Australian Government
Medicare Australia

# Medicare and You

## Workbook for new health professionals

www.medicareaustralia.gov.au

Medicare Australia
PO Box 1001
Tuggeranong DC ACT 2901

ABN 75 174 030 967

# Foreword

The *Medicare and You—Workbook for new health professionals* aims to help you understand your obligations under the Medicare program, and support you as a health professional new to billing Medicare items.

Medicare was introduced in 1984 to provide eligible Australian residents with affordable, accessible and high quality health care.

Medicare provides access to:

- treatment as a public patient in a public hospital
- subsidised treatment by health professionals.

Medicare benefits are paid for professional services provided by medical practitioners, participating optometrists, dentists (specified services only) and eligible allied health professionals. Health professionals must meet legislative requirements before their professional services can attract a Medicare benefit.

This workbook features:

- six introductory modules on Medicare
- learning activities to reinforce your understanding of each topic
- a summary at the end of each module identifying key points
- a list of contact details for further information.

After you have completed this workbook you should have a better understanding of the Australian health care system, focusing specifically on Medicare. There is also an eLearning component of Medicare and You that allows you to complete a series of seven interactive web-based modules. This provides information and education for new health professionals in a convenient and accessible format.

For more information about how we aim to support you, please refer to the *Provider Strategy at a glance 2008–2011* and the *National Compliance Program 2008–09*, which can be found on our website. These documents are a summary of our approach to more effective and efficient service delivery. We aim to improve the way we do business by making it easier, less intrusive and more efficient for you.

As the landscape, roles and interactions with health professionals evolve and change, Medicare Australia continues to build on our promises. We will:

- make it easier for you
- get it right
- be genuinely interested in you
- respect your rights.

We look forward to working with you in the future.

Colin Bridge

General Manager
Program Review Division
Medicare Australia

# Contents

## Module five—Referrals and requests



## Module six—Enhanced Primary Care



## Module seven—Learning activity answers and further information



## Key for symbols within the workbook:

Information

Learning activity

# Module one
## *What is Medicare?*

1

This module provides an overview of the Australian health care system, focusing on the Medicare program. It explains the eligibility requirements for health professionals wanting to participate in Medicare, and provides information about patient eligibility and when Medicare benefits can be paid.

**In this module:**

# 1.1 Introduction to Medicare

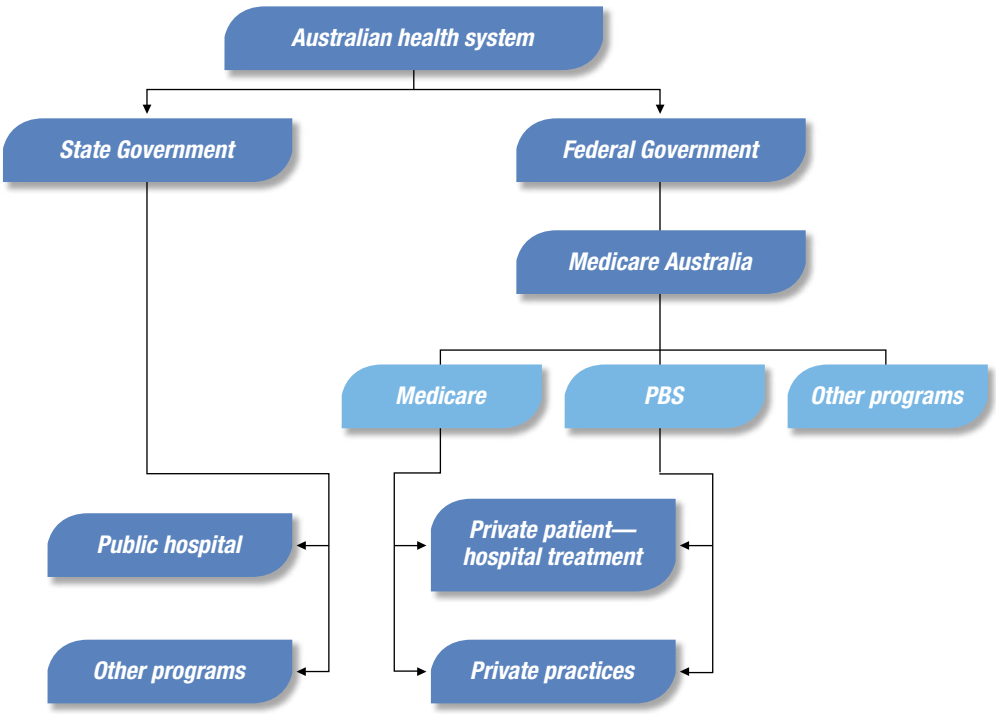
This topic will help you understand the role of the Medicare program within the Australian health care system.

## The Australian health care system

The Australian Government funds three major national subsidy schemes:

1. **Medicare**—providing free or subsidised treatment by health professionals including medical practitioners, participating optometrists, dentists (specified services only), eligible allied health professionals, and free treatment as a public (Medicare) patient in a public hospital.
2. **The Pharmaceutical Benefits Scheme (PBS)**—subsidises a significant proportion of the cost of prescription medicine.
3. **The 30 per cent Private Health Insurance (PHI) Rebate**—supports people's choice to take-up and retain private health insurance.

Australia's public hospital system is jointly funded by the Australian Government and state and territory governments, and is administered by state and territory health departments.



## Medicare Australia—delivering Australia's universal health funding program

Medicare Australia works in partnership with the Department of Health and Ageing (DoHA) to achieve the Australian Government's health policy objectives.

Our activities are conducted within the government policy framework set by DoHA, the Department of Veterans' Affairs (DVA), the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) and relevant legislation.

DoHA is responsible for:

- the policy development of Medicare
- the production of the Medicare Benefits Schedule (MBS).

Medicare Australia is responsible for:

- making sure Medicare benefits are paid to eligible Australian residents for services provided by eligible health professionals
- assessing and paying Medicare benefits for a range of medical services—provided in or out of hospital, based on a schedule of fees determined by DoHA in consultation with professional bodies.

Medicare Australia's goal is to deliver great service to the Australian public by providing services and making payments that are quick and effective. An inherent part of Medicare Australia's great service is managing the integrity in the delivery of Medicare so the right person receives the right payment at the right time—no more, no less.

For more information on the Australian health care system and the health programs administered by Medicare Australia, visit the Medicare Australia website **www.medicareaustralia.gov.au**

# 1.2 Health professional eligibility

This topic will help you understand the importance of your provider number and how to use it correctly.

## What is a provider number?

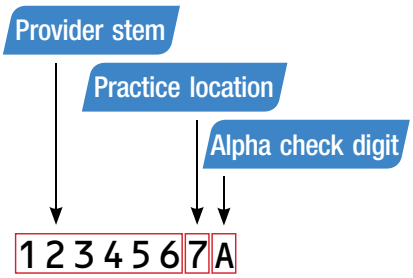
Provider numbers are unique numbers issued by Medicare Australia to registered health professionals including medical practitioners, optometrists, dentists and allied health professionals.

Medicare Australia uses provider numbers to identify health professionals and the location from which the health professional renders services.

A provider number is also known as a provider/registration number for eligible allied health professionals.

A provider number consists of:

- six numbers referred to as the provider stem (for example **123456**)
- an alpha or numeric character that identifies the practice location (for example **7**)
- an alpha check digit (for example **A**)




As a health professional, you must have a provider number for every location you practise at.

## How do I apply for a provider number?

Before you apply for a provider number with Medicare Australia, you must have current medical registration with the relevant state or territory in which you are situated. You should send a copy of your registration certificate or confirmation from the registration board, advising your current registration status to Medicare Australia with your application for a provider number.

Some health professionals do not have a registration board—in these cases you must be a member of the relevant national association before you can apply for a provider number. For example, Dietitians, must be an 'Accredited Practising Dietitian' as recognised by the Dietitians Association of Australia (DAA).

To apply for a provider number you must complete one of the following forms, depending on your health profession:

- *Application for an initial Medicare provider number (medical practitioner)*
- *Application for an initial Medicare provider number (optometrist)*
- *Application for an initial Medicare provider number (dentist, dental specialist or dental prosthetist)*
- *Application for an initial Medicare provider/registration number (allied health professional).*

If you already have a provider number and want to apply for a provider number for a new location, you can complete the following form:

- *Application for a Medicare provider number for a new location.*

To download the relevant application form, visit the Medicare Australia website **www.medicareaustralia.gov.au** then go to **For health professionals** > **Forms, publications & statistics** > **Medicare Forms** > **Apply for provider number**

Once completed, you should send your application and supporting documentation (if required) to Medicare Australia before your proposed start date.

Once Medicare Australia receives your application, it will be processed within five working days. Applications for some medical practitioners may take longer if other organisations or DoHA need to approve your eligibility.

You must not start billing Medicare services until Medicare Australia has advised you of your provider number and Medicare eligibility.

## How is my provider number used?

Apart from uniquely identifying you and the physical location from which you practise, a provider number also allows for the payment of Medicare benefits. All claims lodged with Medicare Australia must include your name and either:

- your provider number for the location where the service was provided (preferable)

or

- the address of the location from which the service was provided.

A provider number may also allow you to refer your patients to specialists or consultant physicians, or request diagnostic imaging or pathology services. Your referral letter must include your name and either:

- your provider number for the location where the referral or request was written (preferable)

or

- the address of the location from which the referral or request was written.

If you have questions about your eligibility to access Medicare benefits for services you provide call the Medicare provider enquiry line **132 150***.

## Will my services attract a Medicare benefit?

A provider number does not necessarily mean you can attract Medicare benefits for the services you provide. For example, a medical practitioner must meet legislative requirements set out in the *Health Insurance Act 1973* before Medicare benefits can be paid for their services.

Some provider numbers can only be used to refer/request diagnostic tests.

## Working in place of another health professional (locum tenens arrangements)

A locum is a health professional who temporarily fulfils the duties of another health professional. A locum may use one of their provider numbers for another location if they meet **all** of the following criteria:

- they have unrestricted access to Medicare benefits (including no restriction at the locations at which they can attract Medicare benefits for their services)
- the practice is not participating in the Practice Incentive Program (PIP)
- they are not bulk billing
- they will be providing the locum service for two weeks or less
- they will not be returning to that location again
- the provider number used is for a location in the same state or territory as the locum service.

If working in place of another health professional or working in a state or territory other than the one you are registered in, you must contact the Medicare provider enquiry line **132 150*** to discuss your options.

# 1.3 Patient eligibility

This topic will help you understand who is eligible to enrol with Medicare and the importance of a Medicare card.

## Who is eligible for Medicare?

To be eligible for Medicare benefits under the *Health Insurance Act 1973*, a patient must meet **one** of the following criteria:

- is either an Australian resident or an eligible overseas representative (see subsection 3–1 of the *Health Insurance Act 1973*)
- has been declared eligible by a Ministerial Order (see subsection 6–1 of the *Health Insurance Act 1973*)
- is a visitor from a country Australia has signed a Reciprocal Health Care Agreement (RHCA) with.

## Australian residents

Australian citizens, permanent residents and some applicants for permanent residency who reside in Australia, are eligible for a Medicare card. Residents of Norfolk Island are not eligible for enrolment in Medicare.

## Eligible overseas representatives

Permanent employees of government agencies who are posted overseas for varying periods of time to act as agency representatives remain eligible for Medicare as they are Australian citizens.

## Ministerial Orders

The *Health Insurance Act 1973* allows the Minister to order that a particular person, or group of persons, is eligible for enrolment in Medicare, even though they would not ordinarily meet the eligibility criteria. For example, holders of temporary protection visas are currently eligible for Medicare under a Ministerial Order.

## Reciprocal Health Care Agreement

The Australian Government has signed a RHCA with the governments of the United Kingdom, Sweden, the Netherlands, Finland, Norway, Malta, Ireland, New Zealand and Italy, which provides entitlement for visitors from these countries to limited subsidised health services for medically necessary treatment, while visiting Australia.

Medically necessary treatment is defined as any ill-health or injury which occurs while visiting in Australia that requires treatment before returning home.

## The importance of the Medicare card

Eligible people must enrol with Medicare before they can receive a Medicare card, claim Medicare benefits or seek treatment as a public patient in a public hospital.

The possession of a Medicare card by your patient is an easy way to identify if they are eligible for Medicare benefits.

If your patient has forgotten their Medicare card you can call the Medicare provider enquiry line on **132 150*** to confirm their eligibility and obtain their Medicare number.

If you need the Medicare number for an Aboriginal or Torres Strait Islander person, you should call Medicare Australia's Indigenous Access line on **1800 556 955****.

## What are the types of Medicare cards?

There are three types of Medicare cards (green, yellow and blue).

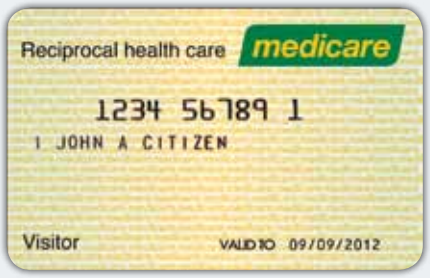
Medicare cards display a 10 digit number—the last digit indicates the card issue number. Up to nine people can be listed under a card number with a maximum of five people on each card.


**Australian resident card (green card)**

These cards are issued to Australian citizens and permanent Australian residents.

The possession of a green card by your patient is an easy way to identify if they are eligible for Medicare benefits.

Medicare cards for eligible overseas visitors or an applicant for permanent residency will be identified with either **Reciprocal health care visitor** or **Interim card** appearing on the card, as shown in the following samples.

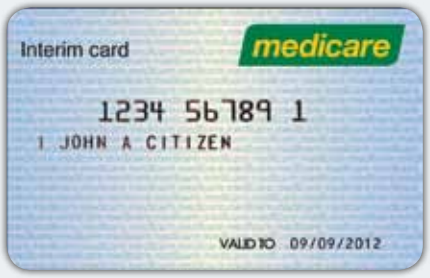



**RHCA card (yellow card)**

RHCA cards are issued to residents of the United Kingdom, Sweden, Finland, Norway and the Netherlands. Visitors are covered for the **duration** of their approved visit to Australia.

RHCA cards are also issued to residents and citizens of Malta and Italy. Visitors are covered for a period of **six months** from the date of arrival in Australia.

RHCA cards are not issued to visitors from Ireland and New Zealand. To access public hospital care and PBS medicine, visitors must present their passports before treatment.




**Interim card (blue card)**

An Interim card is issued to people eligible for Medicare benefits based on their application for permanent residency or covered under a Ministerial Order.

Their eligibility for Medicare benefits is not limited, however, coverage is limited to a specified period of time. Eligibility is valid until the date shown in the bottom right corner of the card.

# 1.4 Service eligibility

## 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 Medicare Benefits Schedule (MBS). A medical service is clinically relevant if it is generally accepted in the medical profession as being necessary for the appropriate treatment of the patient.

## 1.5 Summary

- Medicare provides all eligible Australians with affordable, accessible and high quality health care.
- Medicare benefits are paid for professional services provided by medical practitioners, participating optometrists, dentists (specified services only) and eligible allied health professionals, as long as these health professionals satisfy certain legislative requirements.
- Provider numbers are important for uniquely identifying you as a health professional and identifying the location from which you are practising.
- There are three different Medicare cards (green, yellow and blue) that identify people who are eligible for Medicare benefits.
- With the exception of certain eligible overseas visitors, your patient must have a valid Medicare number in order to access Medicare benefits for private health professional's accounts, or when seeking treatment as a public patient in a public hospital.

* Call charges apply.

** Call charges apply from mobile and pay phones only.

# Module two
## *How to use the Medicare Benefits Schedule*

**2**



This module explains the Medicare Benefits Schedule (MBS) terms, item numbers, descriptors and explanatory notes and how they apply in your work.

**In this module:**

# 2.1 Navigating the MBS

This topic will help you identify how the MBS is structured and the professional services listed in the MBS (including index structure and general explanatory notes).

## What is the MBS?

The MBS is developed, maintained, and published by the Department of Health and Ageing (DoHA). The MBS contains information on professional services covered by Medicare. It has explanatory notes to explain the Medicare program in detail.

The professional services that attract Medicare benefits are listed in five schedules:

- *Medicare Benefits Schedule* (includes oral and maxillofacial surgery)
- *Medicare Benefits Schedule Optometry Services*
- *Medicare Benefits Schedule for Cleft Lip and Cleft Palate Services*
- *Medicare Benefits Schedule for Allied Health Services*
- *Medicare Benefits Schedule for Dental Services.*

## What is MBS Online?

MBS Online is a useful tool to search the MBS by item numbers and keywords. MBS Online contains the latest MBS information and is updated as changes to the MBS occur.

You can access the MBS:

- directly from MBS Online using 'Search the MBS'

or

- by downloading a PDF version of all, or part, of the MBS.


To access MBS Online visit **www.mbsonline.gov.au**

Simulation training on MBS Online is available through our eLearning programs. Visit **www.medicareaustralia.gov.au/education** and complete Medicare and You eLearning for health professionals module two *How to use the MBS*.

## How is the MBS structured?

The MBS has been structured to group health professional services according to their general nature.

The MBS is divided into:

**General explanatory notes**

An outline of the Medicare benefit arrangements and general notes for all services.

**General medical services**

This section of the MBS is comprised of several categories.

**Category one—Professional attendances**

Information on medical practitioner attendances, including attendances for the purposes of health assessment and Chronic Disease Management (CDM).

**Category two—Diagnostic procedures and investigations**

Information on diagnostic services such as Electrocardiogram (ECG), audiology and respiratory service.

**Category three—Therapeutic procedures**

Information on surgical operations, obstetric services and a wide range of other therapeutic procedures—also includes specific explanatory notes for each group.

**Relative value guide for anaesthesia**

Information on anaesthetic services.

**Category four—Oral and maxillofacial services**

Information on oral and maxillofacial services by approved dental practitioners, an outline of arrangements and an index.

**Category five—Diagnostic imaging services**

Information on diagnostic imaging services (x-ray, ultrasound, MRI and CT scanning), an outline of arrangements, specific explanatory notes and an index to assist in finding the correct item listing for the service provided.

**Category six—Pathology services**

Information on pathology services, including some basic pathology services that GPs can directly provide to their patients. It also contains an outline of arrangements, specific explanatory notes and an index to assist in finding the correct item listing for the service provided.

**Category eight—Services provided by nurses, allied and dental health professionals**

Information on eligible allied health services such as diabetes education, physiotherapy and podiatry, as well as outlining services that can be provided on your behalf by Aboriginal health workers and practice nurses.

# 2.2 MBS item numbers and descriptors for medical practitioners

This topic will help you correctly select the MBS item number for the services you provide.

## How do I locate an item number using the general medical services index?

Most sections in the MBS include an index of the services contained within that section. The general medical services index provides an alphabetical listing of services listed in categories one, two, three and eight.

## Index

The following example illustrates how information for an antenatal attendance appears in the general medical services index.

| | |
|---|---|
| sensation, measurement of | 11850 |
| Anorectoplasty of anorectal malformation | 43963,43966 |
| Antenatal cardiotocography (restriction) | 16514 |
| care, independent of confinement | 16500 |
| service provided by a midwife, nurse or registered Aboriginal Health Worker | 16400 |
| Antepartum haemorrhage, treatment of | 16509 |
| Anterior chamber, irrigation of blood from | 42743 |

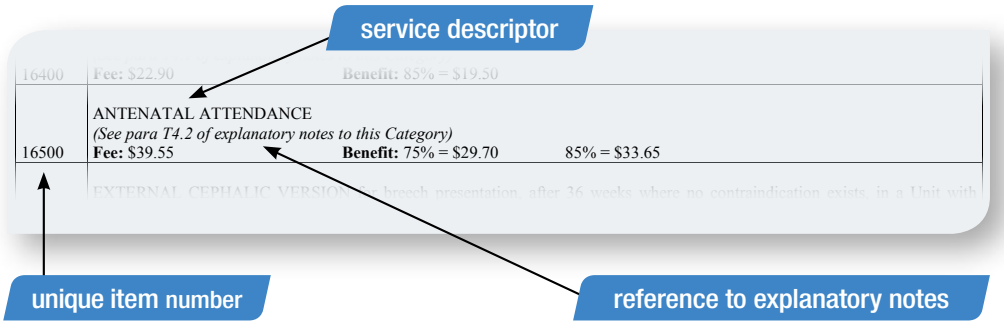
## What are MBS item numbers and descriptors?

Each professional service contained in the MBS has been allocated:

- a unique item number
- a service descriptor
- a reference to explanatory notes relating to the item number, where applicable.

The MBS lists item numbers in ascending order (with exception of MBS attendance items 601, 602, 697 and 698). Once you have located an item number from the index (in this case Item 16500), you should turn to that item within the MBS and read the item descriptor.

This is how Item number 16500 appears in the MBS.



## MBS item explanatory notes

Some professional services are more complex than others. To bill an item you must make sure that you have fulfilled the service requirements as specified in the item descriptor.

In the previous example, Item 16500 has a reference to 'explanatory notes' (See paragraph T4.2 of the explanatory notes). These notes provide additional information and guidance to you, as the health professional, to make sure the service requirements for the item have been met.

**T.4.2. ANTENATAL CARE - (ITEM 16500)**

In addition to routine antenatal attendances covered by Item 16500 the following services, where rendered during the antenatal period, attract benefits:-

(a) Items 16501, 16502, 16504, 16505, 16508, 16509 (but not normally before the 24th week of pregnancy), 16511, 16512, 16514 and 16600 to 16636.
(b) The initial consultation at which pregnancy is diagnosed.
(c) The first referred consultation by a specialist obstetrician when called in to advise on the pregnancy.
(d) All other services, excluding those in Category 1 and Group T4 of Category 3 not mentioned above.
(e) Treatment of an intercurrent condition not directly related to the pregnancy.

Item 16504 relates to the treatment of habitual miscarriage by injection of hormones. A case becomes one of habitual miscarriage following two consecutive spontaneous miscarriages or where progesterone deficiency has been proved by hormonal assay of cells obtained from a smear of the lateral vaginal wall.

Item 16514 relates to antenatal cardiotocography in the management of high risk pregnancy. Benefits for this service are not attracted when performed during the course of the labour and delivery.

Where there is reference to the explanatory notes in the item descriptor, these notes will appear at the beginning of the category in which that item is located.

Incorrect use of MBS items can result in the health professional being asked to repay money that has been incorrectly received. Therefore, it is extremely important that you understand the full requirements of each service before billing a MBS item.

## MBS item number selection

When using the MBS, there are three steps to identify the correct item for the services you have provided.

**Scenario:**

You have performed a health assessment in your consulting room on a 60 year old Indigenous patient and now want to select the correct item number.

**Step 1:** Locate the item using the general medical services index. Use a keyword to locate a range of items that may be appropriate for the service you have provided. The example below shows a range of items (700–706), which are health assessments.

**Step 2:** Read the item descriptor for each item that may be appropriate. Item 704 (example below) states '**a health assessment for a patient who is at least 55 years old and of Aboriginal or Torres Strait Islander decent**'.

| ENHANCED PRIMARY CARE | | ENHANCED PRIMARY CARE |
|---|---|---|
| | **GROUP A14 - HEALTH ASSESSMENTS** | |
| 700 | Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) **AT CONSULTING ROOMS** for a health assessment - of a patient who is **at least 75 years old** - not being a health assessment of a patient in respect of whom, in the preceding 12 months, a payment has been made under this item or **item 702, 704 or 706**<br>*(See para A24 of explanatory notes to this Category)*<br>**Fee:** $175.10 **Benefit:** 100% = $175.10 | |
| 702 | Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) **NOT BEING AN ATTENDANCE AT CONSULTING ROOMS, A HOSPITAL OR A RESIDENTIAL AGED CARE FACILITY** for a health assessment - of a patient who is **at least 75 years old** - not being a health assessment of a patient in respect of whom, in the preceding 12 months, a payment has been made under this item or **item 700**, **704 or 706**<br>*(See para A24 of explanatory notes to this Category)*<br>**Fee:** $247.60 **Benefit:** 100% = $247.60 | |
| 704 | Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) **AT CONSULTING ROOMS** for a health assessment - of a patient who is **at least 55 years old and of Aboriginal or Torres Strait Islander descent** - not being a health assessment of a patient in respect of whom, in the preceding 12 months, a payment has been made under this item or **item 700, 702 or 706**<br>*(See para A24 of explanatory notes to this Category)*<br>**Fee:** $175.10 **Benefit:** 100% = $175.10 | |
| 706 | Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) **NOT BEING AN ATTENDANCE AT CONSULTING ROOMS, A HOSPITAL OR A RESIDENTIAL AGED CARE FACILITY,** for a health assessment - of a patient who is **at least 55 years old and of Aboriginal or Torres Strait Islander descent** - not being a health assessment of a patient in respect of whom, in the preceding 12 months, a payment has been made under this item or **item 700, 702 or 704**<br>*(See para A24 of explanatory notes to this Category)*<br>**Fee:** $247.60 **Benefit:** 100% = $247.60 | |
| | **ABORIGINAL AND TORRES STRAIT ISLANDER CHILD HEALTH CHECK** | |
| | Attendance by a medical practitioner, other than a specialist or a consultant physician, at consulting rooms or in another place | |

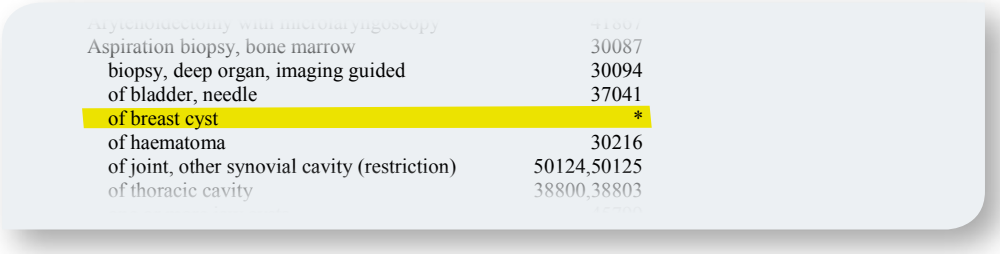
**Step 3:** Read the explanatory notes. After you have identified the MBS item which reflects the service you have provided, you should read any explanatory notes referred to in the item descriptor.

| | | |
|---|---|---|
| | *(See para A24 of explanatory notes to this Category)* | |
| 702 | **Fee:** $247.60 **Benefit:** 100% = $247.60 | |
| 704 | Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) **AT CONSULTING ROOMS** for a health assessment - of a patient who is **at least 55 years old and of Aboriginal or Torres Strait Islander descent** - not being a health assessment of a patient in respect of whom, in the preceding 12 months, a payment has been made under this item or **item 700, 702 or 706**<br>*(See para A24 of explanatory notes to this Category)*<br>**Fee:** $175.10 **Benefit:** 100% = $175.10 | |
| | Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) **NOT** | |

## Services not listed in the MBS

Medicare benefits are **not** payable for a service not listed in the MBS. However, there are some procedural services that are regarded as forming part of a consultation or do attract benefits on an attendance basis.

A procedural service that attracts a benefit on an attendance basis appears in the general medical services index with an asterisk (*). The following example illustrates how this information appears for 'Aspiration of breast cyst'.



| | |
|---|---|
| Aspiration biopsy, bone marrow | 30087 |
| biopsy, deep organ, imaging guided | 30094 |
| of bladder, needle | 37041 |
| of breast cyst | * |
| of haematoma | 30216 |
| of joint, other synovial cavity (restriction) | 50124,50125 |
| of thoracic cavity | 38800,38803 |

For a better understanding of how to navigate the MBS, complete the following learning activities.

### Learning activity 1: MBS item number selection—medical practitioners

Using the MBS, select the correct item number for each of the following medical services.

1. Antenatal care, independent of confinement:

a. 23

b. 30094

c. 16500

d. 45617

**Hint:** search either 'antenatal' or 'attendance'.

2. Removal of a subcutaneous foreign body by incision and exploration:

a. 11700

b. 30064

c. 20100

d. 30061

**Hint:** search either 'subcutaneous' or 'foreign body'.

3. Aspiration of a haematoma:

a. 30216

b. 78306

c. 56001

d. 17610

**Hint:** search either 'haematoma' or 'aspiration'.

## Learning activity 2: MBS item descriptors—medical practitioners

Using the following scenarios, pick the appropriate item number from the range provided.

**Scenario one:**

You remove a foreign body from a patient's foot—no incision is required. Circle the item you would use.

| | | | | |
|---|---|---|---|---|
| 30058 | **Fee:** $133.35 | **Benefit:** 75% = $100.05 | 85% = $113.35 | |
| 30061 | SUPERFICIAL FOREIGN BODY, REMOVAL OF, (including from cornea or sclera), as an independent procedure (Anaes.)<br>**Fee:** $21.70 | **Benefit:** 75% = $16.30 | 85% = $18.45 | |

| | | | | |
|---|---|---|---|---|
| 30062 | **Fee:** $56.10 | **Benefit:** 75% = $42.10 | 85% = $47.70 | |
| 30064 | SUBCUTANEOUS FOREIGN BODY, removal of, requiring incision and exploration, including closure of wound if performed, as an independent procedure (Anaes.)<br>**Fee:** $101.55 | **Benefit:** 75% = $76.20 | 85% = $86.35 | |

| | | | | |
|---|---|---|---|---|
| 35331 | **Fee:** $547.30 | **Benefit:** 75% = $410.50 | | |
| 35360 | Retrieval of foreign body in PULMONARY ARTERY, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare<br>***(foreign body** does not include an instrument inserted for the purpose of a service being rendered)* (Anaes.) (Assist.)<br>**Fee:** $765.10 | **Benefit:** 75% = $573.85 | | |

| | | | | |
|---|---|---|---|---|
| | SUBGROUP 8 - EAR, NOSE AND THROAT | | | |
| 41500 | EAR, foreign body (other than ventilating tube) in, removal of, other than by simple syringing (Anaes.)<br>*(See para T8.72 of explanatory notes to this Category)*<br>**Fee:** $76.20 | **Benefit:** 75% = $57.15 | 85% = $64.80 | |

**Scenario two:**

You suture a superficial 8 cm wound on the neck of a patient. Circle the item you would use.

| | | | |
|---|---|---|---|
| 30023 | **Fee:** $301.20 | **Benefit:** 75% = $225.90 | 85% = $256.05 |
| 30024 | WOUND OF SOFT TISSUE, debridement of extensively infected post-surgical incision or Fournier's Gangrene, under general anaesthesia or regional or field nerve block, including suturing of that wound when performed (Anaes.) (Assist.)<br>**Fee:** $301.20 | **Benefit:** 75% = $225.90 | 85% = $256.05 |

| | | | |
|---|---|---|---|
| 30029 | **Fee:** $83.10 | **Benefit:** 75% = $62.35 | 85% = $70.65 |
| 30032 | SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, small (NOT MORE THAN 7 CM LONG), superficial (Anaes.)<br>*(See para T8.7 of explanatory notes to this Category)*<br>**Fee:** $76.20 | **Benefit:** 75% = $57.15 | 85% = $64.80 |

OPERATIONS — GENERAL

| | | | |
|---|---|---|---|
| 30038 | SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, large (MORE THAN 7 CM LONG), superficial, not being a service to which another item in Group T4 applies (Anaes.)<br>*(See para T8.7 of explanatory notes to this Category)*<br>**Fee:** $83.10 | **Benefit:** 75% = $62.35 | 85% = $70.65 |

| | | | |
|---|---|---|---|
| 30042 S | **Fee:** $171.50 | **Benefit:** 75% = $128.65 | 85% = $145.80 |
| 30045 | SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, large (MORE THAN 7 CM LONG), superficial (Anaes.)<br>*(See para T8.7 of explanatory notes to this Category)*<br>**Fee:** $108.60 | **Benefit:** 75% = $81.45 | 85% = $92.35 |

# 2.3 MBS item numbers and descriptors for allied health professionals

This topic will help you correctly select the MBS item number for the services you provide.

## What are MBS item numbers and descriptors?

Each professional service contained in the MBS for Allied Health Services has been allocated:

- a unique item number
- a service descriptor
- a reference to item notes (referred to as 'parts') relating to the item number, where applicable.

The MBS for Allied Health Services lists item numbers in ascending order.

## MBS item notes

Some professional services are more complex than others. To bill an item you must make sure you have fulfilled the service requirements as specified in the item descriptor.

You will notice a reference to notes at the beginning of the section in which the MBS item is contained. The MBS for Allied Health Services contains the following item notes, referred to as 'parts'.

PART 1 Services for patients who have a chronic condition and complex care needs (MBS items 10950–10970).

PART 2 Follow-up allied health services for people of Aboriginal or Torres Strait Islander descent who have had a health assessment (MBS items 81300–81360).

PART 3 Services for patients with Type 2 Diabetes (MBS items 81100–81125).

PART 4 Psychological therapy services for patients with an assessed mental disorder (MBS items 80000–80020).

PART 5 Focused psychological strategy services for patients with an assessed mental disorder (MBS items 80100–80170).

PART 6 Services for women who are concerned about a pregnancy (MBS items 81000–81010).

PART 7 Services for children with autism or any other pervasive developmental disorder (MBS items 82000–82025).

## MBS item number selection

When using the MBS for Allied Health Services there are three steps you will take to identify the correct item for the service you have provided.

**Scenario:**

A GP has referred a patient to you, who is being managed under an Enhanced Primary Care (EPC) plan (MBS items 721–731). This now makes you (the allied health professional) eligible to claim MBS items 10950–10970, depending on your speciality.

**Step 1:** Locate the item using Appendix 1of the MBS for Allied Health Services which lists the range of items relevant to your speciality.

**Step 2:** Read the item descriptor for each item. Pay particular attention to the components of the attendance item.

**Step 3:** Refer to the relevant 'part' associated with your speciality.

*i* Incorrect use of MBS items can result in the health professional being asked to repay money that has been incorrectly received. Therefore, it is extremely important that you understand the full requirements of each service, before billing an MBS item.

# 2.4 How are Medicare benefits calculated?

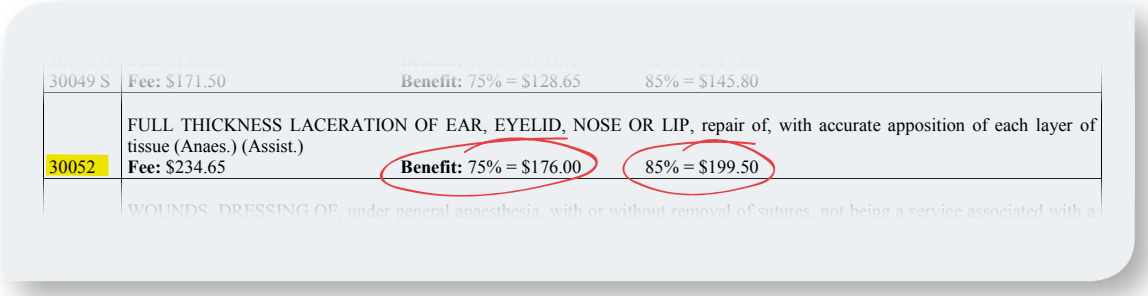
This topic will help you identify the Medicare benefit for each item listed in the MBS.

## Medicare benefits for medical practitioners

Medicare benefits are based on a percentage of the schedule fee determined for each medical service. Schedule fees (abbreviated to 'fee') are uniform across Australia and are determined by DoHA in consultation with professional bodies. These fees are used as the basis for all benefit calculations.

| Service | Benefit |
|---|---|
| • Out-patient GP<br>• non referred attendance items | 100 per cent of the fee |
| All other out-patient services | 85 per cent of the fee |
| In-patient services | 75 per cent of the fee |

For example:



| | | | |
|---|---|---|---|
| 30049 S | **Fee:** $171.50 | **Benefit:** 75% = $128.65 | 85% = $145.80 |
| 30052 | FULL THICKNESS LACERATION OF EAR, EYELID, NOSE OR LIP, repair of, with accurate apposition of each layer of tissue (Anaes.) (Assist.)<br>**Fee:** $234.65 | **Benefit:** 75% = $176.00 | 85% = $199.50 |
| | WOUNDS, DRESSING OF, under general anaesthesia, with or without removal of sutures, not being a service associated with a | | |

Refer to the latest MBS **Category one—Professional attendances** for a full list of services that attract benefit at 100 per cent of the fee.

## Medicare benefits for allied health professionals

The Medicare benefit for each item is provided in the item description for allied health services. The benefit amounts are calculated at **85 per cent** of the fee since the services listed in the MBS for Allied Health Services are for patients who are not an admitted patient of a hospital.

## 2.5 Summary

- The MBS contains a listing of professional services that attract a Medicare benefit under the Medicare program.
- The MBS is divided into a number of categories–for example, professional attendances and pathology investigations.
- The MBS contains indexes that will assist you in identifying the appropriate item numbers for the service/s you provide.
- Each Medicare service is allocated a unique MBS item number.
- The MBS can be accessed through MBS Online at **www.mbsonline.gov.au**
- To bill an MBS item you must make sure that you have fulfilled all of the service requirements as specified in the item descriptor and explanatory notes.

# Module three
## *Patient consultations (attendances)*

3

As a health professional the majority of your time is spent seeing patients. This module will outline the different components of attendance items and guide you in selecting the right item number for a variety of attendances.

**In this module:**

# 3.1 Professional attendances

This topic will help you correctly select the MBS attendance item for the service you provide.

## What are professional attendances?

Professional attendances by health professionals cover consultations during which you evaluate your patient's condition/s and develop a management plan.

## Personal attendance by a health professional

A health professional must **personally attend** a patient for the consultation to be regarded as a professional attendance for Medicare purposes. Health professionals who provide a service should make sure they maintain **adequate** and **contemporaneous** records.

The MBS general explanatory notes state:

| | |
|---|---|
| To be **adequate**, the patient or clinical record needs to: | • clearly identify the name of the patient<br>• contain a separate entry for each attendance by the patient and the date on which a service was rendered or initiated<br>• each entry needs to provide adequate clinical information to explain the type of service rendered or initiated<br>• each entry needs to be sufficiently comprehensible that another health professional 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 the service was rendered or as soon as practicable afterwards. |

## Components of an attendance

There are various components that determine which MBS attendance item you should bill. Firstly, select the correct MBS attendance item category. For example:

- **Category one**—Professional attendances

or

- **Category eight**—Services provided by nurses, allied and dental health professionals.

Secondly, consider whether one or more of the following factors will affect your MBS item selection.

| | |
|---|---|
| **Location** | Where did the attendance take place? (For example, at a medical practice, the patient's residence, hospital, residential aged care facility or other institution) |
| **Day** | What day of the week did the attendance take place? |
| **Time** | What time of day/night was it? (8.00 am, 12.15 pm or 8.15 pm) |
| **Content/complexity** | What was the attendance about, were there multiple problems/ conditions to treat? |
| **Nature/urgency** | Standard or non urgent, urgent or life threatening? |
| **Duration** | How long did you spend personally attending the patient? |

The example below illustrates some of the components (detailed above) as they appear within the item description.

| | |
|---|---|
| 5010 | **Derived Fee:** The fee for item 5000, plus $42.30 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5000 plus $3.05 per patient |
| | **LEVEL 'B'**<br>Professional attendance involving taking a selective history, examination of the patient with implementation of a management plan in relation to 1 or more problems, OR a professional attendance of less than 20 minutes duration involving components of a service to which item 5040, 5043, 5046, 5049, 5060, 5063, 5064 or 5067 applies<br><br>**SURGERY CONSULTATION**<br>(Professional attendance at consulting rooms. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day.)<br>*(See para A5 of explanatory notes to this Category)* |
| 5020 | **Fee:** $44.45 **Benefit:** 100% = $44.45 |
| | **HOME VISIT**<br>(Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, residential aged care |

You should only count the time during which the patient is receiving personal attendance in the total attendance time. You should not include periods such as when a patient is resting between blood pressure readings or the time taken to travel to see a patient at home or at an aged care facility in the calculation of the total attendance time. Similarly, you should also not include the time spent by a practice nurse treating a patient in the total attendance time.

## Where do I find attendance items in the MBS?

You can find professional attendance items in the MBS in Category one—Professional attendances (GPs, specialists, consultant physicians) and Category eight—Services provided by nurses, allied and dental health professionals.

## Schedule of services

### Category one—Professional attendances

| MBS group | Name of group | Description | MBS Item |
|---|---|---|---|
| Group A1 | GP attendances | Urgent after hours | 1, 2, 601, 602, 603 |
| | | Level A† | 3–20 |
| | | Level B† | 23–35 |
| | | Level C† | 36–43 |
| | | Level D† | 44–51 |
| Group A22 | GP attendances | Level A†—after hours | 5000–5010 |
| | | Level B†—after hours | 5020–5028 |
| | | Level C†—after hours | 5040–5049 |
| | | Level D†—after hours | 5060–5067 |

† Time and complexity based item numbers. Refer to latest MBS general explanatory notes for more information.

| MBS group | Name of group | Description | MBS Item |
|---|---|---|---|
| Group A2 | Other non referred attendances | Surgery± | 52–57 |
| | | Home± | 58–65 |
| | | Institution± | 81–86 |
| | | Hospital± | 87–91 |
| | | Residential Aged Care facility± | 92–96 |
| | | Urgent after hours | 97, 98, 696, 697, 698 |
| Group A23 | Other non referred attendances | Surgery± | 5200–5208 |
| | | Home± | 5220–5228 |
| | | Institution± | 5240–5248 |
| | | Residential Aged Care facility± | 5260–5267 |

± Time based item numbers. Refer to latest MBS general explanatory notes for more information.

## Schedule of services

### Category eight—Services provided by nurses, allied and dental health professionals

| MBS group | Name of group | MBS Item |
|---|---|---|
| Group M1 | Management of bulk billed services | 10990–10992 |
| Group M2 | Services provided by a practice nurse on behalf of a medical practitioner | 10987<br>10993–10999 |
| Group M3 | Allied health services | 10950–10970 |
| Group M5 | Services provided by a registered Aboriginal health worker on behalf of a medical practitioner | 10987–10989<br>10997 |

Health professionals should only use those items which relate to their particular group/s.

### Where do I find attendance items for allied health services?

You can find professional attendance items in the MBS for Allied Health Services under the following 'parts'.

| PART | Name of PART | MBS Item |
|---|---|---|
| PART 1 | Services for patients who have a chronic condition and complex care needs | 10950–10970 |
| PART 2 | Follow-up allied health services for people of Aboriginal or Torres Strait Islander descent who have had a health assessment | 81300–81360 |
| PART 3 | Services for patients with Type 2 Diabetes | 81100–81125 |
| PART 4 | Psychological therapy services for patients with an assessed mental disorder | 80000–80020 |
| PART 5 | Focused psychological strategy services for patients with an assessed mental disorder | 80100–80170 |
| PART 6 | Services for women who are concerned about a pregnancy | 81000–81010 |
| PART 7 | Services for children with autism or any other pervasive developmental disorder. | 82000–82025 |

# 3.2 Multiple attendances—medical practitioners

This topic will help you correctly bill multiple attendances on the same day for the same patient.

## Multiple attendances on the same day for the same patient

Medicare benefits may be paid for several MBS attendance items for a single patient, on the same day, and by the same health professional provided the subsequent attendances are not a continuation of an earlier episode/s of treatment for that patient on the same day.

## What is meant by the term 'continuation'?

Where the patient is seen twice or more on the same day in relation to the same medical condition, it may be considered to be a continuation of the earlier attendance/s. Where this occurs, the multiple attendances are to be treated as a single attendance for Medicare billing purposes. Each situation needs to be judged on its merits.

The following examples demonstrate situations that are considered to be a continuation of a previous attendance:

1. Allergens are applied to a patient's skin for the purpose of skin sensitivity testing. The patient is asked to return to the waiting room for 20 minutes to allow time for any reaction while the medical practitioner sees other patients. After 20 minutes, the patient goes back to see the medical practitioner so they can observe the results.
2. A patient is issued a prescription for a vaccine at an attendance with the medical practitioner. The patient then goes to the pharmacy to have the prescription filled and returns with the vaccine 30 minutes later to have the medical practitioner administer the injection.

## How do I bill multiple attendances on the same day?

Where you perform multiple attendances for the same patient, on the same day, and the subsequent attendances are not considered to be a continuation of earlier treatment on that day, the time of each attendance should be stated on the account to assist in the correct payment of benefits.

**For example:** you see a patient in the morning for review of an infected ulcer and they return later that day complaining of chest pain. It would be appropriate to bill two attendances that day as outlined below.

| Date | Time | Treatment | MBS Item |
|---|---|---|---|
| 25/06/08 | 10.30 am | Review infected ulcer | 23 |
| 25/06/08 | 5.30 pm | Acute onset chest pain | 23, 11700 |

# 3.3 Multiple attendances—allied health professionals

This topic will help you correctly bill multiple attendances on the same day for the same patient.

## Multiple attendances on the same day

Generally, consultations that run longer than the minimum time specified in the item description should be billed as a single attendance. For payment of a benefit for more than one attendance with a patient on the same day by the same allied health professional, the subsequent attendance must not be a continuation of the initial attendance.

There should be a reasonable lapse of time between such attendances before they can be regarded as separate attendances.

In the case of group services for patients with Type 2 Diabetes (items 81105, 81115 and 81125), where clinically relevant, up to two group services may be provided consecutively on the same day by the same allied health professional.

## How do I bill multiple attendances on the same day?

Where you perform multiple attendances on the one day and the subsequent attendance is not considered to be a continuation of earlier treatment on that day, the time of each attendance should be stated on the account (for example, 9.30 am and 3.15 pm) to assist in the correct payment of benefits.

If you are unsure about correct billing procedures, call the Medicare provider enquiry line on **132 150***.

For a better understanding of how to bill multiple attendances, complete the following learning activity.

## Learning activity 3: Multiple attendances—allied health professionals

**Scenario:**

You have received an Enhanced Primary Care (EPC) referral form for managing a patient with a chronic condition.

The minimum time requirement for allied health services (items 10950–10970) is 20 minutes.

Your appointments are of 30 minutes duration and the patient arrives at 10.00 am. After 10 minutes, you identify that you will need to spend 60 minutes with this particular patient for their first attendance.

You advise the patient that you would like to spend more time with them, however you cannot see them for 60 minutes continuously due to another appointment at 10.30 am.

You ask if the patient is happy to have 30 minutes initially (10.00–10.30 am), then have a further 30 minute appointment at 11.00 am. The patient agrees.

**How would you bill for this service?**

a. Two attendance items at 30 minutes each as both of these attendances have met the time requirement of 20 minutes per attendance.

b. One attendance item as the 11.00 am appointment is a continuation of the 10.00 am appointment.

c. Three attendance items at 20 minutes each as you have spent 60 minutes with this patient and the minimum time requirement of 20 minutes has been met.

# 3.4 Consultations with procedures

This topic will help you correctly bill an attendance item and a procedural item for a single episode of care.

## When can I charge for an MBS item in conjunction with a procedure?

If during the course of an attendance there is a need for a surgical procedure, such as repairing a wound, Medicare benefits are generally payable for both the attendance and the medical procedure.

**Scenario:**

You spend 15 minutes taking a selective history (including tetanus status), performing an examination and implementing a management plan for a patient who fell and sustained a superficial hand laceration. Based on this, you would bill two MBS items:

1. The relevant MBS item number for a repair of wound medical procedure (for example, Item 30026—if less than 7 cm)

| | |
|---|---|
| 30024 | **Fee:** $301.20 **Benefit:** 75% = $225.90 85% = $256.05 |
| 30026 | SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, small (NOT MORE THAN 7 CM LONG), superficial, not being a service to which another item in Group T4 applies (Anaes.)<br>*(See para T8.7 of explanatory notes to this Category)*<br>**Fee:** $48.25 **Benefit:** 75% = $36.20 85% = $41.05 |

2. MBS A1 (GP) attendance item based on the 15 minute consultation (Item 23 based on time and complexity).

| ATTENDANCES | GENERAL PRACTITIONER |
|---|---|
| 23 | **LEVEL 'B'**<br>Professional attendance involving taking a selective history, examination of the patient with implementation of a management plan in relation to 1 or more problems, OR a professional attendance of less than 20 minutes duration involving components of a service to which item 36, 37, 38, 40, 43, 44, 47, 48, 50 or 51 applies<br>**SURGERY CONSULTATION**<br>(Professional attendance at consulting rooms)<br>*(See para A5 of explanatory notes to this Category)*<br>**Fee:** $33.55 **Benefit:** 100% = $33.55 |

**or**

MBS A2 (other non referred) attendance item based on the 15 minute consultation (Item 53 based on time)

| | |
|---|---|
| 53 | **STANDARD CONSULTATION** of more than 5 minutes duration but not more than 25 minutes duration<br>**Fee:** $21.00 **Benefit:** 100% = $21.00 |

In cases where the level of benefit for an attendance depends upon consultation time, you must not include the time spent in carrying out a procedure (which is covered by another MBS item) in the total attendance time. In the example on page 37, the 10 minutes spent repairing the wound cannot be added to the total attendance time.

## When should an MBS attendance item not be charged in conjunction with a procedure?

There are some MBS items that include benefits for an attendance in their fee, whether or not an actual consultation takes place. This will be indicated by the inclusion of one of the following terms in the MBS item descriptor:

- 'each attendance'
- 'attendance at which'
- 'including associated attendances/consultations'.

The following is an example of an MBS procedural item containing one of these phrases.

| | | | |
|---|---|---|---|
| 30210 | **Fee:** $150.55 | **Benefit:** 75% = $112.95 | 85% = $128.00 |
| 30213 | TELANGIECTASES OR STARBURST VESSELS on the head or neck where lesions are visible from 4 metres, diathermy or sclerosant injection of, including associated consultation - limited to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - for a session of at least 20 minutes duration (Anaes.)<br>*(See para T8.12 of explanatory notes to this Category)*<br>**Fee:** $101.45 | **Benefit:** 75% = $76.10 | 85% = $86.25 |

When an attendance takes place for the sole purpose of performing a procedure, you cannot charge an attendance item in addition to the procedural item. For example, a skin lesion needing removal, which was identified previously but removed at a later date.

For a better understanding of how to bill attendances with procedures, complete the following learning activity.

### Learning activity 4: Consultations with procedures

Determine which of the MBS procedural items listed below may be billed in conjunction with an MBS attendance item (circle correct answer).

a. Item 30006

b. Item 30219

c. Item 173

**Hint:** use the MBS to review the item descriptors.

# 3.5 Normal aftercare

This topic will help you understand the meaning of the term aftercare.

## What is aftercare?

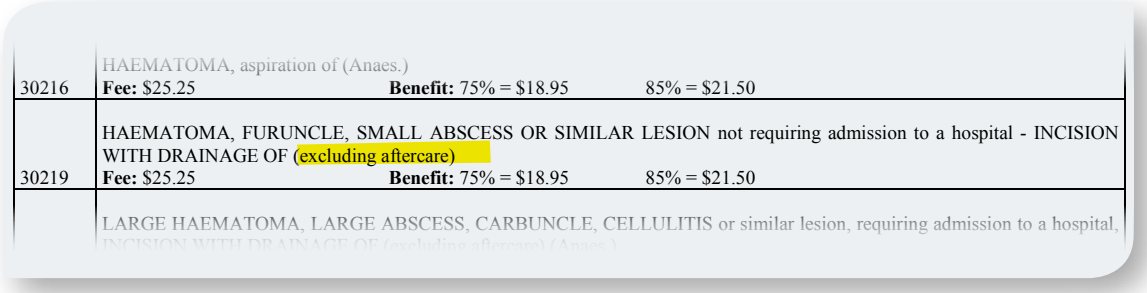
The schedule fee for surgical items in Category three of the MBS includes a component to cover routine post-operative treatment, known as aftercare. This means that by billing the MBS item, you are also receiving in advance, a benefit for the provision of any routine post-operative attendances.

The aftercare period is the duration of the normal healing process. The amount and duration of aftercare following an operation will vary between different operations and, in all cases, covers routine post-operative visits.

Benefits are not payable for routine post-operative attendances provided during the aftercare period.

The aftercare rule applies regardless of whether the patient is seen in hospital, consulting rooms or at home and applies to all medical practitioners not just the surgeon.

Where the phrase 'excluding aftercare' or similar appears in the MBS item descriptor (as displayed in the example below), post-operative attendances do attract a Medicare benefit where they are considered medically necessary.



| | |
|---|---|
| | HAEMATOMA, aspiration of (Anaes.) |
| 30216 | **Fee:** $25.25 **Benefit:** 75% = $18.95 85% = $21.50 |
| | HAEMATOMA, FURUNCLE, SMALL ABSCESS OR SIMILAR LESION not requiring admission to a hospital - INCISION WITH DRAINAGE OF (excluding aftercare) |
| 30219 | **Fee:** $25.25 **Benefit:** 75% = $18.95 85% = $21.50 |
| | LARGE HAEMATOMA, LARGE ABSCESS, CARBUNCLE, CELLULITIS or similar lesion, requiring admission to a hospital, |

## How do I bill attendances not related to aftercare?

Where a patient has had a procedure performed and an **unrelated attendance** takes place during what would be considered to be the aftercare period, a benefit is payable for that attendance.

**Scenario:**

You remove a subcutaneous foreign body from a patient's knee on Monday and they return on Tuesday to see you with a cold. This attendance is not related to the procedure on the knee, however, as the attendance falls within the aftercare period for the procedure on the knee you need to endorse the account/receipt with one of the following (or similar):

- not normal aftercare
- not normal post-operative care.

## Surgical procedures performed by another private practice

If the service you are providing would be considered aftercare for a procedure that has been performed at another private practice, there is no entitlement to a Medicare benefit.

**Scenario:**

You remove sutures for a patient but the initial procedure was performed at another private practice. At this point you have two options:

1. Advise the patient if they return to the private practice where the procedure took place they should be able to have the sutures removed at no cost.

or

2. If they want you to remove the sutures you will issue them with an account for the service you provide, however, no Medicare benefit will apply.

For a better understanding of aftercare, complete the following learning activity.

### Learning activity 5: Normal aftercare—medical practitioners

Read the following scenarios and select where you believe it is appropriate to bill Harry an MBS attendance item (circle correct answer).

1. Harry asks you to inspect a wound on his left arm, which is becoming red and swollen. He lacerated his arm in an accident at home three days ago, and a doctor from a private after hours clinic stitched the wound on the same night the accident occurred. You drain the infected wound, disinfect the area and apply a bandage.

   Appropriate to bill a MBS attendance item? Yes No

2. You have removed a subcutaneous foreign body from Harry's foot and sutured the affected area. A week later, Harry returns to have the sutures removed. There are no complications with the removal of the sutures and the wound has healed quite well.

   Appropriate to bill a MBS attendance item? Yes No

3. You excise a suspicious skin lesion from Harry's face, which turns out to be a basal cell carcinoma. You ask Harry to come back in two weeks time so you can remove the sutures. Harry returns and the sutures are removed without complication. Harry thanks you and advises you that he is out of his blood pressure medication and asks if you can write a script for him. You measure his blood pressure and there has been a slight improvement from the last couple of measurements. You write the prescription for Harry.

   Appropriate to bill a MBS attendance item? Yes No

4. Harry has dropped a hammer on his toe and a large haematoma has formed beneath the nail and is causing great discomfort to Harry. You drain the haematoma and ask Harry to come back in a week to make sure everything is healing normally. Harry returns, you check the affected area and it is healing as it should.

   Appropriate to bill a MBS attendance item? Yes No

## 3.6 Summary

- There are various components of a professional attendance that can impact on which item number is appropriate for the service you provide.
- In some instances, where you treat a patient on more than one occasion on the same day, the subsequent attendance is considered to be a continuation of an earlier episode of treatment and a single MBS attendance item should be billed.
- In most cases the Medicare benefit allocated to the performance of a surgical procedure includes a component for the provision of routine post-operative care or aftercare.
- Where an attendance is considered to be aftercare, you cannot bill an MBS attendance item.

* Call charges apply.

# Module four
# *Medicare billing and claiming*

4

4

This module explains aspects of patient billing and also the type of services which can be provided on behalf of a GP by practice nurses and Aboriginal health workers. In addition, it explains that not all professional services you provide attract a Medicare benefit.

**In this module:**

# 4.1 Billing and claiming methods

This topic will help you identify the different claiming and payment options available for billing Medicare services.

## Billing and claiming

As a health professional you have two options for billing Medicare services:

1. issue an itemised account

or

2. bulk bill your patient.

## Issuing itemised accounts

You can issue two types of accounts to your patients:

1. paid account—where the patient pays for services rendered in full

or

2. unpaid or partially paid accounts—where the patient does not pay, or partially pays their account on the day.

## Paid account

| | |
|---|---|
| **Health professional** | Issues an account and receipt. |
| **Claimant** | Uses the account and receipt, claims the Medicare benefit. |
| **Lodgement options for claimant** | • Uses Medicare Online at their doctor's practice.<br>• Uses Medicare Easyclaim (using existing EFTPOS terminal) at their doctor's practice.<br>• Visits a Medicare office to obtain their benefit in cash (limits apply), cheque, Reverse Electronic Funds Transfer (REFT) in some locations or Electronic Funds Transfer (EFT).<br>• Calls to Medicare Australia (requires paperwork to be forwarded) for payment by EFT or cheque.<br>or<br>• Post account for payment by EFT or cheque. |

## Unpaid account

| | |
|---|---|
| **Health professional** | Issues an account. |
| **Claimant** | • Claims from Medicare using the unpaid account.<br>• Medicare posts a 'pay doctor via claimant' cheque to the claimant.†<br>• Forward Medicare cheque together with the difference (gap amount) between the cheque and the account total, to the health professional. |
| **Lodgement options for claimant** | • Uses Medicare Online at their doctor's practice for 'pay doctor via claimant' cheque to be issued.†<br>• Uses Medicare Easyclaim (using existing EFTPOS terminal) at their doctor's practice for 'pay doctor via claimant' cheque to be issued.†<br>• Visits a Medicare office to lodge account for 'pay doctor via claimant' cheque to be issued.†<br>• Calls to Medicare Australia (requires paperwork to be forwarded) for 'pay doctor via claimant' cheque to be issued.†<br>or<br>• Post account for 'pay doctor via claimant' cheque to be issued.† |

## Partially paid account

(This is the gap difference between the Medicare benefit and the account in total)

| | |
|---|---|
| **Health professional** | Issue an account and receipt (showing amount paid) to the claimant. |
| **Claimant** | • Claims from Medicare using the account and receipt.<br>• Medicare posts a 'pay doctor via claimant' cheque to the claimant.†<br>• Claimant forwards the Medicare cheque to the health professional to finalise the account. |
| **Lodgement options for claimant** | • Uses Medicare Online at their doctor's practice for 'pay doctor via claimant' cheque to be issued.†<br>• Uses Medicare Easyclaim (using existing EFTPOS terminal) at their doctor's practice for 'pay doctor via claimant' cheque to be issued.†<br>• Visits a Medicare office to lodge account and receipt for 'pay doctor via claimant' cheque to be issued.†<br>• Calls to Medicare Australia (requires paperwork to be forwarded) for 'pay doctor via claimant' cheque to be issued.†<br>or<br>• Post for 'pay doctor via claimant' cheque to be issued.† |

† Medicare cheques for unpaid accounts are issued after a minimum of 16 days from the date of lodgment for GPs and 18 days from the date of lodgment for other health professionals.

## Bulk billing

If you agree to bulk bill, you accept the Medicare benefit as full payment for the medical service/s provided. The patient assigns their right to Medicare benefits to you and the payment is made directly from Medicare to you or to your practice.

If you choose this method, with the exception† of certain vaccines, no other charges can be raised for the services provided. This includes booking fees, administration fees, charges for bandages, record keeping or a charge by the health professional service company.

## Bulk billing—options for lodgement

As with lodging itemised accounts, there are a number of options outlined below.

| Health professionals' options for lodgement | Key features | Payment times |
|---|---|---|
| Medicare Online<br>(can be used for itemised accounts and bulk bill claims) | • Internet based—built into existing practice management software.<br>• No paperwork is submitted to Medicare Australia.<br>• No batching or storage required for bulk bill claims by practice. | Money will be deposited into your nominated bank account within 2–3 working days. |
| Medicare Easyclaim<br>(can be used for itemised accounts and bulk bill claims) | • Uses existing EFTPOS terminal.<br>• No paperwork is submitted to Medicare Australia.<br>• No batching or storage required for bulk bill claims by practice. | Money will be deposited into your nominated bank account almost immediately. |
| Manual processing | • Paperwork is submitted to Medicare Australia. | Money will be deposited within 15 working days from the date received by Medicare Australia. |

**Important:** the payment times indicated exclude bulk bill pathology services.

For more information on Medicare claiming visit the Medicare Australia website **www.medicareaustralia.gov.au/providers**

† This only applies to GPs and other non-specialist practitioners for attendance MBS items 3–96, 5000–5267 (inclusive) and Item 10993, and only relates to vaccines that are not available to the patient free of charge through the Australian Government, state or territory funding arrangements or available through the Pharmaceutical Benefits Scheme (PBS). The additional charge must only be to cover the supply of the vaccine.

## Bulk billing incentives for unreferred services

Financial incentives are available for health professionals who bulk bill out-patient (at a practice or consulting room) medical services to Australian Government concession card holders and children under 16 years of age.

When you bulk bill an eligible patient, in addition to receiving the Medicare benefit for the medical services you have provided, you will also receive an incentive payment.

The following MBS item numbers are used by GPs to notify Medicare Australia of a patient's eligibility to attract the incentive payment:

- Item 10990—practices operating within city and major suburban areas
- Item 10991—practices operating in rural and remote† areas and areas of need
- Item 10992—after hours services provided outside of the doctor's surgery, in rural and remote† areas, and areas of need.

You cannot bill combinations of incentive items (for example, items 10991 and 10992). However, you can bill multiples of the same item (for example, Item 10991 twice), where you have provided more than one Medicare service to an eligible patient.

† For more information on rural and remote classifications, call the Medicare provider enquiry line on **132 150***. Higher rates of incentives apply to services provided in rural and remote locations (MBS items 10991 and 10992).

# 4.2 Billing requirements

This topic will help you identify the information which is required on itemised accounts, receipts and bulk bill claims for billing purposes.

## What information is required for Medicare billing purposes?

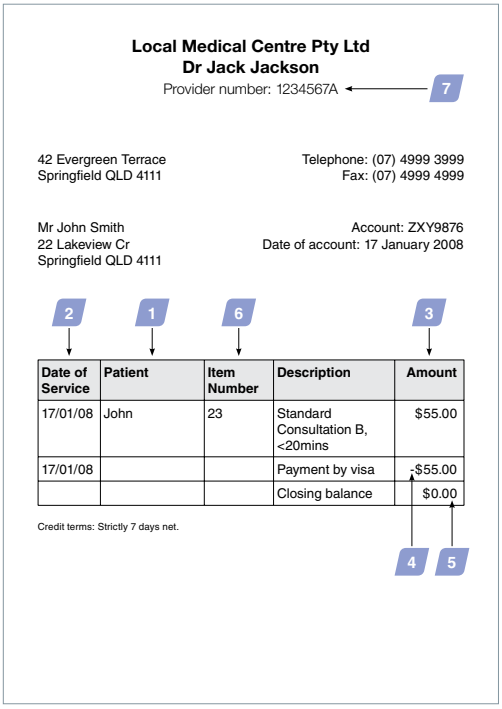
It is important health professionals provide the required information, otherwise the payment of Medicare claims could be delayed or disallowed in the first instance.

The health professional must take full responsibility for the information provided on itemised accounts and bulk bill claims. This includes when someone other than the health professional records the information on their behalf—for example, the practice manager.

## Itemised accounts

The following service details must appear on itemised accounts to ensure the payment of Medicare benefits:

1. patient's name
2. date the service was provided
3. amount charged
4. total amount paid (if any)
5. any amount outstanding
6. MBS item number and/or a description sufficient to identify the relevant item
7. practice name and address or name and provider number of the health professional who provided the service (where the health professional has more than one practice location recorded with Medicare Australia, the provider should use the practice location where the service was provided).




In addition, you will also need to provide the following information where relevant:

- The times of each attendance where you wish to claim for more than one attendance item for the same patient, on the same day.
- The name and provider number of the health professional claiming or receiving payment of benefits (if different to the service provider).
- An indication that a service was provided to a hospital in-patient. To signify in-patient treatment, insert the words 'admitted patient', place an asterisk (*) against the item number or description of the service (not relevant to allied health services, which only attract benefits where performed as an out-patient service).

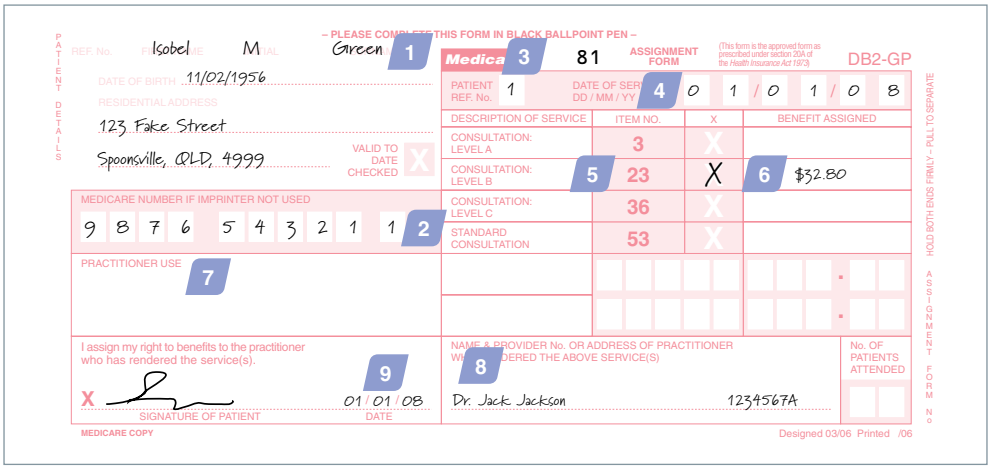
## Bulk bill claims

A bulk bill claim (either paper based or electronic) will consist of the following:

- bulk bill voucher
- bulk bill header.

## Bulk bill voucher

The sample provided is an *Assignment of benefit form DB2 GP*. This voucher is used by GPs when submitting paper based claims to Medicare Australia.




You need to provide the following service details on each bulk bill voucher (paper based or electronic) to make sure of Medicare benefits are paid.

1. Patient's name.
2. Patient's Medicare number—if a patient's Medicare number is not available, you must include the patient's name, date of birth and current address on the voucher.
3. Patient's reference number (identifies the individual named on the card).
4. Date the service was provided.
5. MBS item number and/or a description of the service sufficient to identify the relevant item.
6. Medicare rebate for each item claimed.
7. Times of each attendance—where a health professional is claiming for more than one attendance item on the same patient, on the same day†.
8. Name and provider number of the health professional who provided the service (the provider number used should be applicable to the practice location where the service was given).
9. Patient's signature—the patient must sign and date the voucher indicating their agreement to assign their right to Medicare benefits to the health professional††.

† For more information about multiple attendances, see Module three.

†† Where a patient is unable to sign the voucher, the signature of the patient's parent, guardian or other responsible person is acceptable. The reason the patient is unable to sign should be stated.

In the absence of a 'responsible person', the patient signature section should be left blank and in the section headed 'Practitioner's use' (see point 7 in the example above), an explanation should be given as to why the patient was unable to sign (for example, they're unconscious) and this note should be signed or initialled by the health professional.

It is a legal requirement that the voucher (*Assignment of benefit form DB2 GP*) is signed by the patient only after the service has been provided and the form completed. A copy of the completed voucher must be given to the patient.

## Bulk bill voucher—allied health professionals

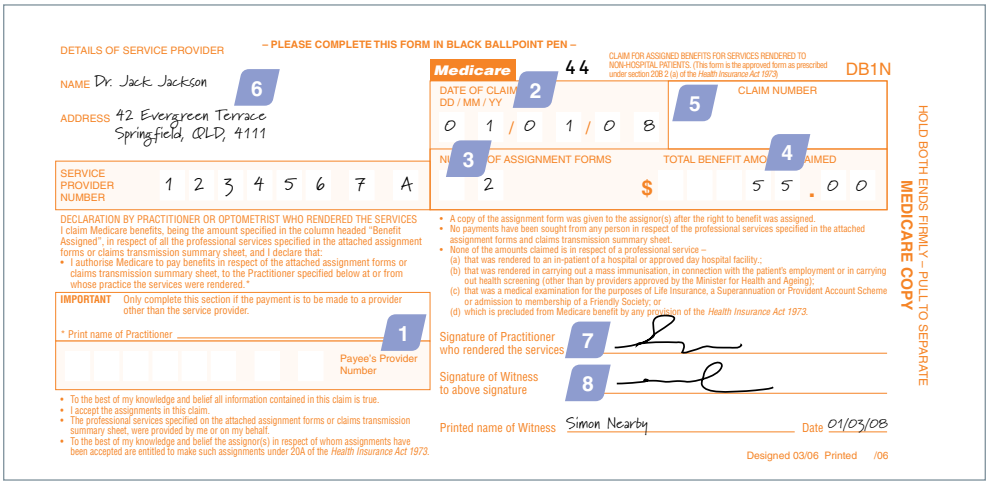
For services provided by an allied health professional, you must provide the name and provider number of the referring medical practitioner, as well as the date of referral on the bulk bill voucher.

This information must appear in the 'Referral details' box on the voucher.

## Bulk bill header

Health professionals who lodge bulk bill claims (paper based or electronic) must complete a bulk bill header form. There are a number of bulk bill headers which are used in different circumstances. For example, allied health professionals will use a different header to GPs and there is a separate header for in-patient and out-patient services. However, each header must contain the following information.

The sample provided is a *claim form DB1N*. This header is used by GPs when submitting paper based claims to Medicare Australia.




1. Name and provider number of the health professional claiming or receiving payment of benefits (if different to the health professional providing the service).
2. Date that you are compiling the claim to send to Medicare Australia.
3. Number of bulk bill vouchers in the claim.
4. Combined total of benefit for the bulk bill vouchers in the claim.
5. Bulk bill claim number:
   - for paper based bulk bill claims the header contains a pre-allocated claim number
   - for electronic claims this number will be automatically generated for you when creating the claim (for Medicare Easyclaim a unique claim number is generated for each individual voucher).
6. Name, location and provider number for the health professional providing the services.
7. Signature of the health professional providing the services.
8. Date, name and signature of witness.

# 4.3 Billing for services rendered on behalf of GPs

This topic will help you identify the services practice nurses and Aboriginal health workers can perform on behalf of GPs.

## Practice nurse

A practice nurse is a registered or enrolled nurse, or nurse practitioner who is employed or retained by a general practice.

Practice nurse services are shown in the table below.

| MBS Item | Service description |
|---|---|
| 10987 | Follow up service for Indigenous person who has received a health check |
| 10993 | Immunisation |
| 10996 | Wound management |
| 10994, 10995, 10998, 10999 | A cervical smear and/or preventative checks |
| 10997 | Ongoing support and monitoring for patients with chronic diseases |
| 16400 | Antenatal services† |

## Aboriginal health worker

An Aboriginal health worker is a person in the Northern Territory who is registered as an Aboriginal health worker under the *Health Practitioners Act 2004 (NT)*, who is employed or retained by a general practice, or by a health service that has an exemption to claim Medicare benefits under sub-section 19(2) of the *Health Insurance Act 1973*.

Aboriginal health worker services are shown in the table below.

| MBS Item | Service description |
|---|---|
| 10987 | Follow up service for Indigenous person who has received a health check |
| 10988 | Immunisation |
| 10989 | Wound management |
| 10997 | Ongoing support and monitoring for patients with chronic diseases |
| 16400 | Antenatal services† |

† Antenatal services can also be performed by a midwife on behalf of a GP. A midwife is a registered midwife who holds a current practising certificate issued by a state or territory regulatory authority and employed by, or retained by, the medical practitioner or their practice. This service can only be provided in a regional, rural or remote area.

## Non claimable services provided by practice nurses and Aboriginal health workers

Practice nurses and Aboriginal health workers can also provide assistance to the GP with the provision of the following services. These services do not attract Medicare benefits.

1. **Health checks and assessments**

In accordance with accepted medical practice and under the supervision of the GP, the practice nurse or Aboriginal health worker may assist with:

- identifying eligible patients through examination of patient records and patient information systems used within the practice
- information collection (such as measuring height, weight and blood pressure)
- providing patients with information about recommended interventions at the direction of the GP (such as information about community resources and support services in the local area, referral options).

2. **Chronic Disease Management (CDM), preparing or reviewing a GP Management Plan (GPMP) or Team Care Arrangement (TCA) service**

In accordance with accepted medical practice and under the supervision of the GP, the practice nurse or Aboriginal health worker may assist with chronically ill patient assessments (i.e. identification of patient needs and making arrangements for services).

The GP must personally attend the patient and confirm all elements of assistance provided by practice nurses and Aboriginal health workers in the development of health assessments and CDM services.

A practice nurse and Aboriginal health worker can provide assistance to the GP (monitoring and support of a person) for patients with an existing GPMP, TCA or multidisciplinary care plan. This is a claimable service under Item 10997, which can be billed by the GP up to five times per year.

For a better understanding of how to bill for services rendered on your behalf, complete the following learning activity.

### Learning activity 6: Billing for services rendered on my behalf

Select either **true** or **false** in response to these questions on billing.

As a GP, I can bill an MBS item for a practice nurse or Aboriginal health worker providing the following services are on my behalf and under my supervision.

| Service | True | False |
|---|---|---|
| 1. Providing immunisation services. | | |
| 2. Information collection in regards to health assessments/checks. | | |
| 3. Examining patient records to identify suitable eligible patients for Enhanced Primary Care services. | | |
| 4. Providing antenatal services. | | |
| 5. Providing wound management services. | | |
| 6. Providing ongoing support and monitoring for patients with chronic diseases. | | |

# 4.4 Services not attracting Medicare benefits

This topic will help you identify the services which do not attract a Medicare benefit.

Not every professional service you provide will be eligible for a Medicare benefit. This does not mean that you cannot privately charge your patients for providing the service—it just means that the patient cannot claim a Medicare benefit for that service.

## Which services do not attract a Medicare benefit?

Medicare benefits cannot be paid for services:

- provided to patients who are not eligible for enrolment in the Medicare program
- provided by health professionals who are not registered with Medicare Australia to provide services that can attract Medicare rebates.

Medicare benefits are not payable for any service not considered **medically necessary** and **clinically relevant** for the management of a patient's condition.

A medical service is **clinically relevant** if it is generally accepted by peers as being necessary for the appropriate treatment of the patient.

Medicare benefits are not payable for:

- health screening (multiphasic health screening; screening for osteoporosis; testing to determine fitness for weight reduction classes, scuba diving or other sporting activities; examinations for pilot, driving or other commercial licences)
- mass immunisation programs
- telephone consultations and advice given over the phone
- cosmetic surgery for non-medical reasons
- referrals or repeat prescriptions which do not involve an attendance by the patient
- services where the medical expense is the responsibility of the patient's employer
- medical examinations for life insurance, superannuation, provident account scheme or admission to membership of a friendly society
- treatment of a practice partner or practice partner's dependants unless there is provision for a charge to be made within the partnership agreement
- self-treatment by health professionals or treatment of their dependents
- body piercing
- removal of tattoos.

Refer to the MBS explanatory notes for the full list of services not covered by Medicare.

For a better understanding of services that attract Medicare benefits, complete the following learning activity.

### Learning activity 7: Services attracting Medicare benefits

For each of the following statements, select **true** or **false** as to which services attract a Medicare benefit in normal circumstances.

| Statement | True | False |
|---|---|---|
| 1. Medical services provided in a public hospital to a public in-patient. | | |
| 2. Surgical removal of a tattoo. | | |
| 3. Provision of medical advice over the phone in emergency situations. | | |
| 4. A medical examination for the purposes of claiming social security benefits. | | |
| 5. A medical examination/clearance to be able to take up boxing as a sport. | | |
| 6. A medical examination on your own patient, just to check on and provide advice on their general health. | | |
| 7. Writing a report for one of your patients for life insurance purposes. | | |
| 8. Administering immunisations to year 10 students at the local school. | | |

# 4.5 Inappropriate billing practices

This topic will help you understand the consequences of inappropriately claiming Medicare benefits.

## What if I improperly issue an account?

The following are potential consequences of improperly issuing an account:

- no Medicare benefit will be paid for the service
- the health professional who issued the account, or authorised it to be issued, may face charges under sections 128A and 128B of the *Health Insurance Act 1973*
- excess Medicare benefits paid as a result of a false or misleading statement are recoverable from the health professional under Section 129AC of the *Health Insurance Act 1973*.

## What is enforcement and recovery action?

Medicare Australia has a legal responsibility and power to investigate health professionals suspected of making false or misleading statements and can refer individual health professionals for prosecution if there is evidence of fraudulent activity.

If Medicare benefits have been paid inappropriately or incorrectly, Medicare Australia will take recovery action.

For additional information relating to Medicare Australia's Practitioner Review Program and National Compliance Program visit the Medicare Australia website **www.medicareaustralia.gov.au/providers**

## 4.6 Summary

- There are two alternatives available to health professionals when billing Medicare services—issue an itemised account or bulk bill the patient.
- There are a number of claim lodgement options for either method and you should choose the one/s that suit your practice.
- When a GP bulk bills, they can also claim additional benefits when billing children under 16 years of age or Commonwealth concession cardholders.
- Mandatory information is required on itemised accounts, receipts and bulk bill vouchers and missing information may lead to delays in payment or rejection of a claim.
- There are services that can be provided by practice nurses and registered Aboriginal health workers on behalf of a GP.
- Medicare does not pay for every type of professional service you provide.
- It is a requirement that MBS item numbers you bill accurately reflect the service/s provided.
- Medicare benefits paid inappropriately or incorrectly will be recovered.

* Call charges apply.

** Call charges apply from mobile and pay phones only.

# Module five
## *Referrals and requests*

5

5

This module explains the difference between referrals and requests. It also outlines what constitutes a valid referral for Medicare purposes.

**In this module:**

# 5.1 Referrals

This topic will help you identify the information required when referring your patients for specialist or consultant physician services.

Often while treating your patients it may become apparent that they need to consult a specialist. Certain services provided by specialists and consultant physicians only attract Medicare benefits following the receipt of a valid referral from another health professional.

## What is a referral?

A referral may ask a specialist or consultant physician to further investigate, provide an opinion, treat and/or manage a patient. Alternatively the referral may ask the specialist to perform specific examinations, tests or procedures.

A referral will result in the following:

- consultation by the specialist or consultant physician with the patient as often as required
- liaison between the referring medical practitioner and specialist/consultant physician.

## Who can refer?

A referral is valid when it is made to:

- a specialist by:
  - another medical practitioner
  - an oral surgeon (if arising from a dental service)
  - an optometrist (if referred to a specialist ophthalmologist).
- a consultant physician by:
  - another medical practitioner
  - a dentist (if arising from a dental service).

## What is a valid referral?

Before a referral can be considered valid, you must make sure:

- a professional attendance has been undertaken with the patient and the need for the referral considered—you must communicate the relevant information about the patient to the specialist/ consultant physician (this does not necessarily mean an attendance on the occasion of the referral)
- the referral is in writing by way of a letter or note and must be signed and dated by you
- the written referral is received by the specialist or consultant physician before any service is provided.

## Referral letters (see example on facing page)

The following details must appear on the referral letter:

1. Name and date of birth of the patient you are referring.
2. Name of the specialist or consultant physician to whom you are referring.
3. Condition or problem you are referring the patient for including any specific clinical details that may assist the specialist or consultant physician in treating the patient.
4. Details identifying you as the referring medical practitioner (name and either address or provider number).
5. Your signature.
6. Period of referral from medical practitioners working in general practice, referrals are valid for 12 months unless otherwise specified (for example, '3', '6' or '18' months, or 'indefinitely' where clinically relevant).
7. Date of referral.

## Validity of referral

Referrals are valid from the date of the first attendance with the specialist or consultant physician, **not** from the date the referral was written.

For example:

A GP refers a patient to a specialist on 1 January 2008 for a period of six months. The patient's first appointment with the specialist under this referral is 15 January 2008.

For Medicare purposes, the six month referral becomes active on 15 January 2008 and will remain valid for six months ending 14 July 2008.

*Rural Docs Medical Practice* *Telephone: (07) 4999 3999* *Fax: (07) 4999 4999*

Dr. Jack Jackson
Rural Docs Medical Practice
42 Evergreen Terrace
Springfield QLD 4111
Provider number: 1234567A

4

Attn:
Dr U R Special
24 Kilbirnie Street
Springfield QLD 4111

2

20 September 2007

7

Dear Dr. Special:

**RE: Mrs I M Green**
DOB: 11 February 1956
123 Fake Street
Spoonsville QLD 4999

1

Thank you for seeing Mrs Isobel Mary Green aged 51, for an opinion and management. This patient saw me complaining of abdominal pain and cramping with change in bowel habit and urinary hesitancy. Colonoscopy performed in 2001 was clear.

Abdominal x-rays ordered last month revealed evidence of faecal impaction. I have asked her to show you her x-rays and have enclosed a copy of the radiologist's report for your perusal.

The enclosed pathology results show a positive faecal occult blood test but normal faecal culture, CA 19.9, FBS, ESR, CRP and urine culture. She has been taking antacids and ranitidine prn for heartburn. She also has trouble sleeping.

Proctoscopy was normal including there were no obvious signs of localised causes of bleeding like piles or anal fissure.

As the pain and constipation is now worse, and in light of the positive occult blood result, I would think that a repeat colonoscopy is now warranted and I would appreciate you seeing her to see if you concur. Incidentally, there is no family history of first degree relatives having bowel cancer.

3

**Past Medical History**:

| *Date* | *Condition* |
|---|---|
| 1976 to 1987 | 4 pregnancies, 2 miscarriages |
| 1990 | Bladder repair/hysterectomy |
| 1992 | Palate surgery re: persistent snoring |
| 2001 | Colonoscopy |

**Current Medications**: Influenza vaccine inj, trivalent, annually; Ranitidine 150mg prn; Lorazepam 1mg prn

**Allergies:**
**PENICILLIN (hives and swelling of lips)**

Thank you for seeing her at such short notice. I look forward to your assistance and your findings.

*Jack Jackson*
Dr Jack Jackson
MBBS, FRACGP

5

*Referral valid for 12 months.*

6

# 5.2 Requests

This topic will help you identify the information required when requesting diagnostic imaging and pathology services for your patient.

## What is a diagnostic imaging request?

A diagnostic imaging request asks diagnostic imaging specialists to perform investigations or tests specified and report findings back to the requesting practitioner.

Before requesting a diagnostic imaging service you must consider the clinical relevance of the request and determine that the service is medically necessary for your patient.

## Form of request

A request for a diagnostic imaging service does not have to be in any particular form. However, it must be in writing and contain sufficient information, in terms that are generally understood by the profession, to clearly identify the item/s of service requested. This includes, where relevant, noting on the request the clinical indication/s for the requested service.

When writing a request for diagnostic imaging services you must include the following information:

- the name and address of the patient
- your name and address or name and provider number in respect of the place of practice
- sufficient information to clearly identify the MBS item number/s of the service/s you are requesting
- your signature and date of referral.

The requesting practitioner may use a single request to order a number of diagnostic imaging services.

## What is a pathology request?

A pathology request asks an Approved Pathology Authority or an Approved Pathology Practitioner to perform specific tests specified within the request.

Before requesting a pathology service you must consider the clinical relevance of the request and determine that the service is medically necessary for your patient.

## Form of request

A request for a pathology service/s may be made either verbally or in writing. A written request for a pathology service does not have to be in any particular form. Verbal requests must be confirmed in writing within **14 days** from the day when the request was made.

When writing a request for pathology services you must include the following information:

- the name and address of the patient
- sufficient information to clearly identify the MBS item number/s of the service/s you are requesting
- your surname, initials of given names, practice address and provider number
- your signature and date of request
- details of the hospital status of the patient
- details of the person to whom the request is directed. A pathology request can be directed to an Approved Pathology Authority and/or an Approved Pathology Practitioner:
  - if the request is directed to an Approved Pathology Authority, the form must show the full name and address of the Approved Pathology Authority
  - if the request is directed to an Approved Pathology Practitioner, the form must show the surname, initials or given names and place of practice of the Approved Pathology Practitioner to whom the request is addressed.

## 5.3 Summary

- A referral asks a specialist or consultant physician to investigate, manage and treat a particular medical condition.
- A request asks for a specific service to be performed (diagnostic imaging or pathology services).
- Referrals and requests:
  - provide patients with access to specialist services
  - are only valid after you have had a personal attendance with the patient and determined a clinical need
  - must be in writing
  - a referral must be received before or at the initial attendance by the specialist/consultant physician.

# Module six
## *Enhanced Primary Care*

# 6



This module provides an overview of the Enhanced Primary Care program and the range of allied and mental health services available for patients with chronic conditions and complex care needs.

**In this module:**

# 6.1 Enhanced Primary Care

The Enhanced Primary Care (EPC) program was introduced to provide a structured approach to care for Australians and improve the coordination of care for people with chronic conditions and complex care needs. The program provides a framework for a multidisciplinary approach to health.

EPC services include:

- Chronic Disease Management
- allied health services (individual services and Type 2 Diabetes group services)
- follow-up allied health services for people of Aboriginal or Torres Strait Islander descent who have had a health assessment
- GP mental health care planning
- allied health pervasive developmental disorder services
- health assessments
- medication management reviews.

## Additional resources

It is strongly recommended that health professionals refer to the latest *Medicare Benefits Schedule (MBS)* for full information about EPC items, including the explanatory notes. Information as well as useful tools, templates, checklists and questions and answers are available from **www.health.gov.au/epc**

**Did you know?**
You can find more information on education for health professionals visit the Medicare Australia website **www.medicareaustralia.gov.au/education**

# 6.2 Chronic Disease Management

This topic will help you identify the MBS items for managing patients with chronic medical conditions.

## Chronic disease management (CDM) services (MBS items 721—731)

Chronic Disease Management items help GPs manage the health care of patients with chronic medical conditions, including patients who need multidisciplinary care.

A chronic medical condition is one that has been (or is likely to be) present for six months or longer. It includes, but is not limited to, conditions such as asthma, cancer, cardiovascular disease, diabetes, musculoskeletal conditions and stroke.

Medicare benefits are available to GPs for preparing and reviewing GP Management Plans (GPMP) for patients with chronic medical conditions. For patients requiring multidisciplinary care, GPs can claim from Medicare for coordinating team care planning and review services.

## CDM item numbers

| MBS Item | Service description |
|---|---|
| 721 | Preparation of GPMP |
| 723 | Coordination of Team Care Arrangements (TCA) |
| 725 | Review of GPMP |
| 727 | Coordination of review of TCA |
| 729 | Contribution to a multidisciplinary care plan being prepared by another health professional |
| 731 | Contribution to a multidisciplinary care plan prepared by another health professional |

## GP Management Plan

| MBS Item | Requirements |
|---|---|
| 721 | 1. Assess the patient to identify and/or confirm their health care needs, health problems and conditions.<br>2. Agree on management goals with the patient.<br>3. Identify actions to be taken by the patient.<br>4. Identify treatment and services for the patient.<br>5. Make any necessary arrangements for the provision of treatment and services required by the patient.<br>6. Write a comprehensive plan including the above and specify a date to review the plan (Item 725—recommended every six months).<br>7. Offer a copy of the GPMP to the patient. |

## Team Care Arrangement (TCA)

| MBS Item | Requirements |
|---|---|
| 723 | 1. Discuss with the patient the treatment required and the proposed treatment/service providers.<br>2. Obtain consent from patient to share relevant clinical information with the proposed service providers.<br>3. Obtain agreement from the service providers to participate in the TCA.<br>4. Collaborate with the service providers to discuss potential treatment/services to achieve management goals for the patient.<br>5. Document treatment and service goals for the patient, treatment and services that collaborating providers have agreed to provide, and actions to be taken by the patient.<br>6. Involve at least two other health professionals besides the GP.<br>7. Offer a copy of the TCA to the patient. |

## Which patients are eligible for CDM services?

In general, patients with a chronic or terminal medical condition are eligible for CDM services, subject to also meeting the MBS item descriptor (including any reference to additional MBS explanatory notes).

The *Quick reference guide for general practitioners* provides further information on GPMP and TCA Medicare item requirements. You can download this quick reference guide from **www.medicareaustralia.gov.au/education**

For a better understanding of Chronic Disease Management please complete the following learning activity.

Learning activity 8: Chronic Disease Management

Tick **true** or **false** for the following statements.

| Statement | True | False |
|---|---|---|
| 1. A chronic medical condition is one that is likely to be present for six months or longer. | | |
| 2. The decision on whether a patient is eligible for allied health services rests with the GP. | | |
| 3. You have an obese patient who you would like to refer to a dietician and exercise physiologist. This patient is eligible for allied health services. | | |
| 4. Specific referral forms must be used and completed when referring a patient for psychological therapy services. | | |

# 6.3 Allied health individual services

This topic will help you identify the MBS items to refer eligible patients for allied health services.

## Allied health individual services (MBS items 10950–10970)

In addition to accessing specialist, diagnostic imaging and pathology services, GPs may also refer eligible patients for care and treatment by allied health professionals.

The following groups of **eligible** allied health professionals can provide individual services under Medicare for patients being managed on an EPC plan.

| MBS Item | Allied health professional |
|---|---|
| 10950 | Aboriginal health worker |
| 10952 | Audiologist |
| 10964 | Chiropractor |
| 10951 | Diabetes educator |
| 10954 | Dietitian |
| 10953 | Exercise physiologist |
| 10956 | Mental health worker† |
| 10958 | Occupational therapist |
| 10966 | Osteopath |
| 10960 | Physiotherapist |
| 10962 | Podiatrist |
| 10968 | Psychologist |
| 10970 | Speech pathologist |

## How do I refer patients for allied health services?

For Medicare benefits to be payable, the patient must be referred to an eligible allied health professional by their GP by filling out the *EPC program referral form for allied health services under Medicare*. This form can be downloaded at **www.health.gov.au/epc**

GPs are encouraged to attach a copy of the relevant part of the patient's care plan to the referral form. GPs may modify the referral form to suit their practice needs (for example, relevant software packages) as long as the information is substantially retained.

GPs must advise the allied health professional of the following information:

- their name, address and provider number
- the patient's name and address, including Medicare card number
- details of the allied health professional to whom the patient is being referred.

For the purposes of claiming a Medicare benefit, the allied health professional **must** be in receipt of the written referral before, or on the date of, the first attendance.

## Reporting requirements

A written report is required to be sent from the allied health professional back to the GP when:

- a single service is provided to a patient under a referral—this is required after each service
- multiple services are provided to the same patient under the one referral—this is required after the first and last service, or more often if clinically necessary.

Written reports should include any investigations, tests, and/or assessments carried out on the patient, any treatment provided and future management of the patient's condition or problem.

Eligible patients can claim a maximum of five allied health services per calendar year.

The *Quick reference guide for allied health professionals* provides further information on Medicare items 10950—10970 (allied health services). You can download this guide from **www.medicareaustralia.gov.au/education**

† Includes Aboriginal health workers, mental health nurses, occupational therapists, psychologists and some social workers.

# 6.4 Type 2 Diabetes services

This topic will help you identify the MBS items to refer eligible patients for Type 2 Diabetes services.

## Type 2 Diabetes group services (MBS items 81100—81125)

In addition to accessing individual services, patients with Type 2 Diabetes can receive Medicare benefits for group services, provided by eligible diabetes educators, exercise physiologists and dieticians on referral from a GP.

| MBS Item | Allied health professional |
|---|---|
| 81100<br>assessment for group services | Diabetes educator |
| 81105<br>group service | Diabetes educator |
| 81120<br>assessment for group services | Dietician |
| 81125<br>group service | Dietician |
| 81110<br>assessment for group services | Exercise physiologist |
| 81115<br>group service | Exercise physiologist |

## How do I refer patients for Type 2 Diabetes services?

For Medicare benefits to be payable, the patient must be referred to an eligible allied health professional by their GP using the *Referral form for allied health group services under Medicare*. This form can be downloaded at **www.health.gov.au/epc**

GPs are encouraged to attach a copy of the relevant part of the patient's care plan to the referral form. GPs may modify the referral form to suit their practice needs (for example, relevant software packages) as long as the information is substantially retained.

GPs **must** advise the allied health professional of the following information:

- their name, address and provider number
- the patient's name and address, including Medicare card number
- details of the allied health professional (or practice) to whom the patient is being referred.

For the purposes of claiming a Medicare benefit, the allied health professional **must** be in receipt of the written referral before, or on the date of, the first attendance.

## Reporting requirements

On completion of the assessment service (MBS items 81100, 81120 and 81110), the allied health professional must provide a written report back to the referring GP. This report should outline the assessment undertaken, whether the patient is suitable for group services and, if so, the nature of the group services to be provided.

On completion of the group services (MBS items 81105, 81125 and 81115), each allied health professional must provide or contribute to, a written report back to the referring GP for each patient. The written report should describe the group services provided to the patient and indicate the outcomes achieved.

Eligible patients can access a maximum of **one assessment service** per calendar year. After this assessment, those deemed suitable for group services can claim up to **eight group services in each calendar year**.

# 6.5 GP mental health care services

This topic will help you identify the MBS items to refer eligible patients for mental health care services.

## GP mental health care services (MBS items 2710—2713)

Medicare benefits are payable where GPs undertake early intervention, assessment and management of patients with mental disorders. They include referral pathways for treatment by eligible psychiatrists, clinical psychologists and other allied mental health workers.

There are three GP Mental Health Care items.

| MBS Item | Description | Requirements |
|---|---|---|
| 2710 | Preparation of a GP Mental Health Care Plan | • Involves the assessment of a patient and preparation of a GP Mental Health Care Plan. |
| 2712 | Review of a GP Mental Health Care Plan | • Enables a review of the patient's progress against the goals in the GP Mental Health Care Plan (Item 2710).<br>• This item can also be used where Item 291 has been claimed by a psychiatrist. |
| 2713 | GP Mental Health Care Consultation | • An extended consultation (at least 20 minutes) with a patient where the primary problem treated is related to a mental health disorder.<br>• A GP Mental Health Care Plan (Item 2710) does not have to be in place for this item to be used. |

## What are the steps involved in preparing a GP Mental Health Care Plan (Item 2710)?

Preparation of a GP Mental Health Care Plan involves both assessing the patient and preparing the GP Mental Health Care Plan document.

| | |
|---|---|
| **Assessment** | An assessment of a patient must include:<br>• recording the patient's agreement for the GP Mental Health Care Plan service<br>• taking relevant history (biological, psychological, social) including the presenting complaint<br>• conducting a mental state examination<br>• assessing associated risk and any co-morbidity<br>• making a diagnosis and/or formulation<br>• administering an outcome measurement tool, except where it is considered clinically inappropriate. |
| **Plan** | Preparation of a GP Mental Health Care Plan must include:<br>• discussing the assessment with the patient, including the mental health formulation and/or diagnosis<br>• identifying and discussing referral and treatment options with the patient, including appropriate support services<br>• agreeing on goals with the patient, what should be achieved by the treatment, and any actions the patient will take<br>• provision of psycho-education<br>• planning for crisis intervention and/or for relapse prevention, if appropriate at this stage<br>• arranging required referrals, treatment, appropriate support services, review and follow-up<br>• documenting this (results of assessment, patient needs, goals and actions, referrals and required treatment/services, and review date) in the patient's GP Mental Health Care Plan. |

GPs should make sure that:

- the steps involved have been explained to the patient (and their carer, if appropriate) and the patient agrees
- a copy of the plan is offered to the patient (or carer, if appropriate)
- a copy of the plan is added to the patient's records.

## Which patients are eligible?

The GP Mental Health Care plan items are for patients with a mental disorder who would benefit from a structured approach to the management of their care needs.

A mental health disorder is a term used to describe a range of clinically diagnosable disorders that significantly interfere with an individual's cognitive, emotional or social abilities. For the purposes of these items (2710–2713) the following are not considered mental health disorders:

- dementia
- delirium
- mental retardation
- tobacco use disorder.

## Access to mental health care services

In addition to mental health services you may already be providing to your patients, you can refer eligible patients for care and treatment by mental health professionals.

Patients with mental health disorders may access Medicare benefits for a range of individual and group mental health services listed in the MBS.

All allied mental health professionals must meet specific eligibility requirements and be registered with Medicare Australia to provide services under this initiative.

| MBS Item | Allied health professional | Eligible patients | Prerequisite for claiming |
|---|---|---|---|
| 80000 – 80020 | Clinical psychologist | Patients with an assessed mental disorder | 1. GP Mental Health Care Plan (Item 2710), referred psychiatrist assessment management plan (Item 291 or 293), and/or relevant psychiatrist or paediatrician item must have been claimed.<br>2. No specific referral form required. |
| 80125 – 80145 | Occupational therapist | Patients with an assessed mental disorder | 1. GP Mental Health Care Plan (Item 2710), referred psychiatrists assessment management plan (Item 291 or 293), and/or relevant psychiatrist or paediatrician item must have been claimed.<br>2. No specific referral form required. |

| MBS Item | Allied health professional | Eligible patients | Prerequisite for claiming |
|---|---|---|---|
| 80100 – 80120 | Psychologist | Patients with an assessed mental disorder | 1. GP Mental Health Care Plan (Item 2710), referred psychiatrist assessment management plan (Item 291 or 293), and/or relevant psychiatrist or paediatrician item must have been claimed.<br>2. No specific referral form required. |
| 80150 – 80170 | Social worker | Patients with an assessed mental disorder | 1. GP Mental Health Care Plan (Item 2710), referred psychiatrists assessment management plan (Item 291 or 293), and/or relevant psychiatrist or paediatrician item must have been claimed.<br>2. No specific referral form required. |

## How do I refer patients for mental health care services?

Referrals to eligible allied mental health professionals should include similar information as per normal GP referral to specialists. GPs should specifically consider including both a statement identifying that a GP Mental Health Care Plan has been completed for the patient (including, where appropriate and with the patient's agreement, attaching a copy of the patient's GP Mental Health Care Plan) and clearly identifying the specific number of sessions the patient is being referred for.

Medicare benefits are available for up to 12 individual sessions (up to 18 services where exceptional circumstances apply).

Referrals should be provided, as required in one or more groups of up to six sessions. The GP should consider the patient's need for the second group of sessions after the initial six sessions. A further referral for up to an additional six services in a calendar year can be made in exceptional circumstances.

For the purposes of claiming a Medicare benefit, the allied health professional must be in receipt of the written referral before, or on the date of, the first attendance.

## Reporting requirements

On the completion of the initial course of treatment (six services or less depending on the referral) a written report is required to be sent from the allied health professional back to the referring medical practitioner. The written report should include any investigations, tests, and/or assessments carried out on the patient, any treatment provided and recommendations on the future management of the patient's condition or problem.

If a further referral is recommended by the medical practitioner, the allied health professional must provide a written report back to the referring medical practitioner at the completion of any treatment provided to the patient.

Eligible patients can access up to 12 individual mental health services per calendar year. In addition, the referring practitioner may consider that in exceptional circumstances, the patient may require an additional six mental health services. Eligible patients can access up to 12 group mental health services per calendar year.

# 6.6 Health assessments

This topic will help you identify the MBS items to refer eligible patients for health assessment services.

## Health assessment services (MBS items 700—719)

A health assessment allows a medical practitioner to undertake a more comprehensive assessment of a patient with complex care needs to determine whether preventative health care and education should be offered to the patient.

Health assessments also permit the needs of specific groups (Aboriginal and Torres Strait Islander people, refugees and aged care residents) to be addressed in a targeted and culturally appropriate manner.

Health assessments are not available to in-patients of a hospital or day hospital facility.

## Overview of health assessment MBS items

| MBS Item | Service description |
|---|---|
| 700—706 | Older persons |
| 708 | Aboriginal and Torres Strait Islander Child Health Check |
| 709 and 711 | Healthy Kids Check |
| 710 | Aboriginal and Torres Strait Islander Adult Health Check |
| 712 | Comprehensive Medical Assessment for patients of aged care homes |
| 713 | Type 2 Diabetes Risk Evaluation |
| 714—716 | Refugees and other Humanitarian Entrants |
| 717 | 45 Year Old Health Check |
| 718—719 | Intellectual disability |

A health assessment should generally only be undertaken by the medical practitioner, or a practitioner working in the medical practice, who has provided the majority of services to the patient over the previous 12 months and/or will provide the majority of services to the patient over the coming 12 months.

# 6.7 Medication management reviews

This topic will help you identify the MBS items to refer eligible patients for Medication management review services.

## Medication management reviews

These review services are targeted at patients for whom quality use of medicine may be an issue, or who are at risk of misusing their medication.

These patients may be at risk because of:

- their co-morbidities
- their age or social circumstances
- the characteristics of their medicine
- the complexity of their medication treatment regimen
- a lack of knowledge and skills to use medicine to their best effect.

Medication management reviews are not available to in-patients of a hospital or day hospital facility.

## Domiciliary Medication Management Review (Item 900)

A Domiciliary Medication Management Review is a service for patients living in the community. The goal of this review is to maximise an individual patient's benefit from their medication regime, and prevent medication related problems through a team approach, involving the patient's GP and preferred community pharmacist.

## Residential Medication Management Review (Item 903)

A Residential Medication Management Review is a service for permanent residents of residential aged care facilities, including veterans. It involves collaboration between a GP and pharmacist to review the medication management needs of a resident.

For a better understanding of Chronic Disease Management and allied health services, complete the following learning activity.

## Learning activity 9: allied health services under Medicare

What is the maximum number of services claimable through Medicare for each of the following initiatives?

1. Allied health individual services

2. Type 2 Diabetes assessment service

3. Type 2 Diabetes group services

4. Mental health care services (individual)

5. Mental health care services (group).

## 6.8 Summary

- A chronic medical condition is one that has been (or is likely to be) present for six months or longer.
- To access allied or mental health services a patient must be referred by a medical practitioner to an eligible allied health professional. Specific referral forms and requirements exist.
- If in the opinion of the referring medical practitioner a patient does not have a chronic condition and does not have complex care needs requiring a multidisciplinary team, they are not eligible for referral for services under the allied health initiative.

# Module seven
## *Learning activity answers and further information*

7

**In this module:**


Malaria
Heart disease
Menstrual problems
Rheumatic fever
Epilepsy/Convulsions
Pregnancy/M
or Termination
Ear infection
German measles
Varicose veins
Suicide attempt
Country
Yes

# 7.1 Learning activity answers

## Module two—how to use the Medicare Benefits Schedule (MBS)

### Answers to Learning activity 1: MBS item number selection—medical practitioners

1. Antenatal care, independent of confinement.

   c. 16500

2. Removal of a subcutaneous foreign body by incision and exploration.

   b. 30064

3. Aspiration of a haematoma.

   a. 30216

### Answers to Learning activity 2: MBS item descriptors procedural items—medical practitioners

**Scenario one**:

You remove a foreign body from a patient's foot—no incision is required.

Correct Item:

| | | | |
|---|---|---|---|
| 30058 | **Fee:** $133.35 | **Benefit:** 75% = $100.05 | 85% = $113.35 |
| 30061 | SUPERFICIAL FOREIGN BODY, REMOVAL OF, (including from cornea or sclera), as an independent procedure (Anaes.)<br>**Fee:** $21.70 | **Benefit:** 75% = $16.30 | 85% = $18.45 |

**Scenario two**:

You suture a superficial 8 cm wound on the neck of a patient.

Correct Item:

| | | | |
|---|---|---|---|
| 30042 S | **Fee:** $171.50 | **Benefit:** 75% = $128.65 | 85% = $145.80 |
| 30045 | SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, large (MORE THAN 7 CM LONG), superficial (Anaes.)<br>*(See para T8.7 of explanatory notes to this Category)*<br>**Fee:** $108.60 | **Benefit:** 75% = $81.45 | 85% = $92.35 |

If you chose Item 30026 as your answer this is incorrect. Item 30026 states that the repair of the wound was not more than 7 cm long (the scenario states it was 8 cm long). Additionally, the scenario states that it was on the patient's neck and Item 30026 says 'not on face or neck'.

If you chose Item 30032 as your answer this is incorrect. Item 30032 states that the repair of the wound was 'not more than 7 cm long' (the scenario states that it was 8 cm long).

If you chose Item 30038 as your answer this is incorrect. The case states that the repair of the wound was on the patient's neck. Item 30038 states 'not on face or neck'.

## Module three—patient consultations (attendances)

### Answer to Learning activity 3: Multiple attendances—allied health professionals

b. One attendance item as the 11.00 am appointment is a continuation of the 10.00 am appointment.

### Answer to Learning activity 4: Consultations with procedures

b. Item 30219

### Answers to Learning activity 5: Normal aftercare—medical practitioners

1. Appropriate to bill a different or separate MBS attendance item? Yes

   Aftercare applies to all routine post-operative consultations following a procedure. As the wound became infected and additional treatment had to be administered, this is not considered aftercare and it is appropriate to bill an MBS item for this attendance.

2. Appropriate to bill a different or separate MBS attendance item? No

   Aftercare includes all routine post-operative care up until recovery from the procedure. This includes the removal of sutures.

3. Appropriate to bill a different or separate MBS attendance item? Yes

   Although part of the attendance (removal of sutures) is considered to be aftercare, because you also consulted with the patient on other issues (blood pressure medication), it is appropriate to bill an MBS attendance item. However, you can only bill for the attendance time spent on the non-aftercare related issue.

4. Appropriate to bill a different or separate MBS attendance item? No

   Aftercare includes all routine post-operative care up until recovery from the procedure. This includes the removal of sutures.

## Module four—Medicare billing and claiming

### Answers to Learning activity 6: Billing for services rendered on my behalf

As a GP, I can bill an MBS item for a practice nurse or Aboriginal health worker providing the following services are on my behalf and under my supervision.

| Service | True or False |
|---|---|
| 1. Providing immunisation services. | True |
| 2. Information collection in regards to health assessments/checks. | False |
| 3. Examining patient records to identify suitable eligible patients for Enhanced Primary Care services. | False |
| 4. Providing antenatal services. | True |
| 5. Providing wound management services. | True |
| 6. Providing ongoing support and monitoring for patients with chronic diseases. | True |

### Answers to Learning activity 7: Services attracting Medicare benefits

For each of the following statements, select true or false as to which services attract a Medicare benefit in normal circumstances.

| Statement | True or False |
|---|---|
| 1. Medical services provided in a public hospital to a public patient. | False |
| 2. Surgical removal of a tattoo. | False |
| 3. Provision of medical advice over the phone in emergency situations. | False |
| 4. A medical examination for the purposes of claiming social security benefits. | True |
| 5. A medical examination/clearance to be able to take up boxing as a sport. | False |
| 6. A medical examination on your own patient, just to check on and provide advice on their general health. | True |
| 7. Writing a report for one of your patients for life insurance purposes. | False |
| 8. Administering immunisations to year 10 students at the local school. | False |

## Module six—Enhanced Primary Care (EPC)

**Answers to Learning activity 8: Chronic Disease Management**

| Statement | True or False |
|---|---|
| 1. A chronic medical condition is one that is likely to be present for six months or longer. | True |
| 2. The decision on whether a patient is eligible for allied health services rests with the GP. | True |
| 3. You have an obese patient who you would like to refer to a dietician and exercise physiologist. This patient is eligible for allied health services. | False |
| 4. Specific referral forms must be completed when referring a patient for psychological therapy services. | False |

**Answers to Learning activity 9: allied health services under Medicare**

What is the maximum number of services claimable through Medicare for each of the following initiatives?

**Allied health individual services**

Eligible patients can access up to a maximum of five allied health services per calendar year.

**Type 2 Diabetes assessment service**

Eligible patients can access a maximum of one assessment service per calendar year.

**Type 2 Diabetes group services**

After assessment, those patients deemed eligible for group services can access up to eight group services in each calendar year.

**Mental health care services (individual)**

Eligible patients can access up to a maximum of 18 individual mental health services per calendar year (12 plus an additional six under exceptional circumstances).

**Mental health care services (group)**

Eligible patients can access up to a maximum of 12 group mental health services per calendar year.

# 7.2 Contact details

## Medicare Australia

For all health professional enquiries relating to:

- provider registration and eligibility
- locum arrangements
- MBS item interpretation
- billing and claiming requirements
- Medicare payment of benefits
- patient eligibility—obtaining Medicare card number for certain claiming options

**call 132 150***

- patient eligibility—obtaining Medicare card number for Aboriginal and Torres Strait Islander persons

**call 1800 556 955****

For online information and resources relating to:

- provider registration and eligibility
- Medicare claiming
- forms and publications
- additional contacts for providers

visit **www.medicareaustralia.gov.au/providers**

- education available for health professionals

visit **www.medicareaustralia.gov.au/education**

## Department of Health and Ageing

MBS Online

visit **www.mbsonline.gov.au**

Enhanced Primary Care services—fact sheets, templates and tools

visit **www.health.gov.au/epc**

* Call charges apply.

** Call charges apply from mobile and pay phones only.

## Terms and conditions

1. Medicare Australia does not accept any responsibility for any loss or damage suffered by the user as a result of using the *Medicare and You Workbook for new health professionals*, including, but not limited to, any loss or damage resulting from the user's reliance on any information contained in the workbook.
2. This Medicare Australia education material is copyright. You may download, display, print and reproduce this material in unaltered form only (retaining this notice) for your personal, non-commercial use. Apart from any use as permitted under the *Copyright Act 1968*, all other rights are reserved. Requests and enquiries concerning reproduction and rights should be posted online at **www.medicareaustralia.gov.au** or addressed to:

   **The Manager**
   **Program Review Division**
   **Medicare Australia**
   **National Office**
   **PO Box 1001**
   **Tuggeranong DC ACT 2901**
3. The material contained in this workbook is provided for general use and information purposes only. Medicare Australia recommends that users exercise their own skill and care with respect to its contents.
4. Medicare item examples and activities are sourced from the *1 November 2008 Medicare Benefits Schedule (MBS)*. The use of MBS examples are for education purposes only and are not to be relied upon as being current. For current MBS information, please refer to **www.mbsonline.gov.au**
5. References to web sites are provided as an information service only and do not necessarily constitute endorsement. Conversely, omissions should not be construed as non-endorsement. Although every care is taken to provide links to suitable material, Medicare Australia does not guarantee the suitability, completeness or accuracy of any material encountered through those sites. Further, Medicare Australia does not guarantee that any of the sites listed will be available at any particular time or any services which might be announced.

2454.11.03.09