Medicare Benefits Schedule

Effective - 01 July 2016

Items: 903, 731, 900

Created on 10/08/2016

G1.1 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.

In some cases two levels of fees are applied to the same service in General Medical Services, with each level of fee being allocated a separate item number. The item identified by the letter "S" applies in the case where the procedure has been rendered by a recognised specialist in the practice of his or her specialty and the patient has been referred. The item identified by the letter "G" applies in any other circumstance.

Higher rates of benefits are also 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.

G1.2 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. **The Department of Human Services** 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). In general, the Medicare benefit is 85% of the Schedule fee, otherwise the benefits are

i. 100% of the Schedule fee for services provided by a general practitioner to non-referred, non-admitted patients;

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 public patients);

iv. 75% of the Schedule fee for professional services rendered as part of a privately insured episode of hospital-substitute treatment.

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, the Department of Human Services may request its return from the practitioner concerned.

G1.3 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 the Department of Human Services 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, the Department of Human Services will take recovery action.

The Department of Human Services (DHS) 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 DHS website.

G2.1 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 Department of Human Services to provide these services.

G2.2 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 the Department of Human Services for a Medicare provider number for the locations where these services/referrals/requests will be provided. The form may be downloaded from the Department of Human Services 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.

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.

Practitioners at practices participating in the Practice Incentives Program (PIP) should use a provider number linked to that practice. Under PIP, only services rendered by a practitioner whose provider number is linked to the PIP will be considered for PIP payments.

G2.3 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 the Department of Human Services (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.

G2.4 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.

G2.5 Contact details for the Department of Human Services

Changes to Provider Contact Details

It is important that you contact the Department of Human Services 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 the Department of Human Services at:

Medicare

GPO Box 9822

in your capital city

or

By email: medicare.prov@medicareaustralia.gov.au

You may also be able to update some provider details through HPOS
http://www.medicareaustralia.gov.au/hpos/index.jsp

MBS Interpretations

The day-to-day administration and payment of benefits under the Medicare arrangements is the responsibility of the Department of Human Services. Inquiries concerning matters of interpretation of MBS items should be directed to the Department of Human Services at Email:
askmbs@humanservices.gov.au

or by phone on 132 150

G3.1 Patient eligibility for Medicare

An "eligible person" is a person who resides permanently in Australia. This includes New Zealand citizens and holders of permanent residence visas. Applicants for permanent residence may also be eligible persons, depending on circumstances. Eligible persons must enrol with Medicare before they can receive Medicare benefits.

Medicare covers services provided only in Australia. It does not refund treatment or evacuation expenses overseas.

G3.2 Medicare cards

The **green** Medicare card is for people permanently in Australia. Cards may be issued for individuals or families.

The **blue** Medicare card bearing the words "INTERIM CARD" is for people who have applied for

permanent residence.

Visitors from countries with which Australia has a Reciprocal Health Care Agreement receive a card bearing the words "RECIPROCAL HEALTH CARE"

G3.3 Visitors to Australia and temporary residents

Visitors and temporary residents in Australia are not eligible for Medicare and should therefore have adequate private health insurance.

G3.4 Reciprocal Health Care Agreements

Australia has Reciprocal Health Care Agreements with New Zealand, Ireland, the United Kingdom, the Netherlands, Sweden, Finland, Norway, Italy, Malta, Belgium and Slovenia.

Visitors from these countries are entitled to medically necessary treatment while they are in Australia, comprising public hospital care (as public patients), Medicare benefits and drugs under the Pharmaceutical Benefits Scheme (PBS). Visitors must enroll with the Department of Human Services to receive benefits. A passport is sufficient for public hospital care and PBS drugs.

Exceptions:

- Visitors from Ireland and New Zealand are entitled to public hospital care and PBS drugs, and should present their passports before treatment as they are not issued with Medicare cards.
- Visitors from Italy and Malta are covered for a period of six months only.

The Agreements do not cover treatment as a private patient in a public or private hospital. People visiting Australia for the purpose of receiving treatment are not covered.

G4.1 General Practice

Some MBS items may only be used by general practitioners. For MBS purposes a general practitioner is a medical practitioner who is

(a) vocationally registered under section 3F of the *Health Insurance Act 1973* (see General Explanatory Note below); or

(b) a Fellow of the Royal Australian College of General Practitioners (FRACGP), who participates in, and meets the requirements for the RACGP Quality Assurance and Continuing Medical Education Program; or

(c) a Fellow of the Australian College of Rural and Remote Medicine (FACRRM) who participates in, and meets the requirements for the ACRRM Quality Assurance and Continuing Medical Education Program; or

(d) is undertaking an approved general practice placement in a training program for ***either*** the award of FRACGP***or*** a training program recognised by the RACGP being of an equivalent standard; or

(e) is undertaking an approved general practice placement in a training program for ***either*** the award of FACRRM ***or*** a training program recognised by ACRRM as being of an equivalent standard.

A medical practitioner seeking recognition as an FRACGP should apply to the Department of Human Services, having completed an application form available from the Department of Human Services's website. A general practice trainee should apply to General Practice Education and Training Limited (GPET) for a general practitioner trainee placement. GPET will advise the Department of Human Services when a placement is approved. General practitioner trainees need to apply for a provider number using the appropriate provider number application form available on the Department of Human Services's website.

Vocational recognition of general practitioners

The only qualifications leading to vocational recognition are FRACGP and FACRRM. The criteria for recognition as a GP are:

(a) certification by the RACGP that the practitioner

- is a Fellow of the RACGP; and
- practice is, or will be within 28 days, predominantly in general practice; and
- has met the minimum requirements of the RACGP for taking part in continuing medical education and quality assurance programs.

(b) certification by the General Practice Recognition Eligibility Committee (GPREC) that the practitioner

- is a Fellow of the RACGP; and
- practice is, or will be within 28, predominantly in general practice; and
- has met minimum requirements of the RACGP for taking part in continuing medical education and quality assurance programs.

(c) certification by ACRRM that the practitioner

- is a Fellow of ACRRM; and
- has met the minimum requirements of the ACRRM for taking part in continuing medical education and quality assurance programs.

In assessing whether a practitioner's medical practice is predominantly in general practice, the practitioner must have at least 50% of clinical time and services claimed against Medicare. Regard will also be given as to whether the practitioner provides a comprehensive primary medical service, including treating a wide range of patients and conditions using a variety of accepted medical skills and techniques, providing services away from the practitioner's surgery on request, for example, home visits and making appropriate provision for the practitioner's patients to have access to after hours medical care.

Further information on eligibility for recognition should be directed to:

QI&CPD Program Administrator, RACGP

Tel: 1800 472 247 Email at: qicpd@racgp.org.au

Secretary, General Practice Recognition Eligibility Committee:

Email at gprec@health.gov.au

Executive Assistant, ACRRM:

Tel: (07) 3105 8200 Email at acrrm@acrrm.org.au

How to apply for vocational recognition

Medical practitioners seeking vocational recognition should apply to the Department of Human Services using the approved Application Form available on the the Department of Human Services website: www.humanservices.gov.au. Applicants should forward their applications, as appropriate, to

The Secretariat

The General Practice Recognition Eligibility Committee

National Registration and Accreditation Scheme Policy Section

MDP 152

Department of Health

GPO Box 9848

CANBERRA ACT 2601

email address: gprec@health.gov.au

The Secretariat

The General Practice Recognition Appeal Committee

National Registration and Accreditation Scheme Policy Section

MDP 152

Department of Health

GPO Box 9848

CANBERRA ACT 2601

email address: gprac@health.gov.au

The relevant body will forward the application together with its certification of eligibility to the Department of Human Services CEO for processing.

Continued vocational recognition is dependent upon:

(a) the practitioner's practice continuing to be predominantly in general practice (for medical practitioners in the Register only); and

(b) the practitioner continuing to meet minimum requirements for participation in continuing professional development programs approved by the RACGP or the ACRRM.

Further information on continuing medical education and quality assurance requirements should be directed to the RACGP or the ACRRM depending on the college through which the practitioner is pursuing, or is intending to pursue, continuing medical education.

Medical practitioners refused certification by the RACGP, the ACRRM or GPREC may appeal in writing to The Secretariat, General Practice Recognition Appeal Committee (GPRAC), National Registration and Accreditation Scheme Policy Section, MDP 152, Department of Health, GPO Box 9848, Canberra, ACT, 2601.

Removal of vocational recognition status

A medical practitioner may at any time request the Department of Human Services to remove their name from the Vocational Register of General Practitioners.

Vocational recognition status can also be revoked if the RACGP, the ACRRM or GPREC certifies to the Department of Human Services that it is no longer satisfied that the practitioner should remain vocationally recognised. Appeals of the decision to revoke vocational recognition may be made in writing to GPRAC, at the above address.

A practitioner whose name has been removed from the register, or whose determination has been revoked for any reason must make a formal application to re-register, or for a new determination.

G5.1 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 the Department of Human Services' 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 rebates. Specialist trainees should consult the information available at the Department of Human Services' 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 the Department of Human Services' Medicare website.

The Department of Human Services (DHS) has developed an Health Practitioner Guideline to

substantiate that a valid referral existed (specialist or consultant physician) which is located on the DHS website.

G5.2 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.

G6.1 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.

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 his or her 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) subparagraphs (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) subparagraph (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 <u>not</u> 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.

PublicHospitalPatients

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 whichever is the longer.

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 18 months from the date the service was rendered.

A specialist or a consultant physician is required, if requested by the Department of Human Services CEO, to produce to a medical practitioner who is an employee of the Department of Human Services, 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.

Locumtenens Arrangements

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

G7.1 Billing procedures

The Department of Human Services website contains information on Medicare billing and claiming options. Please visit the Department of Human Services 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 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 on the one occasion and claims multiple Medicare items, the practitioner can choose to bulk bill some or all of those services. Where some but not all of the services are bulk billed a fee may be privately charged for the other service (or services) in excess of the Medicare rebate provided that that fee is only in relation to that service (or services).

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 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).

G8.1 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.

The Department of Human Services monitors health practitioners' claiming patterns. Where the Department of Human Services 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 a 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

G8.2 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).

G8.3 Referral of professional issues to regulatory and other bodies

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

1. 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
2. a statement of concerns of non-compliance by a practitioner with 'professional standards'.

G8.4 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.

G8.5 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.

G8.6 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.

G8.7 Medicare Claims Review Panel

There are MBS items which make the payment of Medicare benefits dependent on a 'demonstrated' clinical need. Services requiring prior approval are those covered by items 11222, 11225, 12207, 12215, 12217, 21965, 21997, 30214, 35534, 32501, 42783, 42786, 42789, 42792, 45019, 45020, 45051, 45528, 45557, 45558, 45559, 45585, 45586, 45588, 45639.

Claims for benefits for these services should be lodged with the Department of Human Services for referral to the National Office of the Department of Human Services for assessment by the Medicare Claims Review Panel (MCRP) and must be accompanied by sufficient clinical and/or photographic evidence to enable the Department of Human Services to determine the eligibility of the service for the payment of benefits.

Practitioners may also apply to the Department of Human Services for prospective approval for proposed surgery.

Applications for approval should be addressed to:

The MCRP Officer

PO Box 9822

SYDNEY NSW 2001

G9.1 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 directbilling 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.

G10.1 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.

In some cases two levels of fees are applied to the same service in General Medical Services, with each level of fee being allocated a separate item number. The item identified by the letter "S" applies in the case where the procedure has been rendered by a recognised specialist in the practice of his or her speciality and the patient has been referred. The item identified by the letter "G" applies in any other circumstances.

Schedule fees are usually adjusted on an annual basis except for Pathology, Diagnostic Imaging and certain other items.

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 public patients). Medical practitioners must indicate on their accounts if a medical service is rendered in these circumstances by placing an asterisk '*' directly after an item number where used; or a description of the professional service, preceded by the word 'patient';

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'.

(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.

(c) **85% of the Schedule fee,** or the Schedule fee less $79.50 (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 National Healthcare Agreement.

A medical service rendered to a patient on the day of admission to, or day of discharge from hospital, *but prior to admission or subsequent to discharge,* will attract benefits at the 85% or 100% level, not 75%. This also applies to a pathology service rendered to a patient prior to admission. Attendances on patients at a hospital (other than patients covered by paragraph (i) above) attract benefits at the 85% level.

The 75% benefit level applies even though a portion of the service (eg. aftercare) may be rendered outside the hospital. 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.

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. Patient's 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.

G10.2 Medicare safety nets

The Medicare Safety Nets provide families and singles 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 and the extended Medicare safety net.

Original Medicare Safety Net:

Under the original Medicare safety net, 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 2016 is $447.40. This threshold applies to all Medicare-eligible singles and families.

Extended Medicare Safety Net:

Under the extended Medicare safety net (EMSN), once an annual threshold in out-of-pocket costs for out-of-hospital Medicare services is reached, Medicare will pay for 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 2016, the threshold for singles and families that hold Commonwealth concession card, families that received Family Tax Benefit Part (A) (FTB(A)) and families that qualify for notional FTB(A) is $647.90. The threshold for all other singles and families in 2016 is $2,030.

The thresholds for both safety nets are usually indexed on 1 January each year.

Individuals are automatically registered with the Department of Human Services for the safety nets; however couples and families are required to register in order to be recognised as a family for the purposes on 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 obtained from the Department of Human Services offices, or completed online at http://www.humanservices.gov.au/customer/services/medicare/medicare-safety-net.

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. As with the safety nets, the EMSN benefit cap only applies to out-of-hospital services.

Where the item has an EMSN benefit cap, the EMSN benefit is calculated as 80% of the out-of-pocket cost for the service. If the calculated EMSN benefit is less than the EMSN benefit cap; then calculated EMSN rebate is paid. If the calculated EMSN benefit is greater than the EMSN benefit cap; the EMSN benefit cap is paid.

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 x 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 is calcualted as $25 x 80% = $20. As this is less than the EMSN benefit cap, the full $20 is paid.

G11.1 Services not listed in the MBS

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

Enquiries about services not listed or on matters of interpretation should be directed to the Department of Human Services on 132 150.

G11.2 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)** ".

G12.1 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 H*ealth Insurance Regulations 1975* specify that 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 170172). The requirement of "personal performance" is met whether or not assistance is provided, according to accepted medical standards:-

(a) All Category 1 (Professional Attendances) items (except 170172, 342-346);

(b) Each of the following items in Group D1 (Miscellaneous Diagnostic):- 11012, 11015, 11018, 11021, 11212, 11304, 11500, 11600, 11627, 11701, 11712, 11724, 11921, 12000, 12003;

(c) All Group T1 (Miscellaneous Therapeutic) items (except 13020, 13025, 13200-13206, 13212-13221, 13703, 13706, 13709, 13750-13760, 13915-13948, 14050, 14053, 14218, 14221 and 14224);

(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 - 12323 when the service is performed by a specialist or consultant physician in the practice of his or her specialty where the patient is referred by another medical practitioner.

G12.2 Services rendered on behalf of medical practitioners

Medical services in Categories 2 and 3 not included in G.12.1 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. the Department of Human Services must be satisfied with the employment and supervision arrangements. 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 selfemployed medical or paramedical personnel, such as radiographers and audiologists, who either bill the patient or the practitioner requesting the service.

G12.3 Mass immunisation

Medicare benefits are payable for a professional attendance that includes an immunisation, provided that the actual administration of the vaccine is not specifically funded through any other Commonwealth or State Government program, nor through an international or private organisation.

The location of the service, or advertising of it, or the number of patients presenting together for it, normally do not indicate a mass immunisation.

G13.1 Services which do not attract Medicare benefits

Services not attracting benefits

(a) telephone consultations;

(b) issue of repeat prescriptions when the patient does not attend the surgery in person;

(c) group attendances (unless otherwise specified in the item, such as items 170, 171, 172, 342, 344 and 346);

(d) non-therapeutic cosmetic surgery;

(e) 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, or in connection with, an injection of blood or ablood product that is autologous.

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) vertebroplasty

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 Papanicolaou 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 examination being a requisite for Social Security benefits or allowances;

(g) 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 on screening for the Prevention of Cervical Cancer (endorsed by the Royal Australian College of General Practitioners, the Royal Australian College of Obstetricians and Gynaecologists, the Royal College of Pathologists of Australasia, the Australian Cancer Society and the National Health and Medical Research Council) is as follows:

(a) an examination interval of two years for a person who has no symptoms or history suggestive of abnormal cervical cytology, commencing between the ages of 18 to 20 years, or one or two years after first sexual intercourse, whichever is later;

(b) cessation of cervical smears at 70 years for a person who has had two normal results within the last five years. A person over 70 who has never been examined, or who request a cervical smear, should be examined.

Note 1: As separate items exist for routine examination of cervical smears, treating practitioners are asked to clearly identify on the request form to the pathologist, if the smear has been taken as a routine examination or for the management of a previously detected abnormality (see paragraph PP.11 of Pathology Services Explanatory Notes in Category 6).

Note 2: 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 of 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.

G14.1 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.

G14.2 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.

G14.3 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.

G14.4 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.

G14.5 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.

G15.1 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 inpatient care.

The Department of Human Services (DHS) has developed an Health Practitioner Guideline to substantiate that a specific treatment was performed which is located on the DHS website.

Associated Notes for Items: 903, 731, 900

A36 Chronic Disease Management Items (Items 721 to 732)

Description	*Item No*	*Minimum claiming period**
Preparation of a GP Management Plan (GPMP)	721	12 months
Coordination of Team Care Arrangements (TCAs)	723	12 months
Contribution to a Multidisciplinary Care Plan, or to a Review of a Multidisciplinary Care Plan, for a patient who is not a care recipient in a residential aged care facility	729	3 months
Contribution to a Multidisciplinary Care Plan, or to a review of a multidisciplinary care plan, for a resident in an aged care facility	731	3 months
Review of a GP Management Plan or Coordination of a Review of Team Care Arrangements	732	3 months

- CDM services may be provided more frequently in the exceptional circumstances defined below.

Exceptional circumstances exist for a patient if there has been a significant change in the patient's clinical condition or care requirements that necessitates the performance of the service for the patient.

Regulatory requirements

Items 721, 723, 729, 731 and 732 provide rebates for GPs to manage chronic or terminal medical conditions by preparing, coordinating, reviewing or contributing to chronic disease management (CDM) plans. They apply for a patient who suffers from at least one medical condition that has been present (or is likely to be present) for at least six months or is terminal.

Restriction of Co-claiming of Chronic Disease and General Consultation Items

Co-claiming of GP consultation items 3, 4, 23, 24, 36, 37, 44, 47, 52, 53, 54, 57, 58, 59, 60, 65, 597, 598, 599, 600, 5000, 5003, 5020, 5023, 5040, 5043, 5060, 5063, 5200, 5203, 5207, 5208, 5220, 5223, 5227 and 5228 with chronic disease management items 721, 723, or 732 is not permitted for the same patient, on the same day.

Patient eligibility

In addition to the eligibility requirements listed in the individual CDM item descriptors, the General Medical Services Table (GMST) mandates the following eligibility criteria:

CDM items 721, 723 and 732

These are:

· available to:

i. patients in the community; and

ii. private in-patients of a hospital (including private in-patients who are residents of aged care facilities) being discharged from hospital.

· not available to:

i. public in-patients of a hospital; or

ii. care recipients in a residential aged care facility.

CDM item 729

This is:

· available to:

i. patients in the community;

ii. both private and public in-patients being discharged from hospital.

· not available to care recipients in a residential aged care facility.

CDM item 731

This item is available to care recipients in a residential aged care facility only.

Item 721

A comprehensive written plan must be prepared describing:

(a) the patient's health care needs, health problems and relevant conditions;

(b) management goals with which the patient agrees;

(c) actions to be taken by the patient;

(d) treatment and services the patient is likely to need;

(e) arrangements for providing this treatment and these services; and

(f) arrangements to review the plan by a date specified in the plan.

In preparing the plan, the provider must:

(a) explain to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) the steps involved in preparing the plan; and

(b) record the plan; and

(c) record the patient's agreement to the preparation of the plan; and

(d) offer a copy of the plan to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees); and

(e) add a copy of the plan to the patient's medical records.

Item 723

When coordinating the development of Team Care Arrangements (TCAs), the medical practitioner must:

(a) consult with at least two collaborating providers, each of whom will provide a different kind of treatment or service to the patient, and one of whom may be another medical practitioner, when making arrangements for the multidisciplinary care of the patient; and

(b) prepare a document that describes:

i. treatment and service goals for the patient;

ii. treatment and services that collaborating providers will provide to the patient; and

iii. actions to be taken by the patient;

iv. arrangements to review (i), (ii) and (iii) by a date specified in the document; and

(c) explain the steps involved in the development of the arrangements to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees);

(d) discuss with the patient the collaborating providers who will contribute to the development of the TCAs and provide treatment and services to the patient under those arrangements; and

(e) record the patient's agreement to the development of TCAs;

(f) give copies of the relevant parts of the document to the collaborating providers;

(g) offer a copy of the document to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees); and

(h) add a copy of the document to the patient's medical records.

One of the minimum two service providers collaborating with the GP can be another medical practitioner. The patient's informal or family carer can be included in the collaborative process but does not count towards the minimum of three collaborating providers.

Item 729

A multidisciplinary care plan means a written plan that:

(a) is prepared for a patient by:

i. a medical practitioner in consultation with two other collaborating providers, each of whom provides a different kind of treatment or service to the patient, and one of whom may be another medical practitioner; or

ii. a collaborating provider (other than a medical practitioner) in consultation with at least two other collaborating providers, each of whom provides a different kind of treatment or services to the patient; and

(b) describes, at least, treatment and services to be provided to the patient by the collaborating providers.

When contributing to a multidisciplinary care plan or to a review of the care plan, the medical practitioner must:

(a) prepare part of the plan or amendments to the plan and add a copy to the patient's medical records; or

(b) give advice to a person who prepares or reviews the plan and record in writing, on the patient's medical records, any advice provided to such a person.

Item 731

A multidisciplinary care plan in a Residential Aged Care Facility (RACF) means a written plan that:

(a) is prepared for a patient by a collaborating provider (other than a medical practitioner, e.g. a RACF), in consultation with at least two other collaborating providers, each of whom provides a different kind of treatment or services to the patient; and

(b) describes, at least, treatment and services to be provided to the patient by the collaborating providers.

When contributing to a multidisciplinary care plan or to a review of the care plan, the medical practitioner must:

(a) prepare part of the plan or amendments to the plan and add a copy to the patient's medical records; or

(b) give advice to a person who prepares or reviews the plan and record in writing, on the patient's medical records, any advice provided to such a person.

Item 731 can also be used for contribution to a multidisciplinary care plan prepared for a resident by another provider before the resident is discharged from a hospital or an approved day-hospital facility, or to a review of such a plan prepared by another provider (not being a service associated with a service to which items 735 to 758 apply).

Item 732

An "associated medical practitioner" is a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) who, if not engaged in the same general practice as the medical practitioner mentioned in that item, performs the service mentioned in the item at the request of the patient (or the patient's guardian).

When reviewing a GP Management Plan, the medical practitioner must:

(a) explain to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) the steps involved in the review;

(b) record the patient's agreement to the review of the plan;

(c) review all the matters set out in the relevant plan;

(d) make any required amendments to the patient's plan;

(e) offer a copy of the amended document to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees);

(f) add a copy of the amended document to the patient's records; and

(g) provide for further review of the amended plan by a date specified in the plan.

When coordinating a review of Team Care Arrangements, a multidisciplinary community care plan or a multidisciplinary discharge care plan, the practitioner must:

(a) explain the steps involved in the review to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees);

(b) record the patient's agreement to the review of the TCAs or plan;

(c) consult with at least two health or care providers (each of whom provides a service or treatment to the patient that is different from each other and different from the service or treatment provided by the medical practitioner who is coordinating the TCAs or plan) to review all the matters set out in the relevant plan;

(d) make any required amendments to the patient's plan;

(e) offer a copy of the amended document to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees);

(f) provide for further review of the amended plan by a date specified in the plan;

(g) give copies of the relevant parts of the amended plan to the collaborating providers; and

(h) add a copy of the amended document to the patient's records.

Item 732 can also be used to COORDINATE A REVIEW OF a Multidisciplinary Community Care Plan (former item 720) or to COORDINATE REVIEW OF A Discharge Care Plan (former item 722), where these services were coordinated or prepared by that medical practitioner (or an associated medical practitioner), and not being a service associated with a service to which items 735-758 apply.

Claiming of benefits

Each service to which item 732 applies (i.e. Review of a GP Management Plan and Review of Team Care Arrangements) may be claimed once in a three-month period, except where there are exceptional circumstances arising from a significant change in the patient's clinical condition or care circumstances that necessitates earlier performance of the service for the patient.

Where a service is provided in exceptional circumstances, the patient's invoice or Medicare voucher should be annotated to indicate the reason why the service was required earlier than the minimum time interval for the relevant item. Payment can then be made.

Item 732 can be claimed twice on the same day providing an item 732 for reviewing a GP Management Plan and another 732 for reviewing Team Care Arrangements (TCAs) are both delivered on the same day as per the MBS item descriptors and explanatory notes.

Medicare requirements when item 732 is claimed twice on the same day

If a GPMP and TCAs are both reviewed on the same date and item 732 is to be claimed twice on the same day, both electronic claims and manual claims need to indicate they were rendered at different times:

· **Non electronic Medicare claiming of items 732 on the same date**
The time that each item 732 commenced should be indicated next to each item

· **Electronic Medicare claiming of item 732 on the same date**
Medicare Easyclaim*:* use the 'ItemOverrideCde" set to 'AP', which flags the item as *not duplicate services*
Medicare Online/ECLIPSE: set the 'DuplicateServiceOverrideIND' to 'Y', which flags the item as *not duplicate*

Items 721, 723 and 732

The GP Management Plan items (721 and 732) and the Team Care Arrangement items (723 and 732) can not be claimed by general practitioners when they are a recognised specialist in the specialty of palliative medicine and treating a referred palliative care patient under items 3005-3093. The referring practitioner is able to provide the CDM services.

Additional information

Advice on the items and further guidance are available at: www.health.gov.au/mbsprimarycareitems

Items 721-732 should generally be undertaken by the patient's **usual medical practitioner**. The patient's "usual GP" means the GP, or a GP working in the medical practice, who has provided the majority of care to the patient over the previous twelve months and/or will be providing the majority of GP services to the patient over the next twelve months. The term "usual GP" would not generally apply to a practice that provides only one specific CDM service.

A **practice nurse, Aboriginal and Torres Strait Islander health practitioner, Aboriginal health worker or other health professional** may assist a GP with items 721, 723, and 732 (e.g. in patient assessment, identification of patient needs and making arrangements for services). However, the GP must meet

all regulatory requirements, review and confirm all assessments and see the patient.

Patients being managed under the chronic disease management items may be eligible for:

- individual allied health services (items 10950 to 10970); and/or
- group allied health services (items 81100 to 81125.

More information on eligibility requirements can be found in the explanatory note for individual allied health services and group allied health services.

Further information is also available for providers from the Department of Human Services provider inquiry line on 132 150.

The Department of Human Services (DHS) has developed two guidelines, the Health Practitioner Guideline to substantiate the preparation of a valid GP Management Plan (for medical practitioners) and the Health Practitioner Guideline to substantiate the coordination of the development of Team Care Arrangements (for medical practitioners) which are both located on the DHS website.

A41 Medication Management Reviews - (Items 900 and 903)

Item 900 - Domiciliary Medication Management Review

A Domiciliary Medication Management Review (DMMR) (Item 900), also known as Home Medicines Review,

is intended to maximise an individual patient's benefit from their medication regimen, and prevent medication-related problems through a team approach, involving the patient's GP and preferred community pharmacy or accredited pharmacist.

Patient eligibility

The item is available to people living in the community who meet the criteria for a DMMR.

The item is not available for in-patients of a hospital, or care recipients in residential aged care facilities.

DMMRs are targeted at patients who are likely to benefit from such a review: patients for whom quality use of medicines may be an issue or; patients who are at risk of medication misadventure because of factors such as their co-morbidities, age or social circumstances, the characteristics of their medicines, the complexity of their medication treatment regimen, or a lack of knowledge and skills to use medicines to their best effect.

Examples of risk factors known to predispose people to medication related adverse events are:

- currently taking five or more regular medications;
- taking more than 12 doses of medication per day;
- significant changes made to medication treatment regimen in the last three months;
- medication with a narrow therapeutic index or medications requiring therapeutic monitoring;
- symptoms suggestive of an adverse drug reaction;
- sub-optimal response to treatment with medicines;
- suspected non-compliance or inability to manage medication related therapeutic devices;
- patients having difficulty managing their own medicines because of literacy or language difficulties, dexterity problems or impaired sight, confusion/dementia or other cognitive difficulties;
- patients attending a number of different doctors, both general practitioners and specialists; and
- recent discharge from a facility / hospital (in the last four weeks).

REGULATORY REQUIREMENTS

In conducting a DMMR, a medical practitioner must:

(a) assess a patient's medication management needs; and

(b) following that assessment, refer the patient to a community pharmacy or an accredited pharmacist for a DMMR; and

(c) with the patient's consent, provide relevant clinical information required for the review; and

(d) discuss with the reviewing pharmacist the results of that review, including suggested medication management strategies; and

(e) develop a written medication management plan following discussion with the patient.

Claiming

A DMMR includes all DMMR-related services provided by the medical practitioner from the time the patient is identified as potentially needing a medication management review to the preparation of a draft medication management plan, and discussion and agreement with the patient.

The benefit is not claimable until all the components of the item have been rendered.

Benefits for a DMMR service under item 900 are payable only once in each 12 month period, except where there has been a significant change in the patient's condition or medication regimen requiring a new DMMR (e.g. diagnosis of a new condition or recent discharge from hospital involving significant changes in medication). In such cases the patient's invoice or Medicare voucher should be annotated to indicate that the DMMR service was required to be provided within 12 months of another DMMR service.

If the DMMR is initiated during the course of a consultation undertaken for another purpose, this consultation may also be claimed separately.

If the consultation at which the medication management review is initiated is only for the purposes of initiating the review only item 900 may be claimed.

If the medical practitioner determines that a DMMR is not necessary, item 900 does not apply. In this case, normal consultation items should be used.

Where a DMMR cannot be completed due to circumstances beyond the control of the medical practitioner (e.g. because the patient decides to not proceed further with the DMMR, or because of a change in the circumstances of the patient), the relevant MBS attendance items should be used.

FURTHER GUIDANCE

A DMMR should generally be undertaken by the patients usual medical practitioner. This is the medical practitioner, or a medical practitioner working in the medical practice, that has provided the majority of services to the patient over the previous 12 months and/or will be providing the majority of services to the patient over the coming 12 months.

The potential need for a DMMR may be identified either by the medical practitioner in the process of a consultation or by receipt of advice from the patient, a carer or another health professional including a pharmacist.

The process of ***referral to a community pharmacyor an accredited pharmacist*** includes:

- Obtaining consent from the patient, consistent with normal clinical practice, for a pharmacist to undertake the medication management review and for a charge to be incurred for the service for which a Medicare rebate is payable. The patient must be clearly informed of the purpose and possible outcomes of the DMMR, the process involved (including that the pharmacist will visit the patient at home, unless the patient prefers another location or other exceptional circumstances apply), what information will be provided to the pharmacist as part of the DMMR, and any additional costs that may be incurred; and
- Provision to the patient's preferred community pharmacy or accredited pharmacist, of relevant clinical information, by the medical practitioner for each individual patient, covering the patient's diagnosis, relevant test results and medication history, and current prescribed medications.
- A DMMR referral form is available for this purpose. If this form is not used, the medical practitioner must provide patient details and relevant clinical information to the patient's preferred community pharmacy or accredited pharmacist.

The ***discussion of the review findings and report including suggested medication management strategies with the reviewing pharmacist*** includes:

- Receiving a written report from the reviewing pharmacist; and
- Discussing the relevant findings and suggested management strategies with the pharmacist (either by phone or face to face); and
- Developing a summary of the relevant review findings as part of the draft medication management plan.

Development of ***a written medication management plan following discussion with the patient*** includes:

· Developing a draft medication management plan and discussing this with the patient; and

· Once agreed, offering a copy of the written medication management plan to the patient and providing a copy to the community pharmacy or accredited pharmacist.

The agreed plan should identify the medication management goals and the proposed medication regimen for the patient.

Item 903 - Residential Medication Management Review

A Residential Medication Management Review (RMMR) is a collaborative service available to permanent residents of a Residential Aged Care facility (RACF) who are likely to benefit from such a review. This includes residents for whom quality use of medicines may be an issue or residents who are at risk of medication misadventure because of a significant change in their condition or medication regimen.

Patient eligibility

RMMRs are available to:

new residents on admission into a RACF; and

existing residents on an 'as required' basis, where in the opinion of the resident's medical practitioner, it is required because of a significant change in medical condition or medication regimen.

RMMRs are not available to people receiving respite care in a RACF. Domiciliary Medicines Reviews are available to these people when they are living in the community setting.

REGULATORY REQUIREMENTS

When conducting a RMMR, a GP must:

(a) discuss the proposed review with the resident and seek the resident's consent to the review; and

(b) collaborate with the reviewing pharmacist about the pharmacist's involvement in the review; and

(c) provide input from the resident's most recent comprehensive medical assessment or, if such an assessment has not been undertaken, provide relevant clinical information for the review and for the resident's records; and

(d) If recommended changes to the resident's medication management arise out

of the review, participate in a post-review discussion (either face-to-face or by telephone) with the pharmacist to discuss the outcomes of the review including:

(i) the findings; and

(ii) medication management strategies; and

(iii) means to ensure that the strategies are implemented and reviewed, including any issues for implementation and follow-up; and

(iv) develop or revise the resident's medication management plan after discussion with the reviewing pharmacist; and

(v) finalise the plan after discussion with the resident.

A medical practitioner's involvement in a residential medication management review also includes:

(a) offering a copy of the medication management plan to the resident (or the resident's carer or representative if appropriate); and

(b) providing copies of the plan for the resident's records and for the nursing staff of the residential aged care facility; and

(c) discussing the plan with nursing staff if necessary.

A post-review discussion is not required if:

(a) there are no recommended changes to the resident's medication management arising out of the review; or

(b) any changes are minor in nature and do not require immediate discussion; or

(c) the pharmacist and medical practitioner agree that issues arising out of the review should be considered in a case conference.

A RMMR comprises all activities to be undertaken by the medical practitioner from the time the resident is identified as potentially needing a medication management review up to the development of a written medication management plan for the resident.

Claiming

A maximum of one RMMR rebate is payable for each resident in any 12 month period, except where there has been a significant change in the resident's medical condition or medication regimen requiring a new RMMR.

Benefits are payable when all the activities of a RMMR have been completed. A RMMR service covers the consultation at which the results of the medication management review are discussed and the medication management plan agreed with the resident:

- any immediate action required to be done at the time of completing the RMMR, based on and as a direct result of information gathered in the RMMR, should be treated as part of the RMMR item;
- any subsequent follow up should be treated as a separate consultation item;
- an additional consultation in conjunction with completing the RMMR should not be undertaken unless it is clinically indicated that a problem must be treated immediately.

In some cases a RMMR may not be able to be completed due to circumstances beyond the control of the medical practitioner (e.g. because the resident decides not to proceed with the RMMR or because of a change in the circumstances of the resident). In these cases the relevant MBS attendance item should be used in relation to any consultation undertaken with the resident.

If the consultation at which the RMMR is initiated, including discussion with resident and obtaining consent for the RMMR, is only for the purposes of initiating the review, only the RMMR item should be claimed.

If the RMMR is initiated during the course of a consultation undertaken for another purpose, the other consultation may be claimed as a separate service and the RMMR service would also apply.

If the medical practitioner determines that an RMMR is not necessary, the RMMR item does not apply. In this case, relevant consultation items should be used.

FURTHER GUIDANCE

A RMMR should generally be undertaken by the resident's 'usual GP'. This is the medical practitioner, or a medical practitioner working in the medical practice, that has provided the majority of care to the resident over the previous 12 months and/or will be providing the majority of care to the resident over the next 12 months.

GPs who provide services on a facility-wide contract basis, and/or who are registered to provide services to RACFs as part of aged care panel arrangements, may also undertake RMMRs for residents as part of their services.

Generally, new residents should receive an RMMR as soon as possible after admission. Where a resident has a Comprehensive Medical Assessment (CMA), the RMMR should be undertaken preferably after the results of the CMA are available to inform the RMMR.

A RMMR service should be completed within a reasonable timeframe. As a general guide, it is expected that most RMMR services would be completed within four weeks of being initiated.

The resident's medical practitioner may identify the potential need for an 'as required' RMMR for existing residents, including in the course of a consultation for another purpose. The potential need for an RMMR may also be identified by the reviewing pharmacist, supply pharmacist, Residential Aged Care Facility staff, the resident, the resident's carer or other members of the resident's health care team.

The medical practitioner should assess the clinical need for an RMMR from a quality use of medicines perspective with the resident as the focus, and initiate an RMMR if appropriate, in collaboration with the reviewing pharmacist.

The medical practitioner and reviewing pharmacist should agree on a preferred means for communicating issues and information relating to the provision of an RMMR service. This should include the method(s) of initiating the RMMR, exceptions to the post review discussion, and the preferred method of communication. This can be done on a facility basis rather than on a case-by-case basis.

Where the provision of RMMR services involves consultation with a resident it should be read as including consultation with the resident and/or their carer or representative where appropriate.

RMMRs do not count for the purposes of derived fee arrangements that apply to other consultations in a Residential Aged Care Facility.

Associated Items: 903, 731, 900

731

CONTRIBUTION by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) to:

(a) **a multidisciplinary care plan for a patient in A RESIDENTIAL AGED CARE FACILITY (RACF)**, prepared by that facility, **or to a REVIEW of such a plan** prepared by a RACF; or

(b) a multidisciplinary care plan prepared for a resident by another provider before the resident is discharged from a hospital or an approved day-hospital facility, or to a review of such a plan prepared by another provider; (not being a service associated with a service to which **items 735 to 758** apply).

This CDM service is for a patient who:

(a) has at least one medical condition that:

i has been (or is likely to be) present for at least six months; or

ii is terminal; and

(b) requires ongoing care from at least three collaborating health or care providers, each of whom provides a different kind of treatment or service to the patient, and at least one of whom is a medical practitioner; and

(c) is a care recipient in a residential aged care facility.

A rebate will not be paid within three months of a previous claim for item 731 or within three months of a claim for item 721, 723, 729 or 732 except where there are exceptional circumstances that require a new contribution to the multidisciplinary care plan.

(See para A36 of explanatory notes to this Category)

Fee: $70.40 **Benefit:** 100% = $70.40

Extended Medicare Safety Net Cap: $211.20

900

Participation by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) in a **Domiciliary Medication Management Review (DMMR)** for patients living in the community setting, where the medical practitioner:

- assesses a patient's medication management needs, and following that assessment, refers the patient to a community pharmacy or an accredited pharmacist for a DMMR, and provides relevant clinical information required for the review, with the patient's consent; and
- discusses with the reviewing pharmacist the results of that review including suggested medication management strategies; and
- develops a written medication management plan following discussion with the patient.

Benefits under this item are payable not more than once in each 12 month period, except where there has been a significant change in the patient's condition or medication regimen requiring a new DMMR.

(See para A41 of explanatory notes to this Category)

Fee: $154.80 **Benefit:** 100% = $154.80

Extended Medicare Safety Net Cap: $464.40

903

Participation by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) in a collaborative **Residential Medication Management Review (RMMR)** for a permanent **resident** of a residential aged care facility, where the medical practitioner:

- discusses and seeks consent for an RMMR from the new or existing resident;
- collaborates with the reviewing pharmacist regarding the pharmacy component of the review;

- provides input from the resident's Comprehensive Medical Assessment (CMA), or if a CMA has not been undertaken, provides relevant clinical information for the resident's RMMR;

- discusses findings of the pharmacist review and proposed medication management strategies with the reviewing pharmacist (unless exceptions apply);

- develops and/or revises a written medication plan for the resident; and

- consults with the resident to discuss the medication management plan and its implementation.

Benefits under this item are payable for one RMMR service for new residents on admission to a Residential Aged Care Facility and for continuing residents on an as required basis, with a maximum of one RMMR for a resident in any 12 month period, except where there has been a significant change in medical condition or medication regimen requiring a new RMMR.

(See para A41 of explanatory notes to this Category)

Fee: $106.00 **Benefit:** 100% = $106.00

Extended Medicare Safety Net Cap: $318.00