billed to Medicare?

Yes, although both services can be provided on the same day. For a course of retreatment, item 14219 must be provided before item 14220, although both services can be provided on the same day.

Can a prescription and mapping service (item 14216) be provided more than once for the same patient?

For most patients, it is expected that item 14216 would only be claimed once, prior to commencing a course of treatment. However, item 14216 may be claimed more than once if there is a clinical need

(e.g. for the purposes of re-establishing threshold for treatment), or if the patient's rTMS treatment is to be continued by another psychiatrist and prescription and mapping with the new practitioner is necessary in order to complete the treatment.

The same arrangements apply to prescription and mapping for a course of re-treatment (item 14219).

If a patient has previously been provided rTMS therapy for a disorder, other than depression, can they claim MBS items for rTMS treatment of depression?

No, regardless of the previous reason for rTMS therapy, if you have received any prior rTMS therapy, prior to 1 November 2021, then the patient is not eligible to claim the MBS rTMS items.

Claiming rTMS MBS items

Can another health care professional (other than a psychiatrist trained in the provision of rTMS) bill the MBS items?

No, while treatment and re-treatment services (covered by items 14217 and 14220) may be provided by an appropriately trained health care professional on behalf of a psychiatrist, the items can only be billed by a psychiatrist trained in rTMS. The health care professional may include a nurse practitioner, practice nurse, registered nurse, enrolled nurse or allied health professional trained in the provision of rTMS.

Prescription and mapping services (covered by items 14216 and 14219) must be physically provided and billed by a psychiatrist trained in rTMS.

Where rTMS services are provided in a private hospital, the MBS items must be billed by a medical practitioner (psychiatrist) – the items cannot be billed by the hospital itself.

Does the health care professional providing rTMS on behalf of the psychiatrist need to be employed by the psychiatrist?

It is the responsibility of the psychiatrist billing the rTMS treatment items (items 14217 and 14220) to ensure when the delivery of the rTMS is performed on their behalf, by a health care professional, that they are appropriately and formally trained in rTMS. Records must also be kept to demonstrate that all health care professionals (may include a nurse practitioner, practice nurse, registered nurse, enrolled nurse or allied health professional) providing rTMS services are appropriately trained.

Under current legislation (Health Insurance Regulation 2021) the health professional providing rTMS "on behalf of" the psychiatrist should either:

- Be employed by the medical practitioner, or
- Supervised by the medical practitioner, in accordance with accepted medical practice.

If the health professional acting on behalf of the psychiatrist meets this second requirement (acts under the supervision of the psychiatrist in accordance with accepted medical practice) they are not required to be 'employed' by the medical practitioner.

What does the term "supervision" mean, is supervision acceptable at a distance?

A psychiatrist trained in rTMS must personally perform the prescription and mapping service items (14216 & 14219), whereas it is considered acceptable medical practice to deliver rTMS treatment (under items 14217 & 14220) under the supervision of the psychiatrist, by a health professional with appropriate rTMS training.

In line with good medical practice, this supervision can be provided from a physical distance, provided the treating psychiatrist is able to provide advice as required during treatment (this could be by phone). When rTMS services are provided on behalf the psychiatrist, the psychiatrist continues to remain responsible for planning and monitoring treatment outcomes.

Will patients be eligible to claim Medicare items for the balance of a partially completed course of self-funded rTMS treatment that commenced prior to 1 November 2021?

No, Medicare-funded rTMS services are only available to patients who have not previously received rTMS therapy in any setting, this includes public or private settings. Therefore, if a patient has commenced a course of treatment privately, before 1 November 2021, they will not be eligible for Medicare-funded rTMS services to complete the course of treatment. This treatment should continue to be funded privately.

If a patient has commenced Medicare-funded rTMS with one provider (psychiatrist), must they complete all their Medicare-funded treatments with that one provider?

No, while it is expected that most patients would receive treatment from a single provider, this is not a requirement.

Is it acceptable for rTMS treatment services items (14217 and 14220) to be claimed more than once per day?

It is not routinely expected that these items will be billed more than once per day. However, there may be circumstances under which more than one treatment a day may be clinically appropriate, provided that rTMS practice follows protocols derived from (and proven effective by) substantive clinical trials. In line with RANZCP Professional Practice Guideline 16 - Administration of repetitive transcranial magnetic stimulation, most clinical trials have evaluated standard rTMS treatment which is applied as a single session on a daily basis, five days per week for between 4 and 6 weeks. If rTMS is prescribed in a manner that varies from standard rTMS treatment this should be clearly documented.

Does the Extended Medicare Safety Net apply to the rTMS items?

Yes, if a patient has reached their annual threshold in out-of-pocket costs for out-of-hospital Medicare services under the Extended Medicare Safety Net (EMSN), they may be eligible to receive a higher Medicare rebate for out-of-hospital treatment for the remainder of the calendar year, depending on what the psychiatrist charges for the service. Out-of-pocket costs are the difference between the Doctor's fee for the service and the Medicare benefit the patient receives.

Once a patient qualifies for the EMSN, for the remainder of the calendar year, they will receive the Medicare benefit for the out-of-hospital medical service and the lowest of either:

- 80% of the out-of-pocket amount or
- EMSN benefit cap amount

Individual patients are automatically registered with Services Australia for the EMSN, however couples and families are required to register in order to be recognised as a family for the purposes of the safety net.

The new rTMS items have EMSN caps applied – these specify the maximum benefit payable in safety net benefits for each service. The EMSN caps are currently $515.00 per service under items 14216 and 14219, and $326.15 per service under items 14217 and 14220.

Example of how the EMSN benefit is calculated, (provided for illustrative purposes only):

A patient has reached their EMSN threshold and is eligible for EMSN benefits. They receive the services on 1 April 2022, for rTMS treatment as per MBS item 14217, in the out-of-hospital setting and are billed $200 for the service.

The patient will receive:

- 85% rebate for item 14217 = $136

  AND

- 80% of the remaining out-of-pocket amount or $326.15 whichever is the lesser amount.

  (In this example, 80% of ($200 - $136) =$51.20.

This means the patient will receive a rebate of $187.20 ($136 + $51.20) and will be out of pocket $12.80 ($200 -$187.20)

Further information about the EMSN is available from the Services Australia website or MBS Online.

Training requirements for providers

What are the training requirements for a psychiatrist delivering rTMS services through Medicare?

The training requirements for psychiatrists have been endorsed through the Royal Australian and New Zealand College of Psychiatrists (RANZCP). RANZCP-endorsed training courses can be found on the RANZCP website here.

From 1 May 2022 all providers will be subject to ongoing Continuing Professional Development requirements set by the RANZCP.

Is there a 'grandparenting' pathway for psychiatrists already trained in rTMS to use the MBS items?

A grandparenting pathway was available for a time-limited period for providers (psychiatrists) who met the RANZCP criteria to qualify under 'grandparenting' rules between 1 November 2021 and 30 April 2022. These providers can claim the rTMS item numbers without completing any additional rTMS training.

Documentation confirming that the provider has met the grandparenting criteria may be requested by the Department of Health and Aged Care as part of MBS compliance processes and activities. Providers should contact the RANZCP if they require clarification about the grandparenting process.

From 1 May 2022 all providers (including those who met the grandparenting rules) will be subject to ongoing Continuing Professional Development requirements set by the RANZCP.

rTMS as part of Hospital Treatment

Can the Medicare items be used for rTMS services provided as part of hospital treatment?

Yes. While it is expected that the majority of rTMS services will be provided as out-of-hospital treatment, there will be circumstances where some patients may require hospital treatment.

For private health insurance benefits purposes, procedures are defined in the *Private Health Insurance (Benefit Requirements) Rules 2011* (the Rules) by categorising MBS items into one of three categories:

- Type A procedures – performed in hospital and include part of an overnight stay (higher accommodation benefits);
- Type B procedures – performed in hospital but do not include part of an overnight stay (lower accommodation benefits); or
- Type C procedures – procedures not normally requiring hospital treatment and therefore hospital treatment benefits are not payable (no insurance benefits).

The rTMS MBS items have a Type C private health insurance procedure classification. Type C procedures are those not normally requiring hospital treatment under the *Private Health Insurance (Benefit Requirements) Rules 2011* (the Rules). However, *the Rules* allow for hospital accommodation and other private health insurance benefits to be paid for Type C procedures if certification is provided.

The medical practitioner (psychiatrist) providing the professional service must certify in writing that, because of the medical condition of the patient or because of the special circumstances specified, it

would be contrary to accepted medical practice to provide the procedure to the patient except as hospital treatment in a hospital.

A Type C certification should document the clinical features, and/or the special circumstances, for that patient that justify admission and would make outpatient rTMS clinically inappropriate. The certification should be written specific to the individual patient. That is, it not sufficient to simply repeat the circumstances as 'risk/safety issues that need to be managed in an inpatient setting' but should explicitly reference the circumstances with specificity of the particular risk or safety issues for that patient

To assist psychiatrists, the Royal Australian and New Zealand College of Psychiatrists (RANZCP) and the Department have published further guidance on the type of information required in a Type C certification. This guidance is located at MBSonline.gov.au under factsheets for 1 November 2021 – New Items – Repetitive Transcranial Magnetic Stimulation (rTMS) therapy or found here.

Is a Type C certification required for each time a rTMS treatment session is claimed through the MBS when delivered as part of hospital treatment?

Yes - The Private Health Insurance (Benefit Requirements) Rules 2011 (the rules) require certification every time the MBS item is claimed, this is a regulatory requirement. It is expected that the majority of rTMS sessions will be provided in the out of hospital setting, but where it is clinically necessary to deliver as part of hospital treatment, it is important providers provide certification in writing for each time rTMS is delivered in accordance with the rules.

Where a patient requires a full "course" of rTMS treatment (up to 35 services) as part of hospital treatment, due to the medical condition of the patient and/or special circumstances, the provider must provide written certification to confirm the specific clinical features for that patient were justified each time the rTMS was delivered. It is important to understand *the rules* require the provider gives consideration of the requirement for treatment in the in hospital setting each time the treatment is delivered and provide written confirmation of this.

Is a Type C certification required to provide rTMS as part of hospital treatment to patients not eligible for Medicare-funded rTMS services?

No, this is not required if the patient is not eligible to receive Medicare-funded rTMS services. If the patient is not eligible to receive Medicare-funded rTMS services, private health insurers are not required to pay benefits for the MBS services. Type C certification is only required if the psychiatrist claims one or more of the MBS items for rTMS in relation to treatment provided during an inpatient admission at a private hospital.

Is a Type C certification required for a patient who has been admitted to a private hospital for psychiatric care or another purpose and receives rTMS in hospital?

Yes, a Type C certification is required to perform rTMS in hospital regardless of the reason for hospital stay. A Type C certificate is required for each single rTMS treatment session when provided while a patient is in hospital.

Can a patient who has been admitted to a private hospital for psychiatric care or another purpose receive rTMS outside of the private hospital environment (e.g from a private psychiatrist or another rTMS community based clinic)?

Yes, as long as the requirements of the MBS items are met. In this scenario, the patient would not be receiving rTMS as part of hospital treatment.

Can patients receive privately-funded treatment after 1 November 2021 if they are not eligible for Medicare-funded rTMS services?

Yes, patients can continue to access privately-funded treatment. Patients with private health insurance should speak to their health fund about what private health benefits would apply under their individual policy.

Where can I find more information?

Further information regarding MSAC and the recommendation to list rTMS on the MBS can be found on MSAC's website at www.msac.gov.au under applications 1196.2 - Repetitive Transcranial Magnetic Stimulation (rTMS) for the treatment of depression (Resubmission) and 1196.3 - Repetitive Transcranial Magnetic Stimulation (rTMS) for the treatment of depression (Resubmission).

The full item descriptors and information on other changes to the MBS are available on the MBS Online website at MBS Online. You can also subscribe to future MBS updates by visiting MBS Online and clicking 'Subscribe' at the bottom of the page.

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

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

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

Please note that the information provided is a general guide only. It is ultimately the responsibility of treating practitioners to use their professional judgment to determine the most clinically appropriate services to provide, and then to ensure that any services billed to Medicare fully meet the eligibility requirements outlined in the legislation. This sheet is current as of the Last updated date shown above and does not account for MBS changes since that date.