

Australian Government
Department of Health and Aged Care

Medicare Benefits Schedule Book

Category 8

Operating from 1 July 2024

Title: Medicare Benefits Schedule Book

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At the time of printing, the relevant legislation giving authority for the changes included in this edition of the book may still be subject to the approval of Executive Council and the usual Parliamentary scrutiny. This book is not a legal document, and, in cases of discrepancy, the legislation will be the source document for payment of Medicare benefits.

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

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GENERAL EXPLANATORY NOTES

GENERAL EXPLANATORY NOTES

GN.0.1 AskMBS Email Advice Service

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

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

If you have a query relating exclusively to interpretation of the Schedule, you should email askMBS@health.gov.au.

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

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

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

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

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

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

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

Explanatory Notes

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

GN.1.2 Medicare - an outline

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

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

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

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

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

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

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

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

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

GN.1.3 Medicare benefits and billing practices

Key information on Medicare benefits and billing practices

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

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

Billing practices contrary to the Act

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

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

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

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

Potential consequence of improperly issuing an account

The potential consequences for improperly issuing an account are

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

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

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

GN.2.4 Provider eligibility for Medicare

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

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

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

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

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

Non-medical practitioners

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

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

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

GN.2.5 Provider Numbers

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

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

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

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

GN.2.6 Locum tenens

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

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

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

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

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

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

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

GN.2.7 Overseas trained doctor

Ten year moratorium

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

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

Exclusions - Practitioners who before 1 January 1997 had

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

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

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

GN.2.8 Contact details for Services Australia

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

Changes to Provider Contact Details

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

Medicare

GPO Box 9822

in your capital city

or

the Medicare Provider telephone line on 132 150.

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

GN.3.9 Patient eligibility for Medicare services

This note sets out who can access Medicare services.

ELIGIBLE GROUPS

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

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

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

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

ENROLLING IN MEDICARE

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

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

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

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

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

RECIPROCAL HEALTH CARE AGREEMENTS

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

Eligible overseas visitors from these countries generally receive:

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

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

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

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

Eligible Countries:

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

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

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

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

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

OTHER VISITORS AND TEMPORARY RESIDENTS

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

RELEVANT LEGISLATION

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

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

SUMMARY

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

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

WHO CAN USE THE MBS GP ITEMS?

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

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

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

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

Medical practitioners that are fellows of either the:

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

are GPs for MBS purposes.

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

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

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

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

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

3. Medical practitioners on the Vocational Register of GPs

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

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

4. Eligible non-vocationally recognised medical practitioners

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

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

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

RELEVANT LEGISLATION

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

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

GN.5.14 Recognition as a Specialist or Consultant Physician

A medical practitioner who:

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

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

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

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

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

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

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

GN.5.15 Emergency Medicine

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

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

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

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

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

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

GN.6.16 Referral Of Patients To Specialists Or Consultant Physicians

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

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

What is a Referral?

A "referral" is a request to a specialist or a consultant physician for investigation, opinion, treatment and/or management of a condition or problem of a patient or for the performance of a specific examination(s) or test(s).

Subject to the exceptions in the paragraph below, for a valid "referral" to take place

- (i) the referring practitioner must have undertaken a professional attendance with the patient and turned their mind to the patient's need for referral and have communicated relevant information about the patient to the specialist or consultant physician (this need not mean an attendance on the occasion of the referral);
- (ii) the instrument of referral must be in writing as a letter or note to a specialist or to a consultant physician and must be signed and dated by the referring practitioner; and
- (iii) the specialist or consultant physician to whom the patient is referred must have received the instrument of referral on or prior to the occasion of the professional service to which the referral relates.

The exceptions to the requirements in paragraph above are that

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

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

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

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

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

Examination by Specialist Anaesthetists

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

Who can Refer?

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

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

For Medicare benefit purposes, a referral may be made to

(i) a recognised specialist:

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

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

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

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

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

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

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

Billing

Routine Referrals

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

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

Special Circumstances

(i) Lost, stolen or destroyed referrals.

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

(ii) Emergencies

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

(iii) Hospital referrals.

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

Public Hospital Patients

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

Bulk Billing

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

Period for which Referral is Valid

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

Specialist Referrals

Where a referral originates from a specialist or a consultant physician, the referral is valid for 3 months, except where the referred patient is an admitted patient. For admitted patients, the referral is valid for 3 months or the duration of the admission and ceases when the patient is discharged.

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

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

Referrals by other Practitioners

Where the referral originates from a practitioner other than those listed in *Specialist Referrals*, the referral is valid for a period of 12 months, unless the referring practitioner indicates that the referral is for a period more or less than 12 months (eg. 3, 6 or 18 months or valid indefinitely). Referrals for longer than 12 months should only be used where the patient's clinical condition requires continuing care and management of a specialist or a consultant physician for a specific condition or specific conditions.

Definition of a Single Course of Treatment

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

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

The receipt by a specialist or consultant physician of a new referral following the expiration of a previous referral for the same condition(s) does not necessarily indicate the commencement of a new course of treatment involving the itemisation of an initial consultation. In the continuing management/treatment situation the new referral is to facilitate the payment of benefits at the specialist or the consultant physician referred rates rather than the unreferred rates.

However, where the referring practitioner:-

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

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

Retention of Referral Letters

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

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

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

Attendance for Issuing of a Referral

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

Locum-tenens Arrangements

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

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

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

Self Referral

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

GN.7.17 Billing procedures

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

Bulk billing

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

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

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

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

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

GN.8.18 Provision for review of individual health professionals

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

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

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

Following a review, the Director must:

decide to take no further action; or

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

refer the matter to a PSR Committee.

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

The Committee is authorized to:

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

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

require the production of documents (including clinical notes).

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

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

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

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

an unusual occurrence;

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

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

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

Additional Information

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

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

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

(i) a reprimand;

(ii) counselling;

(iii) repayment of Medicare benefits; and/or

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

Further information is available from the PSR website - www.psr.gov.au

GN.8.19 Medicare Participation Review Committee

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

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

(b) has breached an Approved Pathology Practitioner undertaking;

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

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

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

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

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

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

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

GN.8.21 Comprehensive Management Framework for the MBS

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

GN.8.22 Medical Services Advisory Committee

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

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

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

GN.8.23 Pathology Services Table Committee

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

GN.9.25 Penalties and Liabilities

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

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

GN.10.26 Schedule fees and Medicare benefits

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

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

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

There are presently three levels of Medicare benefit payable:

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

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

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

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

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

GN.10.27 Medicare Safety Nets

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

Original Medicare Safety Net:

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

Extended Medicare Safety Net:

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

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

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

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

EMSN Benefit Caps:

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

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

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

GN.11.28 Services not listed in the MBS

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

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

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

GN.11.29 Ministerial Determinations

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

GN.12.30 Professional services

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

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

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

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

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

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

GN.12.31 Services rendered on behalf of medical practitioners

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

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

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

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

Supervision from outside of Australia is not acceptable.

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

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

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

GN.12.32 Medicare benefits and vaccinations

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

Example 1

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

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

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

Example 2

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

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

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

Example 3

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

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

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

GN.13.33 Services which do not attract Medicare benefits

Medical services that do not attract Medicare benefits

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

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

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

Unless the Minister otherwise directs

Medicare benefits are not payable where:

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

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

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

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

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

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

(d) the removal of tattoos;

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

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

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

Pain pumps for post-operative pain management

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

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

Non Medicare Services

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

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

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

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

(b) gamma knife surgery;

(c) intradiscal electro thermal arthroplasty;

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

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

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

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

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

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

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

Health Screening Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

b. a person who:

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

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

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

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

GN.14.34 Principles of interpretation of the MBS

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

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

GN.14.35 Services attracting benefits on an attendance basis

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

GN.14.36 Consultation and procedures rendered at the one attendance

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

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

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

GN.14.37 Aggregate items

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

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

GN.14.38 Residential aged care facility

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

GN.15.39 Practitioners should maintain adequate and contemporaneous records

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

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

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

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

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

clearly identify the name of the patient; and

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

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

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

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

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

CATEGORY 8: MISCELLANEOUS SERVICES

SUMMARY OF CHANGES FROM 01/07/2024

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

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

Description Amended

82200 82205 82210 82215

Fee Amended

10950	10951	10952	10953	10954	10955	10956	10957	10958	10959	10960	10962	10964
10966	10968	10970	10983	10987	10988	10989	10990	10991	10992	10997	75855	75856
75857	75858	75870	75871	75872	75873	75874	75875	75876	75880	75881	75882	75883
75884	75885	80000	80002	80005	80006	80010	80012	80015	80016	80020	80021	80022
80023	80024	80025	80100	80102	80105	80106	80110	80112	80115	80116	80120	80121
80122	80123	80125	80127	80128	80129	80130	80131	80135	80137	80140	80141	80145
80146	80147	80148	80150	80152	80153	80154	80155	80156	80160	80162	80165	80166
80170	80171	80172	80173	80174	80175	80176	80177	80178	81000	81005	81010	81100
81105	81110	81115	81120	81125	81300	81305	81310	81315	81320	81325	81330	81335
81340	81345	81350	81355	81360	82000	82001	82002	82003	82005	82010	82015	82020
82025	82030	82035	82100	82105	82110	82115	82116	82118	82120	82123	82125	82127
82130	82135	82140	82200	82205	82210	82215	82226	82227	82228	82300	82301	82302
82304	82306	82309	82312	82315	82318	82324	82332	82350	82352	82354	82355	82357
82358	82359	82360	82362	82363	82365	82366	82367	82368	82370	82371	82373	82374
82375	82376	82378	82379	82381	82382	82383	91166	91167	91168	91169	91170	91171
91172	91173	91174	91175	91176	91177	91178	91179	91180	91181	91182	91183	91184
91185	91186	91187	91188	91189	91190	91191	91192	91193	91194	91195	91196	91197
91198	91199	91200	91201	91202	91203	91204	91205	91211	91212	91214	91215	91218
91219	91221	91222	93000	93013	93026	93029	93032	93033	93035	93036	93040	93041
93043	93044	93048	93061	93074	93076	93079	93084	93087	93092	93095	93100	93103
93108	93110	93113	93118	93121	93126	93129	93134	93137	93200	93201	93202	93203
93284	93285	93286										

Indexation

From 1 July 2024, annual fee indexation will be applied to:

- most of the general medical services items;
- most diagnostic imaging services (excluding nuclear imaging services); and
- pathology items in Group P12.

The MBS indexation factor for 1 July 2024 is 3.5 per cent.

Schedule fee increase for nurse practitioner general attendance items

From 1 July 2024, there will be a 30% schedule fee increase for nurse practitioner items 82200, 82205, 82210, 82215, 91192, 91178, 91179, 91180, 91193, 91189, 91190 and 91191. Additionally, there will be an expansion of eligibility for nurse practitioners to participate in multidisciplinary case conferencing items.

MISCELLANEOUS SERVICES NOTES

MN.1.1 Bulk Billing Incentives

SUMMARY

Bulk billing incentives (BBIs) are additional payments made to medical practitioners when they bulk bill eligible patients for unREFERRED services (NB this includes almost all general practice services).

Eligible patients are:

- Under 16 years of age, or
- A Commonwealth concession card holder. Information on Commonwealth concession cards is available from [Services Australia](#).

Admitted hospital patients are not eligible for BBIs.

The specific BBI item that should be co-claimed with an eligible medical service depends on:

- The geographic location of the practice (by Modified Monash area). This can be checked on the [Health Workforce Locator](#).
- The specific medical service (MBS item) provided, and
- In some cases, whether the patient is enrolled at the practice providing the service through the MyMedicare program. Information on MyMedicare is available on the [Department of Health and Aged Care's website](#).

Claiming tables are available for each Modified Monash area:

- MN.1.3 – Modified Monash 1
- MN.1.4 – Modified Monash 2
- MN.1.5 – Modified Monash 3-4
- MN.1.6 – Modified Monash 5
- MN.1.7 – Modified Monash 6
- MN.1.8 – Modified Monash 7

USE OF THE ITEMS

BBIs can be claimed when a medical practitioner bulk bills an unREFERRED service to an eligible patient.

What is an unREFERRED service?

The Health Insurance (General Medical Services Table) Regulations 2021 defines an unREFERRED service as a "medical service provided by, or on behalf of, a medical practitioner to a patient who has not been referred to the practitioner for the service."

Which bulk billing incentive should be used?

There are 20 BBI items broken into three categories. Each category includes a BBI item number for use in each Modified Monash area (see table below). The Modified Monash area used to determine the appropriate BBI is the area where the medical practitioner's practice is located. BBI items within each category should be used with:

- Category 1: for all eligible patients, any unREFERRED services not covered by category 2 or 3 including, but not limited to:
 - Level A general attendances (and equivalents)
 - Level C, D, E telehealth (telephone and video) attendances where the patient is not enrolled with the practice through [MyMedicare](#)
 - Chronic disease management and health assessment items
 - Better Access mental health and eating disorder items
 - Antenatal attendances

- Minor procedures
- Category 2: for all eligible patients, any Level B general attendances (face to face, telephone, telehealth (video)), and Level C, D and E face to face consultations. This category also includes the equivalent items used in residential aged care facilities, out of consulting rooms, and after hours
- Category 3: for eligible patients enrolled in [MyMedicare](#) only, Level C, D and E telehealth (video) and Level C and D telephone

Note: BBIs cannot be claimed in conjunction with a COVID vaccine support item.

The **practice location** is the location associated with the Medicare provider number used by the medical practitioner when providing the service. In general, the practice location associated with the provider number is used regardless of where the medical service is provided (e.g. out of consulting rooms, in a residential aged care facility) or, in the case of telehealth, the location of the patient. However, for the after-hours BBIs (10992 and 75872), both the practice location and the patient location are considered. These items can only be claimed with specific after-hours MBS items in limited circumstances.

Practice Location:	MM1 Metropolitan Areas	MM1 (but service is provided after hours in MM 2-7)	MM2 Regional centres	MM3-4 Large or medium rural towns	MM5 Small rural towns	MM6 Remote communities	MM7 Very remote communities
Level B, C, D, E (face to face)	75870	75872	75871	75873	75874	75875	75876
Level B (telephone and telehealth (video))							
Level C, D, E telehealth (telephone and video) and the patient is enrolled in MyMedicare	75880	NA	75881	75882	75883	75884	75885
All other eligible services not covered above	10990	10992	10991	75855	75856	75857	75858

Additional information on the after-hours BBIs – MBS items 10992 and 75872

Items **10992** and **75872** can only be claimed in conjunction with specified after-hours MBS items. In addition to the standard requirements for use of BBIs, the following additional requirements apply:

- The service is not provided in consulting rooms

- The service is provided in a Modified Monash 2-7 area, and
- The service is provided by, or on behalf of, a medical practitioner whose practice is in a Modified Monash 1 area.

CO-CLAIMING RESTRICTIONS

BBIs must be claimed in conjunction with an eligible MBS item. BBIs can only be claimed when an eligible patient is bulk billed for the medical service. Only one BBI can be claimed in conjunction with each medical service (i.e. each MBS item) that is provided.

BBIs cannot be claimed in conjunction with MBS COVID vaccine support items.

BBIs cannot be claimed in conjunction with diagnostic imaging or pathology services. A separate set of incentives are available to use in conjunction with diagnostic imaging and pathology services.

ELIGIBLE PATIENTS

Bulk billed patients eligible for the BBI are:

- Under 16 years of age, or
- A Commonwealth concession card holder. Information on Commonwealth concession cards is available on the [Services Australia website](#).

Admitted hospital patients are not eligible for BBIs.

ELIGIBLE PRACTITIONERS

All medical practitioners who bulk bill a relevant medical service to an eligible patient can claim BBIs.

Different BBIs are payable for practice locations in different Modified Monash areas. The relevant Modified Monash area is determined by the location associated with the medical practitioner's provider number used to provide the service. This means that if the service is provided away from the practice location (e.g. in a residential aged care facility or home visits), the location of the practice, not the location of the consultation, is used to determine the relevant Modified Monash area for BBI purposes (except in relation to items 10992 and 75872).

The Modified Monash area for your practice can be checked on the [Health Workforce Locator](#).

RECORD KEEPING AND REPORTING REQUIREMENTS

Medicare benefits are patient benefits. It is a legal requirement that the patient assigns their benefit to the medical practitioner when a service is bulk billed. Information about recording assignment of benefit is available on the [Services Australia website](#).

When claiming BBIs, medical practitioners should ensure that the patient is under 16 or has a valid Commonwealth Concession Card.

The Department of Health and Aged Care undertakes regular post payment auditing to ensure that BBIs are claimed appropriately. Practitioners should ensure they keep relevant and contemporaneous records.

RELEVANT LEGISLATION

BBIs are specified in the [Health Insurance \(General Medical Services Table\) Regulations 2021](#).

MN.1.3 Bulk Billing Incentives for Eligible Patients in Modified Monash Area 1 General Practitioners¹

Bulk billing incentives for eligible patients² – Modified Monash 1 (Metropolitan Area)³

Applicable BBI Item	10990	75870	75880 (MyMedicare enrolled patients only)
Standard hours consultations - in consulting rooms	3	23, 36, 44, 123	
Standard hours consultations - out of consulting rooms	4	24, 37, 47, 124	
Standard hours consultations - residential aged care facility	90020	90035, 90043, 90051, 90054	
Telehealth - video	91790 (all) 91801, 91802, 91920 if not MyMedicare enrolled	91800	91801, 91802, 91920
Telehealth - phone	91890	91891	91900, 91910
After hours consultations - in consulting rooms	5000	5020, 5040, 5060, 5071	
After hours consultations - out of consulting rooms	5003 ⁴	5023 ⁵ , 5043 ⁵ , 5063 ⁵ , 5076 ⁵	
After hours consultations - residential aged care facility	5010 ⁴	5028 ⁵ , 5049 ⁵ , 5067 ⁵ , 5077 ⁵	
Other	All other “unreferred services” ⁶ , including but not limited to: chronic disease management items, Better Access mental health items, health assessments, minor procedures etc.		

¹ For the definition of GP for MBS purposes see [GN.4.13](#)

² Bulk billing incentives can be claimed when you bulk bill a child under 16 or a Commonwealth Concession Card holder www.servicesaustralia.gov.au/concession-and-health-care-cards

³ Practice located in Modified Monash area www.health.gov.au/resources/apps-and-tools/health-workforce-locator/app

⁴ If service is provided in an MM 2 – 7 area by a GP whose practice is located in an MM 1 area, then BBI item number 10992 is claimed

⁵ If service is provided in an MM 2 – 7 area by a GP whose practice is located in an MM 1 area, then BBI item number 75872 is claimed

⁶ Bulk billing incentives cannot be claimed for the provision of COVID vaccine support services

Medical Practitioners¹

Bulk billing incentives for eligible patients² – Modified Monash 1 (Metropolitan Area)³

Applicable BBI Item	10990	75870	75880 (MyMedicare enrolled patients only)
Standard hours consultations - in consulting rooms	52	53, 54, 57, 151	
Standard hours consultations - out of consulting rooms	58	59, 60, 65, 165	
Standard hours consultations - residential aged care facility	90092	90093, 90095, 90096, 90098	
Telehealth - video	91792 (all) 91804, 91805, 91923 if not MyMedicare enrolled	91803	91804, 91805, 91923
Telehealth - phone	91892	91893	91903, 91913
After hours consultations - in consulting rooms	5200, 733	5203, 5207, 5208, 5209, 737, 741, 745, 2197	
After hours consultations - out of consulting rooms	5220 ⁴ , 761 ⁴	5223 ⁵ , 5227 ⁵ , 5228 ⁵ , 5261 ⁵ , 763 ⁵ , 766 ⁵ , 769 ⁵ , 2198 ⁵	
After hours consultations - residential aged care facility	5260 ⁴ , 772 ⁴	5263 ⁵ , 5265 ⁵ , 5267 ⁵ , 5262 ⁵ , 776 ⁵ , 788 ⁵ , 789 ⁵ , 2200 ⁵	
Other	All other “unreferred services” ⁶ Including but not limited to: chronic disease management items, Better Access mental health items, health assessments, minor procedures etc.		

¹ Items in italics can only be claimed by prescribed medical practitioners, that is, medical practitioners that are not GPs, specialists or consultant physicians. Other items can be claimed by medical practitioners that are not GPs.

² Bulk billing incentives can be claimed when you bulk bill a child under 16 or a Commonwealth Concession Card holder www.servicesaustralia.gov.au/concession-and-health-care-cards

³ Practice located in Modified Monash area www.health.gov.au/resources/apps-and-tools/health-workforce-locator/app

⁴ If service is provided in an MM 2 – 7 area by a OMP whose practice is located in an MM 1 area, then BBI item number 10992 is claimed

⁵ If service is provided in an MM 2 – 7 area by a OMP whose practice is located in an MM 1 area, then BBI item number 75872 is claimed

⁶ Bulk billing incentives cannot be claimed for the provision of COVID vaccine support services

MN.1.4 Bulk Billing Incentives for Eligible Patients in Modified Monash Area 2 General Practitioners¹

Bulk billing incentives for eligible patients² – Modified Monash 2 (Regional Centre)³

Applicable BBI Item	10991	75871	75881 (MyMedicare enrolled patients only)
Standard hours consultations - in consulting rooms	3	23, 36, 44, 123	
Standard hours consultations - out of consulting rooms	4	24, 37, 47, 124	
Standard hours consultations - residential aged care facility	90020	90035, 90043, 90051, 90054	
Telehealth - video	91790 (all) 91801, 91802, 91920 if not MyMedicare enrolled	91800	91801, 91802, 91920
Telehealth - phone	91890	91891	91900, 91910
After hours consultations - in consulting rooms	5000	5020, 5040, 5060, 5071	
After hours consultations - out of consulting rooms	5003	5023, 5043, 5063, 5076	
After hours consultations - residential aged care facility	5010	5028, 5049, 5067, 5077	
Other	All other “unreferred services” ⁴ , including but not limited to: chronic disease management items, Better Access mental health items, health assessments, minor procedures etc.		

¹ For the definition of GP for MBS purposes see [GN.4.13](#)

² Bulk billing incentives can be claimed when you bulk bill a child under 16 or a Commonwealth Concession Card holder www.servicesaustralia.gov.au/concession-and-health-care-cards

³ Practice located in Modified Monash area www.health.gov.au/resources/apps-and-tools/health-workforce-locator/app

⁴ Bulk billing incentives cannot be claimed for the provision of COVID vaccine support services

Medical Practitioners¹

Bulk billing incentives for eligible patients² – Modified Monash 2 (Regional Centre)³

Applicable BBI Item	10991	75871	75881 (MyMedicare enrolled patients only)
Standard hours consultations - in consulting rooms	52, <i>179</i>	53, 54, 57, 151, <i>185, 189, 203, 301</i>	
Standard hours consultations - out of consulting rooms	58, <i>181</i>	59, 60, 65, 165, <i>187, 191, 206, 303</i>	
Standard hours consultations - residential aged care facility	90092, <i>90183</i>	90093, 90095, 90096, 90098, <i>90188, 90202, 90212, 90215</i>	
Telehealth - video	91792, <i>91794</i> (all) 91804, 91805, 91923, <i>91807, 91808, 91926</i> if not MyMedicare enrolled	91803, <i>91806</i>	91804, 91805, 91923, <i>91807, 91808, 91926</i>
Telehealth - phone	91892	91893	91903, 91913, <i>91906, 91916</i>
After hours consultations - in consulting rooms	5200, <i>733</i>	5203, 5207, 5208, 5209, <i>737, 741, 745, 2197</i>	
After hours consultations - out of consulting rooms	5220, <i>761</i>	5223, 5227, 5228, 5261, <i>763, 766, 769, 2198</i>	
After hours consultations - residential aged care facility	5260, <i>772</i>	5263, 5265, 5267, 5262, <i>776, 788, 789, 2200</i>	
Other	All other “unreferred services” ⁴ Including but not limited to: chronic disease management items, Better Access mental health items, health assessments, minor procedures etc		

¹ Items in italics can only be claimed by prescribed medical practitioners, that is, medical practitioners that are not GPs, specialists or consultant physicians. Other items can be claimed by medical practitioners that are not GPs.

² Bulk billing incentives can be claimed when you bulk bill a child under 16 or a Commonwealth Concession Card holder www.servicesaustralia.gov.au/concession-and-health-care-cards

³ Practice located in Modified Monash area www.health.gov.au/resources/apps-and-tools/health-workforce-locator/app

⁴ Bulk billing incentives cannot be claimed for the provision of COVID vaccine support services

MN.1.5 Bulk Billing Incentives for Eligible Patients in Modified Monash Area 3 and 4 General Practitioners¹

Bulk billing incentives for eligible patients² – Modified Monash 3 and 4 (Medium and Large Rural Towns)³

Applicable BBI Item	75855	75873	75882 (MyMedicare enrolled patients only)
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Standard hours consultations - in consulting rooms	3	23, 36, 44, 123	
Standard hours consultations - out of consulting rooms	4	24, 37, 47, 124	
Standard hours consultations - residential aged care facility	90020	90035, 90043, 90051, 90054	
Telehealth - video	91790 (all) 91801, 91802, 91920 if not MyMedicare enrolled	91800	91801, 91802, 91920
Telehealth - phone	91890	91891	91900, 91910
After hours consultations - in consulting rooms	5000	5020, 5040, 5060, 5071	
After hours consultations - out of consulting rooms	5003	5023, 5043, 5063, 5076	
After hours consultations - residential aged care facility	5010	5028, 5049, 5067, 5077	
Other	All other “unreferred services” ⁴ , including but not limited to: chronic disease management items, Better Access mental health items, health assessments, minor procedures etc.		

1 For the definition of GP for MBS purposes see [GN.4.13](#)

2 Bulk billing incentives can be claimed when you bulk bill a child under 16 or a Commonwealth Concession Card holder www.servicesaustralia.gov.au/concession-and-health-care-cards

3 Practice located in Modified Monash area www.health.gov.au/resources/apps-and-tools/health-workforce-locator/app

4 Bulk billing incentives cannot be claimed for the provision of COVID vaccine support services

Medical Practitioners¹

Bulk billing incentives for eligible patients² – Modified Monash 3 and 4 (Medium and Large Rural Towns)³

Applicable BBI Item	75855	75873	75882 (MyMedicare enrolled patients only)
Standard hours consultations - in consulting rooms	52, 179	53, 54, 57, 151, 185, 189, 203, 301	
Standard hours consultations - out of consulting rooms	58, 181	59, 60, 65, 165, 187, 191, 206, 303	

Standard hours consultations - residential aged care facility	90092, 90183	90093, 90095, 90096, 90098, 90188, 90202, 90212, 90215	
Telehealth - video	91792, 91794 (all) 91804, 91805, 91923, 91807, 91808, 91926 if not MyMedicare enrolled	91803, 91806	91804, 91805, 91923, 91807, 91808, 91926
Telehealth - phone	91892	91893	91903, 91913, 91906, 91916
After hours consultations - in consulting rooms	5200, 733	5203, 5207, 5208, 5209, 737, 741, 745, 2197	
After hours consultations - out of consulting rooms	5220, 761	5223, 5227, 5228, 5261, 763, 766, 769, 2198	
After hours consultations - residential aged care facility	5260, 772	5263, 5265, 5267, 5262, 776, 788, 789, 2200	
Other	All other “unreferred services” ⁴ Including but not limited to: chronic disease management items, Better Access mental health items, health assessments, minor procedures etc.		

¹ Items in italics can only be claimed by prescribed medical practitioners, that is, medical practitioners that are not GPs, specialists or consultant physicians. Other items can be claimed by medical practitioners that are not GPs.

² Bulk billing incentives can be claimed when you bulk bill a child under 16 or a Commonwealth Concession Card holder www.servicesaustralia.gov.au/concession-and-health-care-cards

³ Practice located in Modified Monash area www.health.gov.au/resources/apps-and-tools/health-workforce-locator/app

⁴ Bulk billing incentives cannot be claimed for the provision of COVID vaccine support services

MN.1.6 Bulk Billing Incentives for Eligible Patients in Modified Monash Area 5 General Practitioners¹

Bulk billing incentives for eligible patients² – Modified Monash 5 (Small Rural Towns)³

Applicable BBI Item	75856	75874	75883 (MyMedicare enrolled patients only)
Standard hours consultations - in consulting rooms	3	23, 36, 44, 123	
Standard hours consultations - out of consulting rooms	4	24, 37, 47, 124	

Standard hours consultations - residential aged care facility	90020	90035, 90043, 90051, 90054	
Telehealth - video	91790 (all) 91801, 91802, 91920 if not MyMedicare enrolled	91800	91801, 91802, 91920
Telehealth - phone	91890	91891	91900, 91910
After hours consultations - in consulting rooms	5000	5020, 5040, 5060, 5071	
After hours consultations - out of consulting rooms	5003	5023, 5043, 5063, 5076	
After hours consultations - residential aged care facility	5010	5028, 5049, 5067, 5077	
Other	All other “unreferred services” ⁴ , including but not limited to: chronic disease management items, Better Access mental health items, health assessments, minor procedures etc.		

¹ For the definition of GP for MBS purposes see [GN.4.13](#)

² Bulk billing incentives can be claimed when you bulk bill a child under 16 or a Commonwealth Concession Card holder www.servicesaustralia.gov.au/concession-and-health-care-cards

³ Practice located in Modified Monash area www.health.gov.au/resources/apps-and-tools/health-workforce-locator/app

⁴ Bulk billing incentives cannot be claimed for the provision of COVID vaccine support services

Medical Practitioners¹

Bulk billing incentives for eligible patients² – Modified Monash 5 (Small Rural Towns)³

Applicable BBI Item	75856	75874	75883 (MyMedicare enrolled patients only)
Standard hours consultations - in consulting rooms	52, 179	53, 54, 57, 151, 185, 189, 203, 301	
Standard hours consultations - out of consulting rooms	58, 181	59, 60, 65, 165, 187, 191, 206, 303	
Standard hours consultations - residential aged care facility	90092, 90183	90093, 90095, 90096, 90098, 90188, 90202, 90212, 90215	

Telehealth - video	91792, 91794 (all) 91804, 91805, 91923, 91807, 91808, 91926 if not MyMedicare enrolled	91803, 91806	91804, 91805, 91923, 91807, 91808, 91926
Telehealth - phone	91892	91893	91903, 91913, 91906, 91916
After hours consultations - in consulting rooms	5200, 733	5203, 5207, 5208, 5209, 737, 741, 745, 2197	
After hours consultations - out of consulting rooms	5220, 761	5223, 5227, 5228, 5261, 763, 766, 769, 2198	
After hours consultations - residential aged care facility	5260, 772	5263, 5265, 5267, 5262, 776, 788, 789, 2200	
Other	All other “unreferred services” ⁴ Including but not limited to: chronic disease management items, Better Access mental health items, health assessments, minor procedures etc.		

¹ Items in italics can only be claimed by prescribed medical practitioners, that is, medical practitioners that are not GPs, specialists or consultant physicians. Other items can be claimed by medical practitioners that are not GPs.

² Bulk billing incentives can be claimed when you bulk bill a child under 16 or a Commonwealth Concession Card holder www.servicesaustralia.gov.au/concession-and-health-care-cards

³ Practice located in Modified Monash area www.health.gov.au/resources/apps-and-tools/health-workforce-locator/app

⁴ Bulk billing incentives cannot be claimed for the provision of COVID vaccine support services

MN.1.7 Bulk Billing Incentives for Eligible Patients in Modified Monash Area 6 General Practitioners¹

Bulk billing incentives for eligible patients² – Modified Monash 6 (Remote Communities)³

Applicable BBI Item	75857	75875	75884 (MyMedicare enrolled patients only)
Standard hours consultations - in consulting rooms	3	23, 36, 44, 123	
Standard hours consultations - out of consulting rooms	4	24, 37, 47, 124	
Standard hours consultations - residential aged care facility	90020	90035, 90043, 90051, 90054	
Telehealth - video	91790 (all)	91800	91801, 91802, 91920

	91801, 91802, 91920 if not MyMedicare enrolled		
Telehealth - phone	91980	91891	91900, 91910
After hours consultations - in consulting rooms	5000	5020, 5040, 5060, 5071	
After hours consultations - out of consulting rooms	5003	5023, 5043, 5063, 5076	
After hours consultations - residential aged care facility	5010	5028, 5049, 5067, 5077	
Other	All other “unreferred services” ⁴ , including but not limited to: chronic disease management items, Better Access mental health items, health assessments, minor procedures etc.		

¹ For the definition of GP for MBS purposes see [GN.4.13](#)

² Bulk billing incentives can be claimed when you bulk bill a child under 16 or a Commonwealth Concession Card holder www.servicesaustralia.gov.au/concession-and-health-care-cards

³ Practice located in Modified Monash area www.health.gov.au/resources/apps-and-tools/health-workforce-locator/app

⁴ Bulk billing incentives cannot be claimed for the provision of COVID vaccine support services

Medical Practitioners¹

Bulk billing incentives for eligible patients² – Modified Monash 6 (Remote Communities)³

Applicable BBI Item	75857	75875	75884 (MyMedicare enrolled patients only)
Standard hours consultations - in consulting rooms	52, 179	53, 54, 57, 151, 185, 189, 203, 301	
Standard hours consultations - out of consulting rooms	58, 181	59, 60, 65, 165, 187, 191, 206, 303	
Standard hours consultations - residential aged care facility	90092, 90183	90093, 90095, 90096, 90098, 90188, 90202, 90212, 90215	
Telehealth - video	91792, 91794 (all)	91803, 91806	91804, 91805, 91923, 91807, 91808, 91926

	91804, 91805, 91923, <i>91807, 91808, 91926</i> if not MyMedicare enrolled		
Telehealth - phone	91892	91893	91903, 91913, <i>91906, 91916</i>
After hours consultations - in consulting rooms	5200, <i>733</i>	5203, 5207, 5208, 5209, <i>737, 741, 745, 2197</i>	
After hours consultations - out of consulting rooms	5200, <i>761</i>	5223, 5227, 5228, 5261, <i>763, 766, 769, 2198</i>	
After hours consultations - residential aged care facility	5260, <i>772</i>	5263, 5265, 5267, 5262, <i>776, 788, 789, 2200</i>	
Other	All other “unreferred services” ⁴ Including but not limited to: chronic disease management items, Better Access mental health items, health assessments, minor procedures etc.		

¹ Items in italics can only be claimed by prescribed medical practitioners, that is, medical practitioners that are not GPs, specialists or consultant physicians. Other items can be claimed by medical practitioners that are not GPs.

² Bulk billing incentives can be claimed when you bulk bill a child under 16 or a Commonwealth Concession Card holder www.servicesaustralia.gov.au/concession-and-health-care-cards

³ Practice located in Modified Monash area www.health.gov.au/resources/apps-and-tools/health-workforce-locator/app

⁴ Bulk billing incentives cannot be claimed for the provision of COVID vaccine support services

MN.1.8 Bulk Billing Incentives for Eligible Patients in Modified Monash Area 7 General Practitioners¹

Bulk billing incentives for eligible patients² – Modified Monash 7 (Very Remote Communities)³

Applicable BBI Item	75858	75876	75885 (MyMedicare enrolled patients only)
Standard hours consultations - in consulting rooms	3	23, 36, 44, 123	
Standard hours consultations - out of consulting rooms	4	24, 37, 47, 124	
Standard hours consultations - residential aged care facility	90020	90035, 90043, 90051, 90054	
Telehealth - video	91790 (all) 91801, 91802, 91920 if not MyMedicare enrolled	91800	91801, 91802, 91920
Telehealth - phone	91890	91891	91900, 91910

After hours consultations - in consulting rooms	5000	5020, 5040, 5060, 5071	
After hours consultations - out of consulting rooms	5003	5023, 5043, 5063, 5076	
After hours consultations - residential aged care facility	5010	5028, 5049, 5067, 5077	
Other	All other “unreferred services” ⁴ , including but not limited to: chronic disease management items, Better Access mental health items, health assessments, minor procedures etc.		

¹ For the definition of GP for MBS purposes see [GN.4.13](#)

² Bulk billing incentives can be claimed you bulk bill a child under 16 or a Commonwealth Concession Card holder www.servicessaustralia.gov.au/concession-and-health-care-cards

³ Practice located in Modified Monash area www.health.gov.au/resources/apps-and-tools/health-workforce-locator/app

⁴ Bulk billing incentives cannot be claimed for the provision of COVID vaccine support services

Medical Practitioners¹

Bulk billing incentives for eligible patients² – Modified Monash 7 (Very Remote communities)³

Applicable BBI Item	75858	75876	75885 (MyMedicare enrolled patients only)
Standard hours consultations - in consulting rooms	52, 179	53, 54, 57, 151, 185, 189, 203, 301	
Standard hours consultations - out of consulting rooms	58, 181	59, 60, 65, 165, 187, 191, 206, 303	
Standard hours consultations - residential aged care facilities	90092, 90183	90093, 90095, 90096, 90098, 90188, 90202, 90212, 90215	
Telehealth - video	91792, 91794 (all) 91804, 91805, 91923, 91807, 91808, 91926 if not MyMedicare enrolled	91803, 91806	91804, 91805, 91923, 91807, 91808, 91926
Telehealth - phone	91892	91893	91903, 91913, 91906, 91916
After hours consultations - in consulting rooms	5200, 733	5203, 5207, 5208, 5209, 737, 741, 745, 2197	

After hours consultations - out of consulting rooms	5220, 761	5223, 5227, 5228, 5261, 763, 766, 769, 2198	
After hours consultations - residential aged care facility	5260, 772	5263, 5265, 5267, 5262, 776, 788, 789, 2200	
Other	All other “unreferred services” ⁴ Including but not limited to: chronic disease management items, Better Access mental health items, health assessments, minor procedures etc.		

¹ Items in italics can only be claimed by prescribed medical practitioners, that is, medical practitioners that are not GPs, specialists or consultant physicians. Other items can be claimed by medical practitioners that are not GPs.

² Bulk billing incentives can be claimed when you bulk bill a child under 16 or a Commonwealth Concession Card holder www.servicesaustralia.gov.au/concession-and-health-care-cards

³ Practice located in Modified Monash area www.health.gov.au/resources/apps-and-tools/health-workforce-locator/app

⁴ Bulk billing incentives cannot be claimed for the provision of COVID vaccine support services

MN.3.1 Individual Allied Health Services (Items 10950, 10951, 10952, 10953, 10954, 10956, 10958, 10960, 10962, 10964, 10966, 10968, 10970, 93000 and 93013) for Chronic Disease Management Eligible patients

Medicare benefits are available for services provided by eligible allied health professionals to patients with chronic or terminal conditions and complex care needs who are being managed by a GP or prescribed medical practitioner using Chronic Disease Management (CDM) MBS items. The allied health services must be recommended in:

- the GP Management Plan as part of the management of a chronic or terminal condition and Team Care Arrangements be undertaken, or
- the multidisciplinary care plan if the patient is a resident of a residential aged care facility.

These items are for patients with one or more medical conditions that have been (or are likely to be) present for at least 6 months, or terminal condition(s). A patient is considered to have complex care needs if they require ongoing care from a multidisciplinary team consisting of their GP or prescribed medical practitioner, and at least 2 other health or care providers.

A prescribed medical practitioner is a medical practitioner other than a GP, specialist, or consultant physician.

Number of services per year

Medicare benefits are available for up to 5 services per eligible patient, per calendar year if clinically indicated and each service meets all the item requirements. The 5 services can be made up of one type of service (e.g. 5 physiotherapy services) or a combination of different types of services (e.g. one dietetic and 4 podiatry services).

Where a patient receives more than the limit of 5 services in a calendar year, the additional service/s will not attract a Medicare benefit and the MBS Safety Net arrangements will not apply to costs incurred by the patient for the service/s.

Aboriginal or Torres Strait Islander patients

Aboriginal or Torres Strait Islander patients can claim additional allied health services under group M11. Refer to [MN.11.1](#) for further information.

Referral requirements

To access these allied health services, patients must have the following MBS services in place:

- GP Management Plan - GP item 721/92024 or prescribed medical practitioner item 229/92055; and
- Team Care Arrangements (TCA) - GP item 723/92025 or prescribed medical practitioner item 230/92056

Alternatively, for patients who are residents of a residential aged care facility, their GP or prescribed medical practitioner must have contributed to a multidisciplinary care plan prepared for them by the facility (MBS GP item 731/92027 or prescribed medical practitioner item 232/92058).

Referral form

For Medicare benefits to be payable, the patient must be referred to an eligible allied health professional by their GP or prescribed medical practitioner using a referral form that has been issued by the Australian Government Department of Health and Aged Care or a form that contains all the components of this form.

The form issued by the department is available on the Department of Health and Aged Care website. GPs and prescribed medical practitioners are encouraged to attach relevant information to the referral form.

GPs and prescribed medical practitioners may use one referral form to refer patients for single or multiple services of the same service type (e.g. 5 chiropractic services). If referring a patient for single or multiple services of different service types (e.g. 2 dietetic services and 3 podiatry services), a separate referral form will be needed for each service type.

Providers should retain referrals for their services for 24 months from the date the service was rendered for Medicare auditing purposes.

Referrals for people of Aboriginal or Torres Strait Islander descent

Referrals for patients of Aboriginal or Torres Strait Islander descent can be made using the 'Referral form for follow-up allied health services under Medicare for people of Aboriginal or Torres Strait Islander descent' or a referral containing the same information as the form. The form issued by the department is available on the department's website. This referral form is to be used for patients of Aboriginal or Torres Strait Islander descent for referral to allied health services under Group M11 (and equivalent telehealth items) where a GP Management Plan and Team Care Arrangements, or a multidisciplinary plan, or a health assessment has been undertaken (see [MN.11.1](#) for more information).

Referral validity

If a patient has not used all their services under a referral in a calendar year, it is not necessary to obtain a new referral for the 'unused' services. The 'unused' services will roll over into the following calendar year and will count towards the total of 5 services for which the patient is eligible in that calendar year.

When patients have used all their referred services or require a referral for a different type of allied health service recommended under their GP Management Plan and Team Care Arrangement, they will need to obtain a new referral from their GP or prescribed medical practitioner. GPs and prescribed medical practitioners may choose to use this visit to undertake a review of the patient's GP Management Plan and Team Care Arrangements or multidisciplinary care plan or, where appropriate, to manage the process using a GP/ prescribed medical practitioner consultation item.

It is not necessary to have a new GP Management Plan prepared each calendar year to access new referral/s for allied health services. Patients continue to be eligible for benefits for individual allied health services under M3 and telehealth equivalent services while they are being managed under the prerequisite GP Management Plan and Team

Care Arrangements items if the need for eligible services continues to be recommended in their plan/s. However, regular reviews are encouraged.

Eligible Allied Health Professionals

To provide services under Medicare for patients with a chronic or terminal medical condition and complex care needs, eligible allied health professionals must meet the eligibility requirements as set out in the *Health Insurance (Section 3C General Medical Services – Allied Health Services) Determination 2024*.

The following allied health professionals are eligible to provide individual allied health services under these items:

- Aboriginal and Torres Strait Islander health practitioners (10950)
- Aboriginal health workers (10950)
- audiologists (10952)
- chiropractors (10964)
- diabetes educators (10951)
- dietitians (10954)
- exercise physiologists (10953)
- mental health service (10956) provided by allied health professionals including Aboriginal and Torres Strait Islander health practitioners, Aboriginal and Torres Strait Islander health workers, mental health nurses, occupational therapists, psychologists and social workers
- occupational therapists (10958)
- osteopaths (10966)
- physiotherapists (10960)
- podiatrists (10962)
- psychologists (10968)
- speech pathologists (10970)

Membership of Team Care Arrangements

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

Reporting back to the Referring Practitioner

Where an allied health professional provides a single service to the patient under a referral, they must provide a written report back to the referring GP or prescribed medical practitioner after each service.

Where an allied health professional provides multiple services to the same patient under the one referral, they must provide a written report back to the referring GP or prescribed medical practitioner after the first and last service only, or more often if clinically necessary. Written reports should include:

- any investigations, tests, and/or assessments carried out on the patient;
- any treatment provided; and
- future management of the patient's condition or problem.

The report/s to the referring practitioner must be kept by the allied health professional who provided the service for 2 years from the date of the service.

MN.3.2 Multidisciplinary Case Conferencing for Chronic Disease Management (Items 10955, 10957, 10959)

These items provide MBS benefits for eligible allied health professionals to participate in a multidisciplinary case conference team in a community case conference with a patient's GP or prescribed medical practitioner and other providers.

A prescribed medical practitioner is a medical practitioner other than a GP, specialist, or consultant physician. A multidisciplinary case conference means a process by which a multidisciplinary case conference team carries out all the following activities:

- discussing a patient's history;
- identifying the patient's multidisciplinary care needs;
- identifying outcomes to be achieved by members of the multidisciplinary case conference team giving care and service to the patient;
- identifying tasks that need to be undertaken to achieve these outcomes, and allocating those tasks to members of the multidisciplinary case conference team;
- assessing whether previously identified outcomes (if any) have been achieved.

These items apply to non-hospital admitted patients for chronic disease management under the care of a GP/prescribed medical practitioner in either the community or for a resident of a residential aged care facility.

Eligible allied health professionals may claim reimbursement for participating in case conferences through the following time-tiered items:

- 15–19 minutes (10955)
- 20–39 minutes (10957)
- 40 minutes or longer (10959)

Eligible Allied Health Professionals

For the purpose of these items, eligible health professionals must meet the eligibility requirements as set out in the *Health Insurance (Section 3C General Medical Services – Allied Health Services) Determination 2024* and include the following:

- Aboriginal health worker
- Aboriginal and Torres Strait Islander health practitioner
- audiologist
- chiropractor
- diabetes educator
- dietitian
- exercise physiologist
- mental health worker which includes allied health professionals that meet the requirements of a mental health service which include Aboriginal and Torres Strait Islander health practitioners, Aboriginal and Torres Strait Islander health workers, mental health nurses, occupational therapists, psychologists and social workers
- nurse practitioner
- occupational therapist
- osteopath
- physiotherapist
- podiatrist
- psychologist
- speech pathologist

Organisation of a case conference

The case conference must be organised by the GP/prescribed medical practitioner. The multidisciplinary case conference team must include a GP/prescribed medical practitioner and at least 2 other members providing different kinds of care to the patient. The multidisciplinary case conference team requirements include:

- each member must provide a different kind of care or service to the patient; and
- each member must not be an unpaid carer of the patient; and
- one member may be another GP/prescribed medical practitioner.

The patient and family members or carers can attend the case conference but will not count towards the minimum team member requirements.

The allied health professional does not need all participants to be MBS-eligible to be able to claim payment for their participation. Members can include allied health professionals, home and community service providers and care organisers, including the following:

- asthma educators;
- dental therapists;
- dentists;
- optometrists;
- orthoptists;
- orthotists or prosthetists;
- pharmacists;
- podiatrists;
- registered nurses;
- education providers;
- “meals on wheels” providers;
- personal care workers; and
- probation officers.

In some instances, 2 allied health professionals from the same profession may participate in the same case conference, where both provide different aspects of care to the patient. For instance, the 2 allied health professionals from the same profession have different specialisations that are clinically relevant to the same patient and cannot be provided by one of them alone. In this instance, both allied health professionals will be able to claim the items.

Participation in a case conference

A referral is not required for an allied health professional to access the multidisciplinary case conferencing items for chronic disease management. However, the allied health professional must be invited to participate in the case conference by the patient’s treating GP/prescribed medical practitioner.

The patient must agree to the allied health professional participating in the case conference and be informed that Medicare will be accessed to fund the service. The patient may agree through discussion with their GP/prescribed medical practitioner. The GP/prescribed medical practitioner should ensure that the patient has agreed and that their agreement has been recorded appropriately.

Allied health professionals claiming a case conferencing item should record the day, start, and end times, the names of all participants and all matters discussed in the patient’s medical record.

The allied health professional is not required to have a pre-existing relationship with the patient. However, the patient should agree to their participation in the case conference and be informed that Medicare will be accessed to fund the service.

The case conference may lead to an agreed care plan between all participating providers, including the number of individual allied health services required and how they are allocated among professions within a patient’s entitlement.

The case conferencing items can be accessed in person, via videoconference or telephone, using the same item number. There is no requirement that all participants use the same communication method.

Frequency limitations

These items cannot be claimed if the service has been performed in the last 3 months, unless in exceptional circumstances. An exceptional circumstance means there has been a significant change in the patient's clinical condition or care circumstances that necessitate the performance of the service.

MN.6.1 Provision of Psychological Therapy Services by Clinical Psychologists

MN.6.2 to MN.6.5 provide information on Individual Psychological Therapy services delivered by clinical psychologists. These notes are also applicable for video and phone equivalent MBS items.

For information on Group Focussed Psychological Strategies services see MN.6.7.

OVERVIEW

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

- psychological therapy - provided by eligible clinical psychologists; and
- focussed psychological strategies - allied mental health - provided by eligible psychologists, occupational therapists and social workers.

MN.6.2 Individual Psychological Therapy Services Attracting Medicare Rebates

Eligible psychological therapy services

There are eight MBS items for the provision of individual psychological therapy services to eligible patients by a clinical psychologist (80000, 80005, 80010, 80015, 91166, 91167, 91181 and 91182).

Clinical psychologists must meet the provider eligibility requirements set out below and be registered with Services Australia.

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

Referrals and Referral Validity

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

- a referral has been made by a GP or medical practitioner who is managing the patient under a GP Mental Health Treatment Plan;
- a referral has been made by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or
- a referral has been made by a psychiatrist or paediatrician from an eligible psychiatric or paediatric service (see Referral Requirements for further details regarding psychiatrist and paediatrician referrals).

Number of services per year

Medicare rebates are available for up to 10 individual mental health services in a calendar year. The services may consist of: GP/medical practitioner focussed psychological strategies services; and/or psychological therapy services delivered by clinical psychologists; and/or focussed psychological strategies - allied mental health services.

The referring practitioner can decide how many sessions the patient will receive in a course of treatment, within the maximum session limit for the course of treatment. The maximum session limit for each course of treatment is set out below:

- Initial course of treatment – a maximum of six sessions.

- Subsequent course of treatment – a maximum of six sessions up to the patient’s cap of ten sessions (for example, if the patient received six sessions in their initial course of treatment, they can only receive four sessions in a subsequent course of treatment).

The written report provided by the clinical psychologist following a course of treatment will be considered by the referring practitioner in assessing the patient's clinical need for further sessions after each course of treatment.

Patients will also be eligible to claim up to 10 separate services within a calendar year for group therapy services, see MN.6.7. These group services are separate from the individual services and do not count towards the individual services per calendar year maximum associated with those items.

Please note if a referral does not specify whether the referral is for individual or group therapy, the patient can use a referral to access either individual or group therapy treatment options. The patient should speak to their GP about their treatment needs and the type of treatment that might be suitable in their particular circumstances.

In the instance where a patient has received the maximum services available under the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative per calendar year and is considered to clinically benefit from some additional services, the patient may be eligible for Primary Health Networks (PHNs) funded psychological therapies if they meet relevant eligibility criteria for the PHN commissioned services. It is recommended that providers refer to their PHN for further guidance.

Referrals for the Additional 10 Sessions (available until 31 December 2022)

In response to the COVID-19 pandemic, the number of Medicare rebateable individual mental health services was temporarily increased from 10 to 20 per calendar year until 31 December 2022.

A patient does not need a new referral to access Better Access sessions from 1 January 2023. If the patient has a current referral (either for the initial 10 sessions or the additional 10 sessions) and has not used all of the sessions, they can use that referral to access sessions in 2023. However, they cannot receive more than 10 individual sessions in 2023.

Service length and type

Services provided by eligible clinical psychologists under these items must be within the specified time period within the item descriptor.

It is expected that professional attendances at places other than consulting rooms would be provided where treatment in other environments is necessary to achieve therapeutic outcomes.

In addition to psycho-education, it is recommended that cognitive-behaviour therapy be provided. However, other evidence-based therapies – such as interpersonal therapy – may be used if considered clinically relevant.

Course of treatment and reporting back to the referring medical practitioner

Eligible patients can claim Medicare subsidies for up to 10 individual mental health services per calendar year.

Within this maximum service allocation, the clinical psychologist can provide one or more courses of treatment (additional information on course of treatment session limits is above). This enables the referring medical practitioner to consider a report from the clinical psychologist on the services provided to the patient, and the need for further treatment.

On completion of the initial course of treatment, the clinical psychologist must provide a written report to the referring GP or medical practitioner, which includes information on:

- assessments carried out on the patient;
- treatment provided; and
- recommendations on future management of the patient's disorder.

A written report must also be provided to the referring GP or medical practitioner at the completion of any subsequent course(s) of treatment provided to the patient.

Out of pocket expenses and Medicare safety net

Charges in excess of the Medicare benefit for these items are the responsibility of the patient. However, if a service was provided out-of-hospital, any out-of-pocket costs will count towards the Medicare safety net for that patient. The out-of-pocket costs for mental health services which are not Medicare eligible do not count towards the Medicare safety net.

Eligible patients

Individual psychological therapy service items apply to people with an assessed mental disorder and where the patient is referred by a GP or medical practitioner who is managing the patient under a GP Mental Health Treatment Plan, under a referred psychiatrist assessment and management plan, or on referral from an eligible psychiatrist or paediatrician.

The conditions classified as mental disorders for the purposes of these services are informed by the World Health Organisation, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care: ICD-10 Chapter V Primary Care Version. For the purposes of these items, dementia, delirium, tobacco use disorder and mental retardation are not regarded as a mental disorder.

Checking patient eligibility for psychological therapy services

If there is any doubt about a patient's eligibility, Services Australia will be able to confirm whether a GP Mental Health Treatment Plan and/or a psychiatrist assessment and management plan is in place and claimed; or an eligible psychiatric or paediatric service has been claimed, as well as the number of allied mental health services already claimed by the patient during the calendar year.

Clinical psychologists can call Services Australia on 132 150 to check this information, while unsure patients can seek clarification by calling 132 011.

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

Publicly funded services

Psychological therapy items do not apply for services that are provided by any other Commonwealth or State funded services or provided to an admitted patient of a hospital. However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or state/territory clinic, the items apply for services that are provided by eligible clinical psychologists salaried by, or contracted to, the service as long as all requirements of the items are met, including registration with Services Australia. These services must be direct billed (that is, the Medicare rebate is accepted as full payment for services).

Private health insurance

Patients need to decide if they will use Medicare or their private health insurance ancillary cover to pay for these services. Patients cannot use their private health insurance ancillary cover to 'top up' the Medicare rebate paid for the services.

MN.6.3 Referral Requirements (GPs, Medical Practitioners, Psychiatrists or Paediatricians to Clinical Psychologists for Psychological Therapy) Referrals

Patients must be referred for psychological therapy services by a GP or medical practitioner managing the patient under a GP Mental Health Treatment Plan or a referred psychiatrist assessment and management plan; or on referral from a psychiatrist or a paediatrician.

Referrals from psychiatrists and paediatricians must be made from eligible Medicare services. For specialist psychiatrists and paediatricians these services include any of the specialist attendance items 104 through 109. For consultant physician psychiatrists the relevant eligible Medicare services cover any of the consultant psychiatrist items 293 through 370; while for consultant physician paediatricians the eligible services are consultant physician attendance items 110 through 133.

Referring practitioners are not required to use a specific form to refer patients for these services. A referral for mental health services should be in writing (signed and dated by the referring practitioner) and include:

- the patient's name, date of birth and address;
- the patient's symptoms or diagnosis and a statement on whether a mental health treatment plan has been prepared;
- a list of any current medications;
- the number of sessions the patient is being referred for (the 'course of treatment');
- a statement about whether the patient has a mental health treatment plan, a shared care plan (prepared on or before 30 June 2021), or a psychiatrist assessment and management plan.

It may be useful for a referral to include a statement indicating whether group sessions could be considered.

A referral should include all of the above details, to assist with any auditing undertaken by the Department of Health and Aged Care. Where appropriate, and with the patient's agreement, the GP can also attach a copy of the mental health treatment plan to the referral.

Number of Sessions

The referring practitioner can decide how many sessions the patient will receive in a course of treatment, within the maximum session limit for the course of treatment. The maximum session limit for each course of treatment is set out below:

- Initial course of treatment – a maximum of six sessions.
- Subsequent course of treatment – a maximum of six sessions up to the patient's cap of ten sessions (for example, if the patient received six sessions in their initial course of treatment, they can only receive four sessions in a subsequent course of treatment).

The written report provided by the clinical psychologist following a course of treatment will be considered by the referring practitioner in assessing the patient's clinical need for further sessions after each course of treatment.

Specifying the Number of Sessions on a Referral

If the referring practitioner:

- Does not specify the number of sessions
- Specifies a number of sessions above the maximum allowed for the course of treatment
- Specifies a number of sessions above the maximum allowed for the calendar year (including any sessions the patient has already received that year)

Then the clinical psychologist can use their clinical judgment to provide services under the referral, noting the patient cannot receive more than:

- the maximum number of sessions allowed for that particular course of treatment (as set out above), and
- the maximum number of sessions allowed in a calendar year.

In these circumstances, a clinical psychologist must provide a report at the end of a course of treatment in line with standard practice for these services. This enables the referring medical practitioner to consider the treating practitioner's report on the services provided to the patient, and the need for further treatment.

Verbal Referral

A referring practitioner can verbally refer a patient for Better Access services only if:

- in their clinical judgement they consider it is necessary for the patient to have immediate access to support from a clinical psychologist, and
- it is not practicable in the circumstances to provide a written referral – for example, to do so would cause delays in treatment to the patient's detriment, and
- the clinical psychologist documents in writing that they are treating the patient based on the referring practitioner's verbal referral, and
- the referring practitioner provides a written referral to the clinical psychologist as soon as possible afterwards.

While waiting for the referring practitioner to provide a written referral, the treating practitioner can provide treatment according to the verbal referral until the referred number of sessions have been completed. If there is any doubt about the number of sessions the patient was verbally referred for, the treating practitioner should follow the guidance provided above under the heading 'Specifying the number of sessions on a referral'.

A verbal referral does not replace any requirement for the GP to review the patient's progress (taking into account the written report from their treating allied health professional) after each course of treatment.

The clinical psychologist must be in receipt of the referral at the first allied mental health consultation. The clinical psychologist must also retain the referral for 7 years (24 months) from the date the service was rendered.

Use of Referrals across Different Calendar Years

Eligible patients can claim Medicare subsidies for up to 10 individual and 10 group mental health services per calendar year.

If a patient has not used all their psychological therapy services and/or focussed psychological strategies services in course of treatment covered by a referral within the calendar year, it is not necessary to obtain a new referral for the "unused" services. However, any "unused" services received from 1 January in the following year under that referral will count as part of the total services for which the patient is eligible in that calendar year.

When patients have used all of their referred services they will need to obtain a new referral from the referring practitioner if they are eligible for further services. Where the patient's care is being managed by a GP or medical practitioner, the GP/medical practitioner may choose to use this visit to undertake a review of the patient's GP Mental Health Treatment Plan and/or psychiatrist assessment and management plan.

It is not necessary to have a new GP Mental Health Treatment Plan and/or psychiatrist assessment and management plan prepared each calendar year in order to access a new referral(s) for eligible psychological therapy services and/or focussed psychological strategies services. Patients continue to be eligible for rebates for psychological therapy services and/or focussed psychological strategies services while they are being managed under a GP Mental Health Treatment Plan and/or a psychiatrist assessment and management plan as long as the need for eligible services continues to be recommended in their plan.

Referrals for the Additional 10 Sessions (available until 31 December 2022)

In response to the COVID-19 pandemic, the number of Medicare rebateable individual mental health services was temporarily increased from 10 to 20 per calendar year until 31 December 2022.

A patient does not need a new referral to access Better Access sessions from 1 January 2023. If the patient has a current referral (either for the initial 10 sessions or the additional 10 sessions) and has not used all of the sessions,

they can use that referral to access sessions in 2023. However, they cannot receive more than 10 individual sessions in 2023.

MN.6.4 Clinical Psychologist Professional Eligibility **Eligible clinical psychologists**

A person is an allied health professional in relation to the provision of a psychological therapy health service if the person:

- a. holds general registration in the health profession of psychology under the applicable law in force in the state or territory in which the service is provided; and
- b. is endorsed by the Psychology Board of Australia to practice in clinical psychology.

Until 31 October 2015, a person was also an allied health professional in relation to the provision of a psychological therapy health service if the person:

- a. holds general registration in the health profession of psychology under the applicable law in force in the state or territory in which the service is provided; and
- b. on 31 October 2015 was an allied health professional in relation to the provision of a psychological therapy health service because the person:
 - i. was a member of the College of Clinical Psychologists of the Australian Psychological Society; or
 - ii. had been assessed by the College of Clinical Psychologists of the Australian Psychological Society as meeting the requirements for membership of that College.

The clinical psychologist must be registered with Services Australia.

Registering with Services Australia

Advice about registering with Services Australia to provide psychological therapy services using items 80000-80021 inclusive is available from the Services Australia provider inquiry line on 132 150.

Further information

For further information about Medicare Benefits Schedule items, please go to the Department of Health and Aged Care's website at www.health.gov.au/mbsonline.

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

MN.6.7 Provision of Group Psychological Therapy Services by Clinical Psychologists

This note provides information on Group Psychological Therapy services delivered by clinical psychologists. It includes an overview of the items, patient and provider eligibility, what activities are involved in providing services rebated by these items, and additional claiming information.

For information on Individual Psychological Therapy services see MN.6.1 to MN.6.5.

OVERVIEW

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

- psychological therapy - provided by eligible clinical psychologists; and
- focussed psychological strategies – allied mental health - provided by eligible psychologists, occupational therapists and social workers.

GROUP PSYCHOLOGICAL THERAPY SERVICES

There are 6 MBS items for the provision of group psychological therapy services to eligible patients by clinical psychologists:

- 80020, 80022, 80024 for provision of psychological therapy services by a clinical psychologist; and
- 80021, 80023, 80025 for provision of video conference services to patients in telehealth eligible areas by a clinical psychologist.

Note, the clinical psychologist must be satisfied that it is clinically appropriate to provide a video consultation to a patient, and the patient must be in a telehealth eligible area (see 'Telehealth eligible areas' below).

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

Referrals

Services provided under the group psychological therapy service items will not attract a Medicare rebate unless:

- a referral has been made by a GP or medical practitioner who is managing the patient under a GP Mental Health Treatment Plan;
- a referral has been made by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or
- a referral has been made by a psychiatrist or paediatrician from an eligible psychiatric or paediatric service.

The clinical psychologist must be in receipt of the referral at the first mental health consultation. The clinical psychologist must also retain the referral for 2 years (24 months) from the date the service was rendered.

Referrals from psychiatrists and paediatricians must be made from eligible Medicare services. For specialist psychiatrists and paediatricians these services include any of the specialist attendance items 104 through 109. For consultant physician psychiatrists the relevant eligible Medicare services cover any of the consultant psychiatrist items 293 through 370; while for consultant physician paediatricians the eligible services are consultant physician attendance items 110 through 133.

Referring practitioners are not required to use a specific form to refer patients for these services. A referral for mental health services should be in writing (signed and dated by the referring practitioner) and include:

- the patient's name, date of birth and address;
- the patient's symptoms or diagnosis and a statement on whether a mental health treatment plan has been prepared;
- a list of any current medications;
- the number of sessions the patient is being referred for;
- a statement about whether the patient has a mental health treatment plan or a psychiatrist assessment and management plan.

It may be useful for a referral to include a statement indicating whether group sessions could be considered. If a referral does not specify whether the referral is for individual or group therapy, the patient can use a referral to access either or both individual and group therapy treatment options. However, the patient should speak to their referring practitioner about their treatment needs and the type of treatment that might be suitable in their particular circumstances.

A referral should include all of the above details, to assist with any auditing undertaken by the Department of Health and Aged Care. Where appropriate, and with the patient's agreement, the GP can also attach a copy of the mental health treatment plan to the referral.

Minimum number of patients

Group psychological therapy service MBS items can be claimed for groups of four to 10 patients. However, clinical psychologists can claim these MBS items if four patients were due to attend and one patient is unable to attend, regardless of the reason.

Number of services per year

Medicare rebates are available for up to 10 group therapy services per calendar year. The services may consist of psychological therapy services delivered by clinical psychologists and/or focussed psychological strategies - allied mental health services. These group services are separate from the individual services and do not count towards the individual services per calendar year maximum associated with those items, see MN.6.1 to MN.6.5.

The referring practitioner can decide how many sessions the patient will receive, within the maximum session limit for the calendar year. If the referring practitioner does not specify the number of sessions on the referral, or specifies a number of sessions above the maximum allowed for the calendar year (including any sessions the patient has already received that year), the clinical psychologist can use their clinical judgement to provide services under the referral up to the maximum.

In the instance where a patient has received the maximum services available under the *Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule* initiative per calendar year and is considered to clinically benefit from some additional services, the patient may be eligible for Primary Health Networks (PHNs) funded psychological therapies if they meet relevant eligibility criteria for the PHN commissioned services. It is recommended that clinical psychologists refer to their PHN for further guidance.

Service length and type

Services provided by eligible clinical psychologists under these items must be within the specified time period within the item descriptor.

In addition to psycho-education, it is recommended that cognitive-behaviour therapy be provided. However, other evidence-based therapies — such as interpersonal therapy — may be used if considered clinically relevant.

Record Keeping

Clinical psychologists must keep contemporaneous notes of the consultation including documenting the date, time and people who attended. Only clinical details recorded at the time of attendance count towards the time of the consultation. Other notes or reports added at a later time are not included.

Use of Referrals across Different Calendar Years

If a patient has not used all their psychological therapy services and/or focussed psychological strategies services covered by a referral within the calendar year, it is not necessary to obtain a new referral for the "unused" services. However, any "unused" services received from 1 January in the following year under that referral will count as part of the total services for which the patient is eligible in that calendar year.

When patients have used all of their referred services they will need to obtain a new referral from the referring practitioner if they are eligible for further services.

It is not necessary to have a new GP Mental Health Treatment Plan and/or psychiatrist assessment and management plan prepared each calendar year in order to access a new referral(s) for group psychological therapy services and/or focussed psychological strategies services. Patients continue to be eligible for rebates for psychological therapy services and/or focussed psychological strategies services while they are being managed under a GP Mental Health Treatment Plan and/or a psychiatrist assessment and management plan as long as the need for eligible services continues to be recommended in their plan.

Out-of-pocket expenses and Medicare safety net

Charges in excess of the Medicare benefit for these items are the responsibility of the patient. However, any out-of-pocket costs will count towards the Medicare safety net for that patient. The out-of-pocket costs for mental health services which are not Medicare eligible do not count towards the Medicare safety net.

Publicly funded services

Psychological therapy services items do not apply for services that are provided by any other Commonwealth or state funded services or provided to an admitted patient of a hospital. However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or state/territory clinic, the psychological therapy service items apply for services that are provided by clinical psychologists salaried by, or contracted to, the service as long as all requirements of the items are met, including registration with Services Australia. These services must be direct billed (that is, the Medicare rebate is accepted as full payment for services).

PATIENT ELIGIBILITY

Group psychological therapy service items apply to people with an assessed mental disorder and where the patient is referred by a GP or medical practitioner who is managing the patient under a GP Mental Health Treatment Plan or under a referred psychiatrist assessment and management plan; or from an eligible psychiatrist or paediatrician.

The conditions classified as mental disorders for the purposes of these services are informed by the World Health Organisation, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care: ICD-10 Chapter V Primary Care Version. For the purposes of these items, dementia, delirium, tobacco use disorder and mental retardation are not regarded as a mental disorder.

Telehealth eligible areas

Geographic eligibility for telehealth services funded under Medicare (in Groups M6 and M7) is determined according to the Modified Monash Model (MMM) classifications. Telehealth eligible areas are those areas that are within MMM classifications 4 to 7. Patients and clinical psychologists are able to check their eligibility using the Modified Monash Model locator on the Department of Health and Aged Care's website (<https://www.health.gov.au/resources/apps-and-tools/health-workforce-locator>).

There is a requirement for the patient and clinical psychologist to be located a minimum of 15 kilometres apart at the time of the consultation. Minimum distance between clinical psychologist and patient video consultations is measured by the most direct (ie least distance) route by road. The patient or clinical psychologist is not permitted to travel to an area outside the minimum 15 kilometres distance in order to claim a video consultation.

Checking patient eligibility for psychological therapy services

If there is any doubt about a patient's eligibility, Services Australia will be able to confirm whether a GP Mental Health Treatment Plan and/or a psychiatrist assessment and management plan is in place and claimed; or an eligible psychiatric or paediatric service has been claimed, as well as the number of group services already claimed by the patient during the calendar year.

Clinical psychologists can call Services Australia on 132 150 to check this information, while unsure patients can seek clarification by calling 132 011.

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

CLINICAL PSYCHOLOGIST PROFESSIONAL ELIGIBILITY

A person is an allied health professional in relation to the provision of a psychological therapy health service if the person:

- holds general registration in the health profession of psychology under the applicable law in force in the state or territory in which the service is provided; and
- is endorsed by the Psychology Board of Australia to practice in clinical psychology.

Until 31 October 2015, a person was also an allied health professional in relation to the provision of a psychological therapy health service if the person:

- holds general registration in the health profession of psychology under the applicable law in force in the state or territory in which the service is provided; and
- on 31 October 2015 was an allied health professional in relation to the provision of a psychological therapy health service because the person:
 - was a member of the College of Clinical Psychologists of the Australian Psychological Society; or
 - had been assessed by the College of Clinical Psychologists of the Australian Psychological Society as meeting the requirements for membership of that College.

The clinical psychologist must be registered with Services Australia.

Registering with the Services Australia

Advice about registering with the Services Australia to provide psychological therapy services is available from the Services Australia provider enquiry line on 132 150.

Further information

For further information about Medicare Benefits Schedule items, please go to the Department of Health and Aged Care's website at www.health.gov.au/mbsonline.

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

MN.6.8 Provision of Psychological Therapy Services by Clinical Psychologists to a Person other than the Patient (80002, 80006, 80012, 80016, 91168, 91171, 91198 and 91199)

OVERVIEW

The purpose of these MBS items is to enable clinical psychologists to involve another person in a patient's treatment, under the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access) initiative, where:

- the patient has been referred for Better Access services,
- the clinical psychologist providing the service, or the referring practitioner, determines it is clinically appropriate,
- the patient consents for the service to be provided to the other person as part of their treatment,
- the service is part of the patient's treatment, and
- the patient is not in attendance.

These MBS items recognise the important role another person, such as a family member or carer, can play in supporting patients with mental illness, and the benefits that can result from involving them in treatment.

Under these MBS items, Medicare rebates are available to a patient for up to two services provided to another person per calendar year. Any services delivered using these items count towards the patient's course of treatment and calendar year allocations under Better Access. For further information on patient allocations, please see explanatory note MN.6.2.

For Medicare benefit purposes, charges relating to services covered by these MBS items should be raised against the patient rather than against the person receiving the service.

SERVICES ATTRACTING MEDICARE REBATES

MBS items

There are eight MBS items for the provision of psychological therapy health services to a person other than the patient by clinical psychologists:

- 80002, 80006, 80012, 80016 for provision of in person psychological therapy health services;
- 91168 and 91171 for provision of telehealth psychological therapy health services; and
- 91198 and 91199 for provision of phone psychological therapy health services.

Telehealth services are the preferred approach for substituting a face-to-face consultation. However, clinical psychologists will also be able to offer phone (audio-only) services if video is not available or appropriate. As outlined above, there are separate items available for phone services.

To claim these MBS items the clinical psychologist must meet the provider eligibility requirements for the delivery of psychological therapy health services. For further information, please see explanatory note MN.6.4.

Eligible psychological therapy health services

Clinical psychologists must use their professional judgement to determine what would be an appropriate psychological therapy health service to deliver to another person as part of the patient's treatment.

Publicly funded services

These MBS items do not apply for services provided by any other Commonwealth or state funded services, or provided to an admitted patient of a hospital, unless there is an exemption under subsection 19(2) of the *Health Insurance Act 1973*.

SERVICE LIMITATIONS

Medicare rebates are available to a patient for up to two services provided to another person per calendar year. The two services may consist of:

- Clinical psychologist items: 80002, 80006, 80012, 80016, 91168, 91171, 91198 and 91199
- GP items: 2739, 2741, 2743, 2745, 91859, 91861, 91864 and 91865
- Other medical practitioner items: 309, 311, 313, 315, 91862, 91863, 91866 and 91867
- Psychologist items: 80102, 80106, 80112, 80116, 91174, 91177, 91200 and 91201
- Occupational therapist items: 80129, 80131, 80137, 80141, 91194, 91195, 91202 and 91203
- Social worker items: 80154, 80156, 80162, 80166, 91196, 91197, 91204 and 91205

Any services delivered using these MBS items count towards:

- the maximum session limit for each course of treatment under Better Access, and
- the patient's calendar year allocation for individual services under Better Access.

For further information on the maximum session limits for each course of treatment and maximum calendar year allocation, please see explanatory note MN.6.2.

CLAIMING REQUIREMENTS

Referrals

Services provided under these MBS items will not attract a Medicare rebate unless the patient has been referred for Better Access services by a referring practitioner. Referring practitioner means:

- a medical practitioner who has referred the patient as part of a GP Mental Health Treatment Plan or psychiatrist assessment and management plan; or

- a specialist or consultant physician specialising in the practice of their field of psychiatry; or
- a specialist or consultant physician specialising in the practice of their field of paediatrics.

The referring practitioner can indicate in the patient's mental health treatment plan, psychiatrist assessment and management plan or the referral if they consider it would be clinically appropriate for sessions to be delivered to another person as part of the patient's treatment.

Regardless, clinical psychologists can use their clinical judgment to provide services to another person under the patient's referral. For further information on patient referrals for Better Access services, please see explanatory note MN.6.3.

Determining service is clinically appropriate

The clinical psychologist providing the service, or the referring practitioner, must use their professional judgment to determine it is clinically appropriate, and would form part of the patient's treatment, to provide a psychological therapy health service to another person.

This determination must be recorded in writing in the patient's records.

Obtaining and recording patient consent to deliver the service

The patient must consent to the other person receiving a psychological therapy health service using these MBS items. The eligible clinical psychologist providing the service must:

- Explain the service to the patient.
- Obtain the patient's consent for the service to be provided to the other person as part of the patient's treatment.
- Make a written record of the patient's consent.

The patient may withdraw their consent at any time.

In the case of a child, the general laws relating to consent to medical treatment apply. These may differ between states and territories, and the clinical psychologist should be aware of the requirements in the relevant state or territory.

Service must be part of the patient's treatment

Any service delivered using these MBS items must be part of the patient's treatment. These MBS items are not for the purposes of providing mental health treatment to the person receiving the service. Should that person also require mental health treatment, they will need to speak with a referring practitioner.

Patient is not in attendance

These MBS items are for clinical psychologists to provide services to another person when the patient is not in attendance. If the patient is in attendance, clinical psychologists can consider whether the requirements of the patient MBS items for delivering Better Access services have been met. For further information, please see explanatory note MN.6.2.

Course of treatment and reporting back to the referring practitioner

These services may be accessed at any stage of a patient's course of treatment and do not need to be accessed consecutively, provided no more than two services are delivered to another person and delivering these services does not exceed the maximum allowed for the patient in a course of treatment or calendar year under Better Access.

On completion of a course of treatment by the patient, the eligible clinical psychologist must provide a written report to the referring medical practitioner on assessments carried out on the patient, treatment provided, and recommendations on future management of the patient's disorder. This report should also include relevant information on any services delivered using these MBS items to another person where relevant.

ADDITIONAL INFORMATION

Out-of-pocket expenses and Medicare safety net

For Medicare benefit purposes, charges relating to services covered by these MBS items should be raised against the patient rather than against the person receiving the service.

Charges in excess of the Medicare benefit for these items are the responsibility of the patient. However, if a service was provided out of hospital, any out-of-pocket costs will count towards the Medicare safety net for that patient. The out-of-pocket costs for mental health services which are not Medicare eligible do not count towards the Medicare safety net.

Checking patient eligibility for Better Access services

As outlined above, patients seeking Medicare rebates for services delivered to another person will need to have a referral from a GP, medical practitioner, psychiatrist or paediatrician. If there is any doubt about a patient's eligibility, Services Australia will be able to confirm whether an eligible service has been claimed, as well as the number of mental health services already claimed by the patient during the calendar year. Clinical psychologists can call Services Australia on 132 150 to check this information, while patients can call on 132 011.

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

Further information

For further information about Medicare Benefits Schedule items, please go to the Department of Health and Aged Care's website at www.health.gov.au/mbsonline.

For providers, further information is also available from the Services Australia Medicare Provider Enquiry Line on 132 150.

MN.7.1 Provision of Individual Focussed Psychological Strategies Services by Allied Health Providers - (Items 80100 to 80165)

This note provides information on Individual Focussed Psychological Strategies services delivered by allied health providers, and is also applicable for video and phone equivalent MBS items. It includes an overview of the items, patient and provider eligibility, what activities are involved in providing services rebated by these items, and additional claiming information.

For information on Group Focussed Psychological Strategies services see MN.7.4.

OVERVIEW

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

- psychological therapy - provided by eligible clinical psychologists; and
- focussed psychological strategies – allied mental health - provided by eligible psychologists, occupational therapists and social workers.

FOCUSSED PSYCHOLOGICAL STRATEGIES – ALLIED MENTAL HEALTH SERVICES ATTRACTING MEDICARE REBATES

Eligible focussed psychological strategies services

There are 24 MBS items for the provision of individual focussed psychological strategies (FPS) - allied mental health services to eligible patients by allied health professionals:

- 80100, 80105, 80110 and 80115 for provision of FPS services by a psychologist;
- 91169, 91170, 91183 and 91184 for provision of video conference and phone FPS services by a psychologist;
- 80125, 80130, 80135 and 80140 for provision of FPS services by an occupational therapist;
- 91172, 91173, 91185 and 91186 for provision of video conference and phone FPS services by an occupational therapist;
- 80150, 80155, 80160 and 80165 for provision of FPS services by a social worker; and
- 91175, 91176, 91187 and 91188 for provision of video conference and phone FPS services by a social worker.

The allied health professional must meet the provider eligibility requirements set out below and be registered with Services Australia.

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

Referrals

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

- a referral has been made by a GP or medical practitioner who is managing the patient under a GP Mental Health Treatment Plan;
- a referral has been made by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or
- a referral has been made by a psychiatrist or paediatrician from an eligible psychiatric or paediatric service (see Referral Requirements for further details regarding psychiatrist and paediatrician referrals).

Number of services per year

Medicare rebates are available for up to 10 individual mental health services in a calendar year. The services may consist of: GP or medical practitioner focussed psychological strategies services; and/or psychological therapy services delivered by clinical psychologists; and/or focussed psychological strategies - allied mental health services.

Patients will also be eligible to claim up to 10 separate services within a calendar year for group therapy services see MN.7.4. These group services are separate from the individual services and do not count towards the individual services per calendar year maximum associated with those items.

Please note if a referral does not specify whether the referral is for individual or group therapy, the patient can use a referral to access either individual or group therapy treatment options. The patient should speak to their GP about their treatment needs and the type of treatment that might be suitable in their particular circumstances.

In the instance where a patient has received the maximum services available under the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative per calendar year and is considered to clinically benefit from some additional services, the patient may be eligible for Primary Health Networks (PHNs) funded psychological therapies if they meet relevant eligibility criteria for the PHN commissioned services. It is recommended that providers refer to their PHN for further guidance.

Service length and type

Services provided by eligible allied health professionals under these items must be within the specified time period within the item descriptor.

It is expected that professional attendances at places other than consulting rooms would be provided where treatment in other environments is necessary to achieve therapeutic outcomes.

A range of acceptable strategies has been approved for use by allied mental health professionals utilising the FPS items.

These are:

1. Psycho-education

(including motivational interviewing)

2. Cognitive-behavioural therapy including:

• **Behavioural interventions**

- Behaviour modification
- Exposure techniques
- Activity scheduling

• **Cognitive interventions**

- Cognitive therapy

3. Relaxation strategies

- Progressive muscle relaxation
- Controlled breathing

4. Skills training

- Problem solving skills and training
- Anger management
- Social skills training
- Communication training
- Stress management
- Parent management training

5. Interpersonal therapy (especially for depression)

6. Narrative therapy (for Aboriginal and Torres Strait Islander people).

7. Eye-Movement Desensitisation Reprocessing (EMDR)

Course of treatment and reporting back to the referring medical practitioner

Eligible patients can claim Medicare subsidies for up to 10 individual mental health services per calendar year.

Within this maximum service allocation, the allied mental health professional can provide one or more courses of treatment (additional information on course of treatment session limits is above). This enables the referring medical practitioner to consider a report from the allied mental health professional on the services provided to the patient, and the need for further treatment.

On completion of the initial course of treatment, the allied mental health professional must provide a written report to the referring medical practitioner, which includes information on:

- assessments carried out on the patient;
- treatment provided; and
- recommendations on future management of the patient's disorder.

A written report must also be provided to the referring medical practitioner at the completion of any subsequent course(s) of treatment provided to the patient.

Out-of-pocket expenses and Medicare safety net

Charges in excess of the Medicare benefit for these items are the responsibility of the patient. However, if a service was provided out of hospital, any out-of-pocket costs will count towards the Medicare safety net for that patient. The out-of-pocket costs for mental health services which are not Medicare eligible do not count towards the Medicare safety net.

Eligible patients

Individual FPS items apply to people with an assessed mental disorder and where the patient is referred by a GP or medical practitioner who is managing the patient under a GP Mental Health Treatment Plan or under a referred psychiatrist assessment and management plan; or from an eligible psychiatrist or paediatrician.

The conditions classified as mental disorders for the purposes of these services are informed by the World Health Organisation, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care: ICD-10 Chapter V Primary Care Version. For the purposes of these items, dementia, delirium, tobacco use disorder and mental retardation are not regarded as a mental disorder.

Checking patient eligibility for focussed psychological strategies – allied mental health services

If there is any doubt about a patient's eligibility, Services Australia will be able to confirm whether a GP Mental Health Treatment Plan and/or a psychiatrist assessment and management plan is in place and claimed; or an eligible psychiatric or paediatric service has been claimed, as well as the number of allied mental health services already claimed by the patient during the calendar year.

Allied mental health professionals can call Services Australia on 132 150 to check this information, while unsure patients can seek clarification by calling 132 011.

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

Publicly funded services

Focussed psychological strategies (FPS) services items do not apply for services that are provided by any other Commonwealth or state funded services or provided to an admitted patient of a hospital. However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or state/territory clinic, the FPS services items apply for services that are provided by eligible allied mental health professionals salaried by, or contracted to, the service as long as all requirements of the items are met, including registration with Services Australia. These services must be direct billed (that is, the Medicare rebate is accepted as full payment for services).

Private health insurance

Patients need to decide if they will use Medicare or their private health insurance ancillary cover to pay for these services. Patients cannot use their private health insurance ancillary cover to 'top up' the Medicare rebate paid for the services.

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

Referrals

Patients must be referred for focussed psychological strategies – allied mental health services by either a GP or medical practitioner managing the patient under a GP Mental Health Treatment Plan or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or on referral from a psychiatrist or a paediatrician.

Referrals from psychiatrists and paediatricians must be made from eligible Medicare services. For specialist psychiatrists and paediatricians these services include any of the specialist attendance items 104 through 109. For consultant physician psychiatrists the relevant eligible Medicare services cover any of the consultant psychiatrist items 293 through 370; while for consultant physician paediatricians the eligible services are consultant physician attendance items 110 through 133.

Referring practitioners are not required to use a specific form to refer patients for these services. A referral for mental health services should be in writing (signed and dated by the referring practitioner) and include:

- the patient's name, date of birth and address;
- the patient's symptoms or diagnosis and a statement on whether a mental health treatment plan has been prepared;
- a list of any current medications;
- the number of sessions the patient is being referred for (the 'course of treatment');
- a statement about whether the patient has a mental health treatment plan or a psychiatrist assessment and management plan.

It may be useful for a referral to include a statement indicating whether group sessions could be considered.

A referral should include all of the above details, to assist with any auditing undertaken by the Department of Health and Aged Care. Where appropriate, and with the patient's agreement, the GP can also attach a copy of the mental health treatment plan to the referral.

Number of Sessions

The referring practitioner can decide how many sessions the patient will receive in a course of treatment, within the maximum session limit for the course of treatment. The maximum session limit for each course of treatment is set out below:

- Initial course of treatment – a maximum of six sessions.
- Subsequent course of treatment – a maximum of six sessions up to the patient's cap of ten sessions (for example, if the patient received six sessions in their initial course of treatment, they can only receive four sessions in a subsequent course of treatment).

The written report provided by the allied mental health professional following a course of treatment will be considered by the referring practitioner in assessing the patient's clinical need for further sessions after each course of treatment.

Specifying the Number of Sessions on a Referral

If the referring practitioner:

- Does not specify the number of sessions
- Specifies a number of sessions above the maximum allowed for the course of treatment
- Specifies a number of sessions above the maximum allowed for the calendar year (including any sessions the patient has already received that year)

Then the allied mental health professional can use their clinical judgment to provide services under the referral, noting the patient cannot receive more than:

- the maximum number of sessions allowed for that particular course of treatment (as set out above), and
- the maximum number of sessions allowed in a calendar year.

In these circumstances, an allied mental health professional must provide a report at the end of a course of treatment in line with standard practice for these services. This enables the referring medical practitioner to consider the treating practitioner's report on the services provided to the patient, and the need for further treatment.

Verbal Referral

A referring practitioner can verbally refer a patient for Better Access services only if:

- in their clinical judgement they consider it is necessary for the patient to have immediate access to support from an allied mental health professional, and
- it is not practicable in the circumstances to provide a written referral – for example, to do so would cause delays in treatment to the patient's detriment, and
- the allied mental health professional documents in writing that they are treating the patient based on the referring practitioner's verbal referral, and
- the referring practitioner provides a written referral to the allied mental health professional as soon as possible afterwards.

While waiting for the referring practitioner to provide a written referral, the treating practitioner can provide treatment according to the verbal referral until the referred number of sessions have been completed. If there is any doubt about the number of sessions the patient was verbally referred for, the treating practitioner should follow the guidance provided above under the heading 'Specifying the number of sessions on a referral'.

A verbal referral does not replace any requirement for the GP to review the patient's progress (taking into account the written report from their treating allied health professional) after each course of treatment.

The allied mental health professional must be in receipt of the referral at the first allied mental health consultation. The allied health professional must also retain the referral for 2 years (24 months) from the date the service was rendered.

Use of Referrals across Different Calendar Years

Eligible patients can claim Medicare subsidies for up to 10 individual and 10 group mental health services per calendar year.

If a patient has not used all their psychological therapy services and/or focussed psychological strategies services in course of treatment covered by a referral within the calendar year, it is not necessary to obtain a new referral for the "unused" services. However, any "unused" services received from 1 January in the following year under that referral will count as part of the total services for which the patient is eligible in that calendar year.

When patients have used all of their referred services they will need to obtain a new referral from the referring practitioner if they are eligible for further services. Where the patient's care is being managed by a GP or medical practitioner, the GP/medical practitioner may choose to use this visit to undertake a review of the patient's GP Mental Health Treatment Plan and/or psychiatrist assessment and management plan.

It is not necessary to have a new GP Mental Health Treatment Plan and/or psychiatrist assessment and management plan prepared each calendar year in order to access a new referral(s) for eligible psychological therapy services and/or focussed psychological strategies services. Patients continue to be eligible for rebates for psychological therapy services and/or focussed psychological strategies services while they are being managed under a GP Mental Health Treatment Plan and/or a psychiatrist assessment and management plan as long as the need for eligible services continues to be recommended in their plan.

Referrals for the Additional 10 Sessions (available until 31 December 2022)

In response to the COVID-19 pandemic, the number of Medicare rebateable individual mental health services was temporarily increased from 10 to 20 per calendar year until 31 December 2022.

A patient does not need a new referral to access Better Access sessions from 1 January 2023. If the patient has a current referral (either for the initial 10 sessions or the additional 10 sessions) and has not used all of the sessions, they can use that referral to access sessions in 2023. However, they cannot receive more than 10 individual sessions in 2023.

ALLIED MENTAL HEALTH PROFESSIONAL ELIGIBILITY

Eligible allied health professionals

A person is an allied health professional in relation to the provision of a FPS service if the person meets one of the following requirements:

- the person is a psychologist who holds general registration in the health profession of psychology under the applicable law in force in the State or Territory in which the service is provided;
- the person is a member of the Australian Association of Social Workers (AASW) and certified by AASW as the meeting the standards for mental health set out in the document published by AASW titled 'Practice Standards for Mental Health Social Workers 2014' as in force on 25 September 2014;
- the person is an occupational therapist who is registered as a person who may provide that kind of service under the applicable law in force in the State or Territory in which the service is provided; and is accredited by Occupational Therapy Australia as:
 - having a minimum of two years experience in mental health; and
 - having undertaken to observe the standards set out in the document published by Occupational Therapy Australia's 'Australian Competency Standards for Occupational Therapists in Mental Health' as in force on 1 November 2006.

Continuing professional development (CPD) for Occupational Therapists and Social Workers providing focussed psychological strategies (FPS) services

Occupational Therapists and Social Workers providing FPS services are required to have completed 10 hours FPS CPD.

A CPD year for the purposes of these items is from 1 July to 30 June annually.

Part-time allied mental health professionals are required to have 10 hours of FPS related CPD, the same as full-time allied mental health professionals.

Occupational Therapists and Social Workers who are registered during the course of the CPD year, their obligation to undertake CPD will be on a pro-rata basis. The amount of units will be calculated from the 1st of the month immediately succeeding the month they obtained initial registration. The obligation will be one-twelfth of the yearly requirement for each month.

CPD activities must be relevant to delivering FPS services. Acceptable CPD activities where the content is related to FPS can include formal postgraduate education, workshops, seminars, lectures, journal reading, writing papers, receipt of supervision and peer consultation, and online training.

There is flexibility in the CPD activities that can be undertaken to meet individual professional needs and their practice/client base and client needs. For example, activities could also include assessment and treatment of specific disorders and client types such as youth, or different modalities and delivery such as working with groups.

Registering with Services Australia

Advice about registering with Services Australia to provide focussed psychological strategies - allied mental health services is available from the Services Australia provider enquiry line on 132 150.

Further information

For further information about Medicare Benefits Schedule items, please go to the Department of Health and Aged Care's website at www.health.gov.au/mbsonline

For providers, further information is also available for providers from the Services Australia provider enquiry line on 132 150.

Services Australia, in consultation with the Department of Health and Aged Care, has developed a [Health Practitioner Guideline to substantiate that a valid Allied Mental Health service has been provided \(for allied health professionals\)](#) which is located on the Department of Health and Aged Care's website.

MN.7.4 Provision of Group Focussed Psychological Strategies Services by Allied Health Providers

This note provides information on Group Focussed Psychological Strategies services delivered by allied health providers. It includes an overview of the items, patient and provider eligibility, what activities are involved in providing services rebated by these items, and additional claiming information.

For information on Individual Focussed Psychological Strategies services see MN.7.1.

OVERVIEW

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

psychological therapy - provided by eligible clinical psychologists; and
focussed psychological strategies – allied mental health - provided by eligible psychologists, occupational therapists and social workers.

FOCUSSED PSYCHOLOGICAL STRATEGIES – ALLIED MENTAL HEALTH SERVICES ATTRACTING MEDICARE REBATES

Group focussed psychological strategies services

There are 18 MBS items for the provision of group focussed psychological strategies (FPS) - allied mental health services to eligible patients by allied health providers:

- 80120, 80122, 80127 for provision of FPS services by a psychologist;
- 80121, 80123, 80128 for provision of video conference FPS services to patients in telehealth eligible areas by a psychologist;
- 80145, 80147, 80152 for provision of FPS services by an occupational therapist;
- 80146, 80148, 80153 for provision of video conference FPS services to patients in telehealth eligible areas by an occupational therapist;
- 80170, 80172, 80174 for provision of FPS services by a social worker; and
- 80171, 80173, 80175 for provision of video conference FPS services to patients in telehealth eligible areas by a social worker.

Note, the allied health provider must be satisfied that it is clinically appropriate to provide a video consultation to a patient, and the patient must be in a telehealth eligible area (see 'Telehealth eligible areas' below).

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

Referrals

Services provided under the group FPS items will not attract a Medicare rebate unless:

- a referral has been made by a GP or medical practitioner who is managing the patient under a GP Mental Health Treatment Plan;
- a referral has been made by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or
- a referral has been made by a psychiatrist or paediatrician from an eligible psychiatric or paediatric service.

The allied health provider must be in receipt of the referral at the first allied mental health consultation. The allied health provider must also retain the referral for 2 years (24 months) from the date the service was rendered.

Referrals from psychiatrists and paediatricians must be made from eligible Medicare services. For specialist psychiatrists and paediatricians these services include any of the specialist attendance items 104 through 109. For consultant physician psychiatrists the relevant eligible Medicare services cover any of the consultant psychiatrist items 293 through 370; while for consultant physician paediatricians the eligible services are consultant physician attendance items 110 through 133.

Referring practitioners are not required to use a specific form to refer patients for these services. A referral for mental health services should be in writing (signed and dated by the referring practitioner) and include:

- the patient's name, date of birth and address;
- the patient's symptoms or diagnosis and a statement on whether a mental health treatment plan has been prepared;
- a list of any current medications;
- the number of sessions the patient is being referred for;
- a statement about whether the patient has a mental health treatment plan or a psychiatrist assessment and management plan.

It may be useful for a referral to include a statement indicating whether group sessions could be considered. If a referral does not specify whether the referral is for individual or group therapy, the patient can use a referral to access either or both individual and group therapy treatment options. However, the patient should speak to their referring practitioner about their treatment needs and the type of treatment that might be suitable in their particular circumstances.

A referral should include all of the above details, to assist with any auditing undertaken by the Department of Health and Aged Care. Where appropriate, and with the patient's agreement, the GP can also attach a copy of the mental health treatment plan to the referral.

Minimum number of patients

Group FPS services MBS items can be claimed for groups of four to 10 patients. However, allied health professions can claim these MBS items if four **patients** were due to attend and one patient is unable to attend, regardless of the reason.

Number of services per year

Medicare rebates are available for up to 10 group therapy services per calendar year. The services may consist of psychological therapy services delivered by clinical psychologists and/or focussed psychological strategies - allied mental health services. These group services are separate from the individual services and do not count towards the individual services per calendar year maximum associated with those items, see MN.7.1.

The referring practitioner can decide how many sessions the patient will receive, within the maximum session limit for the calendar year. If the referring practitioner does not specify the number of sessions on the referral, or specifies a number of sessions above the maximum allowed for the calendar year (including any sessions the patient has already received that year), the allied health provider can use their clinical judgement to provide services under the referral up to the maximum.

In the instance where a patient has received the maximum services available under the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative per calendar year and is considered to clinically benefit from some additional services, the patient may be eligible for Primary Health Networks (PHNs) funded psychological therapies if they meet relevant eligibility criteria for the PHN commissioned services. It is recommended that providers refer to their PHN for further guidance.

Service length and type

Services provided by eligible allied health providers under these items must be within the specified time period within the item descriptor.

These MBS items cannot be used to deliver family and couples therapy. A range of acceptable strategies has been approved for use by allied health providers utilising the FPS items. These are:

1. Psycho-education

(including motivational interviewing)

2. Cognitive-behavioural therapy including:

• **Behavioural interventions**

- Behaviour modification
- Exposure techniques
- Activity scheduling

• **Cognitive interventions**

- Cognitive therapy

3. Relaxation strategies

- Progressive muscle relaxation
- Controlled breathing

4. Skills training

- Problem solving skills and training
- Anger management
- Social skills training
- Communication training
- Stress management
- Parent management training

5. Interpersonal therapy (especially for depression)

6. Narrative therapy (for Aboriginal and Torres Strait Islander people).

7. Eye-Movement Desensitisation Reprocessing (EMDR)

Record Keeping

Allied health providers must keep contemporaneous notes of the consultation including documenting the date, time and people who attended. Only clinical details recorded at the time of attendance count towards the time of the consultation. Other notes or reports added at a later time are not included.

Use of Referrals across Different Calendar Years

If a patient has not used all their psychological therapy services and/or focussed psychological strategies services covered by a referral within the calendar year, it is not necessary to obtain a new referral for the "unused" services. However, any "unused" services received from 1 January in the following year under that referral will count as part of the total services for which the patient is eligible in that calendar year.

When patients have used all of their referred services they will need to obtain a new referral from the referring practitioner if they are eligible for further services.

It is not necessary to have a new GP Mental Health Treatment Plan and/or psychiatrist assessment and management plan prepared each calendar year in order to access a new referral(s) for group psychological therapy services and/or focussed psychological strategies services. Patients continue to be eligible for rebates for psychological therapy services and/or focussed psychological strategies services while they are being managed under a GP Mental Health Treatment Plan and/or a psychiatrist assessment and management plan as long as the need for eligible services continues to be recommended in their plan.

Out-of-pocket expenses and Medicare safety net

Charges in excess of the Medicare benefit for these items are the responsibility of the patient. However, any out-of-pocket costs will count towards the Medicare safety net for that patient. The out-of-pocket costs for mental health services which are not Medicare eligible do not count towards the Medicare safety net.

Publicly funded services

FPS services items do not apply for services that are provided by any other Commonwealth or state funded services or provided to an admitted patient of a hospital. However, where an exemption under subsection 19(2) of *the Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or state/territory clinic, the FPS services items apply for services that are provided by eligible allied health providers salaried by, or contracted to, the service as long as all requirements of the items are met, including registration with Services Australia. These services must be direct billed (that is, the Medicare rebate is accepted as full payment for services).

PATIENT ELIGIBILITY

Group FPS items apply to people with an assessed mental disorder and where the patient is referred by a GP or medical practitioner who is managing the patient under a GP Mental Health Treatment Plan or under a referred psychiatrist assessment and management plan; or from an eligible psychiatrist or paediatrician.

The conditions classified as mental disorders for the purposes of these services are informed by the World Health Organisation, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care: ICD-10 Chapter V Primary Care Version. For the purposes of these items, dementia, delirium, tobacco use disorder and mental retardation are not regarded as a mental disorder.

Telehealth eligible areas

Geographic eligibility for telehealth services funded under Medicare (in Groups M6 and M7) is determined according to the Modified Monash Model (MMM) classifications. Telehealth eligible areas are those areas that are within MMM classifications 4 to 7. Patients and providers are able to check their eligibility using the Modified Monash Model locator on the Department of Health and Aged Care's website (<https://www.health.gov.au/resources/apps-and-tools/health-workforce-locator>).

There is a requirement for the patient and allied health provider to be located a minimum of 15 kilometres apart at the time of the consultation. Minimum distance between allied health provider and patient video consultations are measured by the most direct (ie least distance) route by road. The patient or allied health provider is not permitted to travel to an area outside the minimum 15 kilometres distance in order to claim a video consultation.

Checking patient eligibility for focussed psychological strategies – allied mental health services

If there is any doubt about a patient's eligibility, Services Australia will be able to confirm whether a GP Mental Health Treatment Plan and/or a psychiatrist assessment and management plan is in place and claimed; or an eligible psychiatric or paediatric service has been claimed, as well as the number of group services already claimed by the patient during the calendar year.

Allied health providers can call Services Australia on 132 150 to check this information, while unsure patients can seek clarification by calling 132 011.

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

ALLIED HEALTH PROVIDER ELIGIBILITY

Eligible allied health provider

A person is an allied health provider in relation to the provision of a FPS service if the person meets one of the following requirements:

- the person is a psychologist who holds general registration in the health profession of psychology under the applicable law in force in the State or Territory in which the service is provided;
- the person is a member of the Australian Association of Social Workers (AASW) and certified by AASW as the meeting the standards for mental health set out in the document published by AASW titled 'Practice Standards for Mental Health Social Workers 2014' as in force on 25 September 2014;
- the person is an occupational therapist who is registered as a person who may provide that kind of service under the applicable law in force in the State or Territory in which the service is provided; and is accredited by Occupational Therapy Australia as:
 - having a minimum of two years experience in mental health; and
 - having undertaken to observe the standards set out in the document published by Occupational Therapy Australia's 'Australian Competency Standards for Occupational Therapists in Mental Health' as in force on 1 November 2006.

Continuing professional development (CPD) for Occupational Therapists and Social Workers providing focussed psychological strategies (FPS) services

Occupational Therapists and Social Workers providing FPS services are required to have completed 10 hours FPS CPD.

A CPD year for the purposes of these items is from 1 July to 30 June annually.

Part-time allied health providers are required to have 10 hours of FPS related CPD, the same as full-time allied health providers.

Occupational Therapists and Social Workers who are registered during the course of the CPD year, their obligation to undertake CPD will be on a pro-rata basis. The amount of units will be calculated from the 1st of the month immediately succeeding the month they obtained initial registration. The obligation will be one-twelfth of the yearly requirement for each month.

CPD activities must be relevant to delivering FPS services. Acceptable CPD activities where the content is related to FPS can include formal postgraduate education, workshops, seminars, lectures, journal reading, writing papers, receipt of supervision and peer consultation, and online training.

There is flexibility in the CPD activities that can be undertaken to meet individual professional needs and their practice/client base and client needs. For example, activities could also include assessment and treatment of specific disorders and client types such as youth, or different modalities and delivery such as working with groups.

Registering with the Services Australia

Advice about registering with the Services Australia to provide focussed psychological strategies - allied mental health services is available from the Services Australia provider enquiry line on 132 150.

Further information

For further information about Medicare Benefits Schedule items, please go to the Department of Health and Aged Care's website at www.health.gov.au/mbsonline.

For providers, further information is also available for providers from the Services Australia provider enquiry line on 132 150.

MN.7.5 Provision of Focussed Psychological Strategies Services by Eligible Allied Health Professionals to a Person Other than the Patient

Relevant MBS items - 80102, 80106, 80112, 80116, 80129, 80131, 80137, 80141, 80154, 80156, 80162, 80166, 91174, 91177, 91194, 91195, 91196, 91197, 91200, 91201, 91202, 91203, 91204 and 91205

OVERVIEW

The purpose of these MBS items is to enable psychologists, eligible occupational therapists and eligible social workers (referred to as eligible allied health professionals) to involve another person in a patient's treatment, under the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access) initiative, where:

- the patient has been referred for Better Access services,
- the eligible allied health professional providing the service, or the referring practitioner, determines it is clinically appropriate,
- the patient consents for the service to be provided to the other person as part of their treatment,
- the service is part of the patient's treatment, and
- the patient is not in attendance.

These MBS items recognise the important role another person, such as a family member or carer, can play in supporting patients with mental illness, and the benefits that can result from involving them in treatment.

Under these MBS items, Medicare rebates are available to a patient for up to two services provided to another person per calendar year. Any services delivered using these items count towards the patient's course of treatment and calendar year allocations under Better Access. For further information on patient allocations, please see explanatory note MN.7.1.

For Medicare benefit purposes, charges relating to services covered by these MBS items should be raised against the patient rather than against the person receiving the service.

SERVICES ATTRACTING MEDICARE REBATES

MBS items

There are 24 MBS items for the provision of focussed psychological strategies (FPS) health services to a person other than the patient by eligible allied health professionals:

- 80102, 80106, 80112 and 80116 for provision of in person FPS services by a psychologist;
- 91174 and 91177 for provision of telehealth FPS services by a psychologist;
- 91200 and 91201 for provision of phone FPS services by a psychologist;
- 80129, 80131, 80137 and 80141 for provision of in person FPS services by an occupational therapist;
- 91194 and 91195 for provision of telehealth FPS services by an occupational therapist;
- 91202 and 91203 for provision of phone FPS services by an occupational therapist;
- 80154, 80156, 80162 and 80166 for provision of in person FPS services by a social worker;
- 91196 and 91197 for provision of telehealth FPS services by a social worker; and
- 91204 and 91205 for provision of phone FPS services by a social worker.

Telehealth services are the preferred approach for substituting a face-to-face consultation. However, eligible allied health professionals will also be able to offer phone (audio-only) services if video is not available or appropriate. As outlined above, there are separate items available for phone services.

To claim these MBS items the eligible allied health professional must meet the provider eligibility requirements for the delivery of FPS services. For further information, please see explanatory note MN.7.1.

Eligible focussed psychological strategies services

A range of acceptable strategies have been approved for use by eligible allied health professionals utilising FPS items. For further information, please see explanatory note MN.7.1.

Eligible allied health professionals must use their professional judgement to determine what would be an appropriate FPS service to deliver to another person as part of the patient's treatment within the approved list of FPS.

Publicly funded services

These MBS items do not apply for services provided by any other Commonwealth or state funded services, or provided to an admitted patient of a hospital, unless there is an exemption under subsection 19(2) of the *Health Insurance Act 1973*.

SERVICE LIMITATIONS

Medicare rebates are available to a patient for up to two services provided to another person per calendar year. The two services may consist of:

- Psychologist items: 80102, 80106, 80112, 80116, 91174, 91177, 91200 and 91201
- Occupational therapist items: 80129, 80131, 80137, 80141, 91194, 91195, 91202 and 91203
- Social worker items: 80154, 80156, 80162, 80166, 91196, 91197, 91204 and 91205
- Clinical psychologist items: 80002, 80006, 80012, 80016, 91168, 91171, 91198 and 91199
- GP items: 2739, 2741, 2743, 2745, 91859, 91861, 91864 and 91865
- Other medical practitioner items: 309, 311, 313, 315, 91862, 91863, 91866 and 91867

Any services delivered using these MBS items count towards:

- the maximum session limit for each course of treatment under Better Access, and
- the patient's calendar year allocation for individual services under Better Access.

For further information on the maximum session limits for each course of treatment and maximum calendar year allocation, please see explanatory note MN.7.1.

CLAIMING REQUIREMENTS

Referrals

Services provided under these MBS items will not attract a Medicare rebate unless the patient has been referred for Better Access services by a referring practitioner. Referring practitioner means:

- a medical practitioner who has referred the patient as part of a GP Mental Health Treatment Plan or psychiatrist assessment and management plan; or
- a specialist or consultant physician specialising in the practice of their field of psychiatry; or
- a specialist or consultant physician specialising in the practice of their field of paediatrics.

The referring practitioner can indicate in the patient's mental health treatment plan, psychiatrist assessment and management plan or the referral if they consider it would be clinically appropriate for sessions to be delivered to another person as part of the patient's treatment.

Regardless, eligible allied health professionals can use their clinical judgment to provide services to another person under the patient's referral. For further information on patient referrals for Better Access services, please see explanatory note MN.7.1.

Determining service is clinically appropriate

The eligible allied health professional providing the service, or the referring practitioner, must use their professional judgment to determine it is clinically appropriate, and would form part of the patient's treatment, to provide a FPS service to another person.

This determination must be recorded in writing in the patient's records.

Obtaining and recording patient consent to deliver the service

The patient must consent to the other person receiving a FPS service using these MBS items. The eligible allied health professional providing the service must:

- Explain the service to the patient.
- Obtain the patient's consent for the service to be provided to the other person as part of the patient's treatment.
- Make a written record of the patient's consent.

The patient may withdraw their consent at any time.

In the case of a child, the general laws relating to consent to medical treatment apply. These may differ between states and territories, and the allied health professional should be aware of the requirements in the relevant state or territory.

Service must be part of the patient's treatment

Any service delivered using these MBS items must be part of the patient's treatment. These MBS items are not for the purposes of providing mental health treatment to the person receiving the service. Should that person also require mental health treatment, they will need to speak with a referring practitioner.

Patient is not in attendance

These MBS items are for eligible allied health professionals to provide services to another person when the patient is not in attendance. If the patient is in attendance, the allied health professional can consider whether the requirements of the patient MBS items for delivering Better Access services have been met. For further information, please see explanatory note MN.7.1.

Course of treatment and reporting back to the referring practitioner

These services may be accessed at any stage of a patient's course of treatment and do not need to be accessed consecutively, provided no more than two services are delivered to another person and delivering these services does not exceed the maximum allowed for the patient in a course of treatment or calendar year under Better Access.

On completion of a course of treatment by the patient, the eligible allied health professional must provide a written report to the referring medical practitioner on assessments carried out on the patient, treatment provided, and recommendations on future management of the patient's disorder. This report should also include relevant information on any services delivered using these MBS items to another person where relevant.

ADDITIONAL INFORMATION

Out-of-pocket expenses and Medicare safety net

For Medicare benefit purposes, charges relating to services covered by these MBS items should be raised against the patient rather than against the person receiving the service.

Charges in excess of the Medicare benefit for these items are the responsibility of the patient. However, if a service was provided out of hospital, any out-of-pocket costs will count towards the Medicare safety net for that patient. The out-of-pocket costs for mental health services which are not Medicare eligible do not count towards the Medicare safety net.

Checking patient eligibility for Better Access services

As outlined above, patients seeking Medicare rebates for services delivered to another person will need to have a referral from a GP, medical practitioner, psychiatrist or paediatrician. If there is any doubt about a patient's eligibility, Services Australia will be able to confirm whether an eligible service has been claimed, as well as the number of mental health services already claimed by the patient during the calendar year. Eligible allied health professionals can call Services Australia on 132 150 to check this information, while patients can call on 132 011.

The patient will not be eligible if they have not been appropriately referred and a relevant Medicare service provided to them. If the referring service has not yet been claimed, Services Australia will not be aware of the patient's

eligibility. In this case the eligible allied health professional should, with the patient's permission, contact the referring practitioner to ensure the relevant service has been provided to the patient.

Further information

For further information about Medicare Benefits Schedule items, please go to the Department of Health and Aged Care's website at www.health.gov.au/mbsonline.

For providers, further information is also available from the Services Australia Medicare Provider Enquiry Line on 132 150.

MN.7.6 Mental Health Case Conferences - Allied Health Professionals

Items 80176, 80177 and 80178 provide rebates for eligible allied health professionals to participate in mental health case conferences. They apply for a patient who is being treated under the Better Access to Psychiatrist and paediatricians, Psychologists and General Practitioners through the Medicare Benefits Schedule (MBS) initiative (Better Access) or an eating disorder treatment and management plan (EDTP).

The purpose of a case conference is to establish and coordinate the management of the care needs of the patient. A case conference is a process by which a multidisciplinary team carries out the following activities:

- discusses a patient's history;
- identifies the patient's multidisciplinary care needs;
- identifies outcomes to be achieved by members of the case conference team giving care and service to the patient;
- identifies tasks that need to be undertaken to achieve these outcomes, and allocating those tasks to members of the case conference team; and
- assesses whether previously identified outcomes (if any) have been achieved.

PATIENT ELIGIBILITY

Case conferences using these new MBS items can be held for patients who have been referred for treatment under Better Access or have an active eating disorder treatment and management plan.

Patients can be referred for treatment under Better Access by a:

- GP or OMP under a mental health treatment plan or psychiatrist assessment and management plan,
- psychiatrist, or
- paediatrician.

Treated under Better Access means a patient has been referred for a:

- a focussed psychological strategies service delivered by a GP, OMP, psychologist, social worker or occupational therapist, or
- psychological therapy service delivered by a clinical psychologist

REGULATORY REQUIREMENTS

To participate in mental health case conferences using items 80176, 80177 and 80178, the allied health professional must:

- a. explain to the patient the nature of a mental health case conference and ask for their agreement to the allied health professional's participation in the conference; and
- b. record the patient's agreement to the allied health professional's participation; and
- c. record the day on which the conference was held, and the times at which the conference started and ended; and
- d. record the names of the participants; and

- e. record all matters discussed and identified by the case conferencing team and put a copy of that record in the patient's medical records.

ADDITIONAL INFORMATION

Mental health case conference team members

The case conference must be organised by a medical practitioner (GP, OMP or consultant physician in their specialty of paediatrics or psychiatry) and involve at least two other members of the multidisciplinary case conference team providing different kinds of treatment to the patient. Participating providers must be invited to attend by the organising practitioner. The case conferencing team must include one medical practitioner (including a general practitioner, but not a specialist or consultant physician).

The case conference must be arranged in advance, within a time frame that allows for all the participants to attend. The minimum of three care providers for a case conference must be present for the whole of the case conference. All participants must be in communication with each other throughout the conference, either face to face, by telephone or by video link, or a combination of these.

The patient should be given the option to attend the case conference, however may choose not to do so. Family members or carers, as well as other individuals providing support to the patient (such as a close friend, counsellor, teacher or peer worker) can also attend the case conference if the patient has agreed. However, these individuals do not count towards the minimum number of providers required.

Eligible Allied Health Professionals

Items 80176, 80177 and 80178 can only be provided by a person who is an allied health professional in relation to the provision of psychological therapy health services, focussed psychological strategies or dietetics health services in accordance with Schedule 1 of the *Health Insurance (Allied Health Services) Determination 2014*.

In some instances, two providers from the same profession may both participate in the case conference if they each provide different aspects of care to the patient – for example, if the providers have different specialisations which are both clinically relevant to the patient.

Psychological therapy health service

A person is an allied health professional in relation to the provision of a psychological therapy health service if the person:

- (a) holds general registration in the health profession of psychology under the applicable law in force in the State or Territory in which the service is provided; and
- (b) is endorsed by the Psychology Board of Australia to practice in clinical psychology.

Until 31 October 2015, a person is also an allied health professional in relation to the provision of a psychological therapy health service if the person:

- (a) holds general registration in the health profession of psychology under the applicable law in force in the State or Territory in which the service is provided; and
- (b) on 31 October 2014 was an allied health professional in relation to the provision of a psychological therapy health service because the person:

- (i) was a member of the College of Clinical Psychologists of the Australian Psychological Society; or
- (ii) had been assessed by the College of Clinical Psychologists of the Australian Psychological Society as meeting the requirements for membership of that College.

Focussed psychological strategies health service

A person is an allied health professional in relation to the provision of a focussed psychological strategies health service if the person meets one of the following requirements:

(a) the person holds general registration in the health profession of psychology under the applicable law in force in the State or Territory in which the service is provided;

(b) the person is a member of the Australian Association of Social Workers (AASW) and certified by AASW as meeting the standards for mental health set out in the document published by AASW titled 'Practice Standards for Mental Health Social Workers 2014' as in force on 25 September 2014;

(c) the person:

(i) is an occupational therapist who is registered as a person who may provide that kind of service under the applicable law in force in the State or Territory in which the service is provided; and

(ii) is accredited by Occupational Therapy Australia as:

(A) having a minimum of two years experience in mental health; and

(B) having undertaken to observe the standards set out in the document published by Occupational Therapy Australia 'Australian Competency Standards for Occupational Therapists in Mental Health' as in force on 1 November 2006.

Dietetics health service

A person is an allied health professional in relation to the provision of a dietetics health service if the person is accredited by the Dietitians Association of Australia as an 'Accredited Practising Dietitian'.

Claiming frequency

These case conferencing items can be accessed no more than once every 3 months. However, where there has been a significant change in the patient's clinical condition, another case conference may be arranged earlier than the three months limitation. This would be for exceptional circumstances and the claim must be annotated with this advice to enable Services Australia to properly assess the claim. A change of care providers does not qualify as an exceptional circumstance.

Further information

Further information is also available for providers from the Services Australia provider enquiry line on 132 150.

MN.8.1 Pregnancy Support Counselling - Eligible Patients - (Items 81000 - 81010, 93026 and 93029)

Medicare benefits are available for non-directive pregnancy support counselling services provided to a person who is pregnant or who has been pregnant in the 12 months preceding the first service to which item 81000, 81005, 81010, 93026 and 93029 applies in relation to that pregnancy. Services can be provided either by an eligible GP/medical practitioner or by an eligible psychologist, social worker or mental health nurse on referral from a GP or medical practitioner.

The items may be used to address any pregnancy related issues for which non-directive counselling is appropriate.

MN.8.2 Pregnancy Support Counselling - Eligible Services - (Items 81000, 81005, 81010, 93026 and 93029)

There are 5 in person MBS items for the provision of non-directive pregnancy support counselling services:

- Item 4001 - services provided by an eligible GP;
- Item 792 - services provided by an eligible medical practitioner;
- Item 81000 - services provided by an eligible psychologist;

- Item 81005 - services provided by an eligible social worker; and
- Item 81010 - services provided by an eligible mental health nurse.

There are 6 telehealth MBS items for the provision of non-directive pregnancy support counselling services:

- Item 92136 - services provided by an eligible GP by telehealth via videoconference
- Item 92138 - services provided by an eligible GP by telephone
- Item 92137 - services provided by an eligible medical practitioner by telehealth via videoconference
- Item 92139 - services provided by an eligible medical practitioner by telephone
- Item 93026 - services provided by an eligible psychologist, social worker or mental health nurse by telehealth via videoconference
- Item 93029 - services provided by an eligible psychologist, social worker or mental health nurse by telephone

These notes relate to items 81000, 81005, 81010, 93026 and 93029. Each individual allied health professional must meet the provider eligibility requirements set out below and be registered with Services Australia.

Service length and type

Non-directive pregnancy support counselling services provided by eligible psychologists, social workers and mental health nurses using items 81000, 81005, 81010, 93026 and 93029 must be of at least 30 minutes duration and provided to an individual patient. For items 81000, 81005 and 81010, the allied health professional must personally attend the patient.

The service involves the psychologist, social worker or mental health nurse undertaking a safe, confidential process that helps the patient explore concerns they have about a current pregnancy or a pregnancy that occurred in the preceding 12 months. This includes providing, on request, unbiased, evidence-based information about all options and services available to the patient.

Non-directive counselling is a form of counselling that is based on the understanding that, in many situations, people can resolve their own problems without being provided with a solution by the counsellor. The counsellor's role is to encourage the person to express their feelings but not suggest what decision the person should make. By listening and reflecting back what the person reveals to them, the counsellor helps them explore and understand their feelings. With this understanding, the person is able to make the decision that is best for them.

Number of services per year

Medicare benefits are available for a maximum of 3 services (including services to which items 792, 4001, 81000, 81005, and 81010 in the general medical services table, or items 92136, 92137, 92138, 92139, 93026, or 93029 in the Telehealth and Telephone Determination apply) for each pregnancy.

Where the patient is unsure of the number of Medicare rebated non-directive pregnancy support counselling services they have already accessed, the patient may check with Services Australia on 132 011. Alternatively, the psychologist, social worker or mental health nurse may check with Services Australia.

Partners of eligible patients may attend each or any counselling session, however, only one fee applies to each service.

Out-of-pocket expenses and Medicare Safety Net

Charges in excess of the Medicare benefit for these items are the responsibility of the patient. However, such out-of-pocket costs will count toward the Medicare safety net for that patient. Non-directive pregnancy support counselling services in excess of 3 per pregnancy will not attract a Medicare benefit and the safety net arrangements will not apply to costs incurred by the patient for such services.

Publicly funded services

Items 81000, 81005, 81010, 93026 and 93029 do not apply for services that are provided by any other Commonwealth or State funded services or provided to an admitted patient of a hospital.

However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or state/territory clinic, these items can be claimed for services provided by an eligible psychologist, social worker or mental health nurse salaried by or contracted to the service, where all requirements of the relevant item are met, including registration with Services Australia. These services must be bulk billed (that is, the Medicare benefit is accepted as full payment for services).

Private health insurance

Patients need to decide if they will use Medicare or their private health insurance general treatment cover (also known as ancillary or extras cover) cover to pay for these services. Patients cannot use their general treatment cover to 'top up' the Medicare benefit paid for the services.

MN.8.3 Pregnancy Support Counselling - Referral Requirements (Items 81000, 81005, 81010, 93026 and 93029)

Patients must be referred for non-directive pregnancy support counselling services by a GP or medical practitioner. GPs/medical practitioners are not required to use a specific form to refer patients for these services. The referral may be a letter or note to an eligible allied health professional signed and dated by the referring GP/medical practitioner.

Patients may be referred by a GP or medical practitioner to more than one eligible allied health professional for eligible non-directive pregnancy support counselling services (for example, where a patient does not wish to continue receiving services from the provider they were referred to in the first instance).

The relevant allied health professional must be in receipt of the referral at the first non-directive pregnancy support counselling service and must retain the referral for 2 years from the date the service was rendered, for Services Australia auditing purposes.

A copy of the referral is not required to accompany Medicare claims. However, referral details are required to be included on patients' itemised accounts/receipts or Medicare assignment of benefit forms.

Referral validity

The referral is valid for up to 3 non-directive pregnancy support counselling services, per patient, per pregnancy.

Subsequent Referrals

A new referral is required where the patient seeks to access non-directive pregnancy support counselling in relation to a different pregnancy or where the patient wishes to be referred to a different allied health professional than the one they were referred to in the first instance.

MN.8.4 Pregnancy Support Counselling - Allied Health Professional Eligibility (Items 81000, 81005, 81010, 93026 and 93029)

Eligible allied health professionals

Items 81000, 81005, 81010, 93026 and 93029 can only be claimed for services provided by psychologists, social workers and mental health nurses who meet the following specific eligibility requirements, and are registered with Services Australia.

To be eligible to provide services using MBS items 81000, 93026 and 93029, a psychologist must hold general registration in the health profession of psychology under the applicable law in force in the state or territory in which the service is provided and be certified by the Australian Psychological Society as appropriately trained in non-directive pregnancy counselling.

To be eligible to provide services using MBS items 81005, 93026 and 93029, a social worker must be a 'Member' of the Australian Association of Social Workers (AASW), be certified by AASW either as meeting the standards for mental health set out in the document published by AASW titled 'Practice Standards for Mental Health Social Workers 2014' as in force on 25 September 2014 and certified by AASW as appropriately trained in non-directive pregnancy counselling.

To be eligible to provide services using MBS items 81010, 93026 and 93029, a mental health nurse must be a 'Credentialled Mental Health Nurse' as certified by the Australian College of Mental Health Nurses, and be appropriately trained in non-directive pregnancy counselling.

Registering with Services Australia

Advice about registering with Services Australia to provide non-directive pregnancy support counselling services using items 81000 – 81010, 93026 and 93029 is available from Services Australia provider inquiry line on 132 150.

Further information

Additional information can be found on the [Department of Health and Aged Care](#) and [Services Australia website](#) by searching 'allied health'.

Further information is also available for providers from the Services Australia provider inquiry line on 132 150.

MN.9.1 Group Allied Health Services (Items 81100, 81105, 81110, 81115, 81120 and 81125) for People with Type 2 Diabetes - Eligible Patients

MBS items (81100, 81105, 81110, 81115, 81120 and 81125) are available for group allied health services for patients with type 2 diabetes. These items apply to services provided by eligible diabetes educators, exercise physiologists and dietitians, on referral from a GP or medical practitioner.

Services available under these items are in addition to the 5 individual allied health services available to patients each calendar year (refer to items 10950, 10951, 10952, 10953, 10954, 10956, 10958, 10960, 10962, 10964, 10966, 10968, 10970, 93000 and 93013).

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

- a GP Management Plan (GPMP) (GP item 721 or medical practitioner item 229); OR
- for a resident of a residential aged care facility, the GP or medical practitioner must have contributed to a multidisciplinary care plan, or contributed to a review of a multidisciplinary care plan prepared for them by the facility (GP item 731 or medical practitioner item 232). [Note: Generally, residents of an aged care facility rely on the facility for assistance to manage their type 2 diabetes. Therefore, the resident may not need to be referred for group allied health services under these items, as the self-management approach offered in group services may not be appropriate.]

Unlike the individual allied health services, there is no additional requirement for a Team Care Arrangement (GP item 723 or medical practitioner item 230) in order for the patient to be referred for group allied health services.

Once the patient has been referred by their GP or medical practitioner, a diabetes educator, exercise physiologist or dietitian will conduct an individual assessment (under items 81100, 81110, 81120, 93284 or 93286). A maximum of one assessment service is available per calendar year. After assessment, the patient may receive up to 8 group services per calendar year from an eligible diabetes educator, exercise physiologist and/or dietitian (under items 81105, 81115, 81125 or 93285). A collaborative approach, where diabetes educators, exercise physiologists and dietitians work together to develop group service programs in their local area, is encouraged.

MN.9.2 Group Allied Health Services (Items 81100, 81110, 81120, 93284 and 93286) for People with Type 2 Diabetes - GP Referral Requirements

Patients must be referred by their GP or medical practitioner to an eligible allied health professional (diabetes educator, exercise physiologist or dietitian) who will undertake an individual assessment (under item 81100, 81110, 81120, 93284 or 93286) of the patient's suitability for a group services program.

MN.9.3 Group Allied Health Services (Items 81100, 81105, 81110, 81115, 81120, 81125, 93284, 93285 and 93286) for People with Type 2 Diabetes - Eligible Allied Health Professionals

Items 81100, 81105, 81110, 81115, 81120, 81125, 93284, 93285 and 93286 only apply to services provided by eligible diabetes educators, exercise physiologists and dietitians who are registered with Services Australia. If providers are already registered with Services Australia to use items 10951, 10953, 10954, they do not need to register separately for these items. Eligibility criteria are as follows:

Diabetes educator: must be a 'credentialed diabetes educator' as credentialed by the Australian Diabetes Educators Association.

Exercise physiologist: must be an 'accredited exercise physiologist' as accredited by Exercise and Sports Science Australia.

Dietitian: must be an 'accredited practising dietitian' as recognised by the Dietitians Association of Australia.

Services Australia registration forms may be obtained from Services Australia on 132 150 or on the [Services Australia website](#).

MN.9.4 Assessment for Group Allied Health Services (Items 81100, 81110, 81120, 93284 and 93286) for People with Type 2 Diabetes

An assessment service is provided by a diabetes educator (item 81100), an exercise physiologist (item 81110) or a dietitian (items 81120, 93284 and 93286), on referral from a GP or medical practitioner.

The purpose of this service is to undertake an individual assessment and determine the patient's suitability for a group services program. It involves taking a comprehensive patient history and identification of individual goals. This may also provide an opportunity to identify any patient who is likely to be unsuitable for group services.

Number of services per year

Patients are eligible for a maximum of one assessment for group services (either item 81100, 81110, 81120, 93284 or 93286) per calendar year. If more than one assessment service is provided in a calendar year, the subsequent service/s will not attract a Medicare rebate and the MBS Safety Net arrangements will not apply to costs incurred by the patient for the service/s.

If there is any doubt about a patient's eligibility for these items, the allied health professional should contact Services Australia to confirm the number of assessment services already claimed by the patient in the calendar year. Allied health professionals can call Services Australia on 132 150 to check this information.

Referral form

The GP or medical practitioner must refer the patient using the *Referral form for group allied health services* under Medicare for patients with type 2 diabetes or a form that contains all the components of this form. This includes:

- identifying that the patient has type 2 diabetes and either:
 - has prepared a new GP Management Plan (MBS item 721) OR
 - has reviewed an existing GP Management Plan (MBS item 732) OR
 - for a resident of an aged care facility, the GP or medical practitioner has contributed to or reviewed a multidisciplinary care plan prepared by the facility (MBS item 731) [Note: Generally, residents of an aged care facility rely on the facility for assistance to manage their type 2 diabetes.

Therefore, residents may not need to be referred for allied health group services as the self-management approach may not be appropriate.]

- GP or medical practitioner details including provider number, name, address, signature and date of referral
- Patient details including name and address
- Allied Health Practitioner (or practice) the patient is referred to for assessment and the address

The allied health professional undertaking the assessment service will need to complete Part B of this form providing information on:

- Name of provider/s
- Name of program
- Number of sessions in the program
- Venue (if known)
- Name of allied health professional undertaking the assessment

The patient will then need to present this form/information to the provider/s of group services.

Length of service

This service must be of at least 45 minutes duration and provided to an individual patient. For items 81100, 81110 and 81120, the allied health professional must personally attend the patient.

Reporting requirements

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

MN.9.5 Group Allied Health Services (Items 81105, 81115, 81125 and 93285) for People with Type 2 Diabetes - Service Requirements and Referral Forms

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

Number of services per year

Patients are eligible for up to 8 group allied health services in total (items 81105, 81115, 81125 and 93285 inclusive) per calendar year. Each separate group service must be provided to the patient by only one type of allied health professional (i.e. by a diabetes educator, or by an exercise physiologist or by a dietitian). However, the overall group services program provided for the patient could be comprised of one type of service only (e.g. 8 diabetes education services) or a combination of services (e.g. 3 diabetes education services, 3 dietitian services and 2 exercise physiology services). An eligible allied health professional with more than one Medicare provider number (e.g. for the provision of diabetes education and dietetics) may provide separate services under each of these provider numbers.

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

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

If there is any doubt about a patient's eligibility for group services, the allied health professional should contact Services Australia to confirm the number of group services already claimed by the patient in the calendar year. Allied health professionals can call Services Australia on 132 150 to check this information.

Multiple services on the same day

Where clinically relevant, up to 2 group services may be provided consecutively on the same day by the same allied health professional.

Referral form

The GP or medical practitioner must refer the patient using the referral form for group allied health services under Medicare for patients with type 2 diabetes or a form that contains all the components of this form. This includes:

- identifying that the patient has type 2 diabetes and either: has prepared a new GP Management Plan (MBS item 721/229) OR
- has reviewed an existing GP Management Plan (MBS item 732/233) OR
- for a resident of an aged care facility, the GP or medical practitioner has contributed to or reviewed a multidisciplinary care plan prepared by the facility (MBS item 731/232) [Note: Generally, residents of an aged care facility rely on the facility for assistance to manage their type 2 diabetes. Therefore, residents may not need to be referred for allied health group services as the self-management approach may not be appropriate.]
- GP or medical practitioner details including provider number, name, address, signature and date of referral
- Patient details including name and address
- Allied Health Practitioner (or practice) the patient is referred to for assessment and the address

The allied health professional undertaking the assessment service will need to complete Part B of this form providing information on:

- Name of provider/s
- Name of program
- Number of sessions in the program
- Venue (if known)
- Name of allied health professional undertaking the assessment
- The patient will then need to present this form/information to the provider/s of group services

Group size

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

Length of service

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

Reporting requirements

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

MN.9.6 Group Allied Health Services (Items 81100, 81105, 81110, 81115, 81120, 81125, 93284, 93285 and 93286) for People with Type 2 Diabetes - Additional Requirements **Retention of Referral Form for Services Australia Audit Purposes**

It is recommended that Allied health professionals retain a copy of the referral form for 2 years from the date the service was rendered (for Services Australia auditing purposes).

Publicly funded services

Items 81100, 81105, 81110, 81115, 81120, 81125, 93284, 93285 and 93286 do not apply for services that are provided by any other Commonwealth or state-funded services or provided to an admitted patient of a hospital. However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or a state/territory government health clinic, these items can be claimed for services provided by eligible allied health professionals salaried by, or contracted to, service or health clinic. All requirements of the relevant item must be met, including registration of the allied health professional with Services Australia. These services must also be bulk billed.

Private health insurance

Patients need to decide if they will use Medicare or their private health insurance general treatment cover (also known as ancillary or extras cover) to pay for these services. Patients cannot use their private health insurance general cover to 'top up' the Medicare rebate paid.

Out-of-pocket expenses and Medicare Safety Net

Allied health professionals are free to determine their own fees for the professional service. Charges in excess of the Medicare benefit for the allied health items are the responsibility of the patient. However, such out-of-pocket costs will count toward the Medicare Safety Net for that patient.

MN.10.1 Assessment to assist with Diagnostic Formulation and Contribution to a Treatment and Management Plan by Eligible Allied Health Practitioner(s) for Complex Neurodevelopmental Disorder (such as Autism Spectrum Disorder) or Eligible Disability Services

These allied health items provide rebates for:

- the assessment of patients for the purpose of assisting the referring eligible medical practitioner with the diagnosis (including a differential diagnosis) of a complex Neurodevelopmental Disorder (such as Autism Spectrum Disorder) or an eligible disability; or
- to contribute to a treatment and management plan that is being developed by the referring eligible medical practitioner.

The list of eligible disabilities can be found at MN.10.3.

Number of services

- A maximum of 8 services can be claimed per patient per lifetime, including services consisting of any combination of 82000, 82005, 82010, 82030, 93032, 93033, 93040 or 93041.
- A course of assessment means up to 4 services.
- Up to 4 of these services may be provided to the same patient on the same day.
- Where a patient requires more than 4 services from the same eligible allied health provider, review and agreement is required by the referring medical practitioner before further Medicare eligible services can be claimed.

Provision of assessment services and need for review and agreement by the referring eligible medical practitioner

- An eligible allied health practitioner can provide up to 4 assessment services without the need for review and agreement by the referring eligible medical practitioner.
- If an eligible allied health professional has provided 4 assessment services to a patient and proposes to provide more assessment services to that patient, review and agreement from the referring eligible medical practitioner must be obtained prior.
- The referring eligible medical practitioner may specify the type of review that should be undertaken as part of the original referral. If it is not specified, an acceptable means of review includes: a case conference,

phone call, written correspondence, secure online messaging exchange, or attendance with the referring eligible medical practitioner.

- The review and agreement by the referring eligible medical practitioner should be recorded by the eligible allied health practitioner in the patient notes.

Referral requirements

For an MBS rebate to be claimed for these services, a valid referral from an eligible medical practitioner (or subsequent interdisciplinary referral) is required. The eligible medical practitioner referral is only valid if the referring eligible medical practitioner used any of the following MBS items* for the suspected diagnosis of:

- **complex Neurodevelopmental Disorders** referred by a:
 - **consultant psychiatrist** using items 296 to 308, 310, 312, 314, 316, 318 or 319 to 352 of the general medical services table or items 91827, 91828, 91829, 91830, 91831, 91837, 91838, 91839, 92437, 92455, 92456, 92457, 92458, 92459 or 92460 of the COVID 19 Determination.
 - **consultant paediatrician** using items 110 to 131 of the general medical services table or items 91824, 91825, 91826 or 91836 of the COVID 19 Determination.
- **eligible disability** referred by a:
 - **specialist or consultant physician** using items 104 to 131, 296 to 308, 310, 312, 314, 316, 318 or 319 to 352 of the general medical services table or items 91822 to 91839, 92437, 92455, 92456, 92457, 92458, 92459 or 92460 of the COVID 19 Determination.
 - **GP** using items 3 to 47 of the general medical services table or item 91790, 91800, 91801, 91802, 91890, 91891 or 91894 of the COVID 19 Determination.

* Note that more information on the telehealth items that can be claimed for these services can be found in [Note AN.40.1](#).

A separate referral from the eligible medical practitioner is required for each eligible allied health practitioner providing the service. The referral may be a letter, departmental form or note to an eligible allied health practitioner, signed and dated by the referring eligible medical practitioner. A Medicare claim must be submitted for the referring MBS service before a rebate for the subsequent referred allied health service can be paid.

Allied health practitioners should retain referrals for 24 months from the date the service was rendered for Medicare auditing purposes.

Interdisciplinary referrals

If an eligible allied health practitioner seeks to make an interdisciplinary referral of the patient to another eligible allied health professional, this must be undertaken in consultation and agreement with, but without the need for a physical attendance by, the original referring eligible medical practitioner (such as but not limited to, a phone call, written correspondence or secure online messaging exchange). This consultation and agreement should be documented in the patient notes by the eligible allied health practitioner and included in the interdisciplinary referral. The referral may be a letter or note to an eligible allied health practitioner, signed and dated by the referring eligible allied health practitioner. There is no specific form to refer patients for these services. The referral should include a copy of the original referral by the eligible medical practitioner.

Interdisciplinary referrals will only be valid where the referring eligible medical practitioner's referral (whose original referral initiated the assessment and assisting with a diagnosis service/contribution to a treatment and management plan) remains valid.

Reporting requirements for assessment services

After completion of the final assessment service by an eligible allied health practitioner, a written report must be provided to the referring eligible medical practitioner that outlines the assessment findings. Preparation of the report is not counted towards the service time under the item.

The written report must include information on:

- the assessment/s provided;
- the results of the assessment/s that may assist with diagnostic formulation or development of a treatment and management plan by the referring eligible medical practitioner; and
- if applicable, advice on further assessments that could be undertaken by other eligible allied health practitioners to assist with the referring medical practitioners' diagnostic formulation or development of a treatment and management plan by the referring eligible medical practitioner.

MN.10.2 Treatment Services by Eligible Allied Health Practitioners for Complex Neurodevelopmental Disorders (such as Autism Spectrum Disorder) and Eligible Disability Services

These allied health items are available for patients that have been diagnosed with a complex Neurodevelopmental Disorder (such as Autism Spectrum Disorder) or an eligible disability. It is expected that eligible allied health practitioners will deliver treatment under these items that is consistent with the complex Neurodevelopmental Disorder or eligible disability treatment and management plan prepared by the referring eligible medical practitioner and is in keeping with commonly established interventions as practised by their profession and appropriate for the age and particular needs of the patient being treated.

It is anticipated that professional attendances at places other than consulting rooms will be provided where treatment in other environments is necessary to achieve therapeutic outcomes.

Number of services

- A maximum of 20 services can be claimed per patient per lifetime, including services consisting of any combination of 82015, 82020, 82025, 82035, 93035, 93036, 93043 or 93044.
- A course of treatment means up to 10 treatment services.
- Up to 4 of these services may be provided to the same patient on the same day.
- It is the responsibility of the referring eligible medical practitioner to allocate these services in keeping with the patient's individual treatment needs and to refer the patient to the appropriate allied health professional(s) accordingly.

Referral Requirements

For a Medicare rebate to be paid, the eligible allied health practitioner providing the service must be in receipt of a current referral provided by an eligible medical practitioner. A separate referral from an eligible medical practitioner is required for each eligible allied health practitioner. The referral is only valid if the referring provider uses any of the following MBS items*:

- For a **complex Neurodevelopmental Disorder** referred by a:
 - **consultant psychiatrist** using item 289 of the general medical services table or item 92434 of the COVID 19 Determination.

Note. If a patient has previously been provided with a service mentioned in item 289, a consultant physician specialising in the practice of the consultant physician's field of psychiatry may only refer the patient for a service to which any of items 296 to 308, 310, 312, 314, 316, 318 or 319 to 352 of the general medical services table or items 91827, 91828, 91829, 91830, 91831, 91837, 91838, 91839, 92437, 92455, 92456, 92457, 92458, 92459 or 92460 of the COVID 19 Determination applies.

- **paediatrician** using item 135 of the general medical services table or item 92140 of the COVID 19 Determination.

Note. If a patient has previously been provided with a service mentioned in item 135 of the general medical services table or item 92140 of the COVID 19 Determination, a consultant physician specialising in the practice of the consultant physician's field of paediatrics may only refer the patient for a service to which any of items 110 to 131 of the general medical services table or items 91824, 91825, 91826 or 91836 of the COVID 19 Determination applies.

If a patient has previously been provided with a service mentioned in item 137 or 139 of the general medical services table or item 92141 or 92142 of the COVID 19 Determination, the medical practitioner cannot refer the patient for a service to which item 135 or 289 of the general medical services table or item 92140 or 92434 of the COVID 19 Determination applies.

- For an **eligible disability** referred by a:
 - **specialist or consultant physician** using item 137 of the general medical services table or item 92141 of the COVID 19 Determination.
 - **GP** using item 139 of the general medical services table or item 92142 of the COVID 19 Determination.

Note. If a patient has previously been provided with a service mentioned in item 135 or 289 of the general medical services table or item 92140 or 92434 of the COVID 19 Determination, the medical practitioner cannot refer the patient for a service to which item 137 or 139 of the general medical services table or item 92141 or 92142 of the COVID 19 Determination applies.

* Note that more information on the telehealth items that can be claimed for these services can be found in Note [AN.40.1](#).

The referral may be a letter or note to an eligible allied health practitioner, signed and dated by the referring eligible medical practitioner. Referring eligible medical practitioners are not required to use a specific form to refer patients for these services. A Medicare claim must be submitted for the referring service before a rebate for the subsequent referred allied health service can be paid.

The referred service consists of the number of allied health services stated on the patient's referral. This enables the referring practitioner to consider a report from the allied health practitioners about the services provided to the patient, and the need for further treatment.

Within the maximum service allocation of 20 services for the treatment items, the eligible allied health practitioner/s can provide one or more courses of treatment. A new referral is required for each new course of treatment (up to 10 services). The amount of services in each course of treatment is determined by the referring eligible medical practitioner. The referring eligible medical practitioner should review the written report provided by the eligible allied health practitioner after completion of a course of treatment and prior to referring for a subsequent course of treatment.

Eligible allied health practitioners should retain the referral for 24 months from the date the service was rendered for Medicare auditing purposes.

Reporting requirements

On completion of a course of treatment (and any subsequent courses of treatment), the eligible allied health practitioner must provide a written report to the referring eligible medical practitioner which includes information on:

- treatment provided;
- recommendations on future management of the patient's disorder or disability; and
- if applicable, any advice provided to third parties (for example: parents, schools, places of employment).

The writing of the report is not counted towards the service time under the item.

MN.10.3 Eligibility for Allied Health Assessment and Treatment Services for Complex Neurodevelopmental Disorder (such as Autism Spectrum Disorder) and Eligible Disability Services

Eligible patients

These items provide Medicare rebates for allied health services provided to patients under 25 years old with a suspected or diagnosed complex Neurodevelopmental Disorder (such as Autism Spectrum Disorder) or one or more of the eligible disabilities.

Eligible Disabilities

'Eligible disabilities' for the purpose of these services means any of the following conditions:

- (a) Sight impairment that results in vision of less than or equal to 6/18 vision or equivalent field loss in the better eye, with correction.
- (b) Hearing impairment that results in:
 - a hearing loss of 40 decibels or greater in the better ear, across 4 frequencies; or
 - permanent conductive hearing loss and auditory neuropathy
- (c) Deafblindness
- (d) Cerebral palsy
- (e) Down syndrome
- (f) Fragile X syndrome
- (g) Prader-Willi syndrome
- (h) Williams syndrome
- (i) Angelman syndrome
- (j) Kabuki syndrome
- (k) Smith-Magenis syndrome
- (l) CHARGE syndrome
- (m) Cri du Chat syndrome
- (n) Cornelia de Lange syndrome
- (o) Microcephaly if a child has:
 - a head circumference less than the third percentile for age and sex; and
 - a functional level at or below 2 standard deviations below the mean for age on a standard developmental test, or an IQ score of less than 70 on a standardised test of intelligence*
- (p) Rett's disorder
- (q) Fetal Alcohol Spectrum Disorder (FASD)
- (r) Lesch-Nyhan syndrome
- (s) 22q deletion Syndrome

*"standard developmental test" refers to tests such as the Bayley Scales of Infant Development or the Griffiths Mental Development Scales; "standardised test of intelligence" means the Wechsler Intelligence Scale for Children (WISC) or the Wechsler Preschool and Primary Scale of Intelligence (WPPSI). It is up to the clinical judgement of the practitioner to determine which tests are appropriate to be used.

Eligible allied health practitioners

The allied health assessment and treatment services can be provided by eligible audiologists, occupational therapists, optometrists, orthoptists, physiotherapists, psychologists and speech pathologists.

To provide services under these items eligible allied health practitioners must meet the eligibility requirements as set out in the *Health Insurance (Allied Health Services) Determination 2014*.

It is expected that eligible providers will 'self-select' for the complex Neurodevelopmental Disorder and eligible disability items (i.e. possess the skills and experience appropriate for provision of these services and be oriented to work with patients with complex Neurodevelopmental Disorders or eligible disabilities).

MN.10.4 Complex Neurodevelopmental Disorder and Disability Services - Allied Health Case Conferencing Items (82001, 82002 and 82003)

These allied health items provide MBS benefits for eligible allied health professionals to participate in a multidisciplinary case conference team in a community case conference with a patient's medical practitioner and other providers.

A multidisciplinary case conference means a process by which a multidisciplinary case conference team carries out all of the following activities:

- discussing a patient's history;
- identifying the patient's multidisciplinary care needs;
- identifying outcomes to be achieved by members of the multidisciplinary case conference team giving care and service to the patient;
- identifying tasks that need to be undertaken to achieve these outcomes, and allocating those tasks to members of the multidisciplinary case conference team;
- assessing whether previously identified outcomes (if any) have been achieved.

These items apply to non-hospital admitted patients who are under 25 years old and have either been diagnosed with, or are suspected of having:

- a complex neurodevelopmental disorder (such as autism spectrum disorder); or
- an eligible disability.

Eligible allied health professionals may claim reimbursement for participating in case conferences through three time-tiered items:

- 15–19 minutes (82001)
- 20–39 minutes (82002)
- over 40 minutes (82003)

There are no frequency restrictions for case conferencing items for patients with or suspected of having a complex neurodevelopmental disorder or an eligible disability.

Eligible allied health professionals

For the purposes of these items, eligible allied health professional means:

- an eligible Aboriginal health worker;
- an eligible Aboriginal and Torres Strait Islander health practitioner;

- an eligible psychologist;
- an eligible speech pathologist;
- an eligible occupational therapist;
- an eligible audiologist;
- an eligible optometrist;
- an eligible mental health nurse;
- an eligible mental health worker;
- an eligible orthoptist; or
- an eligible physiotherapist.

Eligible health professionals must meet the eligibility requirements as set out in the *Health Insurance (Section 3C General Medical Services – Allied Health Services) Determination 2024*.

Eligible patients

These items apply to non-hospital admitted patients who are under 25 years old and have either been diagnosed with, or are suspected of having:

- a complex neurodevelopmental disorder; or
- an eligible disability.

Organisation of a case conference

The case conference must be organised by the medical practitioner. The multidisciplinary case conference team must include a medical practitioner and at least 2 other members providing different kinds of care to the patient. The multidisciplinary case conference team requirements include:

- each member must provide a different kind of care or service to the patient; and
- each member must not be an unpaid carer of the patient; and
- one member may be another medical practitioner.

The patient and family members or carers can attend the case conference but will not count towards the minimum team member requirements.

The eligible allied health professional does not need all participants to be MBS-eligible to be able to claim payment for their participation. Members can include allied health professionals, home and community service providers and care organisers, including the following:

- Aboriginal and Torres Strait Islander health practitioners
- asthma educators
- audiologists
- dental therapists
- dentists
- diabetes educators
- dieticians
- mental health workers
- occupational therapists
- optometrists
- orthoptists
- orthotists or prosthetists
- pharmacists
- physiotherapists
- podiatrists
- psychologists
- registered nurses

- social workers
- speech pathologists
- education providers
- “meals on wheels” providers
- personal care workers
- probation officers

In some instances, 2 eligible allied health professionals from the same profession may participate in the same case conference, where both provide different aspects of care to the patient. For example, the 2 providers from the same profession have different specialisations that are clinically relevant to the same patient and cannot be provided by one of the providers alone. In this instance, both providers will be able to claim the new items.

Participation in a case conference

A referral is not required for eligible allied health professionals to access the allied health case conferencing items for complex neurodevelopmental disorder and disability services. However, the allied health professional must be invited to participate in the case conference by the patient’s treating medical practitioner.

The patient must agree to the allied health professional participating in the case conference and be informed that Medicare will be accessed to fund the service. The patient may agree through discussion with their medical practitioner. The allied health professional should ensure that the patient has agreed and that their agreement has been recorded appropriately.

Allied health professionals claiming a case conferencing item should record the day, start and end times, the names of all participants and all matters discussed in the patient’s medical record.

The allied health professional is not required to have a pre-existing relationship with the patient. However, the patient must agree to the allied health professional participating in the case conference and be informed that Medicare will be accessed to fund the service.

The case conference may lead to an agreed care plan between all participating providers, including the number of allied health professional services required and how they are allocated among eligible allied health professionals within a patient’s entitlement.

The case conferencing items can be accessed in person, via videoconference or telephone, using the same item number. There is no requirement that all participants use the same communication method.

MN.11.1 Individual Allied Health Services for people of Aboriginal or Torres Strait Islander descent following a health assessment or a Chronic Disease Management plan (items 81300 to 81360, 93048 and 93061)

Eligible Patients

A patient who is of Aboriginal or Torres Strait Islander descent may be referred for individual allied health services under items 81300 to 81360, 93048 and 93061 (MBS Group M11 and equivalent telehealth services) when the GP or prescribed medical practitioner:

- has undertaken a health assessment and identified a need for follow-up allied health services; or
- is managing the patients complex care needs under a GP Management Plan and Team Care Arrangements or, if the patient is a resident of a residential aged care facility, the patient’s GP/prescribed medical practitioner has contributed to a multidisciplinary care plan.

A prescribed medical practitioner is a medical practitioner other than a GP, specialist, or consultant physician.

Number of Services Per Calendar Year

Medicare benefits are available for up to 10 individual allied health services per eligible patient, per calendar year. The 10 services can be made up of one type of service (e.g. 10 physiotherapy services) or a combination of different types of services (e.g. one dietetic service, 2 podiatry services, 2 Aboriginal and Torres Strait Islander health practitioner services, and 5 physiotherapy services).

The annual total limit of 10 individual allied health services per patient can include a combination of the following items:

- up to 5 services under a GP Management Plan and Team Care Arrangement (10950, 10951, 10952, 10953, 10954, 10956, 10958, 10960, 10962, 10964, 10966, 10968, 10970, 93000 and 93013 - MBS Group M3 and equivalent telehealth services) using a referral form for Chronic Disease Management (see [MN 3.1](#)).
- up to 10 services under MBS Group M11 and equivalent telehealth services (81300 to 81360, 93048 and 93061).

Referral Requirements

A referral is required for patients of Aboriginal or Torres Strait Islander descent to access up to 10 individual allied health services following a health assessment, or where the patient is being managed under a GP Management Plan and Team Care Arrangements or a multidisciplinary care plan.

Referral form

For Medicare benefits to be payable, the patient must be referred to an eligible allied health professional by their GP or prescribed medical practitioner using a referral form that has been issued by the Australian Government Department of Health and Aged Care or a form that contains all the components of this form.

The form issued by the department is available on the Department of Health and Aged Care website. This referral form is to be used for a referral to health service/s under M11 (or equivalent telehealth service). GPs and prescribed medical practitioners are encouraged to attach relevant information to the referral form.

GPs and prescribed medical practitioners may use one referral form to refer patients for single or multiple services of the same service type (e.g. 10 dietetic services). If referring a patient for single or multiple services of different service types (e.g. 2 dietetic services and 8 podiatry services), a separate referral form will be needed for each service type.

Providers should retain referrals for their services for 24 months from the date the service was rendered for Medicare auditing purposes.

Referral validity

If a patient has not used all their services under a referral in a calendar year, it is not necessary to obtain a new referral for the 'unused' services. The 'unused' services will roll over into the following calendar year and will count towards the total of 10 services for which the patient is eligible in that calendar year.

When patients have used all their eligible referred services, they will need to obtain a new referral from their GP/prescribed medical practitioner (noting that a new referral will not enable the patient to access more than 10 services in that calendar year).

Eligible Allied Health Professionals

To provide services under these items, allied health professionals must meet the eligibility requirements as set out in the *Health Insurance (Section 3C General Medical Services – Allied Health Services) Determination 2024*.

The following allied health professionals are eligible to provide services under these items:

- Aboriginal and Torres Strait Islander health practitioners (81300)
- Aboriginal health workers (81300)
- audiologists (81310)

- chiropractors (81345)
- diabetes educators (81305)
- dietitians (81320)
- exercise physiologists (81315)
- mental health workers (81325) which include allied health professionals that meet the requirements of a mental health service which include Aboriginal and Torres Strait Islander health practitioners, Aboriginal and Torres Strait Islander health workers, mental health nurses, occupational therapists, psychologists and social workers
- occupational therapists (81330)
- osteopaths (81350)
- physiotherapists (81335)
- podiatrists (81340)
- psychologists (81355)
- speech pathologists (81360)

The telehealth items for these services can be claimed under 93048 and 93061.

Reporting back to the GP/ Prescribed Medical Practitioner

Where an allied health professional provides a single service to the patient under a referral, they must provide a written report back to the referring GP/ prescribed medical practitioner after that service.

Where an allied health professional provides multiple services to the same patient under a referral, they must provide a written report back to the referring GP/ prescribed medical practitioner 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.

The report/s to the referring practitioner must be kept by the allied health professional who provided the service for 2 years from the date of the service.

MN.12.1 Immunisation services provided by an Aboriginal and Torres Strait Islander health practitioner - (Item 10988)

Item 10988 can only be claimed by a medical practitioner where an immunisation is provided to a patient by an Aboriginal and Torres Strait Islander health practitioner on behalf of the medical practitioner.

Item 10988 can be claimed only once per patient visit, even if more than one vaccine is administered during the same patient visit.

An Aboriginal and Torres Strait Islander health practitioner means a person who has been registered as an Aboriginal and Torres Strait Islander health practitioner by the Aboriginal and Torres Strait Islander Health Practice Board of Australia and meets the Board's registration standards. The Aboriginal and Torres Strait Islander health practitioner must be employed or retained by a general practice, or by a health service that has an exemption to claim Medicare benefits under subsection 19(2) of the *Health Insurance Act 1973*.

An Aboriginal and Torres Strait Islander health practitioner may use any of the titles authorised by the Aboriginal and Torres Strait Islander Health Practice Board: Aboriginal health practitioner; Aboriginal and Torres Strait Islander health practitioner; or Torres Strait Islander health practitioner.

The Aboriginal and Torres Strait Islander health practitioner must be appropriately qualified and trained to provide immunisations. This includes compliance with any territory requirements.

The medical practitioner under whose supervision the immunisation is provided retains responsibility for the health, safety and clinical outcomes of the patient.

Supervision may include distance supervision where the medical practitioner does not have to be physically present at the time that the service is provided by the Aboriginal and Torres Strait Islander health practitioner, but should be able to be contacted for advice if required.

The immunisation must be performed by the Aboriginal and Torres Strait Islander health practitioner in accordance with the current edition of the Australian Immunisation Handbook and the Central Australian Rural Practitioners Association (CARPA) Standard Treatment Manual.

Immunisation means the administration of a registered vaccine to a patient for any purpose other than as part of a mass immunisation of persons.

A registered vaccine means a vaccine that is included on the Australian Register of Therapeutic Goods. This includes all vaccines on the Australian Standard Vaccination Schedule and vaccines covered in the current edition of the Australian Immunisation Handbook. The following substances cannot be claimed under this item: vaccines used experimentally; homeopathic substances; immunotherapy for allergies (eg de-sensitisation preparations); and other substances that are not vaccines. There may also be territory limitations on the administration of some vaccines, such as those for tuberculosis, yellow fever and Q-fever.

All GPs whether vocationally registered or not are eligible to claim this item. District Medical Officers (DMOs) employed by the Northern Territory Department of Health and Community Services are also eligible to claim this item.

Where the medical practitioner provides a professional attendance to the patient (in addition to the immunisation service provided by the Aboriginal and Torres Strait Islander health practitioner), the medical practitioner may also claim for the professional attendance they provide to the patient.

Item 10991 can also be claimed in conjunction with item 10988 provided the conditions of both items are satisfied.

Related Items: 10988

MN.12.2 Wound management services provided by an Aboriginal and Torres Strait Islander health practitioner (item 10989)

Item 10989 can only be claimed by a medical practitioner where wound management (other than normal aftercare) is provided to a patient by an Aboriginal and Torres Strait Islander health practitioner on behalf of the medical practitioner.

Item 10989 can be claimed only once per patient visit, even if more than one wound is treated during the same patient visit.

An Aboriginal and Torres Strait Islander health practitioner means a person who has been registered as an Aboriginal and Torres Strait Islander health practitioner by the Aboriginal and Torres Strait Islander Health Practice Board of Australia and meets the Board's registration standards. The Aboriginal and Torres Strait Islander health practitioner must be employed or 806 retained by a general practice, or by a health service that has an exemption to claim Medicare benefits under subsection 19(2) of the *Health Insurance Act 1973*.

An Aboriginal and Torres Strait Islander health practitioner may use any of the titles authorised by the Aboriginal and Torres Strait Islander Health Practice Board: Aboriginal health practitioner; Aboriginal and Torres Strait Islander health practitioner; or Torres Strait Islander health practitioner.

The Aboriginal and Torres Strait Islander health practitioner must be appropriately qualified and trained to treat wounds. This includes compliance with any territory requirements.

The medical practitioner under whose supervision the treatment is provided retains responsibility for the health, safety and clinical outcomes of the patient.

Supervision may include distance supervision where the medical practitioner does not have to be physically present at the time that the service is provided by the Aboriginal and Torres Strait Islander health practitioner, but should be able to be contacted for advice if required.

The medical practitioner must conduct an initial assessment of the patient (including under a distance supervision arrangement if the medical practitioner is not physically present) in order to give instruction in relation to the treatment of the wound.

Where an Aboriginal and Torres Strait Islander health practitioner provides ongoing wound management, the medical practitioner is not required to give instruction or see the patient during each subsequent visit.

MN.12.3 Follow up service provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner, on behalf of a Medical Practitioner, for an Indigenous person who has received a health assessment (Item 10987)

Item 10987 may be claimed by a medical practitioner, where a follow up service is provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner on behalf of that medical practitioner for an Indigenous person who has received a health check.

All GPs whether vocationally registered or not are eligible to claim this item. District Medical Officers (DMOs) employed by state/territory health Departments are also eligible to claim this item. The term 'GP' is used in these notes as a generic reference to medical practitioners able to claim this item.

Item 10987 does not apply for services that are provided by any other Commonwealth or State funded services. However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or State/Territory Government Health clinic, item 10987 can be claimed for services provided by practice nurses or Aboriginal and Torres Strait Islander health practitioner salaried or contracted to, the Service or Health clinic. All requirements of the item must be met.

Item 10987 will assist Indigenous patients who have received a health check which has identified a need for follow up services which can be provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner between further consultations with the patient's GP.

Item 10987 may be used to provide:

- Examinations/interventions as indicated by the health check;
- Education regarding medication compliance and associated monitoring;
- Checks on clinical progress and service access;
- Education, monitoring and counselling activities and lifestyle advice;
- Taking a medical history; and
- Prevention advice for chronic conditions, and associated follow up.

Item 10987 may be claimed up to a maximum of 10 times per patient per calendar year.

Item 10987 may be accessed by an Indigenous patient who has received the Aboriginal and Torres Strait Islander Peoples Health Assessment (item 715), which is available to:

- a) children between the ages of 0 and 14 years;
- b) adults between the ages of 15 and 54 years; and
- c) older people over the age of 55 years.

The item can also be accessed by a child who has received a health check as part of the Northern Territory Emergency Response (NTER).

Patients whose condition is unstable/deteriorating should be referred to their GP for further treatment.

A practice nurse means a registered or enrolled nurse who is employed by, or whose services are otherwise 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*.

An Aboriginal and Torres Strait Islander health practitioner means a person who has been registered as an Aboriginal and Torres Strait Islander health practitioner by the Aboriginal and Torres Strait Islander Health Practice Board of Australia and meets the Board's registration standards. The Aboriginal and Torres Strait Islander health practitioner must be employed or retained by a general practice, or by a health service that has an exemption to claim Medicare benefits under subsection 19(2) of the *Health Insurance Act 1973*.

An Aboriginal and Torres Strait Islander health practitioner may use any of the titles authorised by the Aboriginal and Torres Strait Islander Health Practice Board: Aboriginal health practitioner; Aboriginal and Torres Strait Islander health practitioner; or Torres Strait Islander health practitioner.

In all cases, the GP under whose supervision the health check follow-up is being provided retains responsibility for the health, safety and clinical outcomes of the patient. The GP must be satisfied that the practice nurse or Aboriginal and Torres Strait Islander health practitioner is appropriately qualified and trained to provide the relevant follow up for the patient. GPs are advised to consult their insurer concerning indemnity coverage for services provided on their behalf.

General practices where nurses or Aboriginal and Torres Strait Islander health practitioners provide follow up for Indigenous people who have received a health check, should also have a written clinical risk management strategy covering issues like clinical roles, patient follow up and patient consent.

Continuing professional development is recommended for all nurses and an Aboriginal and Torres Strait Islander health practitioners providing follow up services for Indigenous people who have received a health check.

Supervision of the practice nurse/Aboriginal and Torres Strait Islander health practitioner by the GP at a distance is recognised as an acceptable form of supervision. This means that the claiming GP does not have to be physically present at the time the service is provided. However the GP should be able to be contacted if required.

Where the GP and practice nurse/Aboriginal and Torres Strait Islander health practitioner are at the same location, the GP is not required to be present while the health check follow up is undertaken. It is up to the GP to decide whether they need to see the patient. Where the GP has a consultation with the patient, then the GP is entitled to claim a Medicare item for the time and complexity of their personal attendance on the patient. The time the patient spends receiving a service from the practice nurse or Aboriginal and Torres Strait Islander health practitioner is itemised separately under item 10987 and should not be counted as part of the Medicare items claimed for time spent with the GP. Where the practice nurse or Aboriginal and Torres Strait Islander health practitioner provides another service (eg immunisation, cervical screening) on the same day, the GP is able to claim for all practice nurse/Aboriginal and Torres Strait Islander health practitioner services provided.

Item 10990 or 10991 (bulk billing incentives) can be claimed in conjunction with item 10987 provided the conditions of item 10990 or 10991 are satisfied.

MN.12.4 Provision of monitoring and support for a person with a chronic disease by a practice nurse or Aboriginal and Torres Strait Islander health practitioner (item 10997)

Item 10997 may be claimed by a medical practitioner, where a monitoring and support service for a person with a chronic disease care plan is provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner on behalf of that medical practitioner.

All GPs whether vocationally registered or not are eligible to claim this item. The term 'GP' is used in these notes as a generic reference to medical practitioners able to claim this item.

Item 10997 does not apply for services that are provided by any other Commonwealth or State funded services. However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or State/Territory Government health clinic, item 10997 can

be claimed for services provided by practice nurses or Aboriginal and Torres Strait Islander health practitioners salaried by or contracted to, the Service or health clinic. All requirements of the item must be met.

Item 10997 will assist patients who require access to ongoing care, routine treatment and ongoing monitoring and support between the more structured reviews of the care plan by the patient's usual GP.

Item 10997 may be used to provide:

- checks on clinical progress;
- monitoring medication compliance;
- self management advice, and;
- collection of information to support GP/medical practitioner reviews of Care Plans.

The services provided by the practice nurse or Aboriginal and Torres Strait Islander health practitioner should be consistent with the scope of the GP Management Plan, Team Care Arrangements, or Multidisciplinary Care Plan.

Item 10997 may be claimed up to a maximum of 5 times per patient per calendar year.

Item 10997 may only be accessed by a patient with a GP Management Plan, Team Care Arrangements or Multidisciplinary Care Plan (GP items 721, 723, 729, 731, 732 or medical practitioner items 229, 230, 231, 232, 233).

Patients whose condition is unstable/deteriorating should be referred to their GP or medical practitioner for further treatment.

A practice nurse means a registered or enrolled nurse or Nurse Practitioner who is employed by, or whose services are otherwise retained by a general practice.

An Aboriginal and Torres Strait Islander health practitioner means a person who has been registered as an Aboriginal and Torres Strait Islander health practitioner by the Aboriginal and Torres Strait Islander Health Practice Board of Australia and meets the Board's registration standards. The Aboriginal and Torres Strait Islander health practitioner must be employed or retained by a general practice, or by a health service that has an exemption to claim Medicare benefits under subsection 19(2) of the *Health Insurance Act 1973*.

An Aboriginal and Torres Strait Islander health practitioner may use any of the titles authorised by the Aboriginal and Torres Strait Islander Health Practice Board: Aboriginal health practitioner; Aboriginal and Torres Strait Islander health practitioner; or Torres Strait Islander health practitioner.

In all cases, the GP or medical practitioner under whose supervision the chronic disease monitoring and support is being provided retains responsibility for the health, safety and clinical outcomes of the patient. The GP or medical practitioner must be satisfied that the practice nurse is appropriately qualified and trained to provide chronic disease support and monitoring. GPs and medical practitioners are advised to consult their insurer concerning indemnity coverage for services performed on their behalf.

General practices where nurses or Aboriginal and Torres Strait Islander health practitioner provide chronic disease support and monitoring, should also have a written clinical risk management strategy covering issues like clinical roles, patient follow up and patient consent.

Continuing professional development is recommended for all nurses and Aboriginal and Torres Strait Islander health practitioners providing chronic disease monitoring and support.

Supervision by the GP or medical practitioner at a distance is recognised as an acceptable form of supervision. This means that the claiming GP or medical practitioner does not have to be physically present at the time the service is provided. However, the GP/medical practitioner should be able to be contacted if required.

Where the GP/medical practitioner and the practice nurse/ Aboriginal and Torres Strait Islander health practitioner are at the same location, the GP/medical practitioner is not required to be present while the chronic disease monitoring and support is undertaken. It is up to the GP/medical practitioner to decide whether they need to see the patient. Where the GP/medical practitioner has a consultation with the patient, then the GP/medical practitioner is entitled to claim a Medicare item for the time and complexity of their personal attendance on the patient. The time the patient spends receiving a service from the practice nurse or Aboriginal and Torres Strait Islander health practitioner is itemised separately under item 10997 and should not be counted as part of the Medicare item claimed for time spent with the GP/medical practitioner. Where the practice nurse or Aboriginal and Torres Strait Islander health practitioner provides another service (eg immunisation) on the same day, the GP/medical practitioner is able to claim for both practice nurse/ Aboriginal and Torres Strait Islander health practitioner items.

Item 10990 or 10991 (bulk billing incentives) can be claimed in conjunction with item 10997 provided the conditions of item 10990 or 10991 are satisfied (see explanatory note M.1).

MN.12.5 Telehealth Support Services by Health Professionals

These notes provide information on the telehealth MBS attendance items for health professionals to provide clinical support to their patients during video consultations with a specialist, consultant physicians and psychiatrists under items 10945 and 10946 in Group A10 which are available for participating optometrists and item 10983 in Group M12 for practice nurses, Aboriginal and Torres Strait Islander health practitioners or Aboriginal health workers for services provided for and on behalf of a medical practitioner.

From 1 January 2022, items 10945, 10946 and 10983 apply Australia wide.

Telehealth patient-end support services can only be claimed where:

- a Medicare eligible specialist service is claimed;
- the service is rendered in Australia; and
- where this is necessary for the provision of the specialist service.

Clinical indications

The specialist, consultant physician or psychiatrist must be satisfied that it is clinically appropriate to provide a video consultation to a patient. The decision to provide clinically relevant support to the patient is the responsibility of the specialist, consultant physician or psychiatrist.

Telehealth specialist services can be provided to patients when there is no patient-end support service provided.

Restrictions

The MBS telehealth attendance items are not payable for services to an admitted hospital patient (this includes hospital in the home patients). Benefits are not payable for telephone or email consultations. In order to fulfill the item descriptor there must be a visual and audio link between the patient and the remote practitioner. If the remote practitioner is unable to establish both a video and audio link with the patient, a MBS rebate for a telehealth attendance is not payable.

Record Keeping

Participating telehealth practitioners must keep contemporaneous notes of the consultation including documenting that the service was performed by video conference, the date, time and the people who participated.

Only clinical details recorded at the time of the attendance count towards the time of the consultation. It does not include information added at a later time, such as reports of investigations.

Multiple attendances on the same day

In some situations a patient may receive a telehealth consultation and a face to face consultation by the same or different practitioner on the same day.

Medicare benefits may be paid for more than one video consultation on a patient on the same day by the same practitioner, provided the second (and any following) video consultations are not a continuation of the initial or earlier video consultations. Practitioners will need to provide the times of each consultation on the patient's account or bulk billing voucher.

Aftercare Rule

Video consultations are subject to the same aftercare rules as face to face consultations.

Referrals

The referral procedure for a video consultation is the same as for conventional face-to-face consultations.

Technical requirements

In order to fulfill the item descriptor there must be a visual and audio link between the patient and the remote practitioner. If the remote practitioner is unable to establish both a video and audio link with the patient, a MBS rebate for a telehealth attendance is not payable.

Individual clinicians must be confident that the technology used is able to satisfy the item descriptor and that software and hardware used to deliver a video conference meets the applicable laws for security and privacy.

Duration of attendance

The practitioner attending at the patient end of the video consultation does not need to be present for the entire consultation, only as long as is clinically relevant - this can be established in consultation with the specialist. The MBS fee payable for the supporting practitioner will be determined by the total time spent assisting the patient. This time does not need to be continuous.

Aboriginal health workers

For the purpose of item 10983 an Aboriginal health worker means a person who:

- a) holds a Certificate III in Aboriginal or Torres Strait Islander Health Worker Primary Health Care (Clinical) or other appropriate qualifications; or
- b) is registered, and holds a current registration issued by a State or Territory regulatory authority, as an Aboriginal health worker; and
- c) is employed by, or whose services are otherwise retained by a medical practitioner or their practice. This includes health service in relation to which a direction made under subsection 19(2) of the Act applies.

Aboriginal and Torres Strait Islander health practitioners

For the purpose of item 10983 an Aboriginal and Torres Strait Islander health practitioner means a person who has been registered as an Aboriginal and Torres Strait Islander health practitioner by the Aboriginal and Torres Strait Islander Health Practice Board of Australia and meets the Board's registration standards. The Aboriginal and Torres Strait Islander health practitioner must be employed or retained by a general practice, or by a health service that has an exemption to claim Medicare benefits under subsection 19(2) of the *Health Insurance Act 1973*.

An Aboriginal and Torres Strait Islander health practitioner may use any of the titles authorised by the Aboriginal and Torres Strait Islander Health Practice Board: Aboriginal health practitioner; Aboriginal and Torres Strait Islander health practitioner; or Torres Strait Islander health practitioner.

Practice Nurse

For the purpose of item 10983 a practice nurse means a registered or enrolled nurse who is employed by, or whose services are otherwise retained by a medical practitioner or their practice. This includes a health service in relation to which a direction made under subsection 19(2) of the *Health Insurance Act 1973* applies.

MN.13.1 Maternity Services by Participating Midwives - Overview

As at 1 November 2010, Medicare benefits are payable for antenatal, intrapartum and postnatal care for the first 6 weeks after the delivery, provided by eligible privately practising midwives. Eligible midwives can also request certain pathology and diagnostic imaging services for their patients and refer patients to obstetricians and paediatricians, as the clinical need arises. Each service that attracts a Medicare benefit is identified in the Medicare Benefits Schedule (MBS) by an item number. Each item describes the service that the item covers.

MN.13.2 Participating Midwives

To provide services under Medicare, the legislation requires that a midwife be a participating midwife. A participating midwife is an eligible midwife who provides services in a collaborative arrangement or collaborative arrangements with one or more medical practitioners, of a kind or kinds specified in the regulations.

For more details on collaborative arrangements required under the regulations see Point M.13.5.

MN.13.3 Eligible Midwives

Under the legislation, to be an eligible midwife the midwife must be registered or authorised (however described) under State and Territory law to practice midwifery. The midwife must also demonstrate that he or she has the appropriate qualifications and experience to meet the registration standard developed by the Nursing and Midwifery Board of Australia.

Information regarding eligibility can be found on the Nursing and Midwifery Board of Australia (NMBA) site of the Australian Health Practitioner Regulatory Agency (AHPRA) website at:

<http://www.nursingmidwiferyboard.gov.au/>.

MN.13.4 Midwife Professional Indemnity Insurance

Under National Law, which governs the National Registration and Accreditation Scheme (NRAS), it is a requirement for midwives to have appropriate professional indemnity insurance. All privately practising midwives who wish to provide private midwifery services in must have appropriate professional indemnity insurance from the date the State or Territory in which they were registered enacted National Law.

Further information about professional indemnity insurance for midwives can be found at:

<http://www.health.gov.au/internet/main/publishing.nsf/Content/Maternity+Services+Review-Q&A-PIMI>

MN.13.5 Collaborative Arrangements

To provide Medicare rebate-able services an eligible midwife must have a collaborative arrangement in place that must provide for consultation, referral or transfer of care as clinical needs dictate, to ensure safe, high quality maternity care.

Under the legislation a collaborative arrangement can be with the following "specified" medical practitioners:

1. an obstetrician;
2. a medical practitioner who provides obstetric services; or
3. a medical practitioner employed or engaged by a hospital authority and authorised by the hospital authority to participate in a collaborative arrangement.

The types of practitioners listed 1) and 2) are defined in the Regulations as "obstetric specified medical practitioners".

Collaborative arrangement can be established in the following ways:

- a. where the midwife:
 - i. is employed or engaged by 1 or more obstetric specified medical practitioners or by an entity that employs or engages 1 or more obstetric specified medical practitioners; or
 - ii. has an agreement, in writing, with an entity, other than a hospital, that employs or engages one or more obstetric specified medical practitioners, OR
- b. receiving patients by referral in writing to the midwife for midwifery treatment from a specified medical practitioner, OR
- c. having a signed written agreement with one or more specified medical practitioners, OR
- d. having an arrangement with and acknowledged by at least one specified medical practitioner
 - i. an arrangement requires that the eligible midwife must record the following in the midwife's written records:-
 - i. The name of at least one specified medical practitioner who is, or will be, collaborating with the midwife in the patient's care (a named medical practitioner);
 - ii. That the midwife has told the patient that the midwife will be providing midwifery services to the patient in collaboration with one or more specified medical practitioners;
 - iii. Acknowledgement by a named medical practitioner that the practitioner will be collaborating in the patient's care;
 - iv. Plans for the circumstances in which the midwife will do any of the following:
 - i. consult with an obstetric specified medical practitioner;
 - ii. refer the patient to a specified medical practitioner;
 - iii. transfer the patient's care to an obstetric specified medical practitioner.
 - ii. The midwife must also record the following in the midwife's written records:
 - i. Any consultation or other communication between the midwife and an obstetric specified medical practitioner about the patient's care;
 - ii. Any referral of the patient by the midwife to a specified medical practitioner;
 - iii. Any transfer by the midwife of the patient's care to an obstetric specified medical practitioner;
 - iv. When the midwife gives a copy of the hospital booking letter for the patient to a named medical practitioner - acknowledgement that the named medical practitioner has received the copy;
 - v. When the midwife gives a copy of the patient's maternity care plan prepared by the midwife to a named medical practitioner - acknowledgement that the named medical practitioner has received the copy;
 - vi. If the midwife requests diagnostic imaging or pathology services for the patient - when the midwife gives the results of the services to a named medical practitioner
 - vii. That the midwife has given a discharge summary at the end of the midwife's care for the patient to:
 - i. a named medical practitioner; and
 - ii. the patient's usual general practitioner, OR
- e. In relation to a hospital, the midwife is:
 - i. credentialed to provide midwifery services after successfully completing a formal process to assess the midwife's competence, performance and professional suitability; and
 - ii. given clinical privileges for a defined scope of clinical practice for the hospital; and
 - iii. permitted to provide midwifery care to his or her own patients at the hospital.

The legislation requires that collaborative arrangements must be in place at the time the participating midwife provides the service.

- a. Being employed or engaged by a medical practice or an entity or having a written agreement with an entity
An entity may refer to, for example, a community health centre or a medical practice. For a midwife to have a collaborative arrangement in these circumstances, that midwife must be employed or engaged by or have a written agreement with an entity that also employs or engages 1 or more obstetric specified medical practitioners.

The terms employ or engage covers both employees and contractors. This will cover an eligible midwife

who is employed or engaged by a medical practice so long as that medical practice employs or engages at least one obstetrician or medical practitioner that provides obstetric services. There must be at least one obstetric specified medical practitioner employed or engaged by the entity each time the midwife renders a service/performs treatment. However, there is no requirement that the consultation, referral or transfer of care must always be to the medical practitioner(s) employed/engaged by the entity.

b. Referral from a medical practitioner

A participating midwife's patient will be able to access the MBS and PBS if a patient has been referred in writing to the midwife by a specified medical practitioner. The arrangement must provide for consultation, referral and transfer of care should the clinical need arise.

c. Written agreement with a medical practitioner

A participating midwife's patient will be able to access the MBS and PBS if the nurse practitioner has a written agreement in place with one or more specified medical practitioners. The agreement must be signed by the nurse practitioner and doctor. The arrangement must provide for consultation, referral and transfer of care.

d. Arrangement with, acknowledged by a medical practitioner

Evidence of 'acknowledgement' by an obstetrician/GP obstetrician for each woman for whom the midwife provides care is a requirement to ensure that the medical practitioner being named understands and accepts the collaborative arrangement.

The acknowledgement does not have to be obtained on an individual patient basis. This means that, for example, a midwife could obtain an acknowledgement from a specified medical practitioner that he or she will be the collaborating medical practitioner for some or all of the midwife's patients. Arrangements to collaborate could be obtained in a number of ways including signing of documents, email or fax confirmation, or verbal acknowledgement which the midwife documents in their written records.

The midwife is required to record in written records communications in regard to consultations, referral and transfer of the woman's care with the medical practitioner, including information that has been forwarded to the medical practitioner. The midwife is also required to send a copy of all pathology and diagnostic imaging results to a named medical practitioner and to record in the midwife's written records when this occurs (however, there is no requirement that the midwife consult with a medical practitioner in relation to every test result). The purpose of sharing records with the collaborating medical practitioner is to prevent duplication of services and to ensure continuity of care.

e. Collaborative arrangement with a hospital

This type of collaborative arrangement applies where an eligible midwife is credentialed for a hospital, having successfully completed a formal assessment of his or her qualifications, skills, experience and professional standing. It is expected that the assessment would involve an appropriately qualified medical practitioner/s. The midwife is also required to have a defined scope of clinical practice at the hospital and be eligible to treat his or her own patients at the hospital. The hospital must employ or engage at least one obstetric specified medical practitioner. It is expected that the hospital will have a formal written agreement with such midwives, addressing consultation, referral and transfer of care, relevant clinical guidelines and locally determined policies.

MN.13.6 Provider Numbers

To access the Medicare arrangements, eligible midwives will need to apply to Services Australia for a provider number. A separate provider number is required for each location at which a midwife practices.

Provider registration forms may be obtained from the Services Australia [website](#) or by contacting on Services Australia at 132 150.

MN.13.7 Schedule Fees and Medicare Benefits

Each midwifery service is identified in the MBS by an item number. The fee set for any item in the MBS is known as the "Schedule fee". The Schedule fee and Medicare benefit for each service is listed in the item description.

There are two levels of benefit payable for midwifery services:

75% of the Schedule fee for midwifery services rendered as part of an episode of hospital treatment (other than for public patients) - see GN.1.2; or

85% of the Schedule fee for all other antenatal and postnatal services.

MN.13.8 Safety Nets

Where practitioners charge more than the Medicare benefit, the resultant out-of-pocket costs are the responsibility of the patient.

Assistance is provided to families and singles for out-of-pocket costs for out-of-hospital services through the "original" and "extended" Medicare safety nets:

- the original safety net provides that once the threshold is met, the Medicare benefit increases to 100 per cent of the Schedule fee; and
- under the Extended Medicare Safety Net (EMSN), once certain thresholds are met, Medicare reimburses 80 per cent of the out-of-pocket costs. However, where the item has an EMSN benefit cap, there is a maximum limit on the EMSN benefit that will be paid for that item.

MN.13.10 Where Medicare Benefits are not payable

Medicare benefits are not available:

- a. for services listed in the MBS, where the service rendered does *not* meet the item description and associated requirements;
- b. where the midwifery service is *not* personally performed by the participating midwife;
- c. for MBS services that are time based, the inclusion of any time period in the consultation periods when the patient is *not* receiving active attention e.g. the time the provider may take to travel to the patient's home or where the patient is resting between blood pressure readings; and
- d. services provided where the patient is not in attendance, such as the issuing of repeat prescriptions;
- e. for telephone attendances;
- f. group sessions; and
- g. The issuing of repeat prescriptions, updating patient notes or telephone consultations.

The fee charged under Medicare must not include the cost of services that are not part of the MBS service being claimed. Medicare benefits are not payable for good or appliances associated with the service, such as bandages or other skin dressings

Unless the Minister otherwise directs, Medicare benefits are not payable where funding has already been provided under an arrangement with the Commonwealth, state or a local governing body.

MN.13.11 Billing of Patient

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

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

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

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

MN.13.12 Assignment of Benefits (Direct-Billing) Arrangements

Under the *Health Insurance Act 1973* the Assignment of Benefit (direct-billing) facility for professional services is available to all persons in Australia who are eligible for benefit under the Medicare program. This facility is NOT confined to pensioners or people in special need.

If a participating midwife direct-bills, the participating midwife undertakes to accept the relevant Medicare benefit as full payment for the service. Additional charges for that service (irrespective of the purpose or title of the charge) cannot be raised against the patient. Under these arrangements:-

- The patient's Medicare card number must be quoted on all direct-bill forms for that patient.
- The basic forms provided are loose leaf to enable the patient details to be imprinted from the Medicare card.
- The forms include information required by Regulations under Subsection 19(6) of the *Health Insurance Act 1973*.
- The practitioner must include the particulars relating to the professional service out on the assignment form before the patient signs the form and ensure that the patient to receive a copy of the form as soon as practicable after the patient signs it.
- Where a patient is unable to sign the assignment form the signature of the patient's parent, guardian or other responsible person (other than the practitioner, practitioner's staff, hospital proprietor, hospital staff, residential aged care facility proprietor or residential aged care facility staff) is acceptable. The reason the patient is unable to sign should also be stated.

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

MN.13.13 Assignment of Benefit Forms

Participating midwives wishing to direct-bill are required to use a specific form available from Services Australia. This stationary is available from Services Australia. Note that these forms are approved forms under the *Health Insurance Act 1973*, and no other forms can be used to assign benefits without the approval of Services Australia. Further information about direct-billing stationary can be obtained by telephoning **132150**.

MN.13.14 Time Limits Applicable to Lodgement of Claims for Assigned Benefits

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

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

MN.13.15 Overview of the Maternity Items

Face to Face Services

Antenatal, intrapartum and postnatal care provided by participating midwives are covered by MBS items 82100, 82105, 82110, 82115, 82116, 82118, 82120, 82123, 82125, 82127, 82130, 82135, 82140. These items cover 13 specific types of service that allow the participating midwife to:

- undertake an initial antenatal attendance of more than 40 minutes duration (item 82100);
- provide a short antenatal attendance of up to 40 minutes duration (item 82105);
- provide a long antenatal attendance of more than 40 minutes duration (item 82110);
- make an assessment of and prepare a maternity care plan for a patient across a pregnancy that has progressed beyond 28 weeks and there have been at least two antenatal attendances with the claiming participating midwife in the preceding six months (item 82115);
- undertake management of labour (excluding birth) out of hospital for up to 6 hours (item 82116);
- undertake management of labour (including birth where performed or attendance and immediate post-birth care at an elective caesarean section) in hospital by the first participating midwife for a total of up to 6 hours (item 82118);
- undertake management of labour (including birth where performed) by the first participating midwife for a total of 6 to 12 hours, including birth (item 82120);
- undertake management of labour (including birth where performed) in hospital by the second participating midwife for a total of up to 6 hours (item 82123);
- undertake management of labour (including birth where performed) by the second participating midwife for a total of 6 to 12 hours including birth (item 82125);
- undertake management of labour (including birth where performed) in hospital by the third participating midwife for a total of up to 6 hours (item 82127);
- provide a short postnatal attendance of up to 40 minutes duration (item 82130);
- provide long postnatal attendance of at least 40 minutes duration (item 82135); and
- provide a comprehensive postnatal check to a patient 6 weeks after the birth of the baby (item 82140).

Telehealth Services

- A service may only be provided by telehealth where it is safe and clinically appropriate to do so.
- These MBS telehealth items are for out-of-hospital patients.
- Providers are expected to obtain informed financial consent from patients prior to providing the service including providing details regarding their fees and any out-of-pocket costs.

The participating midwife telehealth items are:

Service	Telehealth items via video-conference	Telephone items for when video-conferencing is not available
Short antenatal attendance lasting up to 40 minutes	91211	91218
Long antenatal attendance lasting at least 40 minutes	91212	91219
Short postnatal attendance lasting up to 40 minutes	91214	91221

Long postnatal attendance lasting at least 40 minutes	91215	91222
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MN.13.16 Maternity Services Attracting Medicare Rebates

Medicare Benefits are only payable for clinically relevant services. Clinically relevant in relation to midwifery care means a service generally accepted by the midwifery profession as necessary to the appropriate treatment of the patient's clinical condition.

Medicare benefits are only payable where the participating midwife provides care to not more than one patient on the one occasion.

Antenatal Care

Eligible maternity care plan service

MBS item 82115 is the one MBS item available for participating midwife practitioners to undertake a comprehensive assessment and prepare a written maternity care plan for a patient, who is not an admitted patient of a hospital, across a pregnancy that has progressed beyond 28 weeks. In order to claim item 82115, the participating midwife is required to have had at least two antenatal attendances (82100, 82105, 82110, 91211, 91212, 91218 or 91219) with the patient in the preceding six months; and the provider who undertakes the care plan should intend to remain the primary health care provider for the remainder of the pregnancy.

There will be a six month transition period for the restriction on the claiming participating midwife having at least two antenatal attendances in the preceding six months. This transition period acknowledges that in the six months prior to 1 March 2022 (before this requirement was legislated), participating midwives may not have had the required two antenatal visits with the patient to claim 82115 as at the time they were not aware of the upcoming requirement. The transition period will end on 1 September 2022.

For example, if 82115 is provided on 1 April 2022 and only one antenatal attendance by the same participating midwife was provided in the past 6 months, then claiming item 82115 will still be permitted. If this same scenario occurs on 1 September 2022, then the claim would not be permitted.

It is expected that the care plan would be agreed with the patient and detail such things as agreed expectation, health problems and care needs and appropriate referrals, medication and diagnostic tests.

This item cannot be claimed if items 16590 or 16591 have previously been claimed during a single pregnancy, except in exceptional circumstances. An exceptional circumstance in which the creation of a new maternity care plan may be required includes a significant change in the patient's clinical condition or maternity care requirements.

For claiming purposes, the exceptional circumstance requiring another maternity care plan needs to be recorded in the patient's notes, and "exceptional circumstance" notated when submitting the claim.

Number of services: Only one (1) midwifery care plan (82115) is payable in any pregnancy.

Antenatal Attendances

Medicare benefits are payable for an antenatal service where a participating midwife provides a clinically relevant service in respect of a miscarriage. Medicare benefits are not payable for an antenatal attendance associated with the labour. The labour items (82116-82127) include all associated intrapartum attendances.

Any clinically relevant indication that requires an antenatal attendance by a participating midwife on an admitted patient in hospital, but that is not associated with the labour, will attract a Medicare benefit.

Number of services: Only one (1) initial antenatal attendance under item 82100 is payable in any pregnancy. There is no limit attached to long and short antenatal attendances (82105, 82110, 91211, 91212, 91218 and 91219) by a participating midwife. However, only clinically relevant attendances should be itemised under Medicare and services provided by participating midwives will be subject to Medicare Audit and Professional Review Processes.

Management of labour

The MBS includes six items for management of labour by a participating midwife;

- undertake management of labour (excluding birth) out of hospital for up to 6 hours (item 82116)
- undertake management of labour (including birth where performed or attendance and immediate post-birth care at an elective caesarean section) in hospital by the first participating midwife for a total of up to 6 hours (item 82118)
- undertake management of labour (including birth where performed) by the first participating midwife for a total of 6 to 12 hours, including birth (item 82120)
- undertake management of labour (including birth where performed) in hospital by the second participating midwife for a total of up to 6 hours (item 82123)
- undertake management of labour (including birth where performed) by the second participating midwife for a total of 6 to 12 hours including birth (item 82125)
- undertake management of labour (including birth where performed) in hospital by the third participating midwife for a total of up to 6 hours (item 82127)

Management of labour out of hospital

Item 82116 is for the management of labour out of hospital for up to six hours. This item is intended to provide benefits for patients whose births occur in hospital. This item is not intended to provide benefits for planned home births.

This item is not claimable if the management of labour and birth is intended to be transferred to an obstetrician, medical practitioner or non-participating midwife. The total attendance time is to be documented in the patient notes.

Management of labour in hospital

The intrapartum items (82118-82127) are claimable for the participating midwife's total attendance managing the patient's labour in hospital. These items are claimable from when the patient is admitted to hospital. The time taken to conduct a patient handover to another participating midwife is counted towards the total attendance. Breaks taken to manage the participating midwife's fatigue are not counted towards the total claimable time. The total attendance time for each participating midwife is to be documented in the patient notes.

Example One:

- The first participating midwife manages the patient's labour at the patient's home for five hours and then for three hours in hospital. To manage their fatigue, the first participating midwife hands over care to a second participating midwife and takes a 10 hour break.
- The second participating midwife takes over the patient's care and manages the labour for 10 hours before handing over care to the first participating midwife to manage their own fatigue.
- The first participating midwife takes over the patient's care and manages their labour and birth for 6 hours.

In this scenario, the first participating midwife would be eligible to claim 82116 (for the five hours in attendance out of hospital) and 82120 (for the total of nine hours in hospital attendance). The second participating midwife would claim 82125 (for the total of 10 hours in hospital attendance).

Example Two:

- The first participating midwife manages the patient's labour in hospital for two hours and as they have been at another birth just prior to this attendance, needs to take a break to manage their fatigue. They handover the patient's care to the second participating midwife before taking a 10 hour break.
- The second participating midwife takes over the patient's care and manages the labour in hospital for six hours before handing over care to the third participating midwife to manage their fatigue.

- The third participating midwife takes over the patient's care. The third midwife has already managed a different patient's labour and birth earlier that day and is able to manage this patient's labour for four hours before handing over care to the first participating midwife to manage their fatigue.
- The first participating midwife manages the labour and birth for four hours.

In this scenario, the first participating midwife would claim 82118 (for the six hours in hospital attendance). The second participating midwife would claim 82123 (for the six hours in hospital attendance) and the third participating midwife would claim 82127 (for the four hours in hospital attendance).

Medicare benefits are payable under items 82118-82127 whether or not the participating midwife undertakes the birth i.e. including where the patient's care is escalated to an obstetrician during labour or for the birth.

Medicare benefits are only payable where the service is provided to an admitted patient of a hospital, including a hospital birthing centre. Labour is taken to commence when the participating midwife attends a patient that is in labour and who has been admitted to the hospital for labour and birth. The time period for these items is the period for which the participating midwife is in exclusive attendance on the patient for labour, and birth where performed.

Medicare benefits are only payable for management of labour where the participating midwife undertaking the service has provided the patient's antenatal care or who is a member of a practice that provided the patient's antenatal care.

It is not intended that these items be claimed routinely by participating midwives who do not intend to undertake the birth i.e. where the participating midwife has arranged beforehand for a medical practitioner to undertake the birth. Where the participating midwife does not undertake the birth it is because:

- In order to manage the participating midwife's fatigue, care was transferred to another participating midwife for management of labour; or
- There was a clinical need to escalate care to an obstetrician or medical practitioner who provides obstetric services.

Number of services: Intrapartum items 82116-82127 can only be claimed once per pregnancy.

Postnatal Care

In addition to the long and short antenatal attendance items for postnatal care in the first six weeks post birth, the MBS provides for a six week postnatal check (82140), after which the patient would be referred back to a GP.

Number of services: Only one (1) postnatal check (82140) by a participating midwife is payable in any pregnancy.

There is no limit attached to long and short postnatal attendances (82130, 82135, 91214, 91215, 91221 and 91222) by a participating midwife. However, only clinically relevant attendances should be itemised under Medicare and services provided by participating midwives will be subject to Medicare Audit and Professional Review Processes.

MN.13.17 Conditions Governing the Provision and Claiming of Items

Service length and type

- Services under these items must be for the time period specified within the item descriptor.
- Professional attendance for MBS items 82100, 82105, 82110, 82115, 82116, 82130, 82135 and 82140 may be provided in an appropriate setting that includes but is not limited to: the patient's home, a midwifery group practice, a participating midwife practitioner's rooms or a medical practice.
- Items 91211, 91212, 91214, 91215 are telehealth items provided via video-conference and items 91218, 91219, 91221 and 91222 are telephone items provided when video-conferencing is not available.

MN.13.18 Referral Requirements

A participating midwife will be able to refer a patient to specialist obstetricians and paediatricians as clinical services dictate.

This measure does not include referral by a participating midwife for allied health care. If a participating midwife refers a patient to an allied health practitioner, no benefits would be payable for that service.

Medicare benefits are not payable specifically for services provided by a lactation consultant at this time. Medicare benefits would be payable for breast feeding support provide as part of the postnatal care by the participating midwife.

A referral is valid for 12 months to cover the labour (antenatal, birthing and postnatal care for 6 weeks post birth). Should there be a new pregnancy in that period, a new referral will be required.

A new pregnancy represents a new episode of care.

A referral to a specialist must be in writing in the form of a letter or a note to the specialist and must be signed and dated by the referring participating midwife. The referral must contain any information relevant to the patient and the specialist must have received the referral on or prior to providing a specialist consultation.

If a specialist provides a consultation without a referral, the specialist's consultation would not attract Medicare benefits at the specialist rate.

There are exemptions from this requirement in an emergency if the participating midwife considers the patient's condition requires immediate attention without a referral. In that situation, the specialist must decide that it is necessary in the patient's interests to render the professional service specified in the item as soon as practicable and they must begin rendering a service within 30 minute of the patient's presentation. If a referral is lost, stolen or destroyed, the participating midwife would need to provide a replacement referral as soon as is practicable after the service is provided.

If the patient is a privately admitted patient of a hospital a letter or note is not required. The referring participating midwife would make a notation in the patient's notes, which they would sign, approving the referral.

A referral is not required to transfer a patient's care during the intra-partum period under items 16527 and 16528. The participating midwife would make a signed notation in the patient's notes approving the transfer of care.

A referral is not required to refer the patient back to their GP after the six week postnatal period. The participating midwife would provide a discharge summary to the GP outlining the maternity history and any relevant clinical issues, which would also be recorded on the patient's notes.

MN.13.19 Requesting Requirements

Pathology Services

Determination of Necessity of Service

The participating midwife requesting a pathology service for a woman must determine that the pathology service is necessary.

Request for Service

The service may only be provided in response to a request from the treating practitioner and the request must be in writing (or, if oral, confirmed in writing within fourteen days).

Pathology Services approved for participating midwives

FBC (item 65070)	vaginal /anal swab/GBS (69312)* varicella 69384 - 69401 (antibody test) parvo virus 69384 - 69401
Hb (item 65060)	rubella titre syphilis Hep B/C - items 69405, 69408, 69411, 69413 or 69415 HIV
Group and antibodies (items 65090, 65093, 65096) glucose load (items 66545, 66548)	Serum Bilirubin (SBR); 66500
Downs Syndrome/ Spina Bifida (items 66743, 66750, 66751)	Direct Coombs; 65114
eye swab (69303)	Blood glucose level (item 66500)
skin swab (69306)	Cord PH and gases cord (O2 and CO2) (Item 66566)
skin scrapings (69309)	Group and Hold (item 65099)
Chlamydia (item 69316)	Coagulation Studies (items 65129, 65070)
Gonorrhea (item 69317)	Mid stream urine (item 69324)
Cervical screening (items 73070, 73071, 73075, 73076)	HCG (item 73529)

Diagnostic Imaging Services

Determination of Necessity of Service

The participating midwife requesting a diagnostic imaging service for a woman must determine that the diagnostic imaging service is necessary for the appropriate professional care of the patient.

Request for Service

The service may only be provided in response to a request from the treating practitioner, and the request must be in writing, signed and dated.

The request does not have to be in a particular form. However, legislation provides that a request 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. The provision of additional relevant clinical information can often assist the service provider, and enhance the overall service provided to the patient.

It is not necessary that a written request for a diagnostic imaging service be addressed to a particular provider or that, if the request is addressed to a particular provider, the service must be rendered by that provider.

A single request may be used to order a number of diagnostic imaging services. However, all services provided under this request must be rendered within seven days after rendering the first service.

Ultrasound:

Routine morphology scan (item 55706)	Nuchal Translucency (item 55707)
Early dating scan (item 55700)	Post 22 weeks scan (item 55718)
Scan at 12-16 weeks (item 55704)	

MN.14.1 Participating Nurse Practitioners Services - Overview

As at 1 November 2010, Medicare benefits are payable for services provided by privately practising participating nurse practitioners in collaboration with other health care providers. Participating nurse practitioners can also

request certain pathology and diagnostic imaging services for their patients and refer patients to specialist, as the clinical need arises. The nurse practitioner services that attract a Medicare benefit are identified in the Medicare Benefits Schedule (MBS) by an item number and the each item describes the service requirements and schedule fee.

MN.14.2 Eligible Nurse Practitioners

Under the legislation, to be an eligible nurse practitioner the nurse practitioner must be registered or authorised (however described) under State and Territory law. The nurse practitioner must also demonstrate that he or she has the appropriate qualifications and experience to meet the registration standard developed by the Nursing and Midwifery Board of Australia (NMBA).

This standard was developed for the purposes of the National Registration and Accreditation Scheme (NRAS), a single regulation and accreditation scheme for health professionals, including nurse practitioners. Additional information is available at the Australian Health Practitioners Regulation Agency (AHPRA) website at: <http://www.ahpra.gov.au/index.php>

MN.14.3 Provider Numbers

To access the Medicare arrangements, eligible nurse practitioners will need to apply to Services Australia for a provider number. A separate provider number is required for each location at which a nurse practitioner practices.

Provider registration forms may be obtained from the Services Australia [website](#) or by contacting on Services Australia at 132 150.

MN.14.4 Participating Nurse Practitioners

To provide services under Medicare, the legislation requires that a nurse practitioner be a participating nurse practitioner. A participating nurse practitioner is an eligible nurse practitioner who has a Medicare provider number and who provides Medicare services in a collaborative arrangement or collaborative arrangements with one or more medical practitioners, of a kind or kinds specified in the regulations.

MN.14.5 Collaborative Arrangements

Under the Medicare program collaboration is having arrangements in place with a medical practitioner/s to consult, refer or transfer care as clinical needs dictate, to ensure safe, high quality maternity care. Under Medicare a collaborative arrangement can be with any medical practitioner.

Collaborative arrangement can be established in the following ways:

- a) being employed or engaged by 1 or more specified medical practitioners or by an entity that employs or engages 1 or more specified medical practitioners; OR
- b) receiving patients by referral in writing to the nurse practitioner for treatment from a specified medical practitioner, OR
- c) having a signed written agreement with one or more specified medical practitioners, OR
- d) having an arrangement with and acknowledged by at least one specified medical practitioners. This includes keeping comprehensive notes on all instances of consultation, referral and transfer of care, diagnostic tests requested and the test results and providing the collaborating practitioner/s with those results.

The legislation requires that collaborative arrangements must be in place at the time the participating nurse practitioner provides the service. The legislation requires that for each kind of collaborative arrangement, at least one medical practitioner is needed; it is not possible for the nurse practitioner to have a collaborative arrangement with an entity such as a health service.

- a) Being employed or engaged by a medical practice or an entity

An entity may refer to a hospital or community health centre. For a nurse practitioner to have a collaborative arrangement in these circumstances, that nurse practitioner must be employed or engaged by an entity that also employs or engages 1 or more specified medical practitioners.

The terms employ or engage covers both employees and contractors. This will cover an eligible nurse practitioner who is employed or engaged by a medical practice so long as that medical practice employs or engages at least one medical practitioner.

There must be at least one specified medical practitioner employed or engaged by the entity each time the nurse practitioner renders a service/performs treatment. However, there is no requirement that the consultation, referral or transfer of care must always be to the medical practitioner(s) employed/engaged by the entity.

b) Referral from a medical practitioner

A participating nurse practitioner's patient will be able to access the MBS and PBS if a patient has been referred in writing to the nurse practitioner by a specified medical practitioner. The arrangement must provide for consultation, referral and transfer of care should the clinical need arise.

c) Written agreement with a medical practitioner

A nurse practitioner's patient will be able to access the MBS and PBS if the nurse practitioner has a written agreement in place with one or more doctors. The agreement must be signed by the nurse practitioner and a doctor. The arrangement must deal with consultation, referral and transfer to a doctor.

d) Arrangement with, acknowledged by a medical practitioner.

Evidence of 'acknowledgement' by a medical practitioner for each patient for whom the nurse practitioner provides care is a requirement to ensure that the medical practitioner being named understands and accepts the collaborative arrangement.

The acknowledgement does not have to be obtained on an individual patient basis. This means that, for example, a nurse practitioner could obtain an acknowledgement from a specified medical practitioner that he or she will be the collaborating medical practitioner for some or all of the nurse practitioner's patients. Arrangements to collaborate could be obtained in a number of ways including signing of documents, email or fax confirmation, or verbal acknowledgement which the nurse practitioner documents in their written records.

The nurse practitioner is required to record in written records any communications in regard to consultations, referral and transfer of the patient's care with the medical practitioner, including information that has been forwarded to the medical practitioner. The nurse practitioner is also required to send a copy of all pathology and diagnostic imaging results to a named medical practitioner and to record in the nurse practitioner's written records when this occurs (however, there is no requirement that the nurse practitioner consult with a medical practitioner in relation to every test result). The purpose of sharing records with the collaborating medical practitioner is to prevent duplication of services and to ensure continuity of care.

Arrangements to collaborate could be obtained in a number of ways including signing of documents, email or fax confirmation, or verbal acknowledgement which the nurse practitioner documents in their written records.

MN.14.6 Schedule Fees and Medicare Benefits

Each nurse practitioner service is identified in the MBS by an item number. The fee set for any item in the MBS is known as the "Schedule fee". The Schedule fee and Medicare benefit for each service is listed in the item description. The Medicare benefit for nurse practitioner services rendered to non-admitted patients is 85% of the Schedule fee.

MN.14.7 Where Medicare Benefits are not payable

Medicare benefits are not available:

- a. where the service rendered does not meet the item description and associated requirements;
- b. where the nurse practitioner service is not personally performed by the participating nurse practitioner;
- c. for any time period in the consultation periods when the patient is not receiving active attention e.g. the time the provider may take to travel to the patient's home or where the patient is resting between blood pressure readings;
- d. services provided where the patient is not in attendance, such as the issuing of repeat prescriptions;
- e. for telephone attendances; and
- f. group sessions.

The fee charged under Medicare must not include the cost of services that are not part of the MBS service being claimed. Medicare benefits are not payable for good or appliances associated with the service, such as bandages or other skin dressings.

Unless the Minister otherwise directs, Medicare benefits are not payable where funding has already been provided under an arrangement with the Commonwealth, state or a local governing body.

MN.14.8 Billing of the Patient

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

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

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

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

MN.14.9 Assignment of Benefits (Direct-Billing Arrangements)

Under the *Health Insurance Act 1973* the Assignment of Benefit (bulk billing) for professional services is available to all persons in Australia who are eligible for benefit under the MBS.

If a participating nurse practitioner bulkbills, the participating nurse practitioner undertakes to accept the relevant Medicare benefit as full payment for the service. Additional charges for that service (irrespective of the purpose or title of the charge) cannot be raised against the patient.

Under these arrangements:

The patient's Medicare card number must be quoted on all bulk bill forms for that patient.

The basic forms provided are loose leaf to enable the patient details to be imprinted from the Medicare card.

The forms include information required by Regulations under Subsection 19(6) of the *Health Insurance Act 1973*.

The nurse practitioner must include the particulars relating to the professional service out on the assignment form before the patient signs the form and ensure that the patient receives a copy of the form as soon as practicable after the patient signs it.

Where a patient is unable to sign the assignment form the signature of the patient's parent, guardian or other responsible person (other than the nurse practitioner, nurse practitioner's staff, hospital proprietor, hospital staff, residential aged care facility proprietor or residential aged care facility staff) is acceptable. The reason the patient is unable to sign should also be stated.

The administration of the bulk billing arrangements under Medicare as well as the payment of Medicare benefits on patient claims is the responsibility of Services Australia. Any enquiries regarding these matters should therefore be directed to Services Australia.

MN.14.10 Assignment of Benefit Forms

Participating nurse practitioners wishing to bulk-bill are required to use a specific form available from Services Australia. This stationary is available from Services Australia. Note that these forms are approved forms under the *Health Insurance Act 1973*, and no other forms can be used to assign benefits without the approval of Services Australia. Further information about bulk-billing stationary can be obtained by telephoning 132 150.

MN.14.11 Time Limits applicable to lodgement of claims for assigned benefits

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

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

MN.14.12 Overview of the Nurse Practitioner items

Services provided by participating nurse practitioners are covered by MBS items 82200, 82205, 82210, 82215. These items cover four time-tiered specific types of service that allow the participating nurse practitioner to perform a:

professional attendance for an obvious problem, straight forward in nature, with limited examination and management required (82200)

professional attendance for a patient presenting with clinical signs and symptoms with an easily identifiable underlying cause following a short consultation lasting less than 20 minutes duration (item 82205)

professional attendance for a patient presenting with clinical signs and symptoms with no obvious underlying cause requiring a more detailed consultation lasting at least than 20 minutes duration (item 82210);

professional attendance for a patient presenting with multiple clinical signs and symptoms with the possibility of multiple causes and outcomes requiring an extensive consultation of at least 40 minutes (item 82215);

MN.14.13 Nurse Practitioner services attracting Medicare rebates

Medicare Benefits are only payable for clinically relevant services. Clinically relevant in relation to nurse practitioner care means a service generally accepted by the nursing profession as necessary to the appropriate treatment of the patient's clinical condition.

Medicare benefits are only payable where the participating nurse practitioner provides care to not more than one patient on one occasion.

MN.14.14 Conditions governing the provision and claiming of items

Service length and type

Services under these items must be for the time period specified within the item descriptor.

Professional attendance for MBS items 82200, 82205, 82210, 82215, may be provided in an appropriate setting that includes but is not limited to: the patient's home, a nurse practitioner group practice, a nurse practitioner's rooms or a medical practice.

MN.14.15 Referral requirements

A participating nurse practitioner will be able to refer private patients to a specialist and consultant physician as clinical services dictate.

This measure does not include referral by a nurse practitioner for allied health care. If a participating nurse practitioner refers a patient to an allied health practitioner, no benefits would be payable for that service provided by the allied health professional.

A referral given by a participating nurse practitioner is valid until 12 months after the first service given in accordance with the referral.

If the referral is lost, stolen or destroyed, the nurse practitioner would need to provide a replacement referral as soon as is practicable after the service is provided.

A referral to a specialist must be in writing in the form of a letter or a note to the specialist and must be signed and dated by the referring nurse practitioner. The referral must contain any information relevant to the patient and the specialist must have received the referral on or prior to providing a specialist consultation.

There are exemptions from this requirement in an emergency if the specialist considers the patient's condition requires immediate attention without a referral. In that situation, the specialist is taken to be the referring practitioner.

MN.14.16 Requesting requirements

Pathology Services

Determination of Necessity of Service

The participating nurse practitioner requesting a pathology service for a patient must determine that the pathology service is necessary.

Request for Service

The service may only be provided in response to a request from the treating practitioner and the request must be in writing (or, if oral, confirmed in writing within fourteen days).

Pathology Services approved for participating nurse practitioners

Nurse practitioners may request MBS pathology items in any Groups P1 to P8 or any of items 73826 to 73837 of the pathology services table. Requesting pathology services must be within the nurse practitioner's scope of practice.

Further information

For further information about Medicare Benefits Schedule items, please refer to the Department of Health and Aged Care's website at www.health.gov.au/mbsonline.

Diagnostic Imaging Services

Determination of Necessity of Service

The participating nurse practitioner requesting a diagnostic imaging service for a patient must determine that the diagnostic imaging service is necessary for the appropriate professional care of the patient.

Request for Service

The service may only be provided in response to a request from the treating nurse practitioner, and the request must be in writing, signed and dated. The legislation provides that a request 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. The provision of additional relevant clinical information can often assist the service provider, and enhance the overall service provided to the patient.

It is not necessary that a written request for a diagnostic imaging service be addressed to a particular provider or that, if the request is addressed to a particular provider, the service must be rendered by that provider.

A single request may be used to order a number of diagnostic imaging services. However, all services provided under this request must be rendered within seven days after rendering the first service.

Further Information

For further information on Medical Benefit Schedule items nurse practitioners can request for Diagnostic Imaging services please refer to note IN.0.6, which can be found [here](#).

MN.15.2 Non-Determinate Audiometry - (Item 82306)

This refers to audiometry covering those services, one or more, referred to in Items 82309-82318 when not performed under the conditions set out in paragraph M15.3.

MN.15.3 Conditions for Audiology Services - (Items 82309 to 82324)

A service specified in items 82309 to 82324 should be rendered:

- (a) in conditions that allow the establishment of determinate thresholds, including better ear threshold in free field testing;
- (b) in a sound attenuated environment with background noise conditions that comply with Australian Standard AS/NZS 1269.3-2005; and
- (c) using calibrated equipment that complies with Australian Standard AS IEC 60645.1-22002, ASIEC60645.2-2002 and AS IEC 60645.3-2002.

MN.15.4 Oto-Acoustic Emission Audiometry - (Item 82332)

Medicare benefits are not payable under Item 82332 for routine screening of infants. The equipment used to provide this service must be capable of displaying the recorded emission and not just a pass/fail indicator.

MN.15.5 Provision of Diagnostic Audiology Services by Audiologists - (Items 82300 to 82332) OVERVIEW

The diagnostic audiology services available through MBS items 82300 to 82332 (excepting 82301, 82302 and 82304) enable an eligible audiologist to perform diagnostic tests upon written request from a medical practitioner. MBS items 82301, 82302 and 82304, for the programming of an auditory implant or the sound processor of an auditory implant, do not require a request from a medical practitioner.

These diagnostic audiology services assist medical practitioners, including ENT specialists and neurologists, in their medical diagnosis and/or treatment and/or management of ear disease or related disorders. The diagnostic audiology items supplement Otolaryngology items for services delivered by, or on behalf of medical practitioners (MBS items 11300 to 11345, excluding 11304).

Requesting arrangements

The written request must be in writing and must contain:

- (a) the date of the request; and
- (b) the name of the medical practitioner who requested the service and either the address of his or her place of practice or the provider number in respect of his or her place of practice; and
- (c) a description of the service which provides sufficient information to identify the service as relating to a particular item (but need not specify the item number).

Written requests should, where possible, note the clinical indication/s for the requested service/s.

A request may be for the performance of more than one diagnostic audiology service making up a single audiological assessment but cannot be for more than one audiological assessment. This means that for Medicare benefits to be payable, any re-evaluation of the patient should be made at the discretion of the medical practitioner through a separate request.

Audiologists do not have the discretion to self-determine diagnostic tests under items 82300 to 82332 (excepting items 82301, 82302 and 82304). If a written request is incomplete or requires clarification, the audiologist should contact the requesting medical practitioner for further information. If an audiologist considers that additional tests may be necessary, the audiologist should contact the requesting medical practitioner to discuss the need and if the requesting practitioner determines that additional tests are necessary, an amended or separate written request must be arranged.

It is recommended that audiologists retain the written request for 24 months from the date the service was rendered (for Medicare auditing purposes). A copy of the written request is not required to accompany Medicare claims or be attached to patients' itemised accounts/receipts or assignment of benefit forms.

Eligibility requirements for audiologists

The diagnostic audiology items (82300 to 82332) can only be claimed by audiologists who are registered with Services Australia. To be eligible to register with the Services Australia to provide these services, audiologists must meet the following requirements:

Audiologists must be either:

- a 'Full Member' of Audiology Australia who is an Audiology Australia Accredited Audiologist; or
- an 'Ordinary Member - Audiologist' or 'Fellow Audiologist' of the Australian College of Audiology (ACAud).

Registering with Services Australia

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

Changes to provider details

Audiologists must notify Services Australia in writing of all changes to mailing details to ensure that they continue to receive information about Medicare services.

Reporting requirements

Where an audiologist provides diagnostic audiology service/s to the patient under a written request, they must provide a copy of the results of the service/s performed together with relevant written comments on those results to the requesting medical practitioner. It is recommended that these be provided within 7 days of the date the service was performed.

Out-of-pocket expenses and Medicare Safety Net

Audiologists can determine their own fees for the professional service. Charges in excess of the Medicare benefit are the responsibility of the patient. However, out-of-pocket costs will count toward the Medicare Safety Net for that patient.

Publicly funded services

Items 82300 to 82332 do not apply for services that are provided by any Commonwealth or state funded services or provided to an admitted patient of a hospital. However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or state/territory government health clinic, items 82300 to 82332 can be claimed for services provided by audiologists salaried by, or contracted to, the service or health clinic. All requirements of the relevant item must be met, including registration of the audiologist with Services Australia. Medicare services provided under a subsection 19(2) exemption must be bulk billed (i.e., the Medicare rebate is accepted as full payment for services).

Private health insurance

Patients need to decide if they will use Medicare or their private health insurance ancillary cover to pay for these services. Patients cannot use their private health insurance ancillary cover to 'top up' the Medicare rebate paid for the services.

MN.16.1 Eating Disorders General Explanatory Notes

Eating Disorders General Explanatory Notes (items 82350, 82352, 82355, 82360, 82363, 82368, 82371, 82376, 82379, 82381, 82382, 82383; 93074, 93076, 93084, 93087, 93092, 93095, 93100, 93103)

This note provides a general overview of the full range of 1 November 2019 eating disorders items and supporting information more specifically on the on the Category 8 – Miscellaneous Services: Group M16 – Eating disorders services (items 82350, 82352, 82355, 82360, 82363, 82368, 82371, 82376, 82379, 82381, 82382, 82383; 93074, 93076, 93079, 93084, 93087, 93092, 93095, 93100, 93103).

It includes an overview of the items, model of care, patient eligibility, and links to other guidance and resources.

Overview

All 1 November 2019 eating disorders items:

The eating disorders items define services for which Medicare rebates are payable where service providers undertake assessment and management of patients with a diagnosis of anorexia nervosa and patients with other

specified eating disorder diagnoses who meet the eligibility criteria (see – patient eligibility). It is expected that there will be a multidisciplinary approach to patient management through these items.

The items mean eligible patients are able to receive a Medicare rebate for development of an eating disorders treatment plan by a medical practitioner in general practice (Group A36, subgroup 1), psychiatry or paediatrics (Group A36, subgroup 2). Patients with an eating disorders treatment and management plan (EDP) will be eligible for comprehensive treatment and management services for a 12 month period, including:

- Up to 20 dietetic services under items 10954, 82350, 93074 and 93108.
- Up to 40 eating disorder psychological treatment services (EDPT service).
- Review and ongoing management services to ensure that the patient accesses the appropriate level of intervention (Group A36, subgroup 3).

An EDPT service includes mental health treatment services which are provided by an allied health professional or a medical practitioner in general practice with appropriate mental health training. These treatment services include:

- Medicare mental health treatment services currently provided to patients under the ‘Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS (‘Better Access’) initiative.
 - This includes medical practitioner items 2721, 2723, 2725, 2727, 283, 285, 286, 287, 91818, 91819, 91820, 91821; 91842, 91843, 91844, 91845 and
 - This includes allied health items in Groups M6 and M7 of Category 8; and
- new items for EDPT services provided by suitably trained medical practitioners in general practice (items 90271, 90272, 90273, 90274, 90275, 90276, 90277, 90278, 92182, 92184, 92186 and 92188; 92194, 92196, 92198 and 92200)
- new items for EDPT services provided by eligible clinical psychologists (items 82352-82359, 93076 and 93079), eligible psychologists (items 82360-82367; 93084 and 93087; 93118, 93121), eligible occupational therapists (items 82368-82375; 93092 and 93095; 93126 and 93129) and eligible social workers (items 82376-82383; 93100 and 93103)

For any particular patient, an eating disorder treatment and management plan expires at the end of a 12 month period following provision of that service. After that period, a patient will require a new EDP to continue accessing EDPT services.

Patient Eligibility

The eating disorder items are available to eligible patients in the community. These items do not apply to services provided to admitted (in-hospital) patients.

The referring practitioner is responsible for determining that a patient is eligible for an EDP and therefore EDPT and dietetic services.

‘Eligible patient’ defines the group of patients who can access the new eating disorder services. There are two cohorts of eligible patients.

1. Patients with a clinical diagnosis of anorexia nervosa; or
2. Patients who meet the eligibility criteria (below), and have a clinical diagnosis of any of the following conditions:
 - i. bulimia nervosa;
 - ii. binge-eating disorder;
 - iii. other specified feeding or eating disorder.

The eligibility criteria, for a patient, is:

- a. a person who has been assessed as having an Eating Disorder Examination Questionnaire score of 3 or more; and
- b. the condition is characterised by rapid weight loss, or frequent binge eating or inappropriate compensatory behaviour as manifested by 3 or more occurrences per week; and
- c. a person who has at least two of the following indicators:
 - i. clinically underweight with a body weight less than 85% of expected weight where weight loss is directly attributable to the eating disorder;
 - ii. current or high risk of medical complications due to eating disorder behaviours and symptoms;
 - iii. serious comorbid medical or psychological conditions significantly impacting on medical or psychological health status with impacts on function;
 - iv. the person has been admitted to a hospital for an eating disorder in the previous 12 months;
 - v. inadequate treatment response to evidence based eating disorder treatment over the past six months despite active and consistent participation.

The Eating Disorders Items Stepped Model of Care

The eating disorder items incorporate a ‘stepped model’ for best practice care for eligible patients with eating disorders that comprise:

- assessment and treatment planning
- provision of and/or referral for appropriate evidence based eating disorder specific treatment services by allied mental health professionals and provision of services by dietitians
- review and ongoing management items to ensure that the patient accesses the appropriate level of intervention.

The Stepped Model

‘STEP 1’ – PLANNING (trigger eating disorders pathway) 90250-90257, 92146-92153 and 90260-90261

An eligible patient receives an eating disorder plan (EDP) developed by a medical practitioner in general practice (items 90250-90257 and 92146-92153), psychiatry (items 90260) or paediatrics (items 90261).

‘STEP 2’ – COMMENCE INITIAL COURSE OF TREATMENT (psychological & dietetic services)

Once an eligible patient has an EDP in place, the 12 month period commences, and the patient is eligible for an initial course of treatment up to 20 dietetic services and 10 eating disorder psychological treatment (EDPT) services. A patient will be eligible for an additional 30 EDPT services in the 12 month period, subject to reviews from medical practitioners to determine appropriate intensity of treatment.

‘STEP 3’ – CONTINUE ON INITIAL COURSE OF TREATMENT 90264-90267 (managing practitioner review and progress up to 20 EDPT services)

It is expected that the managing practitioner will be reviewing the patient on a regular, ongoing and as required basis. However, a patient must have a review of the EDP (90264-90267), to assess the patient’s progress against the EDP or update the EDP, before they can access more than 10 EDPT services. This is known as the ‘first review’. The first review should be provided by the patient’s managing practitioner, where possible.

‘STEP 4’ FORMAL SPECIALIST AND PRACTITIONER REVIEW 90266-90267 (continue beyond 20 EDPT services)

A patient must have two additional reviews before they can access more than 20 EDPT services. One review (the ‘second review’) must be performed by a medical practitioner in general practice (who is expected to be the managing practitioner), and the other (the ‘third review’) must be performed by a paediatrician (90267) or psychiatrist (90266). Should both recommend the patient requires more intensive treatment, the patient would be able to access an additional 10 EDPT services in the 12 month period. These reviews are required to determine that the patient has not responded to treatment at the lower intensity levels.

The patient's managing practitioner should be provided with a copy of the specialist review.

The specialist review by the psychiatrist or paediatrician can occur at any point before 20 EDPT services. The practitioner should refer the patient for specialist review as early in the treatment process as appropriate. If the practitioner is of the opinion that the patient should receive more than 20 EDPT services, the referral should occur at the first practitioner review (after the first course of treatment) if it has not been initiated earlier.

Practitioners should be aware that the specialist review can be provided via telehealth. Where appropriate, provision has been made for practitioner participation on the patient-end of the telehealth consultation.

It is expected that the managing practitioner will be reviewing the patient on a regular, ongoing and as required basis. However, a patient must have a review of the EDP (90264-90267), to assess the patient's progress against the EDP or update the EDP, before they can access the next course of treatment.

'STEP 5' ACCESS TO MAXIMUM INTENSITY OF TREATMENT 90266-90267 (continue beyond 30 EDPT services)

To access more than 30 EDPT treatment services in the 12 month period, patients are required to have an additional review (the 'fourth review') to ensure the highest intensity of treatment is appropriate. Subject to this review, a patient could access the maximum of 40 EDPT treatment services in a 12 month period. The fourth review should be provided by the patient's managing practitioner, where possible.

An Integrated Team Approach

A patient's family and/or carers should be involved in the treatment planning and discussions where appropriate. The family can be involved in care options throughout the diagnosis and assessment, and are usually the support unit that help to bridge the gap between initial diagnosis and eating disorder specific treatment.

The National Standards for the safe treatment of eating disorders specify a multi-disciplinary treatment approach that provides coordinated psychological, physical, behavioural, nutritional and functional care to address all aspects of eating disorders. People with eating disorders require integrated inter-professional treatment that is able to work within a framework of shared goals, care plans and client and family information. Frequent communication is required between treatment providers to prevent deterioration in physical and mental health (RANZCP Clinical Guidelines: Hay et al., 2014). Consider regular case conferencing to ensure that the contributing team members are able to work within a shared care plan and with client and carers to achieve best outcomes.

Clinical guidelines and other resources

Eating Disorders Training

It is expected that allied health professionals who are providing services under these items have appropriate training, skills and experience in treatment of patients with eating disorders and meet [the national workforce core competencies](#) for the safe and effective identification of and response to eating disorders. More information is available at [National Eating Disorders Collaboration](#) and [ANZAED](#).

Training Services

Allied health professionals should contact their professional organisation to identify education and training which may assist to practitioners to gain the skills and knowledge to provide services under these items.

The following organisations provide training which may assist practitioners to meet the workforce competency standards:

- The Australia and New Zealand Academy of eating disorders (ANZAED) - National
- InsideOut Institute - National
- The Victorian Centre of Excellence in Eating Disorders (CEED) - VIC
- Queensland Eating Disorder Service (QuEDS) - QLD

- Statewide Eating Disorder Service (SEDS) - SA
- WA Eating Disorders Outreach & Consultation Service (WAEDOCS) – WA

This list is not exhaustive, but has been included to provide examples on the types of training available which may assist practitioners to upskill in this area.

MN.16.2 Eating Disorders Dietetic Treatment Services

Eating Disorders Dietetic Treatment Services (82350, 93074 and 93108)

This note provides information on the Category 8 – Miscellaneous Services: Group M16 – Subgroup 1 (82350, 93074 and 93108) and should be read in conjunction with MN.16.1 Eating Disorders General Explanatory Notes.

Eating Disorder Dietetic Treatment Services Overview

Provision of eating disorder dietetic services by a suitably trained Dietitian (82350, 93074 and 93108) are for patients with anorexia nervosa and other patients with complex presentations of diagnosed eating disorders who meet the eligibility requirements and would benefit from a structured approach to the management of their treatment needs in the community setting.

A patient with an EDP plan can access up to 20 dietetic services under items 10954, 82350, 93074 and 93108 in a 12-month period. For any particular patient, an eating disorder treatment and management plan expires at the end of a 12-month period following provision of that service. After that period, a patient will require a new EDP to continue accessing eating disorders dietetic services.

Provider Eligibility

In order to provide eating disorder dietetic services, Dietitians must be an 'Accredited Practising Dietitian' as recognised by the Dietitians Association of Australia (DAA).

Checking patient eligibility for services

Note: The 12 month period commences from the date of the EDP.

Patients seeking rebates for eating disorders dietetic services must have had an Eating Disorder Treatment Plan (EDP) 90250-90257, 92146-92153, 90260 or 90261 in the previous 12 months. The plan must require that the patient needs dietetic services for treatment of their eating disorder, and the patient must be provided with a referral for access to the dietetic health services.

If the EDP service has not yet been claimed, the Services Australia will not be aware of the patient's eligibility. In this case the allied health professional should, with the patient's permission, contact the practitioner who developed the plan to ensure the relevant service has been provided to the patient.

Support:

If there is any doubt about whether a patient has had a claim for an eating disorder service, health professionals can access the Health Professionals Online System (HPOS). HPOS is a fast and secure way for health professionals and administrators to check if a patient is eligible for a Medicare benefit for a specific item on the date of the proposed service. However, this system will only return advice that the service/item is payable or not payable.

Patients can also access their own claiming history with a My Health Record or by establishing a Medicare online account through myGov or the Express Plus Medicare mobile app.

Alternatively, health professionals can call the Services Australia on 132 150 to check this information, while patients can seek clarification by calling 132 011.

Additional Claiming Information (general conditions and limitations)

Reporting Back

After each course of treatment, the relevant dietitian is required to provide the referring medical practitioner with a written report on assessments carried out, treatment provided and recommendations for future management of the patient's condition. This reporting is required after the first service, as clinically required following subsequent services and after the final service.

This reporting will inform the managing practitioner's reviews of the EDP and enable the practitioner to assess the patient's progress and response to treatment.

Written reports should include, at a minimum:

- any investigations, tests, and/or assessments carried out on the patient;
- any treatment provided; and
- future management of the patient's condition or problem.

The report to the Practitioner must be kept for 2 years from the date of service.

Where appropriate, it is expected that the report will also be provided to the patients and/or the patient's family/carer (with the patient's agreement).

MN.16.3 Eating Disorders Psychological Treatment (EDPT) Services

Eating Disorders Psychological Treatment (EDPT) services (82352, 82354, 82355, 82357-82360, 82362, 82363, 82365-82368, 82370, 82371, 82373-82376, 82378, 82379, 82381-82383)

This note provides information on the Category 8 – Miscellaneous Services: Group M16 – Subgroups 2-5 (82352, 82354, 82355, 82357-82360, 82362, 82363, 82365-82368, 82370, 82371, 82373-82376, 82378, 82379, 82381-82383) and should be read in conjunction with MN.16.1 Eating Disorders General Explanatory Notes.

For the purpose of this note Allied mental health professional is the generic term used to describe providers eligible to provider services under these items, including; clinical psychologists, registered psychologists, eligible accredited mental health social workers and eligible occupational therapists.

Eating Disorder Psychological Treatment (EDPT) Services Overview

Provision of EDPT services by a suitably trained Allied mental health professional (82352, 82354, 82355, 82357-82360, 82362, 82363, 82365-82368, 82370, 82371, 82373-82376, 82378, 82379, 82381-82383) are for patients with anorexia nervosa and other patients with complex presentations of diagnosed eating disorders who meet the eligibility requirements and would benefit from a structured approach to the management of their treatment needs in the community setting.

There are 24 items for the provision of eating disorder specific evidence based psychological treatment services by eligible allied mental health professionals:

- clinical psychologists (item 82352, 82354, 82355, 82357-82359)
- registered psychologists (item 82360, 82362, 82363, 82365-82367)
- occupational therapists (82368, 82370, 82371, 82373- 82375)
- accredited mental health social workers (items 82376, 82378, 82379, 82381-82383)

Psychological Treatment Service

Patients seeking rebates for EDPT services must have had an EDP 90250-90257 or 90260-90261 in the previous 12 Months.

An 'eating disorder psychological treatment service' (EDPT) is defined in the MN.16.1 Eating Disorders General Explanatory Note. For any particular patient, an eating disorder treatment and management plan expires at the end of a 12 month period following provision of that service. After that period, a patient will require a new EDP to continue accessing EDPT services.

Rendering an EDPT item

Who can provide the service

In order to provide EDPT services, the allied mental health professional must be recognised by Services Australia as eligible to provide focussed psychological strategies (FPS) services under the Better Access to Mental Health items (see Provider Eligibility for more information).

What is Involved in an EDPT service

The eating disorder items incorporate a 'stepped model' for best practice care for eligible patients with eating disorders. Under the Eating Disorders Items Stepped Model of Care a course of treatment is defined as 10 eating disorder psychological treatment (EDPT) services. It is required that a patient must have a review (an EDR item in subgroup 3 of A36) after each course of treatment (see MN.16.1 Eating Disorders General Explanatory Notes).

A range of acceptable treatments has been approved for use by practitioners in this context. It is expected that professionals will have the relevant education and training to deliver these services. The approved treatments are:

- Family Based Treatment for Eating Disorders (EDs) (including whole family, Parent Based Therapy, parent only or separated therapy)
- Adolescent Focused Therapy for EDs
- Cognitive Behavioural Therapy (CBT) for EDs (CBT-ED)
- CBT-Anorexia Nervosa (AN) (CBT-AN)
- CBT for Bulimia Nervosa (BN) and Binge-eating Disorder (BED) (CBT-BN and CBT-BED)
- Specialist Supportive Clinical Management (SSCM) for EDs
- Maudsley Model of Anorexia Treatment in Adults (MANTRA)
- Interpersonal Therapy (IPT) for BN, BED
- Dialectical Behavioural Therapy (DBT) for BN, BED
- Focal psychodynamic therapy for EDs

After each course of treatment, the relevant allied mental health professional is required to provide the referring medical practitioner with a written report on assessments carried out, treatment provided and recommendations for future management of the patient's condition. This reporting is required after the first service, as clinically required following subsequent services and after the final service.

This reporting will inform the managing practitioner's reviews of the EDP and enable the practitioner to assess the patient's progress and response to treatment.

Written reports should include, at a minimum:

- any investigations, tests, and/or assessments carried out on the patient;
- any treatment provided; and
- future management of the patient's condition or problem.

The report to the Practitioner must be kept for 2 years from the date of service.

Where appropriate, it is expected that the report will also be provided to the patients and/or the patient's family/carer (with the patient's agreement).

Checking patient eligibility for services

Note: The 12 month period commences from the date of the EDP.

Patients seeking rebates for EDPT services must have had an EDP 90250-90257 or 90260-90261 in the previous 12 Months. The plan must require that the patient needs mental health services for treatment of their eating disorder, and the patient must be provided with a referral for access to the allied health services.

If the EDP service has not yet been claimed, Services Australia will not be aware of the patient's eligibility. In this case the allied health professional should, with the patient's permission, contact the practitioner who developed the plan to ensure the relevant service has been provided to the patient.

Support:

If there is any doubt about whether a patient has had a claim for an eating disorder service, health professionals can access the Health Professionals Online System (HPOS). HPOS is a fast and secure way for health professionals and administrators to check if a patient is eligible for a Medicare benefit for a specific item on the date of the proposed service. However, this system will only return advice that the service/item is payable or not payable.

Patients can also access their own claiming history with a My Health Record or by establishing a Medicare online account through myGov or the Express Plus Medicare mobile app.

Alternatively, health professionals can call Services Australia on 132 150 to check this information, while patients can seek clarification by calling 132 011.

Provider Eligibility

Advice about registering with Services Australia to provide focussed psychological strategies - allied mental health services is available from Services Australia provider inquiry line on 132 150.

Eligible clinical psychologist - [MN.6.4 - Clinical Psychologist Professional Eligibility](#)

Eligible allied health professionals

A person is an allied health professional in relation to the provision of Better Access to Mental Health items if the person meets one of the following requirements:

- a. the person is a psychologist who holds general registration in the health profession of psychology under the applicable law in force in the State or Territory in which the service is provided;
- b. the person is a member of the Australian Association of Social Workers (AASW) and certified by AASW as the meeting the standards for mental health set out in the document published by AASW titled 'Practice Standards for Mental Health Social Workers 2014' as in force on 25 September 2014;
- c. the person:
 - i. is an occupational therapist who is registered with the Australian Health Practitioners Regulatory Agency as a person who can provide that kind of service under the applicable law in force in the State or Territory in which the service is provided; and
 - ii. is accredited by Occupational Therapy Australia as:
 - having a minimum of two years experience in mental health; and
 - having undertaken to observe the standards set out in the document published by Occupational Therapy Australia's 'Australian Competency Standards for Occupational Therapists in Mental Health' as in force on 1 November 2006; and
 - having undertaken to observe the standards set out in the 2018 'Australian Occupational Therapy Competency Standards' published the Occupational Therapy Board of Australia.

Continuing professional development (CPD) for Occupational Therapists and Social Workers providing focussed psychological strategies (FPS) services

Occupational therapists and accredited mental health social workers providing FPS services are required to have completed 10 hours FPS CPD. A CPD year for the purposes of these items is from 1 July to 30 June annually.

Part-time allied mental health professionals are required to have 10 hours of FPS related CPD, the same as full-time allied mental health professionals.

Occupational Therapists and Social Workers who are registered during the course of the CPD year, their obligation to undertake CPD will be on a pro-rata basis. The amount of units will be calculated from the 1st of the month immediately succeeding the month they obtained initial registration. The obligation will be one-twelfth of the yearly requirement for each month.

CPD activities must be relevant to delivering FPS services. Acceptable CPD activities where the content is related to FPS can include formal postgraduate education, workshops, seminars, lectures, journal reading, writing papers, receipt of supervision and peer consultation, and online training.

There is flexibility in the CPD activities that can be undertaken to meet individual professional needs and their practice/client base and client needs. For example, activities could also include assessment and treatment of specific disorders and client types such as youth, or different modalities and delivery such as working with groups.

Additional Claiming Information (general conditions and limitations)

Other than Consultation Room (items 82354, 82357, 82362, 82365, 82370, 82373, 82378, 82381)

It is expected that this service would be provided only for patients who are unable to attend the practice.

MN.16.4 Eating Disorders Services Telehealth

Eating Disorders Services Telehealth – (items 82359, 82367, 82375, 82383; 93075, 93076, 93079, 93084, 93087, 93092, 93095, 93100, 93103; 93108, 93110, 93113, 93118, 93121, 93126, 93129, 93134 and 93137)

This note provides telehealth supporting information for eating disorders items provided via telehealth by a medical practitioner in general practice and should be read in conjunction with Eating Disorders General Explanatory Notes.

Record Keeping

Participating telehealth practitioners must keep contemporaneous notes of the consultation including documenting that the service was performed by video conference, the date, time and the people who participated.

Only clinical details recorded at the time of the attendance count towards the time of the consultation. It does not include information added at a later time, such as reports of investigations.

Aftercare Rule

Video consultations are subject to the same aftercare rules as allied health practitioners providing face-to-face consultations.

Multiple Attendances on the Same Day

In some situations a patient may receive a consultation via video conference and a face-to-face consultation by the same or different clinical psychologist on the same day.

Medicare benefits may be paid for more than one video consultation on a patient on the same day by the same clinical psychologist, provided the second (and any following) video consultations are not a continuation of the initial or earlier video consultations. Clinical psychologists will need to provide the times of each consultation on the patient's account or bulk-billing voucher.

Referrals

The referral procedure for a video consultation is the same as for conventional face-to-face consultations.

MISCELLANEOUS SERVICES ITEMS

M1. MANAGEMENT OF BULK-BILLED SERVICES	1. MANAGEMENT OF GENERAL BULK BILLED SERVICES
Group M1. Management Of Bulk-Billed Services	
Subgroup 1. Management of general bulk billed services	
<p>Fee 10990</p>	<p>A medical service to which an item in this Schedule (other than this item) applies, if:</p> <ul style="list-style-type: none"> (a) the service is an unreferral service; and (b) the service is provided to a person who is: <ul style="list-style-type: none"> (i) under the age of 16; or (ii) a concessional beneficiary; and (c) the person is not an admitted patient of a hospital; and (d) the service is bulk-billed in relation to the fees for: <ul style="list-style-type: none"> (i) this item; and (ii) any other item in this Schedule applying to the service; other than a service associated with a service: (e) to which another item in this Group applies; or (f) that is a general practice support service; or (g) that is a MyMedicare service <p>(See para MN.1.1, MN.1.3 of explanatory notes to this Category)</p> <p>Fee: \$8.40 Benefit: 85% = \$7.15</p>
<p>Fee 10991</p>	<p>A medical service to which an item in this Schedule (other than this item) applies, if:</p> <ul style="list-style-type: none"> (a) the service is an unreferral service; and (b) the service is provided to a person who is: <ul style="list-style-type: none"> (i) under the age of 16; or (ii) a concessional beneficiary; and (c) the person is not an admitted patient of a hospital; and (d) the service is bulk-billed in relation to the fees for: <ul style="list-style-type: none"> (i) this item; and (ii) any other item in this Schedule applying to the service; and (e) the service is provided at, or from, a practice location in a Modified Monash 2 area; other than a service associated with a service: (f) to which another item in this Group applies; or (g) that is a general practice support service; or (h) that is a MyMedicare service <p>(See para MN.1.1, MN.1.4 of explanatory notes to this Category)</p> <p>Fee: \$12.70 Benefit: 85% = \$10.80</p>
<p>Fee 10992</p>	<p>A medical service to which:</p> <ul style="list-style-type: none"> (a) item 585, 588, 591, 594, 599, 600, 5003, 5010, 5220 or 5260 applies; or (b) item 761 or 772 applies (see the Health Insurance (Section 3C General Medical Services – Other Medical Practitioner) Determination 2018); <p>if:</p> <ul style="list-style-type: none"> (c) the service is an unreferral service; and (d) the service is provided to a person who is under the age of 16 or is a concessional beneficiary; and (e) the person is not an admitted patient of a hospital; and

M1. MANAGEMENT OF BULK-BILLED SERVICES

1. MANAGEMENT OF GENERAL BULK BILLED SERVICES

	<p>(f) the service is not provided in consulting rooms; and</p> <p>(g) the service is provided in any of the following areas:</p> <ul style="list-style-type: none"> (i) a Modified Monash 2 area; (ii) a Modified Monash 3 area; (iii) a Modified Monash 4 area; (iv) a Modified Monash 5 area; (v) a Modified Monash 6 area; (vi) a Modified Monash 7 area; and <p>(h) the service is provided by, or on behalf of, a medical practitioner whose practice location is not in an area mentioned in paragraph (g); and</p> <p>(i) the service is bulk-billed in relation to the fees for:</p> <ul style="list-style-type: none"> (i) this item; and (ii) the other item mentioned in paragraph (a) or (b) applying to the service <p>(See para MN.1.1, MN.1.3, MN.1.3 of explanatory notes to this Category) Fee: \$12.70 Benefit: 85% = \$10.80</p>
<p>Fee 75855</p>	<p>A medical service to which an item in this Schedule (other than this item) applies, if:</p> <ul style="list-style-type: none"> (a) the service is an unREFERRED service; and (b) the service is provided to a person who is: <ul style="list-style-type: none"> (i) under the age of 16; or (ii) a concessional beneficiary; and (c) the person is not an admitted patient of a hospital; and (d) the service is bulk-billed in relation to the fees for: <ul style="list-style-type: none"> (i) this item; and (ii) any other item in this Schedule applying to the service; and (e) the service is provided at, or from, a practice location in: <ul style="list-style-type: none"> (i) a Modified Monash 3 area; or (ii) a Modified Monash 4 area; other than a service associated with a service: <ul style="list-style-type: none"> (f) to which another item in this Group applies; or (g) that is a general practice support service; or (h) that is a MyMedicare service <p>(See para MN.1.1, MN.1.5 of explanatory notes to this Category) Fee: \$13.45 Benefit: 85% = \$11.45</p>
<p>Fee 75856</p>	<p>A medical service to which an item in this Schedule (other than this item) applies, if:</p> <ul style="list-style-type: none"> (a) the service is an unREFERRED service; and (b) the service is provided to a person who is: <ul style="list-style-type: none"> (i) under the age of 16; or

M1. MANAGEMENT OF BULK-BILLED SERVICES	1. MANAGEMENT OF GENERAL BULK BILLED SERVICES
	<p>(ii) a concessional beneficiary; and (c) the person is not an admitted patient of a hospital; and (d) the service is bulk-billed in relation to the fees for: (i) this item; and (ii) any other item in this Schedule applying to the service; and (e) the service is provided at, or from, a practice location in a Modified Monash 5 area; other than a service associated with a service: (f) to which another item in this Group applies; or (g) that is a general practice support service; or (h) that is a MyMedicare service</p> <p>(See para MN.1.1, MN.1.6 of explanatory notes to this Category) Fee: \$14.35 Benefit: 85% = \$12.20</p>
Fee 75857	<p>A medical service to which an item in this Schedule (other than this item) applies, if: (a) the service is an unREFERRED service; and (b) the service is provided to a person who is: (i) under the age of 16; or (ii) a concessional beneficiary; and (c) the person is not an admitted patient of a hospital; and (d) the service is bulk-billed in relation to the fees for: (i) this item; and (ii) any other item in this Schedule applying to the service; and (e) the service is provided at, or from, a practice location in a Modified Monash 6 area; other than a service associated with a service: (f) to which another item in this Group applies; or (g) that is a general practice support service; or (h) that is a MyMedicare service</p> <p>(See para MN.1.1, MN.1.7 of explanatory notes to this Category) Fee: \$15.10 Benefit: 85% = \$12.85</p>
Fee 75858	<p>A medical service to which an item in this Schedule (other than this item) applies, if: (a) the service is an unREFERRED service; and (b) the service is provided to a person who is: (i) under the age of 16; or (ii) a concessional beneficiary; and (c) the person is not an admitted patient of a hospital; and (d) the service is bulk-billed in relation to the fees for: (i) this item; and (ii) any other item in this Schedule applying to the service; and (e) the service is provided at, or from, a practice location in a Modified Monash 7 area; other than a service associated with a service: (f) to which another item in this Group applies; or (g) that is a general practice support service; or (h) that is a MyMedicare service</p> <p>(See para MN.1.1, MN.1.8 of explanatory notes to this Category) Fee: \$16.10 Benefit: 85% = \$13.70</p>

M1. MANAGEMENT OF BULK-BILLED SERVICES	2. GENERAL SUPPORT SERVICE
Group M1. Management Of Bulk-Billed Services	

M1. MANAGEMENT OF BULK-BILLED SERVICES

2. GENERAL SUPPORT SERVICE

Subgroup 2. General support service	
Fee 75870	<p>Professional attendance (the attendance service) by a general practitioner, a medical practitioner or a prescribed medical practitioner, at which a general practice support service is provided, if:</p> <ul style="list-style-type: none"> (a) the attendance service is provided to a patient who is under the age of 16 or who is a concessional beneficiary; and (b) the patient is not an admitted patient of a hospital; and (c) the attendance service is bulk-billed in relation to the fees for: <ul style="list-style-type: none"> (i) this item; and (ii) the general practice support service item applying to the attendance service; other than an attendance service associated with a service to which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75871, 75872, 75873, 75874, 75875, 75876, 75880, 75881, 75882, 75883, 75884 or 75885 applies <p>Subgroup 2 NOTE: this item can be claimed with face to face level B, C, D and E general attendance items, and level B telehealth and telephone general attendance items.</p> <p>(See para MN.1.1, MN.1.3 of explanatory notes to this Category) Fee: \$25.10 Benefit: 85% = \$21.35</p>
Fee 75871	<p>Professional attendance (the attendance service) by a general practitioner, a medical practitioner or a prescribed medical practitioner, at which a general practice support service is provided, if:</p> <ul style="list-style-type: none"> (a) the attendance service is provided to a patient who is under the age of 16 or who is a concessional beneficiary; and (b) the patient is not an admitted patient of a hospital; and (c) the attendance service is bulk-billed in relation to the fees for: <ul style="list-style-type: none"> (i) this item; and (ii) the general practice support service item applying to the attendance service; and (d) the attendance service is provided at, or from, a practice location in a Modified Monash 2 area; other than an attendance service associated with a service to which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75870, 75872, 75873, 75874, 75875, 75876, 75880, 75881, 75882, 75883, 75884 or 75885 applies <p>Subgroup 2 NOTE: this item can be claimed with face to face level B, C, D and E general attendance items, and level B telehealth and telephone general attendance items.</p> <p>(See para MN.1.1, MN.1.4 of explanatory notes to this Category) Fee: \$38.20 Benefit: 85% = \$32.50</p>
Fee 75872	<p>Professional attendance (the attendance service) if:</p> <ul style="list-style-type: none"> (a) item 763, 766, 769, 776, 788, 789, 2198, 2200, 5023, 5028, 5043, 5049, 5063, 5067, 5076, 5077, 5223, 5227, 5228, 5261, 5263, 5265, 5267 or 5262 applies; and (b) the attendance service is an unreferral service; and (c) the attendance service is provided to a patient who is under the age of 16 or who is a concessional beneficiary; and (d) the patient is not an admitted patient of a hospital; and (e) the attendance service is not provided in consulting rooms; and (f) the attendance service is provided in any of the following areas: <ul style="list-style-type: none"> (i) a Modified Monash 2 area; (ii) a Modified Monash 3 area; (iii) a Modified Monash 4 area;

M1. MANAGEMENT OF BULK-BILLED SERVICES

2. GENERAL SUPPORT SERVICE

	<p>(iv) a Modified Monash 5 area; (v) a Modified Monash 6 area; (vi) a Modified Monash 7 area; and (g) the attendance service is provided by, or on behalf of, a general practitioner, a medical practitioner or a prescribed medical practitioner whose practice location is not in an area mentioned in paragraph (f); and (h) the attendance service is bulk-billed in relation to the fees for: (i) this item; and (ii) an item mentioned in paragraph (a) that applies to the service</p> <p>(See para MN.1.1, MN.1.3, MN.1.3 of explanatory notes to this Category) Fee: \$38.20 Benefit: 85% = \$32.50</p>
<p>Fee 75873</p>	<p>Professional attendance (the attendance service) by a general practitioner, a medical practitioner or a prescribed medical practitioner, at which a general practice support service is provided, if: (a) the attendance service is provided to a patient who is under the age of 16 or who is a concessional beneficiary; and (b) the patient is not an admitted patient of a hospital; and (c) the attendance service is bulk-billed in relation to the fees for: (i) this item; and (ii) the general practice support service item applying to the attendance service; and (d) the attendance service is provided at, or from, a practice location in: (i) a Modified Monash 3 area; or (ii) a Modified Monash 4 area; other than an attendance service associated with a service to which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75870, 75871, 75872, 75874, 75875, 75876, 75880, 75881, 75882, 75883, 75884 or 75885 applies</p> <p>Subgroup 2 NOTE: this item can be claimed with face to face level B, C, D and E general attendance items, and level B telehealth and telephone general attendance items.</p> <p>(See para MN.1.1, MN.1.5 of explanatory notes to this Category) Fee: \$40.55 Benefit: 85% = \$34.50</p>
<p>Fee 75874</p>	<p>Professional attendance (the attendance service) by a general practitioner, a medical practitioner or a prescribed medical practitioner, at which a general practice support service is provided, if: (a) the attendance service is provided to a patient who is under the age of 16 or who is a concessional beneficiary; and (b) the patient is not an admitted patient of a hospital; and (c) the attendance service is bulk-billed in relation to the fees for: (i) this item; and (ii) the general practice support service item applying to the attendance service; and (d) the attendance service is provided at, or from, a practice location in a Modified Monash 5 area; other than an attendance service associated with a service which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75870, 75871, 75872, 75873, 75875, 75876, 75880, 75881, 75882, 75883, 75884 or 75885 applies</p> <p>Subgroup 2 NOTE: this item can be claimed with face to face level B, C, D and E general attendance items, and level B telehealth and telephone general attendance items.</p> <p>(See para MN.1.1, MN.1.6 of explanatory notes to this Category)</p>

M1. MANAGEMENT OF BULK-BILLED SERVICES		2. GENERAL SUPPORT SERVICE
	Fee: \$43.10	Benefit: 85% = \$36.65
	Professional attendance (the attendance service) by a general practitioner, a medical practitioner or a prescribed medical practitioner, at which a general practice support service is provided, if: <ul style="list-style-type: none"> (a) the attendance service is provided to a patient who is under the age of 16 or who is a concessional beneficiary; and (b) the patient is not an admitted patient of a hospital; and (c) the attendance service is bulk-billed in relation to the fees for: <ul style="list-style-type: none"> (i) this item; and (ii) the general practice support service item applying to the attendance service; and (d) the attendance service is provided at, or from, a practice location in a Modified Monash 6 area; other than an attendance service associated with a service to which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75870, 75871, 75872, 75873, 75874, 75876, 75880, 75881, 75882, 75883, 75884 or 75885 applies Subgroup 2 NOTE: this item can be claimed with face to face level B, C, D and E general attendance items, and level B telehealth and telephone general attendance items.	
Fee 75875	(See para MN.1.1, MN.1.7 of explanatory notes to this Category) Fee: \$45.50 Benefit: 85% = \$38.70	
	Professional attendance (the attendance service) by a general practitioner, a medical practitioner or a prescribed medical practitioner, at which a general practice support service is provided, if: <ul style="list-style-type: none"> (a) the attendance service is provided to a patient who is under the age of 16 or who is a concessional beneficiary; and (b) the patient is not an admitted patient of a hospital; and (c) the attendance service is bulk-billed in relation to the fees for: <ul style="list-style-type: none"> (i) this item; and (ii) the general practice support service item applying to the attendance service; and (d) the attendance service is provided at, or from, a practice location in a Modified Monash 7 area; other than an attendance service associated with a service to which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75870, 75871, 75872, 75873, 75874, 75875, 75880, 75881, 75882, 75883, 75884 or 75885 applies Subgroup 2 NOTE: this item can be claimed with face to face level B, C, D and E general attendance items, and level B telehealth and telephone general attendance items.	
Fee 75876	(See para MN.1.1, MN.1.8 of explanatory notes to this Category) Fee: \$48.30 Benefit: 85% = \$41.10	

M1. MANAGEMENT OF BULK-BILLED SERVICES		3. PATIENTS ENROLLED IN MYMEDICARE
	Group M1. Management Of Bulk-Billed Services	
	Subgroup 3. Patients enrolled in MyMedicare	
Fee 75880	Professional attendance (the attendance service) by a general practitioner, a medical practitioner or a prescribed medical practitioner, at which a MyMedicare service is provided, if: <ul style="list-style-type: none"> (a) the attendance service is provided to a patient: 	

M1. MANAGEMENT OF BULK-BILLED SERVICES

3. PATIENTS ENROLLED IN MYMEDICARE

	<p>(i) who is enrolled in MyMedicare at the general practice through which the attendance service is provided; and (ii) who is under the age of 16 or who is a concessional beneficiary; and (b) the patient is not an admitted patient of a hospital; and (c) the attendance service is bulk-billed in relation to the fees for: (i) this item; and (ii) the MyMedicare service item applying to the attendance service; other than an attendance service associated with a service to which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75870, 75871, 75872, 75873, 75874, 75875, 75876, 75881, 75882, 75883, 75884 or 75885 applies</p> <p>Subgroup 3 NOTE: this item can be claimed with level C, D, and E telehealth general attendance items, and level C and D telephone general attendance items, where the patient is registered with MyMedicare.</p> <p>(See para MN.1.1, MN.1.3 of explanatory notes to this Category) Fee: \$25.10 Benefit: 85% = \$21.35</p>
<p>Fee 75881</p>	<p>Professional attendance (the attendance service) by a general practitioner, a medical practitioner or a prescribed medical practitioner, at which a MyMedicare service is provided, if: (a) the attendance service is provided to a patient: (i) who is enrolled in MyMedicare at the general practice through which the attendance service is provided; and (ii) who is under the age of 16 or who is a concessional beneficiary; and (b) the patient is not an admitted patient of a hospital; and (c) the attendance service is bulk-billed in relation to the fees for: (i) this item; and (ii) the MyMedicare service item applying to the attendance service; and (d) the attendance service is provided at, or from, a practice location in a Modified Monash 2 area; other than an attendance service associated with a service to which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75870, 75871, 75872, 75873, 75874, 75875, 75876, 75880, 75882, 75883, 75884 or 75885 applies</p> <p>Subgroup 3 NOTE: this item can be claimed with level C, D, and E telehealth general attendance items, and level C and D telephone general attendance items, where the patient is registered with MyMedicare.</p> <p>(See para MN.1.1, MN.1.4 of explanatory notes to this Category) Fee: \$38.20 Benefit: 85% = \$32.50</p>
<p>Fee 75882</p>	<p>Professional attendance (the attendance service) by a general practitioner, a medical practitioner or a prescribed medical practitioner, at which a MyMedicare service is provided, if: (a) the attendance service is provided to a patient: (i) who is enrolled in MyMedicare at the general practice through which the attendance service is provided; and (ii) who is under the age of 16 or who is a concessional beneficiary; and (b) the patient is not an admitted patient of a hospital; and (c) the attendance service is bulk-billed in relation to the fees for: (i) this item; and (ii) the MyMedicare service item applying to the attendance service; and (d) the attendance service is provided at, or from, a practice location in: (i) a Modified Monash 3 area; or (ii) a Modified Monash 4 area;</p>

M1. MANAGEMENT OF BULK-BILLED SERVICES

3. PATIENTS ENROLLED IN MYMEDICARE

	<p>other than an attendance service associated with a service to which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75870, 75871, 75872, 75873, 75874, 75875, 75876, 75880, 75881, 75883, 75884 or 75885 applies</p> <p>Subgroup 3 NOTE: this item can be claimed with level C, D, and E telehealth general attendance items, and level C and D telephone general attendance items, where the patient is registered with MyMedicare.</p> <p>(See para MN.1.1, MN.1.5 of explanatory notes to this Category) Fee: \$40.55 Benefit: 85% = \$34.50</p>
<p>Fee 75883</p>	<p>Professional attendance (the attendance service) by a general practitioner, a medical practitioner or a prescribed medical practitioner, at which a MyMedicare service is provided, if: (a) the attendance service is provided to a patient: (i) who is enrolled in MyMedicare at the general practice through which the attendance service is provided; and (ii) who is under the age of 16 or who is a concessional beneficiary; and (b) the patient is not an admitted patient of a hospital; and (c) the attendance service is bulk-billed in relation to the fees for: (i) this item; and (ii) the MyMedicare service item applying to the attendance service; and (d) the attendance service is provided at, or from, a practice location in a Modified Monash 5 area; other than an attendance service associated with a service to which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75870, 75871, 75872, 75873, 75874, 75875, 75876, 75880, 75881, 75882, 75884 or 75885 applies</p> <p>Subgroup 3 NOTE: this item can be claimed with level C, D, and E telehealth general attendance items, and level C and D telephone general attendance items, where the patient is registered with MyMedicare.</p> <p>(See para MN.1.1, MN.1.6 of explanatory notes to this Category) Fee: \$43.10 Benefit: 85% = \$36.65</p>
<p>Fee 75884</p>	<p>Professional attendance (the attendance service) by a general practitioner, a medical practitioner or a prescribed medical practitioner, at which a MyMedicare service is provided, if: (a) the attendance service is provided to a patient: (i) who is enrolled in MyMedicare at the general practice through which the attendance service is provided; and (ii) who is under the age of 16 or who is a concessional beneficiary; and (b) the patient is not an admitted patient of a hospital; and (c) the attendance service is bulk-billed in relation to the fees for: (i) this item; and (ii) the MyMedicare service item applying to the attendance service; and (d) the attendance service is provided at, or from, a practice location in a Modified Monash 6 area; other than an attendance service associated with a service to which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75870, 75871, 75872, 75873, 75874, 75875, 75876, 75880, 75881, 75882, 75883 or 75885 applies</p> <p>Subgroup 3 NOTE: this item can be claimed with level C, D, and E telehealth general attendance items, and level C and D telephone general attendance items, where the patient is registered with MyMedicare.</p>

M1. MANAGEMENT OF BULK-BILLED SERVICES		3. PATIENTS ENROLLED IN MYMEDICARE
	(See para MN.1.1, MN.1.7 of explanatory notes to this Category) Fee: \$45.50 Benefit: 85% = \$38.70	
	<p>Professional attendance (the attendance service) by a general practitioner, a medical practitioner or a prescribed medical practitioner, at which a MyMedicare service is provided, if:</p> <p>(a) the attendance service is provided to a patient:</p> <p>(i) who is enrolled in MyMedicare at the general practice through which the attendance service is provided; and</p> <p>(ii) who is under the age of 16 or who is a concessional beneficiary; and</p> <p>(b) the patient is not an admitted patient of a hospital; and</p> <p>(c) the attendance service is bulk-billed in relation to the fees for:</p> <p>(i) this item; and</p> <p>(ii) the MyMedicare service item applying to the attendance service; and</p> <p>(d) the attendance service is provided at, or from, a practice location in a Modified Monash 7 area; other than an attendance service associated with a service to which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75870, 75871, 75872, 75873, 75874, 75875, 75876, 75880, 75881, 75882, 75883 or 75884 applies</p> <p>Subgroup 3 NOTE: this item can be claimed with level C, D, and E telehealth general attendance items, and level C and D telephone general attendance items, where the patient is registered with MyMedicare.</p>	
Fee 75885	(See para MN.1.1, MN.1.8 of explanatory notes to this Category) Fee: \$48.30 Benefit: 85% = \$41.10	

M3. ALLIED HEALTH SERVICES		1. CHRONIC DISEASE MANAGEMENT SERVICES
	Group M3. Allied Health Services	
	Subgroup 1. Chronic disease management services	
	<p>Aboriginal and Torres Strait Islander health service provided to a patient by an eligible Aboriginal health worker or eligible Aboriginal and Torres Strait Islander health practitioner if:</p> <p>(a) the service is provided to a patient who has:</p> <p>(i) a chronic condition; and</p> <p>(ii) complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the patient is a resident of an aged care facility, the patient's medical practitioner has contributed to a multidisciplinary care plan; and</p> <p>(b) the service is recommended in the patient's Team Care Arrangements or multidisciplinary care plan as part of the management of the patient's chronic condition and complex care needs; and</p> <p>(c) the service is of at least 20 minutes duration;</p> <p>to a maximum of 5 services (including any services to which this item or any other item in this Subgroup or item 93000 or 93013 in the Telehealth and Telephone Determination applies) in a calendar year</p>	
Fee 10950	(See para MN.3.1 of explanatory notes to this Category)	

M3. ALLIED HEALTH SERVICES		1. CHRONIC DISEASE MANAGEMENT SERVICES
	<p>Fee: \$70.95 Benefit: 85% = \$60.35 Extended Medicare Safety Net Cap: \$212.85</p>	
Fee 10951	<p>Diabetes education health service provided to a patient by an eligible diabetes educator if:</p> <p>(a) the service is provided to a patient who has:</p> <p style="padding-left: 40px;">(i) a chronic condition; and</p> <p style="padding-left: 40px;">(ii) complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the patient is a resident of an aged care facility, the patient's medical practitioner has contributed to a multidisciplinary care plan; and</p> <p>(b) the service is recommended in the patient's Team Care Arrangements or multidisciplinary care plan as part of the management of the patient's chronic condition and complex care needs; and</p> <p>(c) the service is of at least 20 minutes duration;</p> <p>to a maximum of 5 services (including any services to which this item or any other item in this Subgroup or item 93000 or 93013 in the Telehealth and Telephone Determination applies) in a calendar year</p> <p>(See para MN.3.1 of explanatory notes to this Category)</p> <p>Fee: \$70.95 Benefit: 85% = \$60.35 Extended Medicare Safety Net Cap: \$212.85</p>	
Fee 10952	<p>Audiology health service provided to a patient by an eligible audiologist if:</p> <p>(a) the service is provided to a patient who has:</p> <p style="padding-left: 40px;">(i) a chronic condition; and</p> <p style="padding-left: 40px;">(ii) complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the patient is a resident of an aged care facility, the patient's medical practitioner has contributed to a multidisciplinary care plan; and</p> <p>(b) the service is recommended in the patient's Team Care Arrangements or multidisciplinary care plan as part of the management of the patient's chronic condition and complex care needs; and</p> <p>(c) the service is of at least 20 minutes duration;</p> <p>to a maximum of 5 services (including any services to which this item or any other item in this Subgroup or item 93000 or 93013 in the Telehealth and Telephone Determination applies) in a calendar year</p> <p>(See para MN.3.1 of explanatory notes to this Category)</p> <p>Fee: \$70.95 Benefit: 85% = \$60.35 Extended Medicare Safety Net Cap: \$212.85</p>	
Fee 10953	<p>Exercise physiology health service provided to a patient by an eligible exercise physiologist if:</p> <p>(a) the service is provided to a patient who has:</p> <p style="padding-left: 40px;">(i) a chronic condition; and</p>	

M3. ALLIED HEALTH SERVICES

1. CHRONIC DISEASE MANAGEMENT SERVICES

	<p>(ii) complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the patient is a resident of an aged care facility, the patient’s medical practitioner has contributed to a multidisciplinary care plan; and</p> <p>(b) the service is recommended in the patient’s Team Care Arrangements or multidisciplinary care plan as part of the management of the patient’s chronic condition and complex care needs; and</p> <p>(c) the service is of at least 20 minutes duration;</p> <p>to a maximum of 5 services (including any services to which this item or any other item in this Subgroup or items 93000 or 93013 in the Telehealth and Telephone Determination applies) in a calendar year</p> <p>(See para MN.3.1 of explanatory notes to this Category) Fee: \$70.95 Benefit: 85% = \$60.35 Extended Medicare Safety Net Cap: \$212.85</p>
<p>Fee 10954</p>	<p>Dietetics health service provided to a patient by an eligible dietitian if:</p> <p>(a) the service is provided to a patient who has:</p> <p style="padding-left: 40px;">(i) a chronic condition; and</p> <p style="padding-left: 40px;">(ii) complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the patient is a resident of an aged care facility, the patient’s medical practitioner has contributed to a multidisciplinary care plan; and</p> <p>(b) the service is recommended in the patient’s Team Care Arrangements or multidisciplinary care plan as part of the management of the patient’s chronic condition and complex care needs; and</p> <p>(c) the service is of at least 20 minutes duration;</p> <p>to a maximum of 5 services (including any services to which this item or any other item in this Subgroup or item 93000 or 93013 in the Telehealth and Telephone Determination applies) in a calendar year</p> <p>(See para MN.3.1 of explanatory notes to this Category) Fee: \$70.95 Benefit: 85% = \$60.35 Extended Medicare Safety Net Cap: \$212.85</p>
<p>Fee 10956</p>	<p>Mental health service provided to a patient by an eligible mental health worker if:</p> <p>(a) the service is provided to a patient who has:</p> <p style="padding-left: 40px;">(i) a chronic condition; and</p> <p style="padding-left: 40px;">(ii) complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the patient is a resident of an aged care facility, the patient’s medical practitioner has contributed to a multidisciplinary care plan; and</p> <p>(b) the service is recommended in the patient’s Team Care Arrangements or multidisciplinary care plan as part of the management of the patient’s chronic condition and complex care needs; and</p>

M3. ALLIED HEALTH SERVICES

1. CHRONIC DISEASE MANAGEMENT SERVICES

	<p>(c) the service is of at least 20 minutes duration;</p> <p>to a maximum of 5 services (including any services to which this item or any other item in this Subgroup or item 93000 or 93013 in the Telehealth and Telephone Determination applies) in a calendar year</p> <p>(See para MN.3.1 of explanatory notes to this Category) Fee: \$70.95 Benefit: 85% = \$60.35 Extended Medicare Safety Net Cap: \$212.85</p>
<p>Fee 10958</p>	<p>Occupational therapy health service provided to a patient by an eligible occupational therapist if:</p> <p>(a) the service is provided to a patient who has:</p> <ul style="list-style-type: none"> (i) a chronic condition; and (ii) complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the patient is a resident of an aged care facility, the patient’s medical practitioner has contributed to a multidisciplinary care plan; and <p>(b) the service is recommended in the patient’s Team Care Arrangements or multidisciplinary care plan as part of the management of the patient’s chronic condition and complex care needs; and</p> <p>(c) the service is of at least 20 minutes duration;</p> <p>to a maximum of 5 services (including any services to which this item or any other item in this Subgroup or item 93000 or 93013 in the Telehealth and Telephone Determination applies) in a calendar year</p> <p>(See para MN.3.1 of explanatory notes to this Category) Fee: \$70.95 Benefit: 85% = \$60.35 Extended Medicare Safety Net Cap: \$212.85</p>
<p>Fee 10960</p>	<p>Physiotherapy health service provided to a patient by an eligible physiotherapist if:</p> <p>(a) the service is provided to a patient who has:</p> <ul style="list-style-type: none"> (i) a chronic condition; and (ii) complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the patient is a resident of an aged care facility, the patient’s medical practitioner has contributed to a multidisciplinary care plan; and <p>(b) the service is recommended in the patient’s Team Care Arrangements or multidisciplinary care plan as part of the management of the patient’s chronic condition and complex care needs; and</p> <p>(c) the service is of at least 20 minutes duration;</p> <p>to a maximum of 5 services (including any services to which this item or any other item in this Subgroup or item 93000 or 93013 in the Telehealth and Telephone Determination applies) in a calendar year</p> <p>(See para MN.3.1 of explanatory notes to this Category) Fee: \$70.95 Benefit: 85% = \$60.35</p>

M3. ALLIED HEALTH SERVICES

1. CHRONIC DISEASE MANAGEMENT SERVICES

	<p>Extended Medicare Safety Net Cap: \$212.85</p>
<p>Fee 10962</p>	<p>Podiatry health service provided to a patient by an eligible podiatrist if:</p> <p>(a) the service is provided to a patient who has:</p> <ul style="list-style-type: none"> (i) a chronic condition; and (ii) complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the patient is a resident of an aged care facility, the patient’s medical practitioner has contributed to a multidisciplinary care plan; and <p>(b) the service is recommended in the patient’s Team Care Arrangements or multidisciplinary care plan as part of the management of the patient’s chronic condition and complex care needs; and</p> <p>(c) the service is of at least 20 minutes duration;</p> <p>to a maximum of 5 services (including any services to which this item or any other item in this Subgroup or item 93000 or 93013 in the Telehealth and Telephone Determination applies) in a calendar year</p> <p>(See para MN.3.1 of explanatory notes to this Category) Fee: \$70.95 Benefit: 85% = \$60.35 Extended Medicare Safety Net Cap: \$212.85</p>
<p>Fee 10964</p>	<p>Chiropractic health service provided to a patient by an eligible chiropractor if:</p> <p>(a) the service is provided to a patient who has:</p> <ul style="list-style-type: none"> (i) a chronic condition; and (ii) complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the patient is a resident of an aged care facility, the patient’s medical practitioner has contributed to a multidisciplinary care plan; and <p>(b) the service is recommended in the patient’s Team Care Arrangements or multidisciplinary care plan as part of the management of the patient’s chronic condition and complex care needs; and</p> <p>(c) the service is of at least 20 minutes duration;</p> <p>to a maximum of 5 services (including any services to which this item or any other item in this Subgroup or item 93000 or 93013 in the Telehealth and Telephone Determination applies) in a calendar year</p> <p>(See para MN.3.1 of explanatory notes to this Category) Fee: \$70.95 Benefit: 85% = \$60.35 Extended Medicare Safety Net Cap: \$212.85</p>
<p>Fee 10966</p>	<p>Osteopathy health service provided to a patient by an eligible osteopath if:</p> <p>(a) the service is provided to a patient who has:</p> <ul style="list-style-type: none"> (i) a chronic condition; and (ii) complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the

M3. ALLIED HEALTH SERVICES

1. CHRONIC DISEASE MANAGEMENT SERVICES

	<p>patient is a resident of an aged care facility, the patient’s medical practitioner has contributed to a multidisciplinary care plan; and</p> <p>(b) the service is recommended in the patient’s Team Care Arrangements or multidisciplinary care plan as part of the management of the patient’s chronic condition and complex care needs; and</p> <p>(c) the service is of at least 20 minutes duration;</p> <p>to a maximum of 5 services (including any services to which this item or any other item in this Subgroup or item 93000 or 93013 in the Telehealth and Telephone Determination applies) in a calendar year</p> <p>(See para MN.3.1 of explanatory notes to this Category) Fee: \$70.95 Benefit: 85% = \$60.35 Extended Medicare Safety Net Cap: \$212.85</p>
<p>Fee 10968</p>	<p>Psychology health service provided to a patient by an eligible psychologist if:</p> <p>(a) the service is provided to a patient who has:</p> <p style="padding-left: 40px;">(i) a chronic condition; and</p> <p style="padding-left: 40px;">(ii) complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the patient is a resident of an aged care facility, the patient’s medical practitioner has contributed to a multidisciplinary care plan; and</p> <p>(b) the service is recommended in the patient’s Team Care Arrangements or multidisciplinary care plan as part of the management of the patient’s chronic condition and complex care needs; and</p> <p>(c) the service is of at least 20 minutes duration;</p> <p>to a maximum of 5 services (including any services to which this item or any other item in this Subgroup or item 93000 or 93013 in the Telehealth and Telephone Determination applies) in a calendar year</p> <p>(See para MN.3.1 of explanatory notes to this Category) Fee: \$70.95 Benefit: 85% = \$60.35 Extended Medicare Safety Net Cap: \$212.85</p>
<p>Fee 10970</p>	<p>Speech pathology health service provided to a patient by an eligible speech pathologist if:</p> <p>(a) the service is provided to a patient who has:</p> <p style="padding-left: 40px;">(i) a chronic condition; and</p> <p style="padding-left: 40px;">(ii) complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the patient is a resident of an aged care facility, the patient’s medical practitioner has contributed to a multidisciplinary care plan; and</p> <p>(b) the service is recommended in the patient’s Team Care Arrangements or multidisciplinary care plan as part of the management of the patient’s chronic condition and complex care needs; and</p> <p>(c) the service is of at least 20 minutes duration;</p>

M3. ALLIED HEALTH SERVICES		1. CHRONIC DISEASE MANAGEMENT SERVICES
	<p>to a maximum of 5 services (including any services to which this item or any other item in this Subgroup or item 93000 or 93013 in the Telehealth and Telephone Determination applies) in a calendar year</p> <p>(See para MN.3.1 of explanatory notes to this Category)</p> <p>Fee: \$70.95 Benefit: 85% = \$60.35 Extended Medicare Safety Net Cap: \$212.85</p>	

M3. ALLIED HEALTH SERVICES		2. CHRONIC DISEASE MANAGEMENT CASE CONFERENCE SERVICES
Group M3. Allied Health Services		
Subgroup 2. Chronic disease management case conference services		
	<p>Attendance by an eligible allied health practitioner, as a member of a multidisciplinary case conference team, to participate in:</p> <p>(a) a community case conference; or</p> <p>(b) a multidisciplinary case conference in a residential aged care facility;</p> <p>if the conference lasts for at least 15 minutes, but for less than 20 minutes (other than a service associated with a service to which another item in this Group applies)</p> <p>(See para MN.3.2 of explanatory notes to this Category)</p> <p>Fee: \$55.65 Benefit: 85% = \$47.35 Extended Medicare Safety Net Cap: \$166.95</p>	
Fee 10955		
	<p>Attendance by an eligible allied health practitioner, as a member of a multidisciplinary case conference team, to participate in:</p> <p>(a) a community case conference; or</p> <p>(b) a multidisciplinary case conference in a residential aged care facility;</p> <p>if the conference lasts for at least 20 minutes, but for less than 40 minutes (other than a service associated with a service to which another item in this Group applies)</p> <p>(See para MN.3.2 of explanatory notes to this Category)</p> <p>Fee: \$95.45 Benefit: 85% = \$81.15 Extended Medicare Safety Net Cap: \$286.35</p>	
Fee 10957		
	<p>Attendance by an eligible allied health practitioner, as a member of a multidisciplinary case conference team, to participate in:</p> <p>(a) a community case conference; or</p> <p>(b) a multidisciplinary case conference in a residential aged care facility;</p> <p>if the conference lasts for at least 40 minutes (other than a service associated with a service to which another item in this Group applies)</p> <p>(See para MN.3.2 of explanatory notes to this Category)</p> <p>Fee: \$158.80 Benefit: 85% = \$135.00 Extended Medicare Safety Net Cap: \$476.40</p>	
Fee 10959		

M6. PSYCHOLOGICAL THERAPY SERVICES		1. PSYCHOLOGICAL THERAPY HEALTH SERVICES
	Group M6. Psychological Therapy Services	
	Subgroup 1. Psychological therapy health services	
Fee 80000	<p>Psychological therapy health service provided to a patient in consulting rooms by an eligible clinical psychologist if:</p> <ul style="list-style-type: none"> (a) the patient is referred by a referring practitioner; and (b) the service is provided to the patient individually and in person; and (c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and (d) on the completion of the course of treatment, the eligible clinical psychologist gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient's condition; and (e) the service is at least 30 minutes but less than 50 minutes duration <p>(See para AN.0.76 of explanatory notes to this Category)</p> <p>Fee: \$113.65 Benefit: 85% = \$96.65 Extended Medicare Safety Net Cap: \$340.95</p>	
Fee 80002	<p>Psychological therapy health service provided in consulting rooms by an eligible clinical psychologist to a person other than the patient, if:</p> <ul style="list-style-type: none"> (a) the service is part of the patient's treatment; (b) the patient has been referred to the eligible clinical psychologist by a referring practitioner; and (c) the service lasts at least 30 minutes but less than 50 minutes <p>(See para MN.6.8 of explanatory notes to this Category)</p> <p>Fee: \$113.65 Benefit: 85% = \$96.65 Extended Medicare Safety Net Cap: \$340.95</p>	
Fee 80005	<p>Psychological therapy health service provided to a patient at a place other than consulting rooms by an eligible clinical psychologist if:</p> <ul style="list-style-type: none"> (a) the patient is referred by a referring practitioner; and (b) the service is provided to the patient individually and in person; and (c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and (d) on the completion of the course of treatment, the eligible clinical psychologist gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient's condition; and (e) the service is at least 30 minutes but less than 50 minutes duration <p>Fee: \$142.05 Benefit: 85% = \$120.75 Extended Medicare Safety Net Cap: \$426.15</p>	

M6. PSYCHOLOGICAL THERAPY SERVICES		1. PSYCHOLOGICAL THERAPY HEALTH SERVICES
Fee 80006	<p>Psychological therapy health service provided at a place other than consulting rooms by an eligible clinical psychologist to a person other than the patient, if:</p> <ul style="list-style-type: none"> (a) the service is part of the patient’s treatment; (b) the patient has been referred to the eligible clinical psychologist by a referring practitioner; and (c) the service lasts at least 30 minutes but less than 50 minutes <p>(See para MN.6.8 of explanatory notes to this Category)</p> <p>Fee: \$142.05 Benefit: 85% = \$120.75 Extended Medicare Safety Net Cap: \$426.15</p>	
Fee 80010	<p>Psychological therapy health service provided to a patient in consulting rooms by an eligible clinical psychologist if:</p> <ul style="list-style-type: none"> (a) the patient is referred by a referring practitioner; and (b) the service is provided to the patient individually and in person; and (c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and (d) on the completion of the course of treatment, the eligible clinical psychologist gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient’s condition; and (e) the service is at least 50 minutes duration <p>(See para MN.6.4, MN.6.2, MN.6.3 of explanatory notes to this Category)</p> <p>Fee: \$166.85 Benefit: 85% = \$141.85 Extended Medicare Safety Net Cap: \$500.00</p>	
Fee 80012	<p>Psychological therapy health service provided in consulting rooms by an eligible clinical psychologist to a person other than the patient, if:</p> <ul style="list-style-type: none"> (a) the service is part of the patient’s treatment; (b) the patient has been referred to the eligible clinical psychologist by a referring practitioner; and (c) the service lasts at least 50 minutes <p>(See para MN.6.8 of explanatory notes to this Category)</p> <p>Fee: \$166.85 Benefit: 85% = \$141.85 Extended Medicare Safety Net Cap: \$500.00</p>	
Fee 80015	<p>Psychological therapy health service provided to a patient at a place other than consulting rooms by an eligible clinical psychologist if:</p> <ul style="list-style-type: none"> (a) the patient is referred by a referring practitioner; and (b) the service is provided to the patient individually and in person; and (c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and 	

M6. PSYCHOLOGICAL THERAPY SERVICES		1. PSYCHOLOGICAL THERAPY HEALTH SERVICES
	<p>(d) on the completion of the course of treatment, the eligible clinical psychologist gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient's condition; and</p> <p>(e) the service is at least 50 minutes duration</p> <p>(See para AN.0.76 of explanatory notes to this Category) Fee: \$195.20 Benefit: 85% = \$165.95 Extended Medicare Safety Net Cap: \$500.00</p>	
Fee 80016	<p>Psychological therapy health service provided at a place other than consulting rooms by an eligible clinical psychologist to a person other than the patient, if:</p> <p>(a) the service is part of the patient's treatment;</p> <p>(b) the patient has been referred to the eligible clinical psychologist by a referring practitioner; and</p> <p>(c) the service lasts at least 50 minutes</p> <p>(See para MN.6.8 of explanatory notes to this Category) Fee: \$195.20 Benefit: 85% = \$165.95 Extended Medicare Safety Net Cap: \$500.00</p>	
Fee 80020	<p>Psychological therapy health service provided to a patient as part of a group of 4 to 10 patients by an eligible clinical psychologist if:</p> <p>(a) the patient is referred by a referring practitioner; and</p> <p>(b) the service is provided in person; and</p> <p>(c) the service is at least 60 minutes duration</p> <p>(See para MN.6.7, AN.0.76 of explanatory notes to this Category) Fee: \$42.35 Benefit: 85% = \$36.00 Extended Medicare Safety Net Cap: \$127.05</p>	
Fee 80021	<p>Psychological therapy health service provided to a patient as part of a group of 4 to 10 patients by an eligible clinical psychologist if:</p> <p>(a) the patient is referred by a referring practitioner; and</p> <p>(b) the attendance is by video conference; and</p> <p>(c) the patient is located within a telehealth eligible area; and</p> <p>(d) the patient is, at the time of the attendance, at least 15 kilometres by road from the clinical psychologist; and</p> <p>(e) the service is at least 60 minutes duration</p> <p>(See para MN.6.7, AN.0.76 of explanatory notes to this Category) Fee: \$42.35 Benefit: 85% = \$36.00 Extended Medicare Safety Net Cap: \$127.05</p>	
Fee 80022	<p>Psychological therapy health service provided to a patient as part of a group of 4 to 10 patients by an eligible clinical psychologist if:</p>	

M6. PSYCHOLOGICAL THERAPY SERVICES		1. PSYCHOLOGICAL THERAPY HEALTH SERVICES
	<p>(a) the patient is referred for a course of treatment by a referring practitioner; and</p> <p>(b) the service is provided in person; and</p> <p>(c) the service is at least 90 minutes duration</p> <p>(See para MN.6.7 of explanatory notes to this Category) Fee: \$57.70 Benefit: 85% = \$49.05 Extended Medicare Safety Net Cap: \$173.10</p>	
Fee 80023	<p>Psychological therapy health service provided to a patient as part of a group of 4 to 10 patients by an eligible clinical psychologist if:</p> <p>(a) the patient is referred by a referring practitioner; and</p> <p>(b) the attendance is by video conference; and</p> <p>(c) the patient is located within a telehealth eligible area; and</p> <p>(d) the patient is, at the time of the attendance, at least 15 kilometres by road from the clinical psychologist; and</p> <p>(e) the service is at least 90 minutes duration</p> <p>(See para MN.6.7 of explanatory notes to this Category) Fee: \$57.70 Benefit: 85% = \$49.05 Extended Medicare Safety Net Cap: \$173.10</p>	
Fee 80024	<p>Psychological therapy health service provided to a patient as part of a group of 4 to 10 patients by an eligible clinical psychologist if:</p> <p>(a) the patient is referred for a course of treatment by a referring practitioner; and</p> <p>(b) the service is provided in person; and</p> <p>(c) the service is at least 120 minutes duration</p> <p>(See para MN.6.7 of explanatory notes to this Category) Fee: \$78.40 Benefit: 85% = \$66.65 Extended Medicare Safety Net Cap: \$235.20</p>	
Fee 80025	<p>Psychological therapy health service provided to a patient as part of a group of 4 to 10 patients by an eligible clinical psychologist if:</p> <p>(a) the patient is referred by a referring practitioner; and</p> <p>(b) the attendance is by video conference; and</p> <p>(c) the patient is located within a telehealth eligible area; and</p> <p>(d) the patient is, at the time of the attendance, at least 15 kilometres by road from the clinical psychologist; and</p> <p>(e) the service is at least 120 minutes duration</p> <p>(See para MN.6.7 of explanatory notes to this Category) Fee: \$78.40 Benefit: 85% = \$66.65</p>	

M6. PSYCHOLOGICAL THERAPY SERVICES	1. PSYCHOLOGICAL THERAPY HEALTH SERVICES
Extended Medicare Safety Net Cap: \$235.20	

M7. FOCUSED PSYCHOLOGICAL STRATEGIES (ALLIED MENTAL HEALTH)	1. FOCUSED PSYCHOLOGICAL STRATEGIES HEALTH SERVICES
Group M7. Focused Psychological Strategies (Allied Mental Health)	
Subgroup 1. Focused psychological strategies health services	
Fee 80100	<p>Focused psychological strategies health service provided to a patient in consulting rooms by an eligible psychologist if:</p> <ul style="list-style-type: none"> (a) the patient is referred by a referring practitioner; and (b) the service is provided to the patient individually and in person; and (c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and (d) on the completion of the course of treatment, the eligible psychologist gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient's condition; and (e) the service is at least 20 minutes but less than 50 minutes duration <p>(See para MN.7.1, AN.0.76 of explanatory notes to this Category) Fee: \$80.55 Benefit: 85% = \$68.50 Extended Medicare Safety Net Cap: \$241.65</p>
Fee 80102	<p>Focused psychological strategies health service provided in consulting rooms by an eligible psychologist to a person other than the patient, if:</p> <ul style="list-style-type: none"> (a) the service is part of the patient's treatment; (b) the patient has been referred to the eligible psychologist by a referring practitioner; and (c) the service lasts at least 20 minutes but less than 50 minutes <p>(See para MN.7.5 of explanatory notes to this Category) Fee: \$80.55 Benefit: 85% = \$68.50 Extended Medicare Safety Net Cap: \$241.65</p>
Fee 80105	<p>Focused psychological strategies health service provided to a patient at a place other than consulting rooms by an eligible psychologist if:</p> <ul style="list-style-type: none"> (a) the patient is referred by a referring practitioner; and (b) the service is provided to the patient individually and in person; and (c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and (d) on the completion of the course of treatment, the eligible psychologist gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient's condition; and

M7. FOCUSED PSYCHOLOGICAL STRATEGIES (ALLIED MENTAL HEALTH)	1. FOCUSED PSYCHOLOGICAL STRATEGIES HEALTH SERVICES
	<p>(e) the service is at least 20 minutes but less than 50 minutes duration</p> <p>(See para MN.7.1 of explanatory notes to this Category) Fee: \$109.55 Benefit: 85% = \$93.15 Extended Medicare Safety Net Cap: \$328.65</p>
Fee 80106	<p>Focused psychological strategies health service provided at a place other than consulting rooms by an eligible psychologist to a person other than the patient, if:</p> <p>(a) the service is part of the patient’s treatment;</p> <p>(b) the patient has been referred to the eligible psychologist by a referring practitioner; and</p> <p>(c) the service lasts at least 20 minutes but less than 50 minutes</p> <p>(See para MN.7.5 of explanatory notes to this Category) Fee: \$109.55 Benefit: 85% = \$93.15 Extended Medicare Safety Net Cap: \$328.65</p>
Fee 80110	<p>Focused psychological strategies health service provided to a patient in consulting rooms by an eligible psychologist if:</p> <p>(a) the patient is referred by a referring practitioner; and</p> <p>(b) the service is provided to the patient individually and in person; and</p> <p>(c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and</p> <p>(d) on the completion of the course of treatment, the eligible psychologist gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient’s condition; and</p> <p>(e) the service is at least 50 minutes duration</p> <p>(See para MN.7.1 of explanatory notes to this Category) Fee: \$113.65 Benefit: 85% = \$96.65 Extended Medicare Safety Net Cap: \$340.95</p>
Fee 80112	<p>Focused psychological strategies health service provided in consulting rooms by an eligible psychologist to a person other than the patient, if:</p> <p>(a) the service is part of the patient’s treatment;</p> <p>(b) the patient has been referred to the eligible psychologist by a referring practitioner; and</p> <p>(c) the service lasts at least 50 minutes</p> <p>(See para MN.7.5 of explanatory notes to this Category) Fee: \$113.65 Benefit: 85% = \$96.65 Extended Medicare Safety Net Cap: \$340.95</p>
Fee 80115	<p>Focused psychological strategies health service provided to a patient at a place other than consulting rooms by an eligible psychologist if:</p> <p>(a) the patient is referred by a referring practitioner; and</p>

M7. FOCUSED PSYCHOLOGICAL STRATEGIES (ALLIED MENTAL HEALTH)	1. FOCUSED PSYCHOLOGICAL STRATEGIES HEALTH SERVICES
	<p>(b) the service is provided to the patient individually and in person; and</p> <p>(c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and</p> <p>(d) on the completion of the course of treatment, the eligible psychologist gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient's condition; and</p> <p>(e) the service is at least 50 minutes duration</p> <p>(See para MN.7.1, AN.0.76 of explanatory notes to this Category) Fee: \$142.75 Benefit: 85% = \$121.35 Extended Medicare Safety Net Cap: \$428.25</p>
Fee 80116	<p>Focused psychological strategies health service provided at a place other than consulting rooms by an eligible psychologist to a person other than the patient, if:</p> <p>(a) the service is part of the patient's treatment;</p> <p>(b) the patient has been referred to the eligible psychologist by a referring practitioner; and</p> <p>(c) the service lasts at least 50 minutes</p> <p>(See para MN.7.5 of explanatory notes to this Category) Fee: \$142.75 Benefit: 85% = \$121.35 Extended Medicare Safety Net Cap: \$428.25</p>
Fee 80120	<p>Focused psychological strategies health service provided to a patient as part of a group of 4 to 10 patients by an eligible psychologist if:</p> <p>(a) the patient is referred by a referring practitioner; and</p> <p>(b) the service is provided in person; and</p> <p>(c) the service is at least 60 minutes duration</p> <p>(See para MN.7.4, AN.0.76 of explanatory notes to this Category) Fee: \$29.00 Benefit: 85% = \$24.65 Extended Medicare Safety Net Cap: \$87.00</p>
Fee 80121	<p>Focused psychological strategies health service provided to a patient as part of a group of 4 to 10 patients by an eligible psychologist if:</p> <p>(a) the patient is referred by a referring practitioner; and</p> <p>(b) the attendance is by video conference; and</p> <p>(c) the patient is located within a telehealth eligible area; and</p> <p>(d) the patient is, at the time of the attendance, at least 15 kilometres by road from the psychologist; and</p> <p>(e) the service is at least 60 minutes duration</p> <p>(See para MN.7.4, AN.0.76 of explanatory notes to this Category) Fee: \$29.00 Benefit: 85% = \$24.65</p>

M7. FOCUSED PSYCHOLOGICAL STRATEGIES (ALLIED MENTAL HEALTH)	1. FOCUSED PSYCHOLOGICAL STRATEGIES HEALTH SERVICES
	Extended Medicare Safety Net Cap: \$87.00
Fee 80122	<p>Focused psychological strategies health service provided to a patient as part of a group of 4 to 10 patients by an eligible psychologist if:</p> <ul style="list-style-type: none"> (a) the patient is referred by a referring practitioner; and (b) the service is provided in person; and (c) the service is at least 90 minutes duration <p>(See para MN.7.4 of explanatory notes to this Category)</p> <p>Fee: \$39.50 Benefit: 85% = \$33.60 Extended Medicare Safety Net Cap: \$118.50</p>
Fee 80123	<p>Focused psychological strategies health service provided to a patient as part of a group of 4 to 10 by an eligible psychologist if:</p> <ul style="list-style-type: none"> (a) the patient is referred by a referring practitioner; and (b) the attendance is by video conference; and (c) the patient is located within a telehealth eligible area; and (d) the patient is, at the time of the attendance, at least 15 kilometres by road from the psychologist; and (e) the service is at least 90 minutes duration <p>(See para MN.7.4 of explanatory notes to this Category)</p> <p>Fee: \$39.50 Benefit: 85% = \$33.60 Extended Medicare Safety Net Cap: \$118.50</p>
Fee 80125	<p>Focused psychological strategies health service provided to a patient in consulting rooms by an eligible occupational therapist if:</p> <ul style="list-style-type: none"> (a) the patient is referred by a referring practitioner; and (b) the service is provided to the patient individually and in person; and (c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and (d) on the completion of the course of treatment, the eligible occupational therapist gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient's condition; and (e) the service is at least 20 minutes but less than 50 minutes duration <p>(See para MN.7.1, AN.0.76 of explanatory notes to this Category)</p> <p>Fee: \$70.95 Benefit: 85% = \$60.35 Extended Medicare Safety Net Cap: \$212.85</p>
Fee 80127	<p>Focused psychological strategies health service provided to a patient as part of a group of 4 to 10 patients by an eligible psychologist if:</p> <ul style="list-style-type: none"> (a) the patient is referred by a referring practitioner; and

M7. FOCUSED PSYCHOLOGICAL STRATEGIES (ALLIED MENTAL HEALTH)	1. FOCUSED PSYCHOLOGICAL STRATEGIES HEALTH SERVICES
	<p>(b) the service is provided in person; and</p> <p>(c) the service is at least 120 minutes duration</p> <p>(See para MN.7.4 of explanatory notes to this Category) Fee: \$53.65 Benefit: 85% = \$45.65 Extended Medicare Safety Net Cap: \$160.95</p>
Fee 80128	<p>Focused psychological strategies health service provided to a patient as part of a group of 4 to 10 patients by an eligible psychologist if:</p> <p>(a) the patient is referred by a referring practitioner; and</p> <p>(b) the attendance is by video conference; and</p> <p>(c) the patient is located within a telehealth eligible area; and</p> <p>(d) the patient is, at the time of the attendance, at least 15 kilometres by road from the psychologist; and</p> <p>(e) the service is at least 120 minutes duration</p> <p>(See para MN.7.4 of explanatory notes to this Category) Fee: \$53.65 Benefit: 85% = \$45.65 Extended Medicare Safety Net Cap: \$160.95</p>
Fee 80129	<p>Focused psychological strategies health service provided in consulting rooms by an eligible occupational therapist to a person other than the patient, if:</p> <p>(a) the service is part of the patient's treatment;</p> <p>(b) the patient has been referred to the eligible occupational therapist by a referring practitioner; and</p> <p>(c) the service lasts at least 20 minutes but less than 50 minutes</p> <p>(See para MN.7.5 of explanatory notes to this Category) Fee: \$70.95 Benefit: 85% = \$60.35 Extended Medicare Safety Net Cap: \$212.85</p>
Fee 80130	<p>Focused psychological strategies health service provided to a patient at a place other than consulting rooms by an eligible occupational therapist if:</p> <p>(a) the patient is referred by a referring practitioner; and</p> <p>(b) the service is provided to the patient individually and in person; and</p> <p>(c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and</p> <p>(d) on the completion of the course of treatment, the eligible occupational therapist gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient's condition; and</p> <p>(e) the service is at least 20 minutes but less than 50 minutes duration</p> <p>(See para MN.7.1 of explanatory notes to this Category) Fee: \$99.95 Benefit: 85% = \$85.00</p>

M7. FOCUSED PSYCHOLOGICAL STRATEGIES (ALLIED MENTAL HEALTH)	1. FOCUSED PSYCHOLOGICAL STRATEGIES HEALTH SERVICES
Fee 80131	<p>Extended Medicare Safety Net Cap: \$299.85</p> <p>Focused psychological strategies health service provided at a place other than consulting rooms by an eligible occupational therapist to a person other than the patient, if:</p> <ul style="list-style-type: none"> (a) the service is part of the patient’s treatment; (b) the patient has been referred to the eligible occupational therapist by a referring practitioner; and (c) the service lasts at least 20 minutes but less than 50 minutes <p>(See para MN.7.5 of explanatory notes to this Category)</p> <p>Fee: \$99.95 Benefit: 85% = \$85.00 Extended Medicare Safety Net Cap: \$299.85</p>
Fee 80135	<p>Focused psychological strategies health service provided to a patient in consulting rooms by an eligible occupational therapist if:</p> <ul style="list-style-type: none"> (a) the patient is referred by a referring practitioner; and (b) the service is provided to the patient individually and in person; and (c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and (d) on the completion of the course of treatment, the eligible occupational therapist gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient’s condition; and (e) the service is at least 50 minutes duration <p>(See para MN.7.1 of explanatory notes to this Category)</p> <p>Fee: \$100.20 Benefit: 85% = \$85.20 Extended Medicare Safety Net Cap: \$300.60</p>
Fee 80137	<p>Focused psychological strategies health service provided in consulting rooms by an eligible occupational therapist to a person other than the patient, if:</p> <ul style="list-style-type: none"> (a) the service is part of the patient’s treatment; (b) the patient has been referred to the eligible occupational therapist by a referring practitioner; and (c) the service lasts at least 50 minutes <p>(See para MN.7.5 of explanatory notes to this Category)</p> <p>Fee: \$100.20 Benefit: 85% = \$85.20 Extended Medicare Safety Net Cap: \$300.60</p>
Fee 80140	<p>Focused psychological strategies health service provided to a patient at a place other than consulting rooms by an eligible occupational therapist if:</p> <ul style="list-style-type: none"> (a) the patient is referred by a referring practitioner; and (b) the service is provided to the patient individually and in person; and (c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and

M7. FOCUSED PSYCHOLOGICAL STRATEGIES (ALLIED MENTAL HEALTH)	1. FOCUSED PSYCHOLOGICAL STRATEGIES HEALTH SERVICES
	<p>(d) on the completion of the course of treatment, the eligible occupational therapist gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient's condition; and</p> <p>(e) the service is at least 50 minutes duration</p> <p>(See para MN.7.1, AN.0.76 of explanatory notes to this Category) Fee: \$129.10 Benefit: 85% = \$109.75 Extended Medicare Safety Net Cap: \$387.30</p>
Fee 80141	<p>Focused psychological strategies health service provided at a place other than consulting rooms by an eligible occupational therapist to a person other than the patient, if:</p> <p>(a) the service is part of the patient's treatment;</p> <p>(b) the patient has been referred to the eligible occupational therapist by a referring practitioner; and</p> <p>(c) the service lasts at least 50 minutes</p> <p>(See para MN.7.5 of explanatory notes to this Category) Fee: \$129.10 Benefit: 85% = \$109.75 Extended Medicare Safety Net Cap: \$387.30</p>
Fee 80145	<p>Focused psychological strategies health service provided to a patient as part of a group of 4 to 10 patients by an eligible occupational therapist if:</p> <p>(a) the patient is referred by a referring practitioner; and</p> <p>(b) the service is provided in person; and</p> <p>(c) the service is at least 60 minutes duration</p> <p>(See para MN.7.4, AN.0.76 of explanatory notes to this Category) Fee: \$25.40 Benefit: 85% = \$21.60 Extended Medicare Safety Net Cap: \$76.20</p>
Fee 80146	<p>Focused psychological strategies health service provided to a patient as part of a group of 4 to 10 patients by an eligible occupational therapist if:</p> <p>(a) the patient is referred by a referring practitioner; and</p> <p>(b) the attendance is by video conference; and</p> <p>(c) the patient is located within a telehealth eligible area; and</p> <p>(d) the patient is, at the time of the attendance, at least 15 kilometres by road from the occupational therapist; and</p> <p>(e) the service is at least 60 minutes duration</p> <p>(See para MN.7.4, AN.0.76 of explanatory notes to this Category) Fee: \$25.40 Benefit: 85% = \$21.60 Extended Medicare Safety Net Cap: \$76.20</p>
Fee 80147	<p>Focused psychological strategies health service provided to a patient as part of a group of 4 to 10 patients by an eligible occupational therapist if:</p>

M7. FOCUSED PSYCHOLOGICAL STRATEGIES (ALLIED MENTAL HEALTH)	1. FOCUSED PSYCHOLOGICAL STRATEGIES HEALTH SERVICES
	<p>(a) the patient is referred by a referring practitioner; and</p> <p>(b) the service is provided in person; and</p> <p>(c) the service is at least 90 minutes duration</p> <p>(See para MN.7.4 of explanatory notes to this Category) Fee: \$34.55 Benefit: 85% = \$29.40 Extended Medicare Safety Net Cap: \$103.65</p>
Fee 80148	<p>Focused psychological strategies health service provided to a patient as part of a group of 4 to 10 patients by an eligible occupational therapist if:</p> <p>(a) the patient is referred by a referring practitioner; and</p> <p>(b) the attendance is by video conference; and</p> <p>(c) the patient is located within a telehealth eligible area; and</p> <p>(d) the patient is, at the time of the attendance, at least 15 kilometres by road from the occupational therapist; and</p> <p>(e) the service is at least 90 minutes duration</p> <p>(See para MN.7.4 of explanatory notes to this Category) Fee: \$34.55 Benefit: 85% = \$29.40 Extended Medicare Safety Net Cap: \$103.65</p>
Fee 80150	<p>Focused psychological strategies health service provided to a patient in consulting rooms by an eligible social worker if:</p> <p>(a) the patient is referred by a referring practitioner; and</p> <p>(b) the service is provided to the patient individually and in person; and</p> <p>(c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and</p> <p>(d) on the completion of the course of treatment, the eligible social worker gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient's condition; and</p> <p>(e) the service is at least 20 minutes but less than 50 minutes duration</p> <p>(See para MN.7.1, AN.0.76 of explanatory notes to this Category) Fee: \$70.95 Benefit: 85% = \$60.35 Extended Medicare Safety Net Cap: \$212.85</p>
Fee 80152	<p>Focused psychological strategies health service provided to a patient as part of a group of 4 to 10 patients by an eligible occupational therapist if:</p> <p>(a) the patient is referred by a referring practitioner; and</p> <p>(b) the service is provided in person; and</p> <p>(c) the service is at least 120 minutes duration</p>

M7. FOCUSED PSYCHOLOGICAL STRATEGIES (ALLIED MENTAL HEALTH)	1. FOCUSED PSYCHOLOGICAL STRATEGIES HEALTH SERVICES
	<p>(See para MN.7.4 of explanatory notes to this Category) Fee: \$47.10 Benefit: 85% = \$40.05 Extended Medicare Safety Net Cap: \$141.30</p>
Fee 80153	<p>Focused psychological strategies health service provided to a patient as part of a group of 4 to 10 patients by an eligible occupational therapist if:</p> <ul style="list-style-type: none"> (a) the patient is referred by a referring practitioner; and (b) the attendance is by video conference; and (c) the patient is located within a telehealth eligible area; and (d) the patient is, at the time of the attendance, at least 15 kilometres by road from the occupational therapist; and (e) the service is at least 120 minutes duration <p>(See para MN.7.4 of explanatory notes to this Category) Fee: \$47.10 Benefit: 85% = \$40.05 Extended Medicare Safety Net Cap: \$141.30</p>
Fee 80154	<p>Focused psychological strategies health service provided in consulting rooms by an eligible social worker to a person other than the patient, if:</p> <ul style="list-style-type: none"> (a) the service is part of the patient's treatment; (b) the patient has been referred to the eligible social worker by a referring practitioner; and (c) the service lasts at least 20 minutes but less than 50 minutes <p>(See para MN.7.5 of explanatory notes to this Category) Fee: \$70.95 Benefit: 85% = \$60.35 Extended Medicare Safety Net Cap: \$212.85</p>
Fee 80155	<p>Focused psychological strategies health service provided to a patient at a place other than consulting rooms by an eligible social worker if:</p> <ul style="list-style-type: none"> (a) the patient is referred by a referring practitioner; and (b) the service is provided to the patient individually and in person; and (c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and (d) on the completion of the course of treatment, the eligible social worker gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient's condition; and (e) the service is at least 20 minutes but less than 50 minutes duration <p>(See para MN.7.1 of explanatory notes to this Category) Fee: \$99.95 Benefit: 85% = \$85.00 Extended Medicare Safety Net Cap: \$299.85</p>
Fee 80156	<p>Focused psychological strategies health service provided at a place other than consulting rooms by an eligible social worker to a person other than the patient, if:</p>

M7. FOCUSED PSYCHOLOGICAL STRATEGIES (ALLIED MENTAL HEALTH)	1. FOCUSED PSYCHOLOGICAL STRATEGIES HEALTH SERVICES
	<p>(a) the service is part of the patient's treatment;</p> <p>(b) the patient has been referred to the eligible social worker by a referring practitioner; and</p> <p>(c) the service lasts at least 20 minutes but less than 50 minutes</p> <p>(See para MN.7.5 of explanatory notes to this Category) Fee: \$99.95 Benefit: 85% = \$85.00 Extended Medicare Safety Net Cap: \$299.85</p>
Fee 80160	<p>Focused psychological strategies health service provided to a patient in consulting rooms by an eligible social worker if:</p> <p>(a) the patient is referred by a referring practitioner; and</p> <p>(b) the service is provided to the patient individually and in person; and</p> <p>(c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and</p> <p>(d) on the completion of the course of treatment, the eligible social worker gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient's condition; and</p> <p>(e) the service is at least 50 minutes duration</p> <p>(See para MN.7.1 of explanatory notes to this Category) Fee: \$100.20 Benefit: 85% = \$85.20 Extended Medicare Safety Net Cap: \$300.60</p>
Fee 80162	<p>Focused psychological strategies health service provided in consulting rooms by an eligible social worker to a person other than the patient, if:</p> <p>(a) the service is part of the patient's treatment;</p> <p>(b) the patient has been referred to the eligible social worker by a referring practitioner; and</p> <p>(c) the service lasts at least 50 minutes</p> <p>(See para MN.7.5 of explanatory notes to this Category) Fee: \$100.20 Benefit: 85% = \$85.20 Extended Medicare Safety Net Cap: \$300.60</p>
Fee 80165	<p>Focused psychological strategies health service provided to a patient at a place other than consulting rooms by an eligible social worker if:</p> <p>(a) the patient is referred by a referring practitioner; and</p> <p>(b) the service is provided to the patient individually and in person; and</p> <p>(c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and</p> <p>(d) on the completion of the course of treatment, the eligible social worker gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient's condition; and</p>

M7. FOCUSED PSYCHOLOGICAL STRATEGIES (ALLIED MENTAL HEALTH)	1. FOCUSED PSYCHOLOGICAL STRATEGIES HEALTH SERVICES
	<p>(e) the service is at least 50 minutes duration</p> <p>(See para MN.7.1, AN.0.76 of explanatory notes to this Category) Fee: \$129.10 Benefit: 85% = \$109.75 Extended Medicare Safety Net Cap: \$387.30</p>
Fee 80166	<p>Focused psychological strategies health service provided at a place other than consulting rooms by an eligible social worker to a person other than the patient, if:</p> <p>(a) the service is part of the patient’s treatment;</p> <p>(b) the patient has been referred to the eligible social worker by a referring practitioner; and</p> <p>(c) the service lasts at least 50 minutes</p> <p>(See para MN.7.5 of explanatory notes to this Category) Fee: \$129.10 Benefit: 85% = \$109.75 Extended Medicare Safety Net Cap: \$387.30</p>
Fee 80170	<p>Focused psychological strategies health service provided to a patient as part of a group of 4 to 10 patients by an eligible social worker if:</p> <p>(a) the patient is referred by referring practitioner; and</p> <p>(b) the service is provided in person; and</p> <p>(c) the service is at least 60 minutes duration</p> <p>(See para MN.7.4, AN.0.76 of explanatory notes to this Category) Fee: \$25.40 Benefit: 85% = \$21.60 Extended Medicare Safety Net Cap: \$76.20</p>
Fee 80171	<p>Focused psychological strategies health service provided to a patient as part of a group of 4 to 10 patients by an eligible social worker if:</p> <p>(a) the patient is referred by a referring practitioner; and</p> <p>(b) the attendance is by video conference; and</p> <p>(c) the patient is located within a telehealth eligible area; and</p> <p>(d) the patient is, at the time of the attendance, at least 15 kilometres by road from the social worker; and</p> <p>(e) the service is at least 60 minutes duration</p> <p>(See para MN.7.4, AN.0.76 of explanatory notes to this Category) Fee: \$25.40 Benefit: 85% = \$21.60 Extended Medicare Safety Net Cap: \$76.20</p>
Fee 80172	<p>Focused psychological strategies health service provided to a patient as part of a group of 4 to 10 patients by an eligible social worker if:</p> <p>(a) the patient is referred by a referring practitioner; and</p> <p>(b) the service is provided in person; and</p>

M7. FOCUSED PSYCHOLOGICAL STRATEGIES (ALLIED MENTAL HEALTH)	1. FOCUSED PSYCHOLOGICAL STRATEGIES HEALTH SERVICES
	<p>(c) the service is at least 90 minutes duration</p> <p>(See para MN.7.4 of explanatory notes to this Category) Fee: \$34.55 Benefit: 85% = \$29.40 Extended Medicare Safety Net Cap: \$103.65</p>
Fee 80173	<p>Focused psychological strategies health service provided to a patient as part of a group of 4 to 10 patients by an eligible social worker if:</p> <p>(a) the patient is referred by a referring practitioner; and</p> <p>(b) the attendance is by video conference; and</p> <p>(c) the patient is located within a telehealth eligible area; and</p> <p>(d) the patient is, at the time of the attendance, at least 15 kilometres by road from the social worker; and</p> <p>(e) the service is at least 90 minutes duration</p> <p>(See para MN.7.4 of explanatory notes to this Category) Fee: \$34.55 Benefit: 85% = \$29.40 Extended Medicare Safety Net Cap: \$103.65</p>
Fee 80174	<p>Focused psychological strategies health service provided to a patient as part of a group of 4 to 10 patients by an eligible social worker if:</p> <p>(a) the patient is referred by a referring practitioner; and</p> <p>(b) the service is provided in person; and</p> <p>(c) the service is at least 120 minutes duration</p> <p>(See para MN.7.4 of explanatory notes to this Category) Fee: \$47.10 Benefit: 85% = \$40.05 Extended Medicare Safety Net Cap: \$141.30</p>
Fee 80175	<p>Focused psychological strategies health service provided to a patient as part of a group of 4 to 10 patients by an eligible social worker if:</p> <p>(a) the patient is referred by a referring practitioner; and</p> <p>(b) the attendance is by video conference; and</p> <p>(c) the patient is located within a telehealth eligible area; and</p> <p>(d) the patient is, at the time of the attendance, at least 15 kilometres by road from the social worker; and</p> <p>(e) the service is at least 120 minutes duration</p> <p>(See para MN.7.4 of explanatory notes to this Category) Fee: \$47.10 Benefit: 85% = \$40.05 Extended Medicare Safety Net Cap: \$141.30</p>

M7. FOCUSED PSYCHOLOGICAL STRATEGIES (ALLIED MENTAL HEALTH)		2. PSYCHOLOGICAL THERAPY HEALTH, FOCUSED PSYCHOLOGICAL STRATEGIES HEALTH AND EATING DISORDER CASE CONFERENCE SERVICES
	Group M7. Focused Psychological Strategies (Allied Mental Health)	
	Subgroup 2. Psychological therapy health, focused psychological strategies health and eating disorder case conference services	
Fee 80176	<p>Attendance by an eligible allied health practitioner, as a member of a multidisciplinary case conference team, to participate in a mental health case conference if the conference lasts for at least 15 minutes, but for less than 20 minutes</p> <p>(See para MN.7.6 of explanatory notes to this Category)</p> <p>Fee: \$55.65 Benefit: 85% = \$47.35 Extended Medicare Safety Net Cap: \$166.95</p>	
Fee 80177	<p>Attendance by an eligible allied health practitioner, as a member of a multidisciplinary case conference team, to participate in a mental health case conference if the conference lasts for at least 20 minutes, but for less than 40 minutes</p> <p>(See para MN.7.6 of explanatory notes to this Category)</p> <p>Fee: \$95.45 Benefit: 85% = \$81.15 Extended Medicare Safety Net Cap: \$286.35</p>	
Fee 80178	<p>Attendance by an eligible allied health practitioner, as a member of a multidisciplinary case conference team, to participate in a mental health case conference if the conference lasts for at least 40 minutes</p> <p>(See para MN.7.6 of explanatory notes to this Category)</p> <p>Fee: \$158.80 Benefit: 85% = \$135.00 Extended Medicare Safety Net Cap: \$476.40</p>	

M8. PREGNANCY SUPPORT COUNSELLING	
	Group M8. Pregnancy Support Counselling
Fee 81000	<p>Non-directive pregnancy support counselling health service provided to a patient who is currently pregnant or who has been pregnant in the preceding 12 months, by an eligible psychologist if:</p> <p>(a) the patient is concerned about a current pregnancy or a pregnancy that occurred in the 12 months preceding the provision of the first service; and</p> <p>(b) the patient is referred by a medical practitioner who is not a specialist or consultant physician; and</p> <p>(c) the eligible psychologist does not have a direct pecuniary interest in a health service that has as its primary purpose the provision of services for pregnancy termination; and</p> <p>(d) the service is at least 30 minutes duration;</p> <p>to a maximum of 3 services (including services to which items 81000, 81005 or 81010, items 792 or 4001 in the general medical services table, or items 92136, 92138, 93026, 93029, 92137 or 92139 in the Telehealth and Telephone Determination apply) for each pregnancy</p> <p>(See para MN.8.3, MN.8.2, MN.8.1, MN.8.4 of explanatory notes to this Category)</p> <p>Fee: \$83.30 Benefit: 85% = \$70.85 Extended Medicare Safety Net Cap: \$249.90</p>

M8. PREGNANCY SUPPORT COUNSELLING	
Fee 81005	<p>Non-directive pregnancy support counselling health service provided to a patient, who is currently pregnant or who has been pregnant in the preceding 12 months, by an eligible social worker if:</p> <ul style="list-style-type: none"> (a) the patient is concerned about a current pregnancy or a pregnancy that occurred in the 12 months preceding the provision of the first service; and (b) the patient is referred by a medical practitioner who is not a specialist or consultant physician; and (c) the eligible social worker does not have a direct pecuniary interest in a health service that has as its primary purpose the provision of services for pregnancy termination; and (d) the service is at least 30 minutes duration; <p>to a maximum of 3 services (including services to which items 81000, 81005 or 81010, items 792 or 4001 in the general medical services table, or items 92136, 92138, 93026, 93029, 92137 or 92139 in the Telehealth and Telephone Determination apply) for each pregnancy</p> <p>(See para MN.8.3, MN.8.2, MN.8.1, MN.8.4 of explanatory notes to this Category)</p> <p>Fee: \$83.30 Benefit: 85% = \$70.85 Extended Medicare Safety Net Cap: \$249.90</p>
Fee 81010	<p>Non-directive pregnancy support counselling health service provided to a patient, who is currently pregnant or who has been pregnant in the preceding 12 months, by an eligible mental health nurse if:</p> <ul style="list-style-type: none"> (a) the patient is concerned about a current pregnancy or a pregnancy that occurred in the 12 months preceding the provision of the first service; and (b) the patient is referred by a medical practitioner who is not a specialist or consultant physician; and (c) the eligible mental health nurse does not have a direct pecuniary interest in a health service that has as its primary purpose the provision of services for pregnancy termination; and (d) the service is at least 30 minutes duration; <p>to a maximum of 3 services (including services to which items 81000, 81005 or 81010, items 792 or 4001 in the general medical services table, or items 92136, 92138, 93026, 93029, 92137 or 92139 in the Telehealth and Telephone Determination apply) for each pregnancy</p> <p>(See para MN.8.3, MN.8.2, MN.8.1, MN.8.4 of explanatory notes to this Category)</p> <p>Fee: \$83.30 Benefit: 85% = \$70.85 Extended Medicare Safety Net Cap: \$249.90</p>

M9. ALLIED HEALTH GROUP SERVICES		1. DIABETES EDUCATION SERVICES
	Group M9. Allied Health Group Services	
	Subgroup 1. Diabetes education services	
Fee 81100	<p>Diabetes education health service provided to a patient by an eligible diabetes educator for assessing the patient's suitability for group services for the management of type 2 diabetes, including taking a comprehensive patient history, identifying an appropriate group services program based on the patient's needs and preparing the patient for the group services if:</p> <ul style="list-style-type: none"> (a) the patient has type 2 diabetes; and 	

M9. ALLIED HEALTH GROUP SERVICES	1. DIABETES EDUCATION SERVICES
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	<p>(b) the patient is being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under a GP Management Plan or, if the patient is a resident of an aged care facility, the patient’s medical practitioner has contributed to a multidisciplinary care plan; and</p> <p>(c) the patient is referred to an eligible diabetes educator by the medical practitioner using a referral form that has been issued by the Department, or a referral form that contains all the components of the form issued by the Department; and</p> <p>(d) the service is provided to the patient individually and in person; and</p> <p>(e) the service is of at least 45 minutes duration; and</p> <p>(f) after the service, the eligible diabetes educator gives a written report to the referring medical practitioner mentioned in paragraph (c);</p> <p>payable once in a calendar year for this or any other assessment for group services item (including services in items 81100, 81110 and 81120 or items 93284 or 93286 of the Telehealth and Telephone Determination)</p> <p>(See para MN.9.6, MN.9.2, MN.9.3, MN.9.4, MN.9.1 of explanatory notes to this Category)</p> <p>Fee: \$91.05 Benefit: 85% = \$77.40 Extended Medicare Safety Net Cap: \$273.15</p>
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	<p>Diabetes education health service provided to a patient by an eligible diabetes educator, as a group service for the management of type 2 diabetes if:</p> <p>(a) the patient has been assessed as suitable for a type 2 diabetes group service under assessment item 81100, 81110 or 81120 or items 93284 or 93286 of the Telehealth and Telephone Determination; and</p> <p>(b) the service is provided to a patient who is part of a group of between 2 and 12 patients; and</p> <p>(c) the service is provided in person; and</p> <p>(d) the service is of at least 60 minutes duration; and</p> <p>(e) after the last service in the group services program provided to the patient under item 81105, 81115 or 81125 or item 93285 of the Telehealth and Telephone Determination, the eligible diabetes educator prepares, or contributes to, a written report to be provided to the referring medical practitioner; and</p> <p>(f) an attendance record for the group is maintained by the eligible diabetes educator;</p> <p>to a maximum of 8 group services in a calendar year (including services in items 81105, 81115 and 81125 or item 93285 of the Telehealth and Telephone Determination)</p> <p>(See para MN.9.6, MN.9.5, MN.9.3, MN.9.1 of explanatory notes to this Category)</p> <p>Fee: \$22.65 Benefit: 85% = \$19.30 Extended Medicare Safety Net Cap: \$67.95</p>
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Fee
81105

M9. ALLIED HEALTH GROUP SERVICES	2. EXERCISE PHYSIOLOGY SERVICES
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	Group M9. Allied Health Group Services
	Subgroup 2. Exercise physiology services

M9. ALLIED HEALTH GROUP SERVICES

2. EXERCISE PHYSIOLOGY SERVICES

<p>Fee 81110</p>	<p>Exercise physiology health service provided to a person by an eligible exercise physiologist for assessing the person’s suitability for group services for the management of type 2 diabetes, including taking a comprehensive patient history, identifying an appropriate group services program based on the patient’s needs and preparing the person for the group services if:</p> <ul style="list-style-type: none"> (a) the person has type 2 diabetes; and (b) the person is being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under a GP Management Plan or, if the person is a resident of an aged care facility, the person’s medical practitioner has contributed to a multidisciplinary care plan; and (c) the person is referred to an eligible exercise physiologist by the medical practitioner using a referral form that has been issued by the Department, or a referral form that contains all the components of the form issued by the Department; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 45 minutes duration; and (f) after the service, the eligible exercise physiologist gives a written report to the referring medical practitioner mentioned in paragraph (c); <p>payable once in a calendar year for this or any other assessment for group services item (including services in items 81100, 81110 and 81120 or items 93284 or 93286 of the Telehealth and Telephone Determination)</p> <p>(See para MN.9.6, MN.9.2, MN.9.3, MN.9.4, MN.9.1 of explanatory notes to this Category)</p> <p>Fee: \$91.05 Benefit: 85% = \$77.40 Extended Medicare Safety Net Cap: \$273.15</p>
<p>Fee 81115</p>	<p>Exercise physiology health service provided to a person by an eligible exercise physiologist, as a group service for the management of type 2 diabetes if:</p> <ul style="list-style-type: none"> (a) the person has been assessed as suitable for a type 2 diabetes group service under assessment item 81100, 81110 or 81120 or items 93284 or 93286 of the Telehealth and Telephone Determination; and (b) the service is provided to a person who is part of a group of between 2 and 12 patients; and (c) the service is provided in person; and (d) the service is of at least 60 minutes duration; and (e) after the last service in the group services program provided to the person under item 81105, 81115 or 81125 or item 93285 of the Telehealth and Telephone Determination, the eligible exercise physiologist prepares, or contributes to, a written report to be provided to the referring medical practitioner; and (f) an attendance record for the group is maintained by the eligible exercise physiologist; <p>to a maximum of 8 group services in a calendar year (including services in items 81105, 81115 and 81125 or item 93285 of the Telehealth and Telephone Determination)</p> <p>(See para MN.9.6, MN.9.5, MN.9.3, MN.9.1 of explanatory notes to this Category)</p> <p>Fee: \$22.65 Benefit: 85% = \$19.30 Extended Medicare Safety Net Cap: \$67.95</p>

M9. ALLIED HEALTH GROUP SERVICES		3. DIETETICS SERVICES
	Group M9. Allied Health Group Services	
	Subgroup 3. Dietetics services	
	<p>Dietetics health service provided to a person by an eligible dietitian for assessing the person's suitability for group services for the management of type 2 diabetes, including taking a comprehensive patient history, identifying an appropriate group services program based on the patient's needs and preparing the person for the group services if:</p> <p>(a) the person has type 2 diabetes; and</p> <p>(b) the person is being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under a GP Management Plan or, if the person is a resident of an aged care facility, the person's medical practitioner has contributed to a multidisciplinary care plan; and</p> <p>(c) the person is referred to an eligible dietitian by the medical practitioner using a referral form that has been issued by the Department, or a referral form that contains all the components of the form issued by the Department; and</p> <p>(d) the service is provided to the person individually and in person; and</p> <p>(e) the service is of at least 45 minutes duration; and</p> <p>(f) after the service, the eligible dietitian gives a written report to the referring medical practitioner mentioned in paragraph (c);</p> <p>payable once in a calendar year for this or any other assessment for group services item (including services in items 81100, 81110 and 81120 or items 93284 or 93286 of the Telehealth and Telephone Determination)</p> <p>(See para MN.9.6, MN.9.2, MN.9.3, MN.9.4, MN.9.1 of explanatory notes to this Category)</p>	
Fee 81120	<p>Fee: \$91.05 Benefit: 85% = \$77.40 Extended Medicare Safety Net Cap: \$273.15</p>	
	<p>Dietetics health service provided to a person by an eligible dietitian, as a group service for the management of type 2 diabetes if:</p> <p>(a) the person has been assessed as suitable for a type 2 diabetes group service under assessment item 81100, 81110 or 81120 or items 93284 or 93286 of the Telehealth and Telephone Determination; and</p> <p>(b) the service is provided to a person who is part of a group of between 2 and 12 patients; and</p> <p>(c) the service is provided in person; and</p> <p>(d) the service is of at least 60 minutes duration; and</p> <p>(e) after the last service in the group services program provided to the person under item 81105, 81115 or 81125 or item 93285 of the Telehealth and Telephone Determination, the eligible dietitian prepares, or contributes to, a written report to be provided to the referring medical practitioner; and</p> <p>(f) an attendance record for the group is maintained by the eligible dietitian;</p> <p>to a maximum of 8 group services in a calendar year (including services to which items 81105, 81115 and 81125 or item 93285 of the Telehealth and Telephone Determination apply)</p>	
Fee 81125		

M9. ALLIED HEALTH GROUP SERVICES	3. DIETETICS SERVICES
(See para MN.9.6, MN.9.5, MN.9.3, MN.9.1 of explanatory notes to this Category)	
Fee: \$22.65 Benefit: 85% = \$19.30	
Extended Medicare Safety Net Cap: \$67.95	

M10. COMPLEX NEURODEVELOPMENTAL DISORDER AND DISABILITY SERVICES	1. COMPLEX NEURODEVELOPMENTAL DISORDER AND DISABILITY
Group M10. Complex neurodevelopmental disorder and disability services	
Subgroup 1. Complex neurodevelopmental disorder and disability	
Psychology health service provided to a patient aged under 25 years by an eligible psychologist if:	
(a) the patient was referred by an eligible medical practitioner, or by an eligible allied health practitioner following referral by an eligible medical practitioner, to:	
<ul style="list-style-type: none"> (i) assist the eligible medical practitioner with diagnostic formulation where the patient has a suspected complex neurodevelopmental disorder or eligible disability; or (ii) contribute to the patient's treatment and management plan developed by the referring eligible medical practitioner where a complex neurodevelopmental disorder (such as autism spectrum disorder) or eligible disability is confirmed; and 	
(b) the service is provided to the patient individually and in person; and	
(c) the service is at least 50 minutes duration	
Up to 4 services to which this item or any of items 82005, 82010, 82030, 93032, 93033, 93040 or 93041 apply may be provided to the same patient on the same day	
(See para MN.10.1, MN.10.3, AN.0.25 of explanatory notes to this Category)	
Fee 82000	Fee: \$113.65 Benefit: 85% = \$96.65 Extended Medicare Safety Net Cap: \$340.95
Speech pathology health service provided to a patient aged under 25 years by an eligible speech pathologist if:	
(a) the patient was referred by an eligible medical practitioner, or by an eligible allied health practitioner following referral by an eligible medical practitioner, to:	
<ul style="list-style-type: none"> (i) assist the eligible medical practitioner with diagnostic formulation where the patient has a suspected complex neurodevelopmental disorder or eligible disability; or (ii) contribute to the patient's treatment and management plan developed by the referring eligible medical practitioner where a complex neurodevelopmental disorder (such as autism spectrum disorder) or eligible disability is confirmed; and 	
(b) the service is provided to the patient individually and in person; and	
(c) the service is at least 50 minutes duration	
Up to 4 services to which this item or any of items 82000, 82010, 82030, 93032, 93033, 93040 or 93041 apply may be provided to the same patient on the same day	
(See para MN.10.1, MN.10.3, AN.0.25 of explanatory notes to this Category)	
Fee 82005	Fee: \$100.20 Benefit: 85% = \$85.20

M10. COMPLEX NEURODEVELOPMENTAL DISORDER AND DISABILITY SERVICES

1. COMPLEX NEURODEVELOPMENTAL DISORDER AND DISABILITY

	<p>Extended Medicare Safety Net Cap: \$300.60</p>
<p>Fee 82010</p>	<p>Occupational therapy health service provided to a patient aged under 25 years by an eligible occupational therapist if:</p> <p>(a) the patient was referred by an eligible medical practitioner, or by an eligible allied health practitioner following referral by an eligible medical practitioner, to:</p> <p style="padding-left: 40px;">(i) assist the eligible medical practitioner with diagnostic formulation where the patient has a suspected complex neurodevelopmental disorder or eligible disability; or</p> <p style="padding-left: 40px;">(ii) contribute to the patient’s treatment and management plan developed by the referring eligible medical practitioner where a complex neurodevelopmental disorder (such as autism spectrum disorder) or eligible disability is confirmed; and</p> <p>(b) the service is provided to the patient individually and in person; and</p> <p>(c) the service is at least 50 minutes duration</p> <p>Up to 4 services to which this item or any of items 82000, 82005, 82030, 93032, 93033, 93040 or 93041 apply may be provided to the same patient on the same day</p> <p>(See para MN.10.1, MN.10.3, AN.0.25 of explanatory notes to this Category)</p> <p>Fee: \$100.20 Benefit: 85% = \$85.20 Extended Medicare Safety Net Cap: \$300.60</p>
<p>Fee 82015</p>	<p>Psychology health service provided to a patient aged under 25 years for the treatment of a diagnosed complex neurodevelopmental disorder (such as autism spectrum disorder) or eligible disability by an eligible psychologist, if:</p> <p>(a) the patient has a treatment and management plan in place and has been referred by an eligible medical practitioner for a course of treatment consistent with that treatment and management plan; and</p> <p>(b) the service is provided to the patient individually and in person; and</p> <p>(c) the service is at least 30 minutes duration; and</p> <p>(d) on the completion of the course of treatment, the eligible psychologist gives a written report to the referring eligible medical practitioner on assessments (if performed), treatment provided and recommendations on future management of the patient’s condition</p> <p>Up to 4 services to which this item or any of items 82020, 82025, 82035, 93035, 93036, 93043 or 93044 apply may be provided to the same patient on the same day</p> <p>(See para MN.10.2, MN.10.3, AN.0.25 of explanatory notes to this Category)</p> <p>Fee: \$113.65 Benefit: 85% = \$96.65 Extended Medicare Safety Net Cap: \$340.95</p>
<p>Fee 82020</p>	<p>Speech pathology health service provided to a patient aged under 25 years for the treatment of a diagnosed complex neurodevelopmental disorder (such as autism spectrum disorder) or eligible disability by an eligible speech pathologist, if:</p> <p>(a) the patient has a treatment and management plan in place and has been referred by an eligible medical practitioner for a course of treatment consistent with that treatment and management plan; and</p> <p>(b) the service is provided to the patient individually and in person; and</p>

M10. COMPLEX NEURODEVELOPMENTAL DISORDER AND DISABILITY SERVICES	1. COMPLEX NEURODEVELOPMENTAL DISORDER AND DISABILITY
	<p>(c) the service is at least 30 minutes duration; and</p> <p>(d) on the completion of the course of treatment, the eligible speech pathologist gives a written report to the referring eligible medical practitioner on assessments (if performed), treatment provided and recommendations on future management of the patient's condition</p> <p>Up to 4 services to which this item or any of items 82015, 82025, 82035, 93035, 93036, 93043 or 93044 apply may be provided to the same patient on the same day</p> <p>(See para MN.10.2, MN.10.3, AN.0.25 of explanatory notes to this Category) Fee: \$100.20 Benefit: 85% = \$85.20 Extended Medicare Safety Net Cap: \$300.60</p>
Fee 82025	<p>Occupational therapy health service provided to a patient aged under 25 years for the treatment of a diagnosed complex neurodevelopmental disorder (such as autism spectrum disorder) or eligible disability by an eligible occupational therapist, if:</p> <p>(a) the patient has a treatment and management plan in place and has been referred by an eligible medical practitioner for a course of treatment consistent with that treatment and management plan; and</p> <p>(b) the service is provided to the patient individually and in person; and</p> <p>(c) the service is at least 30 minutes duration; and</p> <p>(d) on the completion of the course of treatment, the eligible occupational therapist gives a written report to the referring eligible medical practitioner on assessments (if performed), treatment provided and recommendations on future management of the patient's condition</p> <p>Up to 4 services to which this item or any of items 82015, 82020, 82035, 93035, 93036, 93043 or 93044 apply may be provided to the same patient on the same day</p> <p>(See para MN.10.2, MN.10.3, AN.0.25 of explanatory notes to this Category) Fee: \$100.20 Benefit: 85% = \$85.20 Extended Medicare Safety Net Cap: \$300.60</p>
Fee 82030	<p>Audiology, optometry, orthoptic or physiotherapy health service provided to a patient aged under 25 years by an eligible audiologist, optometrist, orthoptist or physiotherapist if:</p> <p>(a) the patient was referred by an eligible medical practitioner, or by an eligible allied health practitioner following referral by an eligible medical practitioner, to:</p> <p style="padding-left: 40px;">(i) assist the eligible medical practitioner with diagnostic formulation where the patient has a suspected complex neurodevelopmental disorder or eligible disability; or</p> <p style="padding-left: 40px;">(ii) contribute to the patient's treatment and management plan developed by the referring eligible medical practitioner where a complex neurodevelopmental disorder (such as autism spectrum disorder) or eligible disability is confirmed; and</p> <p>(b) the service is provided to the patient individually and in person; and</p> <p>(c) the service is at least 50 minutes duration</p> <p>Up to 4 services to which this item or any of items 82000, 82005, 82010, 93032, 93033, 93040 or 93041 apply may be provided to the same patient on the same day</p> <p>(See para MN.10.1, MN.10.3, AN.0.25 of explanatory notes to this Category)</p>

M10. COMPLEX NEURODEVELOPMENTAL DISORDER AND DISABILITY SERVICES		1. COMPLEX NEURODEVELOPMENTAL DISORDER AND DISABILITY	
	Fee: \$100.20 Benefit: 85% = \$85.20 Extended Medicare Safety Net Cap: \$300.60		
	<p>Audiology, optometry, orthoptic or physiotherapy health service provided to a patient aged under 25 years for the treatment of a diagnosed complex neurodevelopmental disorder (such as autism spectrum disorder) or eligible disability by an eligible audiologist, optometrist, orthoptist or physiotherapist, if:</p> <p>(a) the patient has a treatment and management plan in place and has been referred by an eligible medical practitioner for a course of treatment consistent with that treatment and management plan; and</p> <p>(b) the service is provided to the patient individually and in person; and</p> <p>(c) the service is at least 30 minutes duration; and</p> <p>(d) on the completion of the course of treatment, the eligible audiologist, optometrist, orthoptist or physiotherapist gives a written report to the referring eligible medical practitioner on assessments (if performed), treatment provided and recommendations on future management of the patient's condition</p> <p>Up to 4 services to which this item or any of items 82015, 82020, 82025, 93035, 93036, 93043 or 93044 apply may be provided to the same patient on the same day</p> <p>(See para MN.10.2, MN.10.3, AN.0.25 of explanatory notes to this Category)</p>		
Fee 82035	Fee: \$100.20 Benefit: 85% = \$85.20 Extended Medicare Safety Net Cap: \$300.60		

M10. COMPLEX NEURODEVELOPMENTAL DISORDER AND DISABILITY SERVICES		2. COMPLEX NEURODEVELOPMENTAL DISORDER AND DISABILITY CASE CONFERENCE SERVICES	
	Group M10. Complex neurodevelopmental disorder and disability services		
	Subgroup 2. Complex neurodevelopmental disorder and disability case conference services		
	Attendance by an eligible allied health practitioner, as a member of a multidisciplinary case conference team, to participate in a community case conference if the conference lasts for at least 15 minutes, but for less than 20 minutes (other than a service associated with a service to which another item in this Group applies)		
Fee 82001	(See para MN.10.4 of explanatory notes to this Category) Fee: \$55.65 Benefit: 85% = \$47.35 Extended Medicare Safety Net Cap: \$166.95		
	Attendance by an eligible allied health practitioner, as a member of a multidisciplinary case conference team, to participate in a community case conference if the conference lasts for at least 20 minutes, but for less than 40 minutes (other than a service associated with a service to which another item in this Group applies)		
Fee 82002	(See para MN.10.4 of explanatory notes to this Category) Fee: \$95.45 Benefit: 85% = \$81.15 Extended Medicare Safety Net Cap: \$286.35		
	Attendance by an eligible allied health practitioner, as a member of a multidisciplinary case conference team, to participate in a community case conference if the conference lasts for at least 40 minutes (other than a service associated with a service to which another item in this Group applies)		
Fee 82003	(See para MN.10.4 of explanatory notes to this Category)		

M10. COMPLEX NEURODEVELOPMENTAL DISORDER AND DISABILITY SERVICES

2. COMPLEX NEURODEVELOPMENTAL DISORDER AND DISABILITY CASE CONFERENCE SERVICES

Fee: \$158.80 **Benefit:** 85% = \$135.00
Extended Medicare Safety Net Cap: \$476.40

M11. ALLIED HEALTH SERVICES FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

Group M11. Allied health services for Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander health service provided to a patient of Aboriginal or Torres Strait Islander descent by an eligible Aboriginal health worker or eligible Aboriginal and Torres Strait Islander health practitioner if the service is of at least 20 minutes duration and:

(a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; or

(b) the patient has:

(i) a chronic condition;

(ii) complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the patient is a resident of an aged care facility, the patient's medical practitioner has contributed to a multidisciplinary care plan; and

(iii) the service is recommended in the patient's Team Care Arrangements or multidisciplinary care plan as part of the management of the patient's chronic condition and complex care needs;

to a maximum of 10 services (including any services to which this item or any other item in this Group or Subgroup 1 of Group M3 or item 93000, 93013, 93048 or 93061 of the Telehealth and Telephone Determination applies) in a calendar year

(See para MN.11.1 of explanatory notes to this Category)

Fee 81300 **Fee:** \$70.95 **Benefit:** 85% = \$60.35
Extended Medicare Safety Net Cap: \$212.85

Diabetes education health service provided to a patient who is of Aboriginal or Torres Strait Islander descent by an eligible diabetes educator if the service is of at least 20 minutes duration and:

(a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; or

(b) the patient has:

(i) a chronic condition;

(ii) complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the patient is a resident of an aged care facility, the patient's medical practitioner has contributed to a multidisciplinary care plan; and

(iii) the service is recommended in the patient's Team Care Arrangements or multidisciplinary care plan as part of the management of the patient's chronic condition and complex care needs;

Fee 81305

M11. ALLIED HEALTH SERVICES FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

to a maximum of 10 services (including any services to which this item or any other item in this Group or Subgroup 1 of Group M3 or item 93000, 93013, 93048 or 93061 of the Telehealth and Telephone Determination applies) in a calendar year

(See para MN.11.1 of explanatory notes to this Category)
Fee: \$70.95 **Benefit:** 85% = \$60.35
Extended Medicare Safety Net Cap: \$212.85

Audiology health service provided to a patient who is of Aboriginal or Torres Strait Islander descent by an eligible audiologist if the service is of at least 20 minutes duration and:

(a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; or

(b) the patient has:

- (i) a chronic condition;
- (ii) complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the patient is a resident of an aged care facility, the patient’s medical practitioner has contributed to a multidisciplinary care plan; and
- (iii) the service is recommended in the patient’s Team Care Arrangements or multidisciplinary care plan as part of the management of the patient’s chronic condition and complex care needs;

to a maximum of 10 services (including any services to which this item or any other item in this Group or Subgroup 1 of Group M3 or item 93000, 93013, 93048 or 93061 of the Telehealth and Telephone Determination applies) in a calendar year

(See para MN.11.1 of explanatory notes to this Category)
Fee: \$70.95 **Benefit:** 85% = \$60.35
Extended Medicare Safety Net Cap: \$212.85

Fee
81310

Exercise physiology health service provided to a patient who is of Aboriginal or Torres Strait Islander descent by an eligible exercise physiologist if the service is of at least 20 minutes duration and:

(a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; or

(b) the patient has:

- (i) a chronic condition;
- (ii) complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the patient is a resident of an aged care facility, the patient’s medical practitioner has contributed to a multidisciplinary care plan; and
- (iii) the service is recommended in the patient’s Team Care Arrangements or multidisciplinary care plan as part of the management of the patient’s chronic condition and complex care needs;

Fee
81315

M11. ALLIED HEALTH SERVICES FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

	<p>to a maximum of 10 services (including any services to which this item or any other item in this Group or Subgroup 1 of Group M3 or item 93000, 93013, 93048 or 93061 of the Telehealth and Telephone Determination applies) in a calendar year</p> <p>(See para MN.11.1 of explanatory notes to this Category) Fee: \$70.95 Benefit: 85% = \$60.35 Extended Medicare Safety Net Cap: \$212.85</p>
<p>Fee 81320</p>	<p>Dietetics health service provided to a patient who is of Aboriginal or Torres Strait Islander descent by an eligible dietitian if the service is of at least 20 minutes duration and:</p> <p>(a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; or</p> <p>(b) the patient has:</p> <ul style="list-style-type: none"> (i) a chronic condition; (ii) complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the patient is a resident of an aged care facility, the patient’s medical practitioner has contributed to a multidisciplinary care plan; and (iii) the service is recommended in the patient’s Team Care Arrangements or multidisciplinary care plan as part of the management of the patient’s chronic condition and complex care needs; <p>to a maximum of 10 services (including any services to which this item or any other item in this Group or Subgroup 1 of Group M3 or item 93000, 93013, 93048 or 93061 of the Telehealth and Telephone Determination applies) in a calendar year</p> <p>(See para MN.11.1 of explanatory notes to this Category) Fee: \$70.95 Benefit: 85% = \$60.35 Extended Medicare Safety Net Cap: \$212.85</p>
<p>Fee 81325</p>	<p>Mental health service provided to a patient who is of Aboriginal or Torres Strait Islander descent by an eligible mental health worker if the service is of at least 20 minutes duration and:</p> <p>(a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; or</p> <p>(b) the patient has:</p> <ul style="list-style-type: none"> (i) a chronic condition; (ii) complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the patient is a resident of an aged care facility, the patient’s medical practitioner has contributed to a multidisciplinary care plan; and (iii) the service is recommended in the patient’s Team Care Arrangements or multidisciplinary care plan as part of the management of the patient’s chronic condition and complex care needs;

M11. ALLIED HEALTH SERVICES FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

to a maximum of 10 services (including any services to which this item or any other item in this Group or Subgroup 1 of Group M3 or item 93000, 93013, 93048 or 93061 of the Telehealth and Telephone Determination applies) in a calendar year

(See para MN.11.1 of explanatory notes to this Category)
Fee: \$70.95 **Benefit:** 85% = \$60.35
Extended Medicare Safety Net Cap: \$212.85

Occupational therapy health service provided to a patient who is of Aboriginal or Torres Strait Islander descent by an eligible occupational therapist if the service is of at least 20 minutes duration and:

(a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; or

(b) the patient has:

- (i) a chronic condition;
- (ii) complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the patient is a resident of an aged care facility, the patient’s medical practitioner has contributed to a multidisciplinary care plan; and
- (iii) the service is recommended in the patient’s Team Care Arrangements or multidisciplinary care plan as part of the management of the patient’s chronic condition and complex care needs;

to a maximum of 10 services (including any services to which this item or any other item in this Group or Subgroup 1 of Group M3 or item 93000, 93013, 93048 or 93061 of the Telehealth and Telephone Determination applies) in a calendar year

(See para MN.11.1 of explanatory notes to this Category)
Fee: \$70.95 **Benefit:** 85% = \$60.35
Extended Medicare Safety Net Cap: \$212.85

Fee
81330

Physiotherapy health service provided to a patient who is of Aboriginal or Torres Strait Islander descent by an eligible physiotherapist if the service is of at least 20 minutes duration and:

(a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; or

(b) the patient has:

- (i) a chronic condition;
- (ii) complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the patient is a resident of an aged care facility, the patient’s medical practitioner has contributed to a multidisciplinary care plan; and
- (iii) the service is recommended in the patient’s Team Care Arrangements or multidisciplinary care plan as part of the management of the patient’s chronic condition and complex care needs;

Fee
81335

**M11. ALLIED HEALTH SERVICES FOR
ABORIGINAL AND TORRES STRAIT ISLANDER
PEOPLE**

	<p>to a maximum of 10 services (including any services to which this item or any other item in this Group or Subgroup 1 of Group M3 or item 93000, 93013, 93048 or 93061 of the Telehealth and Telephone Determination applies) in a calendar year</p> <p>(See para MN.11.1 of explanatory notes to this Category) Fee: \$70.95 Benefit: 85% = \$60.35 Extended Medicare Safety Net Cap: \$212.85</p>
<p>Fee 81340</p>	<p>Podiatry health service provided to a patient who is of Aboriginal or Torres Strait Islander descent by an eligible podiatrist if the service is of at least 20 minutes duration and:</p> <p>(a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; or</p> <p>(b) the patient has:</p> <ul style="list-style-type: none"> (i) a chronic condition; (ii) complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the patient is a resident of an aged care facility, the patient’s medical practitioner has contributed to a multidisciplinary care plan; and (iii) the service is recommended in the patient’s Team Care Arrangements or multidisciplinary care plan as part of the management of the patient’s chronic condition and complex care needs; <p>to a maximum of 10 services (including any services to which this item or any other item in this Group or Subgroup 1 of Group M3 or item 93000, 93013, 93048 or 93061 of the Telehealth and Telephone Determination applies) in a calendar year</p> <p>(See para MN.11.1 of explanatory notes to this Category) Fee: \$70.95 Benefit: 85% = \$60.35 Extended Medicare Safety Net Cap: \$212.85</p>
<p>Fee 81345</p>	<p>Chiropractic health service provided to a patient who is of Aboriginal or Torres Strait Islander descent by an eligible chiropractor if the service is of at least 20 minutes duration and:</p> <p>(a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; or</p> <p>(b) the patient has:</p> <ul style="list-style-type: none"> (i) a chronic condition; (ii) complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the patient is a resident of an aged care facility, the patient’s medical practitioner has contributed to a multidisciplinary care plan; and (iii) the service is recommended in the patient’s Team Care Arrangements or multidisciplinary care plan as part of the management of the patient’s chronic condition and complex care needs;

**M11. ALLIED HEALTH SERVICES FOR
ABORIGINAL AND TORRES STRAIT ISLANDER
PEOPLE**

	<p>to a maximum of 10 services (including any services to which this item or any other item in this Group or Subgroup 1 of Group M3 or item 93000, 93013, 93048 or 93061 of the Telehealth and Telephone Determination applies) in a calendar year</p> <p>(See para MN.11.1 of explanatory notes to this Category) Fee: \$70.95 Benefit: 85% = \$60.35 Extended Medicare Safety Net Cap: \$212.85</p>
<p>Fee 81350</p>	<p>Osteopathy health service provided to a patient who is of Aboriginal or Torres Strait Islander descent by an eligible osteopath if the service is of at least 20 minutes duration and:</p> <p>(a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; or</p> <p>(b) the patient has:</p> <ul style="list-style-type: none"> (i) a chronic condition; (ii) complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the patient is a resident of an aged care facility, the patient’s medical practitioner has contributed to a multidisciplinary care plan; and (iii) the service is recommended in the patient’s Team Care Arrangements or multidisciplinary care plan as part of the management of the patient’s chronic condition and complex care needs; <p>to a maximum of 10 services (including any services to which this item or any other item in this Group or Subgroup 1 of Group M3 or item 93000, 93013, 93048 or 93061 of the Telehealth and Telephone Determination applies) in a calendar year</p> <p>(See para MN.11.1 of explanatory notes to this Category) Fee: \$70.95 Benefit: 85% = \$60.35 Extended Medicare Safety Net Cap: \$212.85</p>
<p>Fee 81355</p>	<p>Psychology health service provided to a patient who is of Aboriginal or Torres Strait Islander descent by an eligible psychologist if the service is of at least 20 minutes duration and:</p> <p>(a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; or</p> <p>(b) the patient has:</p> <ul style="list-style-type: none"> (i) a chronic condition; (ii) complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the patient is a resident of an aged care facility, the patient’s medical practitioner has contributed to a multidisciplinary care plan; and (iii) the service is recommended in the patient’s Team Care Arrangements or multidisciplinary care plan as part of the management of the patient’s chronic condition and complex care needs;

M11. ALLIED HEALTH SERVICES FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

	<p>to a maximum of 10 services (including any services to which this item or any other item in this Group or Subgroup 1 of Group M3 or item 93000, 93013, 93048 or 93061 of the Telehealth and Telephone Determination applies) in a calendar year</p> <p>(See para MN.11.1 of explanatory notes to this Category) Fee: \$70.95 Benefit: 85% = \$60.35 Extended Medicare Safety Net Cap: \$212.85</p>
<p>Fee 81360</p>	<p>Speech pathology health service provided to a patient who is of Aboriginal or Torres Strait Islander descent by an eligible speech pathologist if the service is of at least 20 minutes duration and:</p> <p>(a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; or</p> <p>(b) the patient has:</p> <ul style="list-style-type: none"> (i) a chronic condition; (ii) complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the patient is a resident of an aged care facility, the patient’s medical practitioner has contributed to a multidisciplinary care plan; and (iii) the service is recommended in the patient’s Team Care Arrangements or multidisciplinary care plan as part of the management of the patient’s chronic condition and complex care needs; <p>to a maximum of 10 services (including any services to which this item or any other item in this Group or Subgroup 1 of Group M3 or item 93000, 93013, 93048 or 93061 of the Telehealth and Telephone Determination applies) in a calendar year</p> <p>(See para MN.11.1 of explanatory notes to this Category) Fee: \$70.95 Benefit: 85% = \$60.35 Extended Medicare Safety Net Cap: \$212.85</p>

M12. SERVICES PROVIDED BY A PRACTICE NURSE OR ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PRACTITIONER ON BEHALF OF A MEDICAL PRACTITIONER **1. TELEHEALTH SUPPORT SERVICE ON BEHALF OF A MEDICAL PRACTITIONER**

	<p>Group M12. Services Provided By A Practice Nurse Or Aboriginal And Torres Strait Islander Health Practitioner On Behalf Of A Medical Practitioner</p>
	<p>Subgroup 1. Telehealth Support Service On Behalf Of A Medical Practitioner</p>
<p>Fee 10983</p>	<p>Attendance by a practice nurse, an Aboriginal health worker or an Aboriginal and Torres Strait Islander health practitioner on behalf of, and under the supervision of, a medical practitioner, to provide clinical support to a patient who:</p> <p>(a) is participating in a video conferencing consultation with a specialist, consultant physician or psychiatrist; and</p> <p>(b) is not an admitted patient</p> <p>(See para MN.12.5 of explanatory notes to this Category)</p>

M12. SERVICES PROVIDED BY A PRACTICE NURSE OR ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PRACTITIONER ON BEHALF OF A MEDICAL PRACTITIONER	1. TELEHEALTH SUPPORT SERVICE ON BEHALF OF A MEDICAL PRACTITIONER
Fee: \$36.95 Benefit: 100% = \$36.95 Extended Medicare Safety Net Cap: \$110.85	

M12. SERVICES PROVIDED BY A PRACTICE NURSE OR ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PRACTITIONER ON BEHALF OF A MEDICAL PRACTITIONER	3. SERVICES PROVIDED BY A PRACTICE NURSE OR ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PRACTITIONER ON BEHALF OF A MEDICAL PRACTITIONER
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	Group M12. Services Provided By A Practice Nurse Or Aboriginal And Torres Strait Islander Health Practitioner On Behalf Of A Medical Practitioner
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	Subgroup 3. Services Provided By A Practice Nurse Or Aboriginal And Torres Strait Islander Health Practitioner On Behalf Of A Medical Practitioner
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	<p>Follow up service provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner, on behalf of a medical practitioner, for an Indigenous person who has received a health assessment if:</p> <p>a) The service is provided on behalf of and under the supervision of a medical practitioner; and</p> <p>b) the person is not an admitted patient of a hospital; and</p> <p>c) the service is consistent with the needs identified through the health assessment;</p> <p style="padding-left: 20px;">- to a maximum of 10 services per patient in a calendar year</p> <p>(See para MN.12.3 of explanatory notes to this Category)</p> <p>Fee: \$27.30 Benefit: 100% = \$27.30 Extended Medicare Safety Net Cap: \$81.90</p>
Fee 10987	

	<p>Immunisation provided to a person by an Aboriginal and Torres Strait Islander health practitioner if:</p> <p>(a) the immunisation is provided on behalf of, and under the supervision of, a medical practitioner; and</p> <p>(b) the person is not an admitted patient of a hospital.</p> <p>(See para MN.12.1 of explanatory notes to this Category)</p> <p>Fee: \$13.65 Benefit: 100% = \$13.65 Extended Medicare Safety Net Cap: \$40.95</p>
Fee 10988	

	<p>Treatment of a person's wound (other than normal aftercare) provided by an Aboriginal and Torres Strait Islander health practitioner if:</p> <p>(a) the treatment is provided on behalf of, and under the supervision of, a medical practitioner; and</p> <p>(b) the person is not an admitted patient of a hospital.</p> <p>(See para MN.12.2 of explanatory notes to this Category)</p> <p>Fee: \$13.65 Benefit: 100% = \$13.65 Extended Medicare Safety Net Cap: \$40.95</p>
Fee 10989	

M12. SERVICES PROVIDED BY A PRACTICE NURSE OR ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PRACTITIONER ON BEHALF OF A MEDICAL PRACTITIONER	3. SERVICES PROVIDED BY A PRACTICE NURSE OR ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PRACTITIONER ON BEHALF OF A MEDICAL PRACTITIONER
Fee 10997	<p>Service provided to a person with a chronic disease by a practice nurse or an Aboriginal and Torres Strait Islander health practitioner if:</p> <ul style="list-style-type: none"> (a) the service is provided on behalf of and under the supervision of a medical practitioner; and (b) the person is not an admitted patient of a hospital; and (c) the person has a GP Management Plan, Team Care Arrangements or Multidisciplinary Care Plan in place; and (d) the service is consistent with the GP Management Plan, Team Care Arrangements or Multidisciplinary Care Plan <p>to a maximum of 5 services per patient in a calendar year</p> <p>(See para MN.12.4 of explanatory notes to this Category)</p> <p>Fee: \$13.65 Benefit: 100% = \$13.65 Extended Medicare Safety Net Cap: \$40.95</p>

M13. MIDWIFERY SERVICES	1. MBS ITEMS FOR PARTICIPATING MIDWIVES
	Group M13. Midwifery Services
	Subgroup 1. MBS Items For Participating Midwives
Fee 82100	<p>Initial antenatal professional attendance by a participating midwife, lasting at least 40 minutes, including all of the following:</p> <ul style="list-style-type: none"> (a) taking a detailed patient history; (b) performing a comprehensive examination; (c) performing a risk assessment; (d) based on the risk assessment — arranging referral or transfer of the patient’s care to an obstetrician; (e) requesting pathology and diagnostic imaging services, when necessary; (f) discussing with the patient the collaborative arrangements for her maternity care and recording the arrangements in the midwife’s written records in accordance with section 6 of the Health Insurance Regulations 2018 <p>Payable only once for any pregnancy</p> <p>(See para MN.13.16, MN.13.15, MN.13.17, MN.13.18 of explanatory notes to this Category)</p> <p>Fee: \$60.85 Benefit: 85% = \$51.75 Extended Medicare Safety Net Cap: \$25.80</p>
Fee 82105	<p>Short antenatal professional attendance by a participating midwife, lasting up to 40 minutes</p> <p>(See para MN.13.16, MN.13.15, MN.13.17, MN.13.18 of explanatory notes to this Category)</p> <p>Fee: \$36.85 Benefit: 75% = \$27.65 85% = \$31.35</p>

M13. MIDWIFERY SERVICES		1. MBS ITEMS FOR PARTICIPATING MIDWIVES
	Extended Medicare Safety Net Cap: \$19.30	
Fee 82110	<p>Long antenatal professional attendance by a participating midwife, lasting at least 40 minutes</p> <p>(See para MN.13.16, MN.13.15, MN.13.17, MN.13.18 of explanatory notes to this Category)</p> <p>Fee: \$60.85 Benefit: 75% = \$45.65 85% = \$51.75</p> <p>Extended Medicare Safety Net Cap: \$25.80</p>	
Fee 82115	<p>Professional attendance by a participating midwife, lasting at least 90 minutes, for assessment and preparation of a maternity care plan for a patient whose pregnancy has progressed beyond 28 weeks, where the participating midwife has had at least 2 antenatal attendances with the patient in the preceding 6 months, if:</p> <p>(a) the patient is not an admitted patient of a hospital; and</p> <p>(b) the participating midwife undertakes a comprehensive assessment of the patient; and</p> <p>(c) the participating midwife develops a written maternity care plan that contains:</p> <p style="padding-left: 20px;">(i) outcomes of the assessment; and</p> <p style="padding-left: 20px;">(ii) details of agreed expectations for care during pregnancy, labour and birth; and</p> <p style="padding-left: 20px;">(iii) details of any health problems or care needs; and</p> <p style="padding-left: 20px;">(iv) details of collaborative arrangements that apply to the patient; and</p> <p style="padding-left: 20px;">(v) details of any medication taken by the patient during the pregnancy, and any additional medication that may be required by the patient; and</p> <p style="padding-left: 20px;">(vi) details of any referrals or requests for pathology services or diagnostic imaging services for the patient during the pregnancy, and any additional referrals or requests that may be required for the patient; and</p> <p>(d) the maternity care plan is explained and agreed with the patient; and</p> <p>(e) the fee does not include any amount for the management of labour and birth;</p> <p>(Includes any antenatal attendance provided on the same occasion)</p> <p>Payable only once for any pregnancy;</p> <p>This item cannot be claimed if items 16590 or 16591 have previously been claimed during a single pregnancy, except in exceptional circumstances</p> <p>(See para MN.13.16, MN.13.15, MN.13.17, MN.13.18 of explanatory notes to this Category)</p> <p>Fee: \$363.40 Benefit: 85% = \$308.90</p> <p>Extended Medicare Safety Net Cap: \$64.30</p>	
Fee 82116	<p>Management of labour for up to 6 hours, not including birth, at a place other than a hospital if:</p> <p>(a) the attendance is by the participating midwife who:</p> <p style="padding-left: 20px;">(i) provided the patient's antenatal care or</p> <p style="padding-left: 20px;">(ii) is a member of a practice that has provided the patient's antenatal care; and</p> <p>(b) the total attendance time is documented in the patient notes;</p>	

M13. MIDWIFERY SERVICES	1. MBS ITEMS FOR PARTICIPATING MIDWIVES
	<p>This item does not apply if birth is performed during the attendance;</p> <p>Only claimable once per pregnancy</p> <p>(See para MN.13.15, MN.13.17, MN.13.18, MN.13.16 of explanatory notes to this Category)</p> <p>Fee: \$858.20 Benefit: 85% = \$759.50</p>
<p>Fee 82118</p>	<p>Management of labour for up to 6 hours total attendance, including birth where performed or attendance and immediate post-birth care at an elective caesarean section if:</p> <p>(a) the patient is an admitted patient of a hospital; and</p> <p>(b) the attendance is by the first participating midwife who:</p> <p style="padding-left: 20px;">(i) assisted or provided the patient's antenatal care; or</p> <p style="padding-left: 20px;">(ii) is a member of a practice that has provided the patient's antenatal care; and</p> <p>(c) the total attendance time is documented in the patient notes.</p> <p>(Includes all hospital attendances related to the labour by the first participating midwife)</p> <p>Only claimable once per pregnancy;</p> <p>Not being a service associated with a service to which item 82120 applies (H)</p> <p>(See para MN.13.15, MN.13.17, MN.13.18, MN.13.16 of explanatory notes to this Category)</p> <p>Fee: \$858.20 Benefit: 75% = \$643.65</p>
<p>Fee 82120</p>	<p>Management of labour between 6 and 12 hours total attendance, including birth where performed, if:</p> <p>(a) the patient is an admitted patient of a hospital; and</p> <p>(b) the attendance is by the first participating midwife who:</p> <p style="padding-left: 20px;">(i) assisted or provided the patient's antenatal care; or</p> <p style="padding-left: 20px;">(ii) is a member of a practice that provided the patient's antenatal care; and</p> <p>(c) the total attendance time is documented in the patient notes;</p> <p>(Includes all hospital attendances related to the labour by the first participating midwife)</p> <p>Only claimable once per pregnancy;</p> <p>Not being a service associated with a service to which item 82118 applies (H)</p> <p>(See para MN.13.16, MN.13.15, MN.13.17, MN.13.18 of explanatory notes to this Category)</p> <p>Fee: \$1,716.45 Benefit: 75% = \$1287.35</p>
<p>Fee 82123</p>	<p>Management of labour for up to 6 hours total attendance, including birth where performed if:</p> <p>(a) the patient is an admitted patient of a hospital; and</p> <p>(b) the attendance is by the second participating midwife who either:</p> <p style="padding-left: 20px;">(i) assisted or provided the patient's antenatal care; or</p>

M13. MIDWIFERY SERVICES	1. MBS ITEMS FOR PARTICIPATING MIDWIVES
	<p>(ii) is a member of a practice that has provided the patient's antenatal care; and</p> <p>(c) the total attendance time is documented in the patient notes;</p> <p>(Includes all hospital attendances related to the labour by the second participating midwife)</p> <p>Only claimable once per pregnancy;</p> <p>Not being a service associated with a service to which item 82125 applies (H)</p> <p>(See para MN.13.15, MN.13.17, MN.13.18, MN.13.16 of explanatory notes to this Category)</p> <p>Fee: \$858.20 Benefit: 75% = \$643.65</p>
<p>Fee 82125</p>	<p>Management of labour between 6 and 12 hours total attendance, including birth where performed, if:</p> <p>(a) the patient is an admitted patient of a hospital; and</p> <p>(b) the attendance is by the second participating midwife who either:</p> <p style="padding-left: 20px;">(i) assisted or provided the patient's antenatal care; or</p> <p style="padding-left: 20px;">(ii) is a member of a practice that provided the patient's antenatal care; and</p> <p>(c) the total attendance time is documented in the patient notes;</p> <p>(Includes all hospital attendances related to the labour by the second participating midwife)</p> <p>Only claimable once per pregnancy;</p> <p>Not being a service associated with a service to which item 82123 or 82127 applies (H)</p> <p>(See para MN.13.16, MN.13.15, MN.13.17, MN.13.18 of explanatory notes to this Category)</p> <p>Fee: \$1,716.45 Benefit: 75% = \$1287.35</p>
<p>Fee 82127</p>	<p>Management of labour for up to 6 hours total attendance, including birth where performed if:</p> <p>(a) the patient is an admitted patient of a hospital; and</p> <p>(b) the attendance is by a third participating midwife who either:</p> <p style="padding-left: 20px;">(i) assisted or provided the patient's antenatal care; or</p> <p style="padding-left: 20px;">(ii) is a member of a practice that has provided the patient's antenatal care; and</p> <p>(c) an attendance to which item 82123 applies has been provided by a second participating midwife who is a member of a practice that has provided the patient's antenatal care; and</p> <p>(d) the total attendance time is documented in the patient notes;</p> <p>(Includes all hospital attendances related to the labour by the third participating midwife)</p> <p>Only claimable once per pregnancy;</p> <p>Not being a service associated with a service to which item 82125 applies (H)</p> <p>(See para MN.13.15, MN.13.17, MN.13.18, MN.13.16 of explanatory notes to this Category)</p> <p>Fee: \$858.20 Benefit: 75% = \$643.65</p>

M13. MIDWIFERY SERVICES		1. MBS ITEMS FOR PARTICIPATING MIDWIVES
Fee 82130	<p>Short postnatal professional attendance by a participating midwife, lasting up to 40 minutes, within 6 weeks after birth</p> <p>(See para MN.13.16, MN.13.15, MN.13.17, MN.13.18 of explanatory notes to this Category)</p> <p>Fee: \$60.85 Benefit: 75% = \$45.65 85% = \$51.75 Extended Medicare Safety Net Cap: \$19.30</p>	
Fee 82135	<p>Long postnatal professional attendance by a participating midwife, lasting at least 40 minutes, within 6 weeks after birth</p> <p>(See para MN.13.16, MN.13.15, MN.13.17, MN.13.18 of explanatory notes to this Category)</p> <p>Fee: \$89.50 Benefit: 75% = \$67.15 85% = \$76.10 Extended Medicare Safety Net Cap: \$25.80</p>	
Fee 82140	<p>Postnatal professional attendance by a participating midwife on a patient, not less than 6 weeks but not more than 7 weeks after birth of a baby, including:</p> <p>(a) a comprehensive examination of the patient and baby to ensure normal postnatal recovery; and</p> <p>(b) referral of the patient to a general practitioner for the ongoing care of the patient and baby</p> <p>Payable only once for any pregnancy</p> <p>(See para MN.13.16, MN.13.15, MN.13.17, MN.13.18 of explanatory notes to this Category)</p> <p>Fee: \$60.85 Benefit: 85% = \$51.75 Extended Medicare Safety Net Cap: \$19.30</p>	

M14. NURSE PRACTITIONERS		1. NURSE PRACTITIONERS
	Group M14. Nurse Practitioners	
	Subgroup 1. Nurse Practitioners	
Amend Fee 82200	<p>Professional attendance by a participating nurse practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management</p> <p>(See para MN.14.12 of explanatory notes to this Category)</p> <p>Fee: \$14.20 Benefit: 85% = \$12.10 Extended Medicare Safety Net Cap: \$42.60</p>	
Amend Fee 82205	<p>Professional attendance by a participating nurse practitioner lasting less than 20 minutes and including any of the following:</p> <p>a) taking a history;</p> <p>b) undertaking clinical examination;</p> <p>c) arranging any necessary investigation;</p> <p>d) implementing a management plan;</p> <p>e) providing appropriate preventive health care;</p> <p>for 1 or more health related issues, with appropriate documentation</p> <p>(See para MN.14.12 of explanatory notes to this Category)</p> <p>Fee: \$31.05 Benefit: 85% = \$26.40</p>	

M14. NURSE PRACTITIONERS		1. NURSE PRACTITIONERS
	Extended Medicare Safety Net Cap: \$93.15	
Amend Fee 82210	<p>Professional attendance by a participating nurse practitioner lasting at least 20 minutes and including any of the following:</p> <ul style="list-style-type: none"> a) taking a detailed history; b) undertaking clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; <p>for 1 or more health related issues, with appropriate documentation</p> <p>(See para MN.14.12 of explanatory notes to this Category) Fee: \$58.85 Benefit: 85% = \$50.05 Extended Medicare Safety Net Cap: \$176.55</p>	
Amend Fee 82215	<p>Professional attendance by a participating nurse practitioner lasting at least 40 minutes and including any of the following:</p> <ul style="list-style-type: none"> a) taking an extensive history; b) undertaking clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; <p>for 1 or more health related issues, with appropriate documentation</p> <p>(See para MN.14.12 of explanatory notes to this Category) Fee: \$86.80 Benefit: 85% = \$73.80 Extended Medicare Safety Net Cap: \$260.40</p>	
Fee 82226	<p>Burns, involving 1% or more but less than 3% of total body surface, dressing of (including redressing of any related donor site, if required), without anaesthesia, by a participating nurse practitioner—each attendance at which the procedure is performed</p> <p>Not applicable for skin reactions secondary to radiotherapy</p> <p>Fee: \$41.40 Benefit: 75% = \$31.05 85% = \$35.20</p>	
Fee 82227	<p>Burns, involving 3% or more but less than 10% of total body surface, dressing of (including redressing of any related donor site, if required), without anaesthesia, by a participating nurse practitioner—each attendance at which the procedure is performed</p> <p>Not applicable for skin reactions secondary to radiotherapy</p> <p>Fee: \$52.95 Benefit: 75% = \$39.75 85% = \$45.05</p>	
Fee 82228	<p>Nipple or areola or both, intradermal colouration of, by a participating nurse practitioner, following breast reconstruction after mastectomy or for congenital absence of nipple</p>	

M14. NURSE PRACTITIONERS	1. NURSE PRACTITIONERS
Fee: \$225.40	Benefit: 75% = \$169.05 85% = \$191.60

M15. DIAGNOSTIC AUDIOLOGY SERVICES

Group M15. Diagnostic Audiology Services

Fee 82300	<p>Audiology health service, consisting of brain stem evoked response audiometry, performed on a patient by an eligible audiologist if:</p> <p>(a) the service is not for the purposes of programming either an auditory implant or the sound processors of an auditory implant; and</p> <p>(b) the service is performed pursuant to a written request made by a medical practitioner to assist in the diagnosis, treatment or management of ear disease or a related disorder in the patient; and</p> <p>(c) the service is not performed for the purpose of a hearing screening; and</p> <p>(d) the service is performed on the patient individually and in person; and</p> <p>(e) after the service, the eligible audiologist provides a copy of the results of the service performed, together with relevant comments in writing that the eligible audiologist has on those results, to the medical practitioner who requested the service; and</p> <p>(f) a service to which item 11300 applies has not been performed on the patient on the same day</p> <p>(See para MN.15.5 of explanatory notes to this Category)</p> <p>Fee: \$175.40 Benefit: 85% = \$149.10 Extended Medicare Safety Net Cap: \$500.00</p>
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Fee 82301	<p>Audiology health service, consisting of programming an auditory implant or the sound processor of an auditory implant, unilateral, performed on a patient by an eligible audiologist if:</p> <p>(a) the service is performed on the patient individually and in person; and</p> <p>(b) a service to which item 11302, 11342 or 11345 applies has not been performed on the patient on the same day</p> <p>Applicable up to a total of 4 services to which this item, item 82302 or item 82304 applies on the same day</p> <p>(See para MN.15.5 of explanatory notes to this Category)</p> <p>Fee: \$175.40 Benefit: 75% = \$131.55 85% = \$149.10 Extended Medicare Safety Net Cap: \$500.00</p>
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Fee 82302	<p>Audiology health service by telehealth for programming of an auditory implant, or the sound processor of an auditory implant, unilateral, performed on a patient by an eligible audiologist if:</p> <p>(a) the service is not performed for the purpose of a hearing screening; and</p> <p>(b) a service to which item 11302, 11342 or 11345 applies not been performed on the patient on the same day</p> <p>Applicable up to a total of 4 services to which this item, item 82301 or item 82304 applies on the same day</p> <p>(See para MN.15.5 of explanatory notes to this Category)</p> <p>Fee: \$175.40 Benefit: 85% = \$149.10</p>
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M15. DIAGNOSTIC AUDIOLOGY SERVICES

	Extended Medicare Safety Net Cap: \$500.00
Fee 82304	<p>Audiology health service by phone for programming of an auditory implant, or the sound processor of an auditory implant, unilateral, performed on a patient by an eligible audiologist if:</p> <ul style="list-style-type: none">(a) the service is not performed for the purpose of a hearing screening; and(b) a service to which item 11302, 11342 or 11345 applies not been performed on the patient on the same day <p>Applicable up to a total of 4 services to which this item, item 82301 or item 82302 applies on the same day</p> <p>(See para MN.15.5 of explanatory notes to this Category)</p> <p>Fee: \$175.40 Benefit: 85% = \$149.10 Extended Medicare Safety Net Cap: \$500.00</p>
Fee 82306	<p>Audiology health service, consisting of non-determinate audiometry performed on a patient by an eligible audiologist if:</p> <ul style="list-style-type: none">(a) the service is performed pursuant to a written request made by a medical practitioner to assist in the diagnosis, treatment or management of ear disease or a related disorder in the patient; and(b) the service is not performed for the purpose of a hearing screening; and(c) the service is performed on the patient individually and in person; and(d) after the service, the eligible audiologist provides a copy of the results of the service performed, together with relevant comments in writing that the eligible audiologist has on those results, to the medical practitioner who requested the service; and(e) a service to which item 11306 applies has not been performed on the patient on the same day <p>(See para MN.15.5, MN.15.2 of explanatory notes to this Category)</p> <p>Fee: \$19.90 Benefit: 85% = \$16.95 Extended Medicare Safety Net Cap: \$59.70</p>
Fee 82309	<p>Audiology health service, consisting of an air conduction audiogram performed on a patient by an eligible audiologist if:</p> <ul style="list-style-type: none">(a) the service is performed pursuant to a written request made by a medical practitioner to assist in the diagnosis, treatment or management of ear disease or a related disorder in the patient; and(b) the service is not performed for the purpose of a hearing screening; and(c) the service is performed on the patient individually and in person; and(d) after the service, the eligible audiologist provides a copy of the results of the service performed, together with relevant comments in writing that the eligible audiologist has on those results, to the medical practitioner who requested the service; and(e) a service to which item 11309 applies has not been performed on the patient on the same day <p>(See para MN.15.3, MN.15.5 of explanatory notes to this Category)</p> <p>Fee: \$23.95 Benefit: 85% = \$20.40 Extended Medicare Safety Net Cap: \$71.85</p>

M15. DIAGNOSTIC AUDIOLOGY SERVICES

<p>Fee 82312</p>	<p>Audiology health service, consisting of an air and bone conduction audiogram or air conduction and speech discrimination audiogram performed on a patient by an eligible audiologist if:</p> <p>(a) the service is performed pursuant to a written request made by a medical practitioner to assist in the diagnosis, treatment or management of ear disease or a related disorder in the patient; and</p> <p>(b) the service is not performed for the purpose of a hearing screening; and</p> <p>(c) the service is performed on the patient individually and in person; and</p> <p>(d) after the service, the eligible audiologist provides a copy of the results of the service performed, together with relevant comments in writing that the eligible audiologist has on those results, to the medical practitioner who requested the service; and</p> <p>(e) a service to which item 11312 applies has not been performed on the patient on the same day</p> <p>(See para MN.15.3, MN.15.5 of explanatory notes to this Category)</p> <p>Fee: \$33.90 Benefit: 85% = \$28.85 Extended Medicare Safety Net Cap: \$101.70</p>
<p>Fee 82315</p>	<p>Audiology health service, consisting of an air and bone conduction and speech discrimination audiogram performed on a patient by an eligible audiologist if:</p> <p>(a) the service is performed pursuant to a written request made by a medical practitioner to assist in the diagnosis, treatment or management of ear disease or a related disorder in the patient; and</p> <p>(b) the service is not performed for the purpose of a hearing screening; and</p> <p>(c) the service is performed on the patient individually and in person; and</p> <p>(d) after the service, the eligible audiologist provides a copy of the results of the service performed, together with relevant comments in writing that the eligible audiologist has on those results, to the medical practitioner who requested the service; and</p> <p>(e) a service to which item 11315 applies has not been performed on the patient on the same day</p> <p>(See para MN.15.3, MN.15.5 of explanatory notes to this Category)</p> <p>Fee: \$44.80 Benefit: 85% = \$38.10 Extended Medicare Safety Net Cap: \$134.40</p>
<p>Fee 82318</p>	<p>Audiology health service, consisting of an air and bone conduction and speech discrimination audiogram with other cochlear tests performed on a patient by an eligible audiologist if:</p> <p>(a) the service is performed pursuant to a written request made by a medical practitioner to assist in the diagnosis, treatment or management of ear disease or a related disorder in the patient; and</p> <p>(b) the service is not performed for the purpose of a hearing screening; and</p> <p>(c) the service is performed on the patient individually and in person; and</p> <p>(d) after the service, the eligible audiologist provides a copy of the results of the service performed, together with relevant comments in writing that the eligible audiologist has on those results, to the medical practitioner who requested the service; and</p> <p>(e) a service to which item 11318 applies has not been performed on the patient on the same day</p> <p>(See para MN.15.3, MN.15.5 of explanatory notes to this Category)</p> <p>Fee: \$55.35 Benefit: 85% = \$47.05</p>

M15. DIAGNOSTIC AUDIOLOGY SERVICES	
	Extended Medicare Safety Net Cap: \$166.05
Fee 82324	<p>Audiology health service, consisting of an impedance audiogram involving tympanometry and measurement of static compliance and acoustic reflex performed on a patient by an eligible audiologist if:</p> <p>(a) the service is performed pursuant to a written request made by a medical practitioner to assist in the diagnosis, treatment or management of ear disease or a related disorder in the patient; and</p> <p>(b) the service is not performed for the purpose of a hearing screening; and</p> <p>(c) the service is performed on the patient individually and in person; and</p> <p>(d) after the service, the eligible audiologist provides a copy of the results of the service performed, together with relevant comments in writing that the eligible audiologist has on those results, to the medical practitioner who requested the service; and</p> <p>(e) a service to which item 11324 applies has not been performed on the patient on the same day</p> <p>(See para MN.15.3, MN.15.5 of explanatory notes to this Category)</p> <p>Fee: \$18.20 Benefit: 85% = \$15.50 Extended Medicare Safety Net Cap: \$54.60</p>
Fee 82332	<p>Audiology health service, consisting of an oto-acoustic emission audiometry for the detection of outer hair cell functioning in the cochlea, performed by an eligible audiologist, when middle ear pathology has been excluded, if:</p> <p>(a) the service is performed pursuant to a written request made by a medical practitioner to assist in the diagnosis, treatment or management of ear disease or a related disorder in the patient; and</p> <p>(b) the service is performed:</p> <ul style="list-style-type: none"> (i) on an infant or child who is at risk of permanent hearing impairment; or (ii) on a patient who is at risk of oto-toxicity due to medications or medical intervention; or (iii) on a patient at risk of noise induced hearing loss; or (iv) to assist in the diagnosis of auditory neuropathy; and <p>(c) the service is performed on the patient individually and in person; and</p> <p>(d) after the service, the eligible audiologist provides a copy of the results of the service performed, together with relevant comments in writing that the eligible audiologist has on those results, to the medical practitioner who requested the service; and</p> <p>(e) a service to which item 11332 applies has not been performed on the patient on the same day</p> <p>(See para MN.15.4, MN.15.5 of explanatory notes to this Category)</p> <p>Fee: \$53.40 Benefit: 85% = \$45.40 Extended Medicare Safety Net Cap: \$160.20</p>
M16. EATING DISORDERS SERVICES	
1. EATING DISORDERS DIETITIAN HEALTH SERVICES	
	Group M16. Eating Disorders Services

M16. EATING DISORDERS SERVICES		1. EATING DISORDERS DIETITIAN HEALTH SERVICES
	Subgroup 1. Eating disorders dietitian health services	
Fee 82350	<p>Dietetics health service provided to an eligible patient by an eligible dietitian if:</p> <ul style="list-style-type: none"> (a) the service is recommended in the patient’s eating disorder treatment and management plan; and (b) the service is provided to the patient individually and in person; and (c) the service is of at least 20 minutes in duration <p>(See para MN.16.1, MN.16.2 of explanatory notes to this Category)</p> <p>Fee: \$70.95 Benefit: 85% = \$60.35 Extended Medicare Safety Net Cap: \$212.85</p>	

M16. EATING DISORDERS SERVICES		2. EATING DISORDER PSYCHOLOGICAL TREATMENT SERVICES PROVIDED BY ELIGIBLE CLINICAL PSYCHOLOGISTS
	Group M16. Eating Disorders Services	
	Subgroup 2. Eating disorder psychological treatment services provided by eligible clinical psychologists	
Fee 82352	<p>Eating disorder psychological treatment service provided to an eligible patient in consulting rooms by an eligible clinical psychologist if:</p> <ul style="list-style-type: none"> (a) the service is recommended in the patient’s eating disorder treatment and management plan; and (b) the service is provided to the patient individually and in person; and (c) the service is at least 30 minutes but less than 50 minutes in duration <p>(See para MN.16.1, MN.16.3 of explanatory notes to this Category)</p> <p>Fee: \$113.65 Benefit: 85% = \$96.65 Extended Medicare Safety Net Cap: \$340.95</p>	
Fee 82354	<p>Eating disorder psychological treatment service provided to an eligible patient at a place other than consulting rooms by an eligible clinical psychologist if:</p> <ul style="list-style-type: none"> (a) the service is recommended in the patient’s eating disorder treatment and management plan; and (b) the service is provided to the patient individually and in person; and (c) the service is at least 30 minutes but less than 50 minutes in duration <p>(See para MN.16.1, MN.16.3 of explanatory notes to this Category)</p> <p>Fee: \$142.05 Benefit: 85% = \$120.75 Extended Medicare Safety Net Cap: \$426.15</p>	
Fee 82355	<p>Eating disorder psychological treatment service provided to an eligible patient in consulting rooms by an eligible clinical psychologist if:</p> <ul style="list-style-type: none"> (a) the service is recommended in the patient’s eating disorder treatment and management plan; and (b) the service is provided to the patient individually and in person; and 	

M16. EATING DISORDERS SERVICES		2. EATING DISORDER PSYCHOLOGICAL TREATMENT SERVICES PROVIDED BY ELIGIBLE CLINICAL PSYCHOLOGISTS
	<p>(c) the service is at least 50 minutes in duration</p> <p>(See para MN.16.1, MN.16.3 of explanatory notes to this Category) Fee: \$166.85 Benefit: 85% = \$141.85 Extended Medicare Safety Net Cap: \$500.00</p>	
Fee 82357	<p>Eating disorder psychological treatment service provided to an eligible patient at a place other than consulting rooms by an eligible clinical psychologist if:</p> <p>(a) the service is recommended in the patient’s eating disorder treatment and management plan; and</p> <p>(b) the service is provided to the patient individually and in person; and</p> <p>(c) the service is at least 50 minutes in duration</p> <p>(See para MN.16.1, MN.16.3 of explanatory notes to this Category) Fee: \$195.20 Benefit: 85% = \$165.95 Extended Medicare Safety Net Cap: \$500.00</p>	
Fee 82358	<p>Eating disorder psychological treatment service provided to an eligible patient as part of a group of 6 to 10 patients by an eligible clinical psychologist if:</p> <p>(a) the service is recommended in the patient’s eating disorder treatment and management plan; and</p> <p>(b) the service is provided in person; and</p> <p>(c) the service is at least 60 minutes in duration</p> <p>(See para MN.16.1, MN.16.3 of explanatory notes to this Category) Fee: \$42.35 Benefit: 85% = \$36.00 Extended Medicare Safety Net Cap: \$127.05</p>	
Fee 82359	<p>Eating disorder psychological treatment service provided to an eligible patient as part of a group of 6 to 10 patients by an eligible clinical psychologist if:</p> <p>(a) the service is recommended in the patient’s eating disorder treatment and management plan; and</p> <p>(b) the attendance is by video conference; and</p> <p>(c) the patient is located within a telehealth eligible area; and</p> <p>(d) the patient is, at the time of the attendance, at least 15 kilometres by road from the clinical psychologist; and</p> <p>(e) the service is at least 60 minutes in duration</p> <p>(See para MN.16.1, MN.16.3, MN.16.4 of explanatory notes to this Category) Fee: \$42.35 Benefit: 85% = \$36.00 Extended Medicare Safety Net Cap: \$127.05</p>	

M16. EATING DISORDERS SERVICES		3. EATING DISORDER PSYCHOLOGICAL TREATMENT SERVICES PROVIDED BY ELIGIBLE PSYCHOLOGISTS
	Group M16. Eating Disorders Services	

3. EATING DISORDER PSYCHOLOGICAL TREATMENT SERVICES PROVIDED BY ELIGIBLE PSYCHOLOGISTS	
M16. EATING DISORDERS SERVICES	
	Subgroup 3. Eating disorder psychological treatment services provided by eligible psychologists
Fee 82360	<p>Eating disorder psychological treatment service provided to an eligible patient in consulting rooms by an eligible psychologist if:</p> <ul style="list-style-type: none"> (a) the service is recommended in the patient’s eating disorder treatment and management plan; and (b) the service is provided to the patient individually and in person; and (c) the service is at least 20 minutes but less than 50 minutes in duration <p>(See para MN.16.1, MN.16.3 of explanatory notes to this Category)</p> <p>Fee: \$80.55 Benefit: 85% = \$68.50 Extended Medicare Safety Net Cap: \$241.65</p>
Fee 82362	<p>Eating disorder psychological treatment service provided to an eligible patient at a place other than consulting rooms by an eligible psychologist if:</p> <ul style="list-style-type: none"> (a) the service is recommended in the patient’s eating disorder treatment and management plan; and (b) the service is provided to the patient individually and in person; and (c) the service is at least 20 minutes but less than 50 minutes in duration <p>(See para MN.16.1, MN.16.3 of explanatory notes to this Category)</p> <p>Fee: \$109.55 Benefit: 85% = \$93.15 Extended Medicare Safety Net Cap: \$328.65</p>
Fee 82363	<p>Eating disorder psychological treatment service provided to an eligible patient in consulting rooms by an eligible psychologist if:</p> <ul style="list-style-type: none"> (a) the service is recommended in the patient’s eating disorder treatment and management plan; and (b) the service is provided to the patient individually and in person; and (c) the service is at least 50 minutes in duration <p>(See para MN.16.1, MN.16.3 of explanatory notes to this Category)</p> <p>Fee: \$113.65 Benefit: 85% = \$96.65 Extended Medicare Safety Net Cap: \$340.95</p>
Fee 82365	<p>Eating disorder psychological treatment service provided to an eligible patient at a place other than consulting rooms by an eligible psychologist if:</p> <ul style="list-style-type: none"> (a) the service is recommended in the patient’s eating disorder treatment and management plan; and (b) the service is provided to the patient individually and in person; and (c) the service is at least 50 minutes in duration <p>(See para MN.16.1, MN.16.3 of explanatory notes to this Category)</p> <p>Fee: \$142.75 Benefit: 85% = \$121.35 Extended Medicare Safety Net Cap: \$428.25</p>

3. EATING DISORDER PSYCHOLOGICAL TREATMENT SERVICES PROVIDED BY ELIGIBLE PSYCHOLOGISTS	
M16. EATING DISORDERS SERVICES	
Fee 82366	<p>Eating disorder psychological treatment service provided to an eligible patient as part of a group of 6 to 10 patients by an eligible psychologist if:</p> <ul style="list-style-type: none"> (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided in person; and (c) the service is at least 60 minutes in duration <p>(See para MN.16.1, MN.16.3 of explanatory notes to this Category)</p> <p>Fee: \$29.00 Benefit: 85% = \$24.65 Extended Medicare Safety Net Cap: \$87.00</p>
Fee 82367	<p>Eating disorder psychological treatment service provided to an eligible patient as part of a group of 6 to 10 patients by an eligible psychologist if:</p> <ul style="list-style-type: none"> (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the attendance is by video conference; and (c) the patient is located within a telehealth eligible area; and (d) the patient is, at the time of the attendance, at least 15 kilometres by road from the clinical psychologist; and (e) the service is at least 60 minutes in duration <p>(See para MN.16.1, MN.16.3, MN.16.4 of explanatory notes to this Category)</p> <p>Fee: \$29.00 Benefit: 85% = \$24.65 Extended Medicare Safety Net Cap: \$87.00</p>

4. EATING DISORDER PSYCHOLOGICAL TREATMENT SERVICES PROVIDED BY ELIGIBLE OCCUPATIONAL THERAPISTS	
M16. EATING DISORDERS SERVICES	
	Group M16. Eating Disorders Services
	Subgroup 4. Eating disorder psychological treatment services provided by eligible occupational therapists
Fee 82368	<p>Eating disorder psychological treatment service provided to an eligible patient in consulting rooms by an eligible occupational therapist if:</p> <ul style="list-style-type: none"> (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided to the patient individually and in person; and (c) the service is at least 20 minutes but less than 50 minutes in duration <p>(See para MN.16.1, MN.16.3 of explanatory notes to this Category)</p> <p>Fee: \$70.95 Benefit: 85% = \$60.35 Extended Medicare Safety Net Cap: \$212.85</p>

M16. EATING DISORDERS SERVICES		4. EATING DISORDER PSYCHOLOGICAL TREATMENT SERVICES PROVIDED BY ELIGIBLE OCCUPATIONAL THERAPISTS
Fee 82370	<p>Eating disorder psychological treatment service provided to an eligible patient at a place other than consulting rooms by an eligible occupational therapist if:</p> <ul style="list-style-type: none"> (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided to the patient individually and in person; and (c) the service is at least 20 minutes but less than 50 minutes in duration <p>(See para MN.16.1, MN.16.3 of explanatory notes to this Category)</p> <p>Fee: \$99.95 Benefit: 85% = \$85.00 Extended Medicare Safety Net Cap: \$299.85</p>	
Fee 82371	<p>Eating disorder psychological treatment service provided to an eligible patient in consulting rooms by an eligible occupational therapist if:</p> <ul style="list-style-type: none"> (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided to the patient individually and in person; and (c) the service is at least 50 minutes in duration <p>(See para MN.16.1, MN.16.3 of explanatory notes to this Category)</p> <p>Fee: \$100.20 Benefit: 85% = \$85.20 Extended Medicare Safety Net Cap: \$300.60</p>	
Fee 82373	<p>Eating disorder psychological treatment service provided to an eligible patient at a place other than consulting rooms by an eligible occupational therapist if:</p> <ul style="list-style-type: none"> (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided to the patient individually and in person; and (c) the service is at least 50 minutes in duration <p>(See para MN.16.1, MN.16.3 of explanatory notes to this Category)</p> <p>Fee: \$129.10 Benefit: 85% = \$109.75 Extended Medicare Safety Net Cap: \$387.30</p>	
Fee 82374	<p>Eating disorder psychological treatment service provided to an eligible patient as part of a group of 6 to 10 patients by an eligible occupational therapist if:</p> <ul style="list-style-type: none"> (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided in person; and (c) the service is at least 60 minutes in duration <p>(See para MN.16.1, MN.16.3 of explanatory notes to this Category)</p> <p>Fee: \$25.40 Benefit: 85% = \$21.60 Extended Medicare Safety Net Cap: \$76.20</p>	
Fee 82375	<p>Eating disorder psychological treatment service provided to an eligible patient as part of a group of 6 to 10 patients by an eligible occupational therapist if:</p> <ul style="list-style-type: none"> (a) the service is recommended in the patient's eating disorder treatment and management plan; and 	

4. EATING DISORDER PSYCHOLOGICAL TREATMENT SERVICES PROVIDED BY ELIGIBLE OCCUPATIONAL THERAPISTS	
M16. EATING DISORDERS SERVICES	
	(b) the attendance is by video conference; and (c) the patient is located within a telehealth eligible area; and (d) the patient is, at the time of the attendance, at least 15 kilometres by road from the clinical psychologist; and (e) the service is at least 60 minutes in duration (See para MN.16.1, MN.16.3, MN.16.4 of explanatory notes to this Category) Fee: \$25.40 Benefit: 85% = \$21.60 Extended Medicare Safety Net Cap: \$76.20

5. EATING DISORDER PSYCHOLOGICAL TREATMENT SERVICES PROVIDED BY ELIGIBLE SOCIAL WORKERS	
M16. EATING DISORDERS SERVICES	
	Group M16. Eating Disorders Services
	Subgroup 5. Eating disorder psychological treatment services provided by eligible social workers
	Eating disorder psychological treatment service provided to an eligible patient in consulting rooms by an eligible social worker if:
	(a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided to the patient individually and in person; and (c) the service is at least 20 minutes but less than 50 minutes in duration (See para MN.16.1, MN.16.3 of explanatory notes to this Category) Fee: \$70.95 Benefit: 85% = \$60.35 Extended Medicare Safety Net Cap: \$212.85
Fee 82376	
	Eating disorder psychological treatment service provided to an eligible patient at a place other than consulting rooms by an eligible social worker if:
	(a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided to the patient individually and in person; and (c) the service is at least 20 minutes but less than 50 minutes in duration (See para MN.16.1, MN.16.3 of explanatory notes to this Category) Fee: \$99.95 Benefit: 85% = \$85.00 Extended Medicare Safety Net Cap: \$299.85
Fee 82378	
	Eating disorder psychological treatment service provided to an eligible patient in consulting rooms by an eligible social worker if:
	(a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided to the patient individually and in person; and
Fee 82379	

5. EATING DISORDER PSYCHOLOGICAL TREATMENT SERVICES PROVIDED BY ELIGIBLE SOCIAL WORKERS	
M16. EATING DISORDERS SERVICES	<p>(c) the service is at least 50 minutes in duration</p> <p>(See para MN.16.1, MN.16.3 of explanatory notes to this Category) Fee: \$100.20 Benefit: 85% = \$85.20 Extended Medicare Safety Net Cap: \$300.60</p>
Fee 82381	<p>Eating disorder psychological treatment service provided to an eligible patient at a place other than consulting rooms by an eligible social worker if:</p> <p>(a) the service is recommended in the patient’s eating disorder treatment and management plan; and</p> <p>(b) the service is provided to the patient individually and in person; and</p> <p>(c) the service is at least 50 minutes in duration</p> <p>(See para MN.16.1, MN.16.3 of explanatory notes to this Category) Fee: \$129.10 Benefit: 85% = \$109.75 Extended Medicare Safety Net Cap: \$387.30</p>
Fee 82382	<p>Eating disorder psychological treatment service provided to an eligible patient as part of a group of 6 to 10 patients by an eligible social worker if:</p> <p>(a) the service is recommended in the patient’s eating disorder treatment and management plan; and</p> <p>(b) the service is provided in person; and</p> <p>(c) the service is at least 60 minutes in duration</p> <p>(See para MN.16.1, MN.16.3 of explanatory notes to this Category) Fee: \$25.40 Benefit: 85% = \$21.60 Extended Medicare Safety Net Cap: \$76.20</p>
Fee 82383	<p>Eating disorder psychological treatment service provided to an eligible patient as part of a group of 6 to 10 patients by an eligible social worker if:</p> <p>(a) the service is recommended in the patient’s eating disorder treatment and management plan; and</p> <p>(b) the attendance is by video conference; and</p> <p>(c) the patient is located within a telehealth eligible area; and</p> <p>(d) the patient is, at the time of the attendance, at least 15 kilometres by road from the clinical psychologist; and</p> <p>(e) the service is at least 60 minutes in duration</p> <p>(See para MN.16.1, MN.16.3, MN.16.4 of explanatory notes to this Category) Fee: \$25.40 Benefit: 85% = \$21.60 Extended Medicare Safety Net Cap: \$76.20</p>

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES	1. PSYCHOLOGICAL THERAPIES TELEHEALTH SERVICES
Group M18. Allied health telehealth and phone services	

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES

1. PSYCHOLOGICAL THERAPIES TELEHEALTH SERVICES

Subgroup 1. Psychological therapies telehealth services	
<p>Fee 91166</p>	<p>Psychological therapy health service provided by telehealth attendance by an eligible clinical psychologist if:</p> <p>(a) the person is referred by:</p> <ul style="list-style-type: none"> (i) a medical practitioner, either as part of a GP Mental Health Treatment Plan or as part of a psychiatrist assessment and management plan; or (ii) a specialist or consultant physician specialising in the practice of his or her field of psychiatry; or (iii) a specialist or consultant physician specialising in the practice of his or her field of paediatrics; and <p>(b) the service is provided to the person individually; and</p> <p>(c) at the completion of a course of treatment, the referring medical practitioner reviews the need for a further course of treatment; and</p> <p>(d) on the completion of the course of treatment, the eligible clinical psychologist gives a written report to the referring medical practitioner on assessments carried out, treatment provided and recommendations on future management of the person’s condition; and</p> <p>(e) the service is at least 30 minutes but less than 50 minutes duration</p> <p>(See para AN.0.30, AN.0.76 of explanatory notes to this Category)</p> <p>Fee: \$113.65 Benefit: 85% = \$96.65 Extended Medicare Safety Net Cap: \$340.95</p>
<p>Fee 91167</p>	<p>Psychological therapy health service provided by telehealth attendance by an eligible clinical psychologist if:</p> <p>(a) the person is referred by:</p> <ul style="list-style-type: none"> (i) a medical practitioner, either as part of a GP Mental Health Treatment Plan or as part of a psychiatrist assessment and management plan; or (ii) a specialist or consultant physician specialising in the practice of his or her field of psychiatry; or (iii) a specialist or consultant physician specialising in the practice of his or her field of paediatrics; and <p>(b) the service is provided to the person individually; and</p> <p>(c) at the completion of a course of treatment, the referring medical practitioner reviews the need for a further course of treatment; and</p> <p>(d) on the completion of the course of treatment, the eligible clinical psychologist gives a written report to the referring medical practitioner on assessments carried out, treatment provided and recommendations on future management of the person’s condition; and</p>

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES	1. PSYCHOLOGICAL THERAPIES TELEHEALTH SERVICES
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	<p>(e) the service is at least 50 minutes duration</p> <p>(See para AN.0.30, AN.0.76 of explanatory notes to this Category) Fee: \$166.85 Benefit: 85% = \$141.85 Extended Medicare Safety Net Cap: \$500.00</p>
Fee 91168	<p>Telehealth attendance for a psychological therapy health service provided by an eligible clinical psychologist to a person other than the patient, if:</p> <p>(a) the service is part of the patient’s treatment;</p> <p>(b) the patient has been referred to the eligible clinical psychologist by a referring practitioner; and</p> <p>(c) the service lasts at least 30 minutes but less than 50 minutes</p> <p>(See para MN.6.8 of explanatory notes to this Category) Fee: \$113.65 Benefit: 85% = \$96.65 Extended Medicare Safety Net Cap: \$340.95</p>
Fee 91171	<p>Telehealth attendance for a psychological therapy health service provided by an eligible clinical psychologist to a person other than the patient, if:</p> <p>(a) the service is part of the patient’s treatment;</p> <p>(b) the patient has been referred to the eligible clinical psychologist by a referring practitioner; and</p> <p>(c) the service lasts at least 50 minutes</p> <p>(See para MN.6.8 of explanatory notes to this Category) Fee: \$166.85 Benefit: 85% = \$141.85 Extended Medicare Safety Net Cap: \$500.00</p>

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES	2. PSYCHOLOGIST FOCUSED PSYCHOLOGICAL STRATEGIES TELEHEALTH SERVICES
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	Group M18. Allied health telehealth and phone services
	Subgroup 2. Psychologist focussed psychological strategies telehealth services
Fee 91169	<p>Focussed psychological strategies health service provided by telehealth attendance by an eligible psychologist if:</p> <p>(a) the person is referred by:</p> <p style="padding-left: 20px;">(i) a medical practitioner, either as part of a GP Mental Health Treatment Plan or as part of a psychiatrist assessment and management plan; or</p> <p style="padding-left: 20px;">(ii) a specialist or consultant physician specialising in the practice of his or her field of psychiatry;</p> <p style="padding-left: 20px;">or</p>

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES

2. PSYCHOLOGIST FOCUSED PSYCHOLOGICAL STRATEGIES TELEHEALTH SERVICES

	<p>(iii) a specialist or consultant physician specialising in the practice of his or her field of paediatrics; and</p> <p>(b) the service is provided to the person individually; and</p> <p>(c) at the completion of a course of treatment, the referring medical practitioner reviews the need for a further course of treatment; and</p> <p>(d) on the completion of the course of treatment, the eligible psychologist gives a written report to the referring medical practitioner on assessments carried out, treatment provided and recommendations on future management of the person’s condition; and</p> <p>(e) the service is at least 20 minutes but less than 50 minutes duration</p> <p>(See para AN.0.30, MN.7.1, AN.0.76 of explanatory notes to this Category) Fee: \$80.55 Benefit: 85% = \$68.50 Extended Medicare Safety Net Cap: \$241.65</p>
<p>Fee 91170</p>	<p>Focused psychological strategies health service provided by telehealth attendance by an eligible psychologist if:</p> <p>(a) the person is referred by:</p> <p style="padding-left: 20px;">(i) a medical practitioner, either as part of a GP Mental Health Treatment Plan or as part of a psychiatrist assessment and management plan; or</p> <p style="padding-left: 20px;">(ii) a specialist or consultant physician specialising in the practice of his or her field of psychiatry; or</p> <p style="padding-left: 20px;">(iii) a specialist or consultant physician specialising in the practice of his or her field of paediatrics; and</p> <p>(b) the service is provided to the person individually; and</p> <p>(c) at the completion of a course of treatment, the referring medical practitioner reviews the need for a further course of treatment; and</p> <p>(d) on the completion of the course of treatment, the eligible psychologist gives a written report to the referring medical practitioner on assessments carried out, treatment provided and recommendations on future management of the person’s condition; and</p> <p>(e) the service is at least 50 minutes duration</p> <p>(See para AN.0.30, MN.7.1, AN.0.76 of explanatory notes to this Category) Fee: \$113.65 Benefit: 85% = \$96.65 Extended Medicare Safety Net Cap: \$340.95</p>
<p>Fee 91174</p>	<p>Telehealth attendance for a focussed psychological strategies health service provided by an eligible psychologist to a person other than the patient, if:</p>

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES		2. PSYCHOLOGIST FOCUSED PSYCHOLOGICAL STRATEGIES TELEHEALTH SERVICES
	<ul style="list-style-type: none"> (a) the service is part of the patient’s treatment; (b) the patient has been referred to the eligible psychologist by a referring practitioner; and (c) the service lasts at least 20 minutes but less than 50 minutes <p>(See para MN.7.5 of explanatory notes to this Category) Fee: \$80.55 Benefit: 85% = \$68.50 Extended Medicare Safety Net Cap: \$241.65</p>	
Fee 91177	<p>Telehealth attendance for a focussed psychological strategies health service provided by an eligible psychologist to a person other than the patient, if:</p> <ul style="list-style-type: none"> (a) the service is part of the patient’s treatment; (b) the patient has been referred to the eligible psychologist by a referring practitioner; and (c) the service lasts at least 50 minutes <p>(See para MN.7.5 of explanatory notes to this Category) Fee: \$113.65 Benefit: 85% = \$96.65 Extended Medicare Safety Net Cap: \$340.95</p>	

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES		3. OCCUPATIONAL THERAPIST FOCUSED PSYCHOLOGICAL STRATEGIES TELEHEALTH SERVICES
	Group M18. Allied health telehealth and phone services	
	Subgroup 3. Occupational therapist focussed psychological strategies telehealth services	
Fee 91172	<p>Focussed psychological strategies health service provided by telehealth attendance by an eligible occupational therapist if:</p> <ul style="list-style-type: none"> (a) the person is referred by: <ul style="list-style-type: none"> (i) a medical practitioner, either as part of a GP Mental Health Treatment Plan or as part of a psychiatrist assessment and management plan; or (ii) a specialist or consultant physician specialising in the practice of his or her field of psychiatry; or (iii) a specialist or consultant physician specialising in the practice of his or her field of paediatrics; and (b) the service is provided to the person individually; and (c) at the completion of a course of treatment, the referring medical practitioner reviews the need for a further course of treatment; and (d) on the completion of the course of treatment, the eligible occupational therapist gives a written report to the referring medical practitioner on assessments carried out, treatment provided and recommendations on future management of the person’s condition; and 	

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES

3. OCCUPATIONAL THERAPIST FOCUSED PSYCHOLOGICAL STRATEGIES TELEHEALTH SERVICES

	<p>(e) the service is at least 20 minutes but less than 50 minutes duration</p> <p>(See para AN.0.30, MN.7.1, AN.0.76 of explanatory notes to this Category)</p> <p>Fee: \$70.95 Benefit: 85% = \$60.35 Extended Medicare Safety Net Cap: \$212.85</p>
<p>Fee 91173</p>	<p>Focused psychological strategies health service provided by telehealth attendance by an eligible occupational therapist if:</p> <p>(a) the person is referred by:</p> <p style="padding-left: 40px;">(i) a medical practitioner, either as part of a GP Mental Health Treatment Plan or as part of a psychiatrist assessment and management plan; or</p> <p style="padding-left: 40px;">(ii) a specialist or consultant physician specialising in the practice of his or her field of psychiatry; or</p> <p style="padding-left: 40px;">(iii) a specialist or consultant physician specialising in the practice of his or her field of paediatrics; and</p> <p>(b) the service is provided to the person individually; and</p> <p>(c) at the completion of a course of treatment, the referring medical practitioner reviews the need for a further course of treatment; and</p> <p>(d) on the completion of the course of treatment, the eligible occupational therapist gives a written report to the referring medical practitioner on assessments carried out, treatment provided and recommendations on future management of the person's condition; and</p> <p>(e) the service is at least 50 minutes in duration</p> <p>(See para AN.0.30, MN.7.1, AN.0.76 of explanatory notes to this Category)</p> <p>Fee: \$100.20 Benefit: 85% = \$85.20 Extended Medicare Safety Net Cap: \$300.60</p>
<p>Fee 91194</p>	<p>Telehealth attendance for a focussed psychological strategies health service provided by an eligible occupational therapist to a person other than the patient, if:</p> <p>(a) the service is part of the patient's treatment;</p> <p>(b) the patient has been referred to the eligible occupational therapist by a referring practitioner; and</p> <p>(c) the service lasts at least 20 minutes but less than 50 minutes</p> <p>(See para MN.7.5 of explanatory notes to this Category)</p> <p>Fee: \$70.95 Benefit: 85% = \$60.35 Extended Medicare Safety Net Cap: \$212.85</p>
<p>Fee 91195</p>	<p>Telehealth attendance for a focussed psychological strategies health service provided by an eligible occupational therapist to a person other than the patient, if:</p> <p>(a) the service is part of the patient's treatment;</p>

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES	3. OCCUPATIONAL THERAPIST FOCUSED PSYCHOLOGICAL STRATEGIES TELEHEALTH SERVICES
	<p>(b) the patient has been referred to the eligible occupational therapist by a referring practitioner; and</p> <p>(c) the service lasts at least 50 minutes</p> <p>(See para MN.7.5 of explanatory notes to this Category)</p> <p>Fee: \$100.20 Benefit: 85% = \$85.20 Extended Medicare Safety Net Cap: \$300.60</p>

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES	4. SOCIAL WORKER FOCUSED PSYCHOLOGICAL STRATEGIES TELEHEALTH SERVICES
	Group M18. Allied health telehealth and phone services
	Subgroup 4. Social worker focussed psychological strategies telehealth services
	<p>Focussed psychological strategies health service provided by telehealth attendance by an eligible social worker if:</p> <p>(a) the person is referred by:</p> <p style="padding-left: 40px;">(i) a medical practitioner, either as part of a GP Mental Health Treatment Plan or as part of a psychiatrist assessment and management plan; or</p> <p style="padding-left: 40px;">(ii) a specialist or consultant physician specialising in the practice of his or her field of psychiatry; or</p> <p style="padding-left: 40px;">(iii) a specialist or consultant physician specialising in the practice of his or her field of paediatrics; and</p> <p>(b) the service is provided to the person individually; and</p> <p>(c) at the completion of a course of treatment, the referring medical practitioner reviews the need for a further course of treatment; and</p> <p>(d) on the completion of the course of treatment, the eligible social worker gives a written report to the referring medical practitioner on assessments carried out, treatment provided and recommendations on future management of the person’s condition; and</p> <p>(e) the service is at least 20 minutes but less than 50 minutes duration</p> <p>(See para AN.0.30, MN.7.1, AN.0.76 of explanatory notes to this Category)</p> <p>Fee: \$70.95 Benefit: 85% = \$60.35 Extended Medicare Safety Net Cap: \$212.85</p>
Fee 91175	<p>Focussed psychological strategies health service provided by telehealth attendance by an eligible social worker if:</p> <p>(a) the person is referred by:</p> <p style="padding-left: 40px;">(i) a medical practitioner, either as part of a GP Mental Health Treatment Plan or as part of a psychiatrist assessment and management plan; or</p>
Fee 91176	

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES	4. SOCIAL WORKER FOCUSED PSYCHOLOGICAL STRATEGIES TELEHEALTH SERVICES
	<p>(ii) a specialist or consultant physician specialising in the practice of his or her field of psychiatry; or</p> <p>(iii) a specialist or consultant physician specialising in the practice of his or her field of paediatrics; and</p> <p>(b) the service is provided to the person individually; and</p> <p>(c) at the completion of a course of treatment, the referring medical practitioner reviews the need for a further course of treatment; and</p> <p>(d) on the completion of the course of treatment, the eligible social worker gives a written report to the referring medical practitioner on assessments carried out, treatment provided and recommendations on future management of the person’s condition; and</p> <p>(e) the service is at least 50 minutes duration</p> <p>(See para AN.0.30, MN.7.1, AN.0.76 of explanatory notes to this Category) Fee: \$100.20 Benefit: 85% = \$85.20 Extended Medicare Safety Net Cap: \$300.60</p>
Fee 91196	<p>Telehealth attendance for a focussed psychological strategies health service provided by an eligible social worker to a person other than the patient, if:</p> <p>(a) the service is part of the patient’s treatment;</p> <p>(b) the patient has been referred to the eligible social worker by a referring practitioner and</p> <p>(c) the service lasts at least 20 minutes but less than 50 minutes</p> <p>(See para MN.7.5 of explanatory notes to this Category) Fee: \$70.95 Benefit: 85% = \$60.35 Extended Medicare Safety Net Cap: \$212.85</p>
Fee 91197	<p>Telehealth attendance for a focussed psychological strategies health service provided by an eligible social worker to a person other than the patient, if:</p> <p>(a) the service is part of the patient’s treatment;</p> <p>(b) the patient has been referred to the eligible social worker by a referring practitioner; and</p> <p>(c) the service lasts at least 50 minutes</p> <p>(See para MN.7.5 of explanatory notes to this Category) Fee: \$100.20 Benefit: 85% = \$85.20 Extended Medicare Safety Net Cap: \$300.60</p>

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES	5. NURSE PRACTITIONER TELEHEALTH SERVICES
	<p>Group M18. Allied health telehealth and phone services</p>
	<p>Subgroup 5. Nurse practitioner telehealth services</p>

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES

5. NURSE PRACTITIONER TELEHEALTH SERVICES

<p>Fee 91178</p>	<p>Telehealth attendance by a participating nurse practitioner lasting less than 20 minutes if the attendance includes any of the following that are clinically relevant:</p> <ul style="list-style-type: none"> (a) taking a short history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care. <p>Fee: \$31.05 Benefit: 85% = \$26.40 Extended Medicare Safety Net Cap: \$93.15</p>
<p>Fee 91179</p>	<p>Telehealth attendance by a participating nurse practitioner lasting at least 20 minutes if the attendance includes any of the following that are clinically relevant:</p> <ul style="list-style-type: none"> (a) taking a detailed history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care. <p>Fee: \$58.85 Benefit: 85% = \$50.05 Extended Medicare Safety Net Cap: \$176.55</p>
<p>Fee 91180</p>	<p>Telehealth attendance by a participating nurse practitioner lasting at least 40 minutes if the attendance includes any of the following that are clinically relevant:</p> <ul style="list-style-type: none"> (a) taking an extensive history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care. <p>Fee: \$86.80 Benefit: 85% = \$73.80 Extended Medicare Safety Net Cap: \$260.40</p>
<p>Fee 91192</p>	<p>Telehealth attendance by a participating nurse practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited management.</p>

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES	5. NURSE PRACTITIONER TELEHEALTH SERVICES
	<p>Fee: \$14.20 Benefit: 85% = \$12.10 Extended Medicare Safety Net Cap: \$42.60</p>

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES	6. PSYCHOLOGICAL THERAPIES PHONE SERVICES
	Group M18. Allied health telehealth and phone services
	Subgroup 6. Psychological therapies phone services
	<p>Psychological therapy health service provided by phone attendance by an eligible clinical psychologist if:</p> <p>(a) the person is referred by:</p> <p style="padding-left: 20px;">(i) a medical practitioner, either as part of a GP Mental Health Treatment Plan or as part of a psychiatrist assessment and management plan; or</p> <p style="padding-left: 20px;">(ii) a specialist or consultant physician specialising in the practice of his or her field of psychiatry; or</p> <p style="padding-left: 20px;">(iii) a specialist or consultant physician specialising in the practice of his or her field of paediatrics; and</p> <p>(b) the service is provided to the person individually; and</p> <p>(c) at the completion of a course of treatment, the referring medical practitioner reviews the need for a further course of treatment; and</p> <p>(d) on the completion of the course of treatment, the eligible clinical psychologist gives a written report to the referring medical practitioner on assessments carried out, treatment provided and recommendations on future management of the person's condition; and</p> <p>(e) the service is at least 30 minutes but less than 50 minutes duration</p> <p>(See para AN.0.76 of explanatory notes to this Category)</p> <p>Fee: \$113.65 Benefit: 85% = \$96.65 Extended Medicare Safety Net Cap: \$340.95</p>
Fee 91181	<p>Psychological therapy health service provided by phone attendance by an eligible clinical psychologist if:</p> <p>(a) the person is referred by:</p> <p style="padding-left: 20px;">(i) a medical practitioner, either as part of a GP Mental Health Treatment Plan or as part of a psychiatrist assessment and management plan; or</p> <p style="padding-left: 20px;">(ii) a specialist or consultant physician specialising in the practice of his or her field of psychiatry; or</p>
Fee 91182	

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES	6. PSYCHOLOGICAL THERAPIES PHONE SERVICES
	<p>(iii) a specialist or consultant physician specialising in the practice of his or her field of paediatrics; and</p> <p>(b) the service is provided to the person individually; and</p> <p>(c) at the completion of a course of treatment, the referring medical practitioner reviews the need for a further course of treatment; and</p> <p>(d) on the completion of the course of treatment, the eligible clinical psychologist gives a written report to the referring medical practitioner on assessments carried out, treatment provided and recommendations on future management of the person's condition; and</p> <p>(e) the service is at least 50 minutes duration</p> <p>(See para AN.0.76 of explanatory notes to this Category) Fee: \$166.85 Benefit: 85% = \$141.85 Extended Medicare Safety Net Cap: \$500.00</p>
Fee 91198	<p>Phone attendance for a psychological therapy health service provided by an eligible clinical psychologist to a person other than the patient, if:</p> <p>(a) the service is part of the patient's treatment;</p> <p>(b) the patient has been referred to the eligible clinical psychologist by a referring practitioner; and</p> <p>(c) the service lasts at least 30 minutes but less than 50 minutes</p> <p>(See para MN.6.8 of explanatory notes to this Category) Fee: \$113.65 Benefit: 85% = \$96.65 Extended Medicare Safety Net Cap: \$340.95</p>
Fee 91199	<p>Phone attendance for a psychological therapy health service provided by an eligible clinical psychologist to a person other than the patient, if:</p> <p>(a) the service is part of the patient's treatment;</p> <p>(b) the patient has been referred to the eligible clinical psychologist by a referring practitioner; and</p> <p>(c) the service lasts at least 50 minutes</p> <p>(See para MN.6.8 of explanatory notes to this Category) Fee: \$166.85 Benefit: 85% = \$141.85 Extended Medicare Safety Net Cap: \$500.00</p>

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES	7. PSYCHOLOGIST FOCUSED PSYCHOLOGICAL STRATEGIES PHONE SERVICE
	<p>Group M18. Allied health telehealth and phone services</p>
	<p>Subgroup 7. Psychologist focussed psychological strategies phone service</p>
Fee 91183	<p>Focussed psychological strategies health service provided by phone attendance by an eligible psychologist if:</p>

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES

7. PSYCHOLOGIST FOCUSED PSYCHOLOGICAL STRATEGIES PHONE SERVICE

	<p>(a) the person is referred by:</p> <p style="padding-left: 40px;">(i) a medical practitioner, either as part of a GP Mental Health Treatment Plan or as part of a psychiatrist assessment and management plan; or</p> <p style="padding-left: 40px;">(ii) a specialist or consultant physician specialising in the practice of his or her field of psychiatry; or</p> <p style="padding-left: 40px;">(iii) a specialist or consultant physician specialising in the practice of his or her field of paediatrics; and</p> <p>(b) the service is provided to the person individually; and</p> <p>(c) at the completion of a course of treatment, the referring medical practitioner reviews the need for a further course of treatment; and</p> <p>(d) on the completion of the course of treatment, the eligible psychologist gives a written report to the referring medical practitioner on assessments carried out, treatment provided and recommendations on future management of the person’s condition; and</p> <p>(e) the service is at least 20 minutes but less than 50 minutes duration</p> <p>(See para MN.7.1, AN.0.76 of explanatory notes to this Category) Fee: \$80.55 Benefit: 85% = \$68.50 Extended Medicare Safety Net Cap: \$241.65</p>
<p>Fee 91184</p>	<p>Focused psychological strategies health service provided by phone attendance by an eligible psychologist if:</p> <p>(a) the person is referred by:</p> <p style="padding-left: 40px;">(i) a medical practitioner, either as part of a GP Mental Health Treatment Plan or as part of a psychiatrist assessment and management plan; or</p> <p style="padding-left: 40px;">(ii) a specialist or consultant physician specialising in the practice of his or her field of psychiatry; or</p> <p style="padding-left: 40px;">(iii) a specialist or consultant physician specialising in the practice of his or her field of paediatrics; and</p> <p>(b) the service is provided to the person individually; and</p> <p>(c) at the completion of a course of treatment, the referring medical practitioner reviews the need for a further course of treatment; and</p> <p>(d) on the completion of the course of treatment, the eligible psychologist gives a written report to the referring medical practitioner on assessments carried out, treatment provided and recommendations on future management of the person’s condition; and</p> <p>(e) the service is at least 50 minutes duration</p> <p>(See para MN.7.1, AN.0.76 of explanatory notes to this Category) Fee: \$113.65 Benefit: 85% = \$96.65 Extended Medicare Safety Net Cap: \$340.95</p>

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES		7. PSYCHOLOGIST FOCUSED PSYCHOLOGICAL STRATEGIES PHONE SERVICE
Fee 91200	<p>Phone attendance for a focussed psychological strategies health service provided by an eligible psychologist to a person other than the patient, if:</p> <ul style="list-style-type: none"> (a) the service is part of the patient’s treatment; (b) the patient has been referred to the eligible psychologist by a referring practitioner; and (c) the service lasts at least 20 minutes but less than 50 minutes <p>(See para MN.7.5 of explanatory notes to this Category) Fee: \$80.55 Benefit: 85% = \$68.50 Extended Medicare Safety Net Cap: \$241.65</p>	
Fee 91201	<p>Phone attendance for a focussed psychological strategies health service provided by an eligible psychologist to a person other than the patient, if:</p> <ul style="list-style-type: none"> (a) the service is part of the patient’s treatment; (b) the patient has been referred to the eligible psychologist by a referring practitioner; and (c) the service lasts at least 50 minutes <p>(See para MN.7.5 of explanatory notes to this Category) Fee: \$113.65 Benefit: 85% = \$96.65 Extended Medicare Safety Net Cap: \$340.95</p>	

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES		8. OCCUPATIONAL THERAPIST FOCUSED PSYCHOLOGICAL STRATEGIES PHONE SERVICES
	Group M18. Allied health telehealth and phone services	
	Subgroup 8. Occupational therapist focussed psychological strategies phone services	
Fee 91185	<p>Focused psychological strategies health service provided by phone attendance by an eligible occupational therapist if:</p> <ul style="list-style-type: none"> (a) the person is referred by: <ul style="list-style-type: none"> (i) a medical practitioner, either as part of a GP Mental Health Treatment Plan or as part of a psychiatrist assessment and management plan; or (ii) a specialist or consultant physician specialising in the practice of his or her field of psychiatry; or (iii) a specialist or consultant physician specialising in the practice of his or her field of paediatrics; and (b) the service is provided to the person individually; and (c) at the completion of a course of treatment, the referring medical practitioner reviews the need for a further course of treatment; and 	

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES	8. OCCUPATIONAL THERAPIST FOCUSED PSYCHOLOGICAL STRATEGIES PHONE SERVICES
	<p>(d) on the completion of the course of treatment, the eligible occupational therapist gives a written report to the referring medical practitioner on assessments carried out, treatment provided and recommendations on future management of the person's condition; and</p> <p>(e) the service is at least 20 minutes but less than 50 minutes duration</p> <p>(See para MN.7.1, AN.0.76 of explanatory notes to this Category) Fee: \$70.95 Benefit: 85% = \$60.35 Extended Medicare Safety Net Cap: \$212.85</p>
Fee 91186	<p>Focussed psychological strategies health service provided by phone attendance by an eligible occupational therapist if:</p> <p>(a) the person is referred by:</p> <ul style="list-style-type: none"> (i) a medical practitioner, either as part of a GP Mental Health Treatment Plan or as part of a psychiatrist assessment and management plan; or (ii) a specialist or consultant physician specialising in the practice of his or her field of psychiatry; or (iii) a specialist or consultant physician specialising in the practice of his or her field of paediatrics; and <p>(b) the service is provided to the person individually; and</p> <p>(c) at the completion of a course of treatment, the referring medical practitioner reviews the need for a further course of treatment; and</p> <p>(d) on the completion of the course of treatment, the eligible occupational therapist gives a written report to the referring medical practitioner on assessments carried out, treatment provided and recommendations on future management of the person's condition; and</p> <p>(e) the service is at least 50 minutes in duration</p> <p>(See para MN.7.1, AN.0.76 of explanatory notes to this Category) Fee: \$100.20 Benefit: 85% = \$85.20 Extended Medicare Safety Net Cap: \$300.60</p>
Fee 91202	<p>Phone attendance for a focussed psychological strategies health service provided by an eligible occupational therapist to a person other than the patient, if:</p> <p>(a) the service is part of the patient's treatment;</p> <p>(b) the patient has been referred to the eligible occupational therapist by a referring practitioner; and</p> <p>(c) the service lasts at least 20 minutes but less than 50 minutes</p> <p>(See para MN.7.5 of explanatory notes to this Category) Fee: \$70.95 Benefit: 85% = \$60.35 Extended Medicare Safety Net Cap: \$212.85</p>
Fee 91203	<p>Phone attendance for a focussed psychological strategies health service provided by an eligible occupational therapist to a person other than the patient, if:</p>

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES	8. OCCUPATIONAL THERAPIST FOCUSED PSYCHOLOGICAL STRATEGIES PHONE SERVICES
	<ul style="list-style-type: none"> (a) the service is part of the patient's treatment; (b) the patient has been referred to the eligible occupational therapist by a referring practitioner; and (c) the service lasts at least 50 minutes <p>(See para MN.7.5 of explanatory notes to this Category) Fee: \$100.20 Benefit: 85% = \$85.20 Extended Medicare Safety Net Cap: \$300.60</p>

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES	9. SOCIAL WORKER FOCUSED PSYCHOLOGICAL STRATEGIES PHONE SERVICES
	Group M18. Allied health telehealth and phone services
	Subgroup 9. Social worker focussed psychological strategies phone services
	<p>Focused psychological strategies health service provided by phone attendance by an eligible social worker if:</p> <ul style="list-style-type: none"> (a) the person is referred by: <ul style="list-style-type: none"> (i) a medical practitioner, either as part of a GP Mental Health Treatment Plan or as part of a psychiatrist assessment and management plan; or (ii) a specialist or consultant physician specialising in the practice of his or her field of psychiatry; or (iii) a specialist or consultant physician specialising in the practice of his or her field of paediatrics; and (b) the service is provided to the person individually; and (c) at the completion of a course of treatment, the referring medical practitioner reviews the need for a further course of treatment; and (d) on the completion of the course of treatment, the eligible social worker gives a written report to the referring medical practitioner on assessments carried out, treatment provided and recommendations on future management of the person's condition; and (e) the service is at least 20 minutes but less than 50 minutes duration <p>(See para MN.7.1, AN.0.76 of explanatory notes to this Category) Fee: \$70.95 Benefit: 85% = \$60.35 Extended Medicare Safety Net Cap: \$212.85</p>
Fee 91187	<p>Focused psychological strategies health service provided by phone attendance by an eligible social worker if:</p> <ul style="list-style-type: none"> (a) the person is referred by:
Fee 91188	

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES

9. SOCIAL WORKER FOCUSED PSYCHOLOGICAL STRATEGIES PHONE SERVICES

	<p>(i) a medical practitioner, either as part of a GP Mental Health Treatment Plan or as part of a psychiatrist assessment and management plan; or</p> <p>(ii) a specialist or consultant physician specialising in the practice of his or her field of psychiatry; or</p> <p>(iii) a specialist or consultant physician specialising in the practice of his or her field of paediatrics; and</p> <p>(b) the service is provided to the person individually; and</p> <p>(c) at the completion of a course of treatment, the referring medical practitioner reviews the need for a further course of treatment; and</p> <p>(d) on the completion of the course of treatment, the eligible social worker gives a written report to the referring medical practitioner on assessments carried out, treatment provided and recommendations on future management of the person's condition; and</p> <p>(e) the service is at least 50 minutes duration</p> <p>(See para MN.7.1, AN.0.76 of explanatory notes to this Category) Fee: \$100.20 Benefit: 85% = \$85.20 Extended Medicare Safety Net Cap: \$300.60</p>
<p>Fee 91204</p>	<p>Phone attendance for a focussed psychological strategies health service provided by an eligible social worker to a person other than the patient, if:</p> <p>(a) the service is part of the patient's treatment;</p> <p>(b) the patient has been referred to the eligible social worker by a referring practitioner; and</p> <p>(c) the service lasts at least 20 minutes but less than 50 minutes</p> <p>(See para MN.7.5 of explanatory notes to this Category) Fee: \$70.95 Benefit: 85% = \$60.35 Extended Medicare Safety Net Cap: \$212.85</p>
<p>Fee 91205</p>	<p>Phone attendance for a focussed psychological strategies health service provided by an eligible social worker to a person other than the patient, if:</p> <p>(a) the service is part of the patient's treatment;</p> <p>(b) the patient has been referred to the eligible social worker by a referring practitioner; and</p> <p>(c) the service lasts at least 50 minutes</p> <p>(See para MN.7.5 of explanatory notes to this Category) Fee: \$100.20 Benefit: 85% = \$85.20 Extended Medicare Safety Net Cap: \$300.60</p>

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES

10. NURSE PRACTITIONER PHONE SERVICES

	<p>Group M18. Allied health telehealth and phone services</p>
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M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES

10. NURSE PRACTITIONER PHONE SERVICES

Subgroup 10. Nurse practitioner phone services	
Fee 91189	<p>Phone attendance by a participating nurse practitioner lasting less than 20 minutes if the attendance includes any of the following that are clinically relevant:</p> <ul style="list-style-type: none"> (a) taking a short history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care. <p>Fee: \$31.05 Benefit: 85% = \$26.40 Extended Medicare Safety Net Cap: \$93.15</p>
Fee 91190	<p>Phone attendance by a participating nurse practitioner lasting at least 20 minutes if the attendance includes any of the following that are clinically relevant:</p> <ul style="list-style-type: none"> (a) taking a detailed history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care. <p>Fee: \$58.85 Benefit: 85% = \$50.05 Extended Medicare Safety Net Cap: \$176.55</p>
Fee 91191	<p>Phone attendance by a participating nurse practitioner lasting at least 40 minutes if the attendance includes any of the following that are clinically relevant:</p> <ul style="list-style-type: none"> (a) taking an extensive history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care. <p>Fee: \$86.80 Benefit: 85% = \$73.80 Extended Medicare Safety Net Cap: \$260.40</p>

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES		10. NURSE PRACTITIONER PHONE SERVICES
	Phone attendance by a participating nurse practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited management.	
Fee 91193	Fee: \$14.20 Benefit: 85% = \$12.10 Extended Medicare Safety Net Cap: \$42.60	

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES		11. GENERAL ALLIED HEALTH TELEHEALTH SERVICES
	Group M18. Allied health telehealth and phone services	
	Subgroup 11. General allied health telehealth services	
	Telehealth attendance by an eligible allied health practitioner if:	
	(a) the service is provided to a person who has:	
	(i) a chronic condition; and	
	(ii) complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the person is a resident of an aged care facility, the person's medical practitioner has contributed to a multidisciplinary care plan; and	
	(b) the service is recommended in the person's Team Care Arrangements or multidisciplinary care plan as part of the management of the person's chronic condition and complex care needs; and	
	(c) the person is referred to the eligible allied health practitioner by the medical practitioner using a referral form that has been issued by the Department or a referral form that contains all the components of the form issued by the Department; and	
	(d) the service is provided to the person individually; and	
	(e) the service is of at least 20 minutes duration; and	
	(f) after the service, the eligible allied health practitioner gives a written report to the referring medical practitioner mentioned in paragraph (c):	
	(i) if the service is the only service under the referral—in relation to that service; or	
	(ii) if the service is the first or last service under the referral—in relation to that service; or	
	(iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of—in relation to those matters;	
	to a maximum of 5 services (including any services to which this item, item 93013 or any item in Subgroup 1 of Group M3 of the Allied Health Determination applies) in a calendar year	
	(See para MN.3.1 of explanatory notes to this Category)	
Fee 93000	Fee: \$70.95 Benefit: 85% = \$60.35 Extended Medicare Safety Net Cap: \$212.85	

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES	12. GENERAL ALLIED HEALTH PHONE SERVICES
	Group M18. Allied health telehealth and phone services
	Subgroup 12. General allied health phone services
Fee 93013	<p>Phone attendance by an eligible allied health practitioner if:</p> <p>(a) the service is provided to a person who has:</p> <ul style="list-style-type: none"> (i) a chronic condition; and (ii) complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the person is a resident of an aged care facility, the person’s medical practitioner has contributed to a multidisciplinary care plan; and <p>(b) the service is recommended in the person’s Team Care Arrangements or multidisciplinary care plan as part of the management of the person’s chronic condition and complex care needs; and</p> <p>(c) the person is referred to the eligible allied health practitioner by the medical practitioner using a referral form that has been issued by the Department or a referral form that contains all the components of the form issued by the Department; and</p> <p>(d) the service is provided to the person individually; and</p> <p>(e) the service is of at least 20 minutes duration; and</p> <p>(f) after the service, the eligible allied health practitioner gives a written report to the referring medical practitioner mentioned in paragraph (c):</p> <ul style="list-style-type: none"> (i) if the service is the only service under the referral—in relation to that service; or (ii) if the service is the first or last service under the referral—in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of—in relation to those matters; <p>to a maximum of 5 services (including any services to which this item, item 93000 or any item in Subgroup 1 of Group M3 of the Allied Health Determination applies) in a calendar year</p> <p>(See para MN.3.1 of explanatory notes to this Category)</p> <p>Fee: \$70.95 Benefit: 85% = \$60.35 Extended Medicare Safety Net Cap: \$212.85</p>

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES	13. PREGNANCY SUPPORT COUNSELLING TELEHEALTH SERVICES
	Group M18. Allied health telehealth and phone services
	Subgroup 13. Pregnancy support counselling telehealth services
Fee 93026	<p>Non directive pregnancy support counselling health service provided to a person who is currently pregnant or who has been pregnant in the preceding 12 months by an eligible psychologist, eligible social worker or eligible mental health nurse as a telehealth attendance if:</p>

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES	13. PREGNANCY SUPPORT COUNSELLING TELEHEALTH SERVICES
	<p>(a) the person is concerned about a current pregnancy or a pregnancy that occurred in the 12 months preceding the provision of the first service; and</p> <p>(b) the person is referred by a medical practitioner who is not a specialist or consultant physician; and</p> <p>(c) the service is provided to the person individually; and</p> <p>(d) the eligible psychologist, eligible social worker or eligible mental health nurse does not have a direct pecuniary interest in a health service that has as its primary purpose the provision of services for pregnancy termination; and</p> <p>(e) the service is at least 30 minutes duration;</p> <p>to a maximum of 3 services (including services to which items 81000, 81005, 81010 in the Allied Health Determination, item 4001 of the general medical services table and item 93029, 92136 and 92138 apply) for each pregnancy.</p> <p>The service may be used to address any pregnancy related issues for which non directive counselling is appropriate</p> <p>(See para MN.8.2, MN.8.3, MN.8.4, MN.8.1 of explanatory notes to this Category) Fee: \$83.30 Benefit: 85% = \$70.85 Extended Medicare Safety Net Cap: \$249.90</p>

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES	14. PREGNANCY SUPPORT COUNSELLING PHONE SERVICES
	<p>Group M18. Allied health telehealth and phone services</p>
	<p>Subgroup 14. Pregnancy support counselling phone services</p>
<p>Fee 93029</p>	<p>Non directive pregnancy support counselling health service provided to a person, who is currently pregnant or who has been pregnant in the preceding 12 months by an eligible psychologist, eligible social worker or eligible mental health nurse as a phone attendance if:</p> <p>(a) the person is concerned about a current pregnancy or a pregnancy that occurred in the 12 months preceding the provision of the first service; and</p> <p>(b) the person is referred by a medical practitioner who is not a specialist or consultant physician; and</p> <p>(c) the service is provided to the person individually; and</p> <p>(d) the eligible psychologist, eligible social worker or eligible mental health nurse does not have a direct pecuniary interest in a health service that has as its primary purpose the provision of services for pregnancy termination; and</p> <p>(e) the service is at least 30 minutes duration;</p> <p>to a maximum of 3 services (including services to which items 81000, 81005, 81010 in the Allied Health Determination, item 4001 of the general medical services table and item 93026, 92136 and 92138 apply) for each pregnancy.</p> <p>The service may be used to address any pregnancy related issues for which non directive counselling is appropriate</p>

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES	14. PREGNANCY SUPPORT COUNSELLING PHONE SERVICES
	(See para MN.8.2, MN.8.3, MN.8.4, MN.8.1 of explanatory notes to this Category) Fee: \$83.30 Benefit: 85% = \$70.85 Extended Medicare Safety Net Cap: \$249.90

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES	15. COMPLEX NEURODEVELOPMENTAL DISORDER AND DISABILITY TELEHEALTH SERVICES
	Group M18. Allied health telehealth and phone services
	Subgroup 15. Complex neurodevelopmental disorder and disability telehealth services
Fee 93032	<p>Psychology health service provided by telehealth attendance to a patient aged under 25 years by an eligible psychologist if:</p> <p>(a) the patient was referred by an eligible medical practitioner, or by an eligible allied health practitioner following referral by an eligible medical practitioner, to:</p> <ul style="list-style-type: none"> (i) assist the eligible medical practitioner with diagnostic formulation where the patient has a suspected complex neurodevelopmental disorder or eligible disability; or (ii) contribute to the patient’s treatment and management plan developed by the referring eligible medical practitioner where a complex neurodevelopmental disorder (such as autism spectrum disorder) or eligible disability is confirmed; and <p>(b) the service is provided to the patient individually; and</p> <p>(c) the service is at least 50 minutes duration</p> <p>Up to 4 services to which this item or any of items 82000, 82005, 82010, 82030, 93033, 93040 or 93041 apply may be provided to the same patient on the same day</p> <p>Further information on the requirements for this item are available in the explanatory notes to this Category</p> <p>(See para MN.10.1, MN.10.3, AN.0.25 of explanatory notes to this Category)</p> <p>Fee: \$113.65 Benefit: 85% = \$96.65 Extended Medicare Safety Net Cap: \$340.95</p>
Fee 93033	<p>Speech pathology, occupational therapy, audiology, optometry, orthoptic or physiotherapy health service provided by telehealth attendance to a patient aged under 25 years by an eligible speech pathologist, occupational therapist, audiologist, optometrist, orthoptist or physiotherapist if:</p> <p>(a) the patient was referred by an eligible medical practitioner, or by an eligible allied health practitioner following referral by an eligible medical practitioner, to:</p> <ul style="list-style-type: none"> (i) assist the eligible medical practitioner with diagnostic formulation where the patient has a suspected complex neurodevelopmental disorder or eligible disability; or

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15. COMPLEX NEURODEVELOPMENTAL DISORDER AND DISABILITY TELEHEALTH SERVICES

	<p>(ii) contribute to the patient’s treatment and management plan developed by the referring eligible medical practitioner where a complex neurodevelopmental disorder (such as autism spectrum disorder) or eligible disability is confirmed; and</p> <p>(b) the service is provided to the patient individually; and</p> <p>(c) the service is at least 50 minutes duration</p> <p>Up to 4 services to which this item or any of items 82000, 82005, 82010, 82030, 93032, 93040 or 93041 apply may be provided to the same patient on the same day</p> <p>Further information on the requirements for this item are available in the explanatory notes to this Category</p> <p>(See para MN.10.1, MN.10.3, AN.0.25 of explanatory notes to this Category)</p> <p>Fee: \$100.20 Benefit: 85% = \$85.20 Extended Medicare Safety Net Cap: \$300.60</p>
<p>Fee 93035</p>	<p>Psychology health service provided by telehealth attendance to a patient aged under 25 years for the treatment of a diagnosed complex neurodevelopmental disorder (such as autism spectrum disorder) or eligible disability by an eligible psychologist, if:</p> <p>(a) the patient has a treatment and management plan in place and has been referred by an eligible medical practitioner for a course of treatment consistent with that treatment and management plan; and</p> <p>(b) the service is provided to the patient individually; and</p> <p>(c) the service is at least 30 minutes duration; and</p> <p>(d) on the completion of the course of treatment, the eligible psychologist gives a written report to the referring eligible medical practitioner on assessments (if performed), treatment provided and recommendations on future management of the patient’s condition</p> <p>Up to 4 services to which this item or any of items 82015, 82020, 82025, 82035, 93036, 93043 or 93044 apply may be provided to the same patient on the same day</p> <p>Further information on the requirements for this item are available in the explanatory notes to this Category</p> <p>(See para MN.10.1, MN.10.2, MN.10.3, AN.0.25 of explanatory notes to this Category)</p> <p>Fee: \$113.65 Benefit: 85% = \$96.65 Extended Medicare Safety Net Cap: \$340.95</p>
<p>Fee 93036</p>	<p>Speech pathology, occupational therapy, audiology, optometry, orthoptic or physiotherapy health service provided by telehealth attendance to a patient aged under 25 years for the treatment of a diagnosed complex neurodevelopmental disorder (such as autism spectrum disorder) or eligible disability by an eligible speech pathologist, occupational therapist, audiologist, optometrist, orthoptist or physiotherapist, if:</p> <p>(a) the patient has a treatment and management plan in place and has been referred by an eligible medical practitioner for a course of treatment consistent with that treatment and management plan; and</p> <p>(b) the service is provided to the patient individually; and</p>

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES	15. COMPLEX NEURODEVELOPMENTAL DISORDER AND DISABILITY TELEHEALTH SERVICES
	<p>(c) the service is at least 30 minutes duration; and</p> <p>(d) on the completion of the course of treatment, the eligible speech pathologist, occupational therapist, audiologist, optometrist, orthoptist or physiotherapist gives a written report to the referring eligible medical practitioner on assessments (if performed), treatment provided and recommendations on future management of the patient's condition</p> <p>Up to 4 services to which this item or any of items 82015, 82020, 82025, 82035, 93035, 93043 or 93044 apply may be provided to the same patient on the same day</p> <p>Further information on the requirements for this item are available in the explanatory notes to this Category</p> <p>(See para MN.10.1, MN.10.2, MN.10.3, AN.0.25 of explanatory notes to this Category)</p> <p>Fee: \$100.20 Benefit: 85% = \$85.20 Extended Medicare Safety Net Cap: \$300.60</p>

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES	16. COMPLEX NEURODEVELOPMENTAL DISORDER AND DISABILITY PHONE SERVICES
	Group M18. Allied health telehealth and phone services
	Subgroup 16. Complex neurodevelopmental disorder and disability phone services
Fee 93040	<p>Psychology health service provided by phone attendance to a patient aged under 25 years by an eligible psychologist if:</p> <p>(a) the patient was referred by an eligible medical practitioner, or by an eligible allied health practitioner following referral by an eligible medical practitioner, to:</p> <p style="padding-left: 40px;">(i) assist the eligible medical practitioner with diagnostic formulation where the patient has a suspected complex neurodevelopmental disorder or eligible disability; or</p> <p style="padding-left: 40px;">(ii) contribute to the patient's treatment and management plan developed by the referring eligible medical practitioner where a complex neurodevelopmental disorder (such as autism spectrum disorder) or eligible disability is confirmed; and</p> <p>(b) the service is provided to the patient individually; and</p> <p>(c) the service is at least 50 minutes duration</p> <p>Up to 4 services to which this item or any of items 82000, 82005, 82010, 82030, 93032, 93033 or 93041 apply may be provided to the same patient on the same day</p> <p>Further information on the requirements for this item are available in the explanatory notes to this Category</p> <p>(See para MN.10.1, MN.10.3, AN.0.25 of explanatory notes to this Category)</p> <p>Fee: \$113.65 Benefit: 85% = \$96.65 Extended Medicare Safety Net Cap: \$340.95</p>

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16. COMPLEX NEURODEVELOPMENTAL DISORDER AND DISABILITY PHONE SERVICES

<p>Fee 93041</p>	<p>Speech pathology, occupational therapy, audiology, optometry, orthoptic or physiotherapy health service provided by phone attendance to a patient aged under 25 years by an eligible speech pathologist, occupational therapist, audiologist, optometrist, orthoptist or physiotherapist if:</p> <p>(a) the patient was referred by an eligible medical practitioner, or by an eligible allied health practitioner following referral by an eligible medical practitioner, to:</p> <p style="padding-left: 40px;">(i) assist the eligible medical practitioner with diagnostic formulation where the patient has a suspected complex neurodevelopmental disorder or eligible disability; or</p> <p style="padding-left: 40px;">(ii) contribute to the patient’s treatment and management plan developed by the referring eligible medical practitioner where a complex neurodevelopmental disorder (such as autism spectrum disorder) or eligible disability is confirmed; and</p> <p>(b) the service is provided to the patient individually; and</p> <p>(c) the service is at least 50 minutes duration</p> <p>Up to 4 services to which this item or any of items 82000, 82005, 82010, 82030, 93032, 93033 or 93040 apply may be provided to the same patient on the same day</p> <p>Further information on the requirements for this item are available in the explanatory notes to this Category</p> <p>(See para MN.10.1, MN.10.3, AN.0.25 of explanatory notes to this Category)</p> <p>Fee: \$100.20 Benefit: 85% = \$85.20 Extended Medicare Safety Net Cap: \$300.60</p>
<p>Fee 93043</p>	<p>Psychology health service provided by phone attendance to a patient aged under 25 years for the treatment of a diagnosed complex neurodevelopmental disorder (such as autism spectrum disorder) or eligible disability by an eligible psychologist, if:</p> <p>(a) the patient has a treatment and management plan in place and has been referred by an eligible medical practitioner for a course of treatment consistent with that treatment and management plan; and</p> <p>(b) the service is provided to the patient individually; and</p> <p>(c) the service is at least 30 minutes duration; and</p> <p>(d) on the completion of the course of treatment, the eligible psychologist gives a written report to the referring eligible medical practitioner on assessments (if performed), treatment provided and recommendations on future management of the patient’s condition</p> <p>Up to 4 services to which this item or any of items 82015, 82020, 82025, 82035, 93035, 93036 or 93044 apply may be provided to the same patient on the same day</p> <p>Further information on the requirements for this item are available in the explanatory notes to this Category</p> <p>(See para MN.10.1, MN.10.2, MN.10.3, AN.0.25 of explanatory notes to this Category)</p> <p>Fee: \$113.65 Benefit: 85% = \$96.65 Extended Medicare Safety Net Cap: \$340.95</p>
<p>Fee 93044</p>	<p>Speech pathology, occupational therapy, audiology, optometry, orthoptic or physiotherapy health service provided by phone attendance to a patient aged under 25 years for the treatment of a diagnosed complex neurodevelopmental disorder (such as autism spectrum disorder) or eligible disability by an</p>

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES	16. COMPLEX NEURODEVELOPMENTAL DISORDER AND DISABILITY PHONE SERVICES
	<p>eligible speech pathologist, occupational therapist, audiologist, optometrist, orthoptist or physiotherapist, if:</p> <p>(a) the patient has a treatment and management plan in place and has been referred by an eligible medical practitioner for a course of treatment consistent with that treatment and management plan; and</p> <p>(b) the service is provided to the patient individually; and</p> <p>(c) the service is at least 30 minutes duration; and</p> <p>(d) on the completion of the course of treatment, the eligible speech pathologist, occupational therapist, audiologist, optometrist, orthoptist or physiotherapist gives a written report to the referring eligible medical practitioner on assessments (if performed), treatment provided and recommendations on future management of the patient's condition</p> <p>Up to 4 services to which this item or any of items 82015, 82020, 82025, 82035, 93035, 93036 or 93043 apply may be provided to the same patient on the same day</p> <p>Further information on the requirements for this item are available in the explanatory notes to this Category</p> <p>(See para MN.10.1, MN.10.2, MN.10.3, AN.0.25 of explanatory notes to this Category)</p> <p>Fee: \$100.20 Benefit: 85% = \$85.20</p> <p>Extended Medicare Safety Net Cap: \$300.60</p>

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES	17. TELEHEALTH ATTENDANCE TO PERSON OF ABORIGINAL AND TORRES STRAIT ISLANDER DESCENT
	<p>Group M18. Allied health telehealth and phone services</p>
	<p>Subgroup 17. Telehealth attendance to person of Aboriginal and Torres Strait Islander descent</p>
<p>Fee 93048</p>	<p>Telehealth attendance provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible allied health practitioner if:</p> <p>(a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; or</p> <p>(b) the patient has:</p> <p style="padding-left: 20px;">(i) a chronic condition; and</p> <p style="padding-left: 20px;">(ii) complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the patient is a resident of an aged care facility, the patient's medical practitioner has contributed to a multidisciplinary care plan; and</p> <p style="padding-left: 20px;">(iii) the service is recommended in the patient's Team Care Arrangements or multidisciplinary care plan as part of the management of the patient's chronic condition and complex care needs; and</p>

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES	17. TELEHEALTH ATTENDANCE TO PERSON OF ABORIGINAL AND TORRES STRAIT ISLANDER DESCENT
	<p>(c) the person is referred to the eligible allied health practitioner by a medical practitioner using a referral form issued by the Department or a referral form that contains all the components of the form issued by the Department; and</p> <p>(d) the service is provided to the person individually; and</p> <p>(e) the service is of at least 20 minutes duration; and</p> <p>(f) after the service, the eligible allied health practitioner gives a written report to the referring medical practitioner mentioned in paragraph (b):</p> <ul style="list-style-type: none"> (i) if the service is the only service under the referral—in relation to that service; or (ii) if the service is the first or the last service under the referral—in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of—in relation to those matters; <p>to a maximum of 10 services (including any services to which this item or 93000, 93013 or 93061 or any item in Subgroup 1 of Group M3 or any item in Group M11 of the Allied Health Determination applies) in a calendar year</p> <p>(See para MN.11.1 of explanatory notes to this Category) Fee: \$70.95 Benefit: 75% = \$53.25 85% = \$60.35 Extended Medicare Safety Net Cap: \$212.85</p>

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES	18. PHONE ATTENDANCE TO PERSON OF ABORIGINAL AND TORRES STRAIT ISLANDER DESCENT
	Group M18. Allied health telehealth and phone services
	Subgroup 18. Phone attendance to person of Aboriginal and Torres Strait Islander descent
Fee 93061	<p>Phone attendance provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible allied health practitioner if:</p> <p>(a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; or</p> <p>(b) the patient has</p> <ul style="list-style-type: none"> (i) a chronic condition; and (ii) complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the patient is a resident of an aged care facility, the patient’s medical practitioner has contributed to a multidisciplinary care plan; and (iii) the service is recommended in the patient’s Team Care Arrangements or multidisciplinary care plan as part of the management of the patient’s chronic condition and complex care needs; and

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES

18. PHONE ATTENDANCE TO PERSON OF ABORIGINAL AND TORRES STRAIT ISLANDER DESCENT

	<p>(c) the person is referred to the eligible allied health practitioner by a medical practitioner using a referral form issued by the Department or a referral form that contains all the components of the form issued by the Department; and</p> <p>(d) the service is provided to the person individually; and</p> <p>(e) the service is of at least 20 minutes duration; and</p> <p>(f) after the service, the eligible allied health practitioner gives a written report to the referring medical practitioner mentioned in paragraph (b):</p> <p style="padding-left: 40px;">(i) if the service is the only service under the referral—in relation to that service; or</p> <p style="padding-left: 40px;">(ii) if the service is the first or the last service under the referral—in relation to that service; or</p> <p style="padding-left: 40px;">(iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of—in relation to those matters;</p> <p>to a maximum of 10 services (including any services to which this item or item 93000, 93013, 93048 or any item in Subgroup 1 of Group M3 or any item in Group M11 of the Allied Health Determination applies) in a calendar year</p> <p>(See para MN.11.1 of explanatory notes to this Category) Fee: \$70.95 Benefit: 85% = \$60.35 Extended Medicare Safety Net Cap: \$212.85</p>
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M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES

19. EATING DISORDER DIETETICS TELEHEALTH SERVICES

	Group M18. Allied health telehealth and phone services
	Subgroup 19. Eating disorder dietetics telehealth services
	<p>Dietetics health service provided by telehealth attendance to an eligible patient by an eligible dietitian:</p> <p>(a) the service is recommended in the patient’s eating disorder treatment and management plan; and</p> <p>(b) the service is provided to the patient individually; and</p> <p>(c) the service is of at least 20 minutes in duration.</p> <p>(See para MN.16.2 of explanatory notes to this Category) Fee: \$70.95 Benefit: 85% = \$60.35 Extended Medicare Safety Net Cap: \$212.85</p>
Fee 93074	

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES	20. EATING DISORDER PSYCHOLOGICAL TREATMENT SERVICES TELEHEALTH SERVICES
	Group M18. Allied health telehealth and phone services
	Subgroup 20. Eating disorder psychological treatment services telehealth services
Fee 93076	<p>Eating disorder psychological treatment service provided by telehealth attendance to an eligible patient by an eligible clinical psychologist if:</p> <p>(a) the service is recommended in the patient’s eating disorder treatment and management plan; and</p> <p>(b) the service is provided to the patient individually; and</p> <p>(c) the service is at least 30 minutes but less than 50 minutes in duration.</p> <p>Fee: \$113.65 Benefit: 85% = \$96.65 Extended Medicare Safety Net Cap: \$340.95</p>
Fee 93079	<p>Eating disorder psychological treatment service provided by telehealth attendance to an eligible patient by an eligible clinical psychologist if:</p> <p>(a) the service is recommended in the patient’s eating disorder treatment and management plan; and</p> <p>(b) the service is provided to the patient individually; and</p> <p>(c) the service is at least 50 minutes in duration.</p> <p>(See para MN.16.4 of explanatory notes to this Category)</p> <p>Fee: \$166.85 Benefit: 85% = \$141.85 Extended Medicare Safety Net Cap: \$500.00</p>
Fee 93084	<p>Eating disorder psychological treatment service provided by telehealth attendance to an eligible patient by an eligible psychologist if:</p> <p>(a) the service is recommended in the patient’s eating disorder treatment and management plan; and</p> <p>(b) the service is provided to the patient individually; and</p> <p>(c) the service is at least 20 minutes but less than 50 minutes in duration.</p>

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES

20. EATING DISORDER PSYCHOLOGICAL TREATMENT SERVICES TELEHEALTH SERVICES

	<p>(See para MN.16.4 of explanatory notes to this Category) Fee: \$80.55 Benefit: 85% = \$68.50 Extended Medicare Safety Net Cap: \$241.65</p>
<p>Fee 93087</p>	<p>Eating disorder psychological treatment service provided by telehealth attendance to an eligible patient by an eligible psychologist if:</p> <p>(a) the service is recommended in the patient’s eating disorder treatment and management plan; and</p> <p>(b) the service is provided to the patient individually; and</p> <p>(c) the service is at least 50 minutes in duration.</p> <p>(See para MN.16.4 of explanatory notes to this Category) Fee: \$113.65 Benefit: 85% = \$96.65 Extended Medicare Safety Net Cap: \$340.95</p>
<p>Fee 93092</p>	<p>Eating disorder psychological treatment service provided by telehealth attendance to an eligible patient by an eligible occupational therapist if:</p> <p>(a) the service is recommended in the patient’s eating disorder treatment and management plan; and</p> <p>(b) the service is provided to the patient individually person; and</p> <p>(c) the service is at least 20 minutes but less than 50 minutes in duration.</p> <p>(See para MN.16.4 of explanatory notes to this Category) Fee: \$70.95 Benefit: 85% = \$60.35 Extended Medicare Safety Net Cap: \$212.85</p>
<p>Fee 93095</p>	<p>Eating disorder psychological treatment service provided by telehealth attendance to an eligible patient by an eligible occupational therapist if:</p> <p>(a) the service is recommended in the patient’s eating disorder treatment and management plan; and</p> <p>(b) the service is provided to the patient individually; and</p> <p>(c) the service is at least 50 minutes in duration.</p> <p>(See para MN.16.4 of explanatory notes to this Category) Fee: \$100.20 Benefit: 85% = \$85.20 Extended Medicare Safety Net Cap: \$300.60</p>

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES	20. EATING DISORDER PSYCHOLOGICAL TREATMENT SERVICES TELEHEALTH SERVICES
Fee 93100	<p>Eating disorder psychological treatment service provided by telehealth attendance to an eligible patient by an eligible social worker if:</p> <p>(a) the service is recommended in the patient’s eating disorder treatment and management plan; and</p> <p>(b) the service is provided to the patient individually; and</p> <p>(c) the service is at least 20 minutes but less than 50 minutes in duration.</p> <p>Fee: \$70.95 Benefit: 85% = \$60.35 Extended Medicare Safety Net Cap: \$212.85</p>
Fee 93103	<p>Eating disorder psychological treatment service provided by telehealth attendance to an eligible patient by an eligible social worker if:</p> <p>(a) the service is recommended in the patient’s eating disorder treatment and management plan; and</p> <p>(b) the service is provided to the patient individually; and</p> <p>(c) the service is at least 50 minutes in duration.</p> <p>(See para MN.16.4 of explanatory notes to this Category)</p> <p>Fee: \$100.20 Benefit: 85% = \$85.20 Extended Medicare Safety Net Cap: \$300.60</p>

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES	21. EATING DISORDER DIETETICS PHONE SERVICES
	Group M18. Allied health telehealth and phone services
	Subgroup 21. Eating disorder dietetics phone services
Fee 93108	<p>Dietetics health service provided by phone attendance to an eligible patient by an eligible dietitian:</p> <p>(a) the service is recommended in the patient’s eating disorder treatment and management plan; and</p> <p>(b) the service is provided to the patient individually; and</p> <p>(c) the service is of at least 20 minutes in duration.</p> <p>(See para MN.16.2, MN.16.4 of explanatory notes to this Category)</p> <p>Fee: \$70.95 Benefit: 85% = \$60.35 Extended Medicare Safety Net Cap: \$212.85</p>

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES	22. EATING DISORDER PSYCHOLOGICAL TREATMENT PHONE SERVICES
	Group M18. Allied health telehealth and phone services
	Subgroup 22. Eating disorder psychological treatment phone services
Fee 93110	<p>Eating disorder psychological treatment service provided by phone attendance to an eligible patient by an eligible clinical psychologist if:</p> <p>(a) the service is recommended in the patient’s eating disorder treatment and management plan; and</p> <p>(b) the service is provided to the patient individually; and</p> <p>(c) the service is at least 30 minutes but less than 50 minutes in duration.</p> <p>(See para MN.16.4 of explanatory notes to this Category)</p> <p>Fee: \$113.65 Benefit: 85% = \$96.65 Extended Medicare Safety Net Cap: \$340.95</p>
Fee 93113	<p>Eating disorder psychological treatment service provided by phone attendance to an eligible patient by an eligible clinical psychologist if:</p> <p>(a) the service is recommended in the patient’s eating disorder treatment and management plan; and</p> <p>(b) the service is provided to the patient individually; and</p> <p>(c) the service is at least 50 minutes in duration.</p> <p>(See para MN.16.4 of explanatory notes to this Category)</p> <p>Fee: \$166.85 Benefit: 85% = \$141.85 Extended Medicare Safety Net Cap: \$500.00</p>
Fee 93118	<p>Eating disorder psychological treatment service provided by phone attendance to an eligible patient by an eligible psychologist if:</p> <p>(a) the service is recommended in the patient’s eating disorder treatment and management plan; and</p> <p>(b) the service is provided to the patient individually; and</p> <p>(c) the service is at least 20 minutes but less than 50 minutes in duration.</p> <p>(See para MN.16.4 of explanatory notes to this Category)</p> <p>Fee: \$80.55 Benefit: 85% = \$68.50 Extended Medicare Safety Net Cap: \$241.65</p>

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES

22. EATING DISORDER PSYCHOLOGICAL TREATMENT PHONE SERVICES

<p>Fee 93121</p>	<p>Eating disorder psychological treatment service provided by phone attendance to an eligible patient by an eligible psychologist if:</p> <ul style="list-style-type: none"> (a) the service is recommended in the patient’s eating disorder treatment and management plan; and (b) the service is provided to the patient individually; and (c) the service is at least 50 minutes in duration. <p>(See para MN.16.4 of explanatory notes to this Category) Fee: \$113.65 Benefit: 85% = \$96.65 Extended Medicare Safety Net Cap: \$340.95</p>
<p>Fee 93126</p>	<p>Eating disorder psychological treatment service provided by phone attendance to an eligible patient by an eligible occupational therapist if:</p> <ul style="list-style-type: none"> (a) the service is recommended in the patient’s eating disorder treatment and management plan; and (b) the service is provided to the patient individually person; and (c) the service is at least 20 minutes but less than 50 minutes in duration. <p>(See para MN.16.4 of explanatory notes to this Category) Fee: \$70.95 Benefit: 85% = \$60.35 Extended Medicare Safety Net Cap: \$212.85</p>
<p>Fee 93129</p>	<p>Eating disorder psychological treatment service provided by phone attendance to an eligible patient by an eligible occupational therapist if:</p> <ul style="list-style-type: none"> (a) the service is recommended in the patient’s eating disorder treatment and management plan; and (b) the service is provided to the patient individually; and (c) the service is at least 50 minutes in duration. <p>(See para MN.16.4 of explanatory notes to this Category) Fee: \$100.20 Benefit: 85% = \$85.20 Extended Medicare Safety Net Cap: \$300.60</p>
<p>Fee 93134</p>	<p>Eating disorder psychological treatment service provided by phone attendance to an eligible patient by an eligible social worker if:</p> <ul style="list-style-type: none"> (a) the service is recommended in the patient’s eating disorder treatment and management plan; and (b) the service is provided to the patient individually; and

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES	22. EATING DISORDER PSYCHOLOGICAL TREATMENT PHONE SERVICES
	<p>(c) the service is at least 20 minutes but less than 50 minutes in duration.</p> <p>(See para MN.16.4 of explanatory notes to this Category) Fee: \$70.95 Benefit: 85% = \$60.35 Extended Medicare Safety Net Cap: \$212.85</p>
Fee 93137	<p>Eating disorder psychological treatment service provided by phone attendance to an eligible patient by an eligible social worker if:</p> <p>(a) the service is recommended in the patient’s eating disorder treatment and management plan; and</p> <p>(b) the service is provided to the patient individually; and</p> <p>(c) the service is at least 50 minutes in duration.</p> <p>(See para MN.16.4 of explanatory notes to this Category) Fee: \$100.20 Benefit: 85% = \$85.20 Extended Medicare Safety Net Cap: \$300.60</p>

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES	23. FOLLOW UP SERVICE PROVIDED BY A PRACTICE NURSE OR ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PRACTITIONER – TELEHEALTH SERVICES
	<p>Group M18. Allied health telehealth and phone services</p>
	<p>Subgroup 23. Follow up service provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner – Telehealth Services</p>
Fee 93200	<p>Follow-up telehealth attendance provided by a practice nurse or an Aboriginal and Torres Strait Islander health practitioner, on behalf of a medical practitioner, for an Indigenous person who has received a health check if:</p> <p>(a) the service is provided on behalf of and under the supervision of a medical practitioner; and</p> <p>(b) the service is consistent with the needs identified through the health assessment.</p> <p>Fee: \$32.10 Benefit: 85% = \$27.30 Extended Medicare Safety Net Cap: \$96.30</p>
Fee 93201	<p>Telehealth attendance provided by a practice nurse or an Aboriginal and Torres Strait Islander health practitioner to a person with a chronic disease if:</p> <p>(a) the service is provided on behalf of and under the supervision of a medical practitioner; and</p> <p>(b) the person has a GP management plan, team care arrangements or multidisciplinary care plan in place and the service is consistent with the plan or arrangements.</p>

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES	23. FOLLOW UP SERVICE PROVIDED BY A PRACTICE NURSE OR ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PRACTITIONER – TELEHEALTH SERVICES
	Fee: \$16.15 Benefit: 85% = \$13.75 Extended Medicare Safety Net Cap: \$48.45

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES	24. FOLLOW UP SERVICE PROVIDED BY A PRACTICE NURSE OR ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PRACTITIONER – PHONE SERVICES
	Group M18. Allied health telehealth and phone services
	Subgroup 24. Follow up service provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner – Phone Services
	Follow-up phone attendance provided by a practice nurse or an Aboriginal and Torres Strait Islander health practitioner, on behalf of a medical practitioner, for an Indigenous person who has received a health check if: (a) the service is provided on behalf of and under the supervision of a medical practitioner; and (b) the service is consistent with the needs identified through the health assessment.
Fee 93202	Fee: \$32.10 Benefit: 85% = \$27.30 Extended Medicare Safety Net Cap: \$96.30
	Phone attendance provided by a practice nurse or an Aboriginal and Torres Strait Islander health practitioner to a person with a chronic disease if: (a) the service is provided on behalf of and under the supervision of a medical practitioner; and (b) the person has a GP management plan, team care arrangements or multidisciplinary care plan in place and the service is consistent with the plan or arrangements.
Fee 93203	Fee: \$16.15 Benefit: 85% = \$13.75 Extended Medicare Safety Net Cap: \$48.45

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES	25. ALLIED HEALTH, GROUP DIETETICS TELEHEALTH SERVICES
	Group M18. Allied health telehealth and phone services
	Subgroup 25. Allied health, group dietetics telehealth services
	Telehealth attendance by an eligible dietitian to provide a dietetics health service to a person for assessing the person’s suitability for group services for the management of type 2 diabetes, including taking a comprehensive patient history, identifying an appropriate group services program based on the patient’s needs and preparing the person for the group services if: (a) the person has type 2 diabetes; and
Fee 93284	

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES	25. ALLIED HEALTH, GROUP DIETETICS TELEHEALTH SERVICES
	<p>(b) the person is being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under a GP management plan or, if the person is a resident of an aged care facility, the person's medical practitioner has contributed to a multidisciplinary care plan; and</p> <p>(c) the person is referred to an eligible dietitian by the medical practitioner using a referral form that has been issued by the Department, or a referral form that contains all the components of the form issued by the Department; and</p> <p>(d) the service is provided to the person individually; and</p> <p>(e) the service is of at least 45 minutes duration; and</p> <p>(f) after the service, the eligible dietitian gives a written report to the referring medical practitioner mentioned in paragraph (c);</p> <p>payable once in a calendar year for this or any other assessment for group services item (including services to which this item, item 92386, or items 81100, 81110 and 81120 of the Allied Health Determination apply)</p> <p>(See para MN.9.3, MN.9.4, MN.9.6, MN.9.2 of explanatory notes to this Category)</p> <p>Fee: \$91.05 Benefit: 85% = \$77.40 Extended Medicare Safety Net Cap: \$273.15</p>
Fee 93285	<p>Telehealth attendance by an eligible dietitian to provide a dietetics health service, as a group service for the management of type 2 diabetes if:</p> <p>(a) the person has been assessed as suitable for a type 2 diabetes group service under assessment items 81100, 81110 or 81120 of the Allied Health Determination or items 93284 or 93286; and</p> <p>(b) the service is provided to a person who is part of a group of between 2 and 12 patients; and</p> <p>(c) the service is of at least 60 minutes duration; and</p> <p>(d) after the last service in the group services program provided to the person under this item or items 81105, 81115 or 81125 of the Allied Health Determination, the eligible dietitian prepares, or contributes to, a written report to be provided to the referring medical practitioner; and</p> <p>(e) an attendance record for the group is maintained by the eligible dietitian;</p> <p>to a maximum of 8 group services in a calendar year (including services to which this item or items 81105, 81115 and 81125 of the Allied Health Determination apply)</p> <p>(See para MN.9.3, MN.9.5, MN.9.6 of explanatory notes to this Category)</p> <p>Fee: \$22.65 Benefit: 85% = \$19.30 Extended Medicare Safety Net Cap: \$67.95</p>

M18. ALLIED HEALTH TELEHEALTH AND PHONE SERVICES	26. ALLIED HEALTH, GROUP DIETETICS PHONE
	<p>Group M18. Allied health telehealth and phone services</p>
	<p>Subgroup 26. Allied health, group dietetics phone</p>
Fee 93286	<p>Phone attendance by an eligible dietitian to provide a dietetics health service to a person for assessing the person's suitability for group services for the management of type 2 diabetes, including taking a</p>

**M18. ALLIED HEALTH TELEHEALTH AND
PHONE SERVICES**

**26. ALLIED HEALTH, GROUP DIETETICS
PHONE**

comprehensive patient history, identifying an appropriate group services program based on the patient's needs and preparing the person for the group services if:

(a) the person has type 2 diabetes; and

(b) the person is being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under a GP management plan or, if the person is a resident of an aged care facility, the person's medical practitioner has contributed to a multidisciplinary care plan; and

(c) the person is referred to an eligible dietitian by the medical practitioner using a referral form that has been issued by the Department, or a referral form that contains all the components of the form issued by the Department; and

(d) the service is provided to the person individually; and

(e) the service is of at least 45 minutes duration; and

(f) after the service, the eligible dietitian gives a written report to the referring medical practitioner mentioned in paragraph (c);

payable once in a calendar year for this or any other assessment for group services item (including services to which this item, item 92384, or in items 81100, 81110 and 81120 of the Allied Health Determination apply)

(See para MN.9.3, MN.9.4, MN.9.6, MN.9.2 of explanatory notes to this Category)

Fee: \$91.05 **Benefit:** 85% = \$77.40

Extended Medicare Safety Net Cap: \$273.15

M19. MIDWIFERY TELEHEALTH AND PHONE SERVICES		1. MIDWIFERY TELEHEALTH SERVICES
	Group M19. Midwifery telehealth and phone services	
	Subgroup 1. Midwifery telehealth services	
Fee 91211	<p>Short antenatal telehealth attendance by a participating midwife, lasting up to 40 minutes.</p> <p>(See para MN.13.15, MN.13.16, MN.13.17, MN.13.18 of explanatory notes to this Category)</p> <p>Fee: \$36.85 Benefit: 85% = \$31.35 Extended Medicare Safety Net Cap: \$110.55</p>	
Fee 91212	<p>Long antenatal telehealth attendance by a participating midwife, lasting at least 40 minutes.</p> <p>(See para MN.13.15, MN.13.16, MN.13.17, MN.13.18 of explanatory notes to this Category)</p> <p>Fee: \$60.85 Benefit: 85% = \$51.75 Extended Medicare Safety Net Cap: \$182.55</p>	
Fee 91214	<p>Short postnatal telehealth attendance by a participating midwife, lasting up to 40 minutes.</p> <p>(See para MN.13.15, MN.13.16, MN.13.17, MN.13.18 of explanatory notes to this Category)</p> <p>Fee: \$60.85 Benefit: 85% = \$51.75 Extended Medicare Safety Net Cap: \$182.55</p>	
Fee 91215	<p>Long postnatal telehealth attendance by a participating midwife, lasting at least 40 minutes.</p> <p>(See para MN.13.15, MN.13.16, MN.13.17, MN.13.18 of explanatory notes to this Category)</p> <p>Fee: \$89.50 Benefit: 75% = \$67.15 85% = \$76.10 Extended Medicare Safety Net Cap: \$268.50</p>	

M19. MIDWIFERY TELEHEALTH AND PHONE SERVICES		2. MIDWIFERY PHONE SERVICES
	Group M19. Midwifery telehealth and phone services	
	Subgroup 2. Midwifery phone services	
Fee 91218	<p>Short antenatal phone attendance by a participating midwife, lasting up to 40 minutes.</p> <p>(See para MN.13.15, MN.13.16, MN.13.17, MN.13.18 of explanatory notes to this Category)</p> <p>Fee: \$36.85 Benefit: 85% = \$31.35 Extended Medicare Safety Net Cap: \$110.55</p>	
Fee 91219	<p>Long antenatal phone attendance by a participating midwife, lasting at least 40 minutes.</p> <p>(See para MN.13.15, MN.13.16, MN.13.17, MN.13.18 of explanatory notes to this Category)</p> <p>Fee: \$60.85 Benefit: 75% = \$45.65 85% = \$51.75</p>	

M19. MIDWIFERY TELEHEALTH AND PHONE SERVICES

2. MIDWIFERY PHONE SERVICES

	Extended Medicare Safety Net Cap: \$182.55
Fee 91221	<p>Short postnatal phone attendance by a participating midwife, lasting up to 40 minutes.</p> <p>(See para MN.13.15, MN.13.16, MN.13.17, MN.13.18 of explanatory notes to this Category)</p> <p>Fee: \$60.85 Benefit: 85% = \$51.75</p> <p>Extended Medicare Safety Net Cap: \$182.55</p>
Fee 91222	<p>Long postnatal phone attendance by a participating midwife, lasting at least 40 minutes.</p> <p>(See para MN.13.15, MN.13.16, MN.13.17, MN.13.18 of explanatory notes to this Category)</p> <p>Fee: \$89.50 Benefit: 85% = \$76.10</p> <p>Extended Medicare Safety Net Cap: \$268.50</p>