



Medicare items for allied health services for people with chronic conditions and complex care needs

Medicare rebates are available for a maximum of 5 allied health services per patient in a calendar year.

These rebates are available to patients that have a chronic condition and complex care needs being managed by their GP under an Enhanced Primary Care (EPC) plan (see **Overview** for requirements). The need for allied health services must be identified in the patient's plan.

Eligible services include those provided by Aboriginal health workers, audiologists, chiropractors, chiropodists, diabetes educators, exercise physiologists, dietitians, mental health workers, occupational therapists, osteopaths, physiotherapists, podiatrists, psychologists and speech pathologists.

Patients need to be referred by their GP. The GP needs to use an *EPC Program referral form for allied health services under Medicare*. Where a GP is referring a patient to more than one allied health professional, s/he will need to use a **separate** referral form for each referral.

The form can be found on the Department of Health and Ageing website at: www.health.gov.au/strengtheningmedicare or ordered by faxing (02) 6289 7120.

Registration with Medicare Australia

Eligible allied health professionals need to register with Medicare Australia to provide services under this initiative. This includes eligible allied health professionals already registered with Medicare Australia under Department of Veterans' Affairs and Office of Hearing Services programs.

Chiropractors, osteopaths, physiotherapists and podiatrists who were registered with Medicare Australia prior to 1 July 2004, to order diagnostic imaging tests under Medicare, **do not need to**

re-register for this measure. However, those who were not registered with Medicare Australia prior to 1 July 2004 need to register for this initiative.

Registration forms are available at the Medicare Australia website at: www.medicareaustralia.gov.au or on request from Medicare Australia on **132 150**.

Overview

Patients need to have in place:

- A GP Management Plan AND Team Care Arrangements (items 721 and 723); OR
- An EPC multidisciplinary care plan (items 720, 722, 730 or 731).

GPs need to use an *EPC Program referral form for allied health services under Medicare* to refer patient.

Allied Health Professionals need to be registered with Medicare Australia.

Maximum of 5 services per patient per calendar year.

A fact sheet about EPC chronic disease management Medicare items 721, 723 and 731 (and others) can be found at the Department of Health and Ageing website at:

www.health.gov.au/internet/wcms/publishing.nsf/Content/pcd-programs-epc-chronicdisease.

A fact sheet about Medicare rebates for **dental care services** also provided under this initiative can be found on the Medicare Australia website at:

www.medicareaustralia.gov.au.

What are the allied health Medicare items?

There are thirteen MBS items for allied health services requested by a GP on an *EPC Program referral form for allied health services under Medicare*:

Item 10950 – services provided by an **Aboriginal Health Worker**

Item 10951 – services provided by a **Diabetes Educator**

Item 10952 – services provided by an **Audiologist**

Item 10953 – services provided by an **Exercise Physiologist**

Item 10954 – services provided by a **Dietitian**

Item 10956 – services provided by a **Mental Health Worker** (includes Aboriginal health workers, mental health nurses, occupational therapists, psychologists and some social workers)

Item 10958 – services provided by an **Occupational Therapist**

Item 10960 – services provided by a **Physiotherapist**

Item 10962 – services provided by a **Podiatrist or Chiropodist**

Item 10964 – services provided by a **Chiropractor**

Item 10966 – services provided by an **Osteopath**

Item 10968 – services provided by a **Psychologist**

Item 10970 – services provided by a **Speech Pathologist**

As Aboriginal health workers, occupational therapists and psychologists may provide both services relevant to their discipline and mental health services, they may use **either** the MBS item relevant to their discipline or the mental health item (10956), depending on the type of service provided.

Eligible mental health nurses and social workers may use only the mental health item (10956).

All other eligible allied health professionals may use only the item relevant to their discipline, eg: a physiotherapist may only use item 10960.

Allied health professionals may set their own fees. However for each item, the Medicare schedule fee is \$55.05, with a Medicare rebate of \$46.80.

Conditions for claiming the items

The items can only be claimed where all of the following conditions are met:

- (a) the service is provided by an allied health professional registered with Medicare Australia for this initiative;
- (b) the service is provided on referral from a medical practitioner (including a general practitioner but not including a specialist or consultant physician);
- (c) the service is specified in an EPC allied health referral form;
- (d) the person is being managed under an EPC plan;
- (e) the person is not an admitted patient of a hospital or day-hospital facility;
- (f) the service provided is of at least 20 minutes duration, to an individual patient, in person;
- (g) the allied health professional has provided a written report on the service to the referring practitioner (**NOTE**: where the allied health professional has provided more than one service to a patient under the same referral from the referring practitioner, the allied health professional is required to provide a written report to the referring practitioner on the first and last service only, and more often if clinically relevant);
- (h) the person has not received more than 5 services to which items 10950-10970 apply, in a calendar year; and
- (i) the service has not been funded through other State or Commonwealth programs (see **Other publicly funded programs**).

What information is required in the report to the GP?

Allied health professionals should provide the referring GP with information about, eg:

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

Is it necessary for the GP to use the referral form?

Yes, GPs are required to use the referral form. However, signed copies of the form no longer need to accompany Medicare claims.

The format of the form may be modified to suit practice software needs. However, its content must remain substantially the same as the original Department of Health and Ageing form. A Microsoft Word version of the form is available at the Department's website: www.health.gov.au/strengtheningmedicare.

If GPs are concerned about the appropriateness of format and/or minor content changes, they may fax copies of modified forms to the Department's EPC and Allied Health Section on (02) 6289 7120 for approval.

Do patients need to obtain a new referral for these services every 12 months?

Yes, where patients wish to access Medicare rebates for services recommended in their EPC plan during their next period of eligibility (that is, the next calendar year), they should see their GP to obtain new referral forms.

The referral remains valid for the stated number of services. If the services are not used during the calendar year in which the patient was referred, the unused services may be used in the next calendar year. However, they will be counted as part of the five rebates for allied health services available to the patient during that calendar year (that is, the maximum number of rebates a patient can access in a calendar is five regardless of how many were accessed the previous year). GPs may choose to use this visit to undertake a review of the patient's EPC plan where appropriate, or to manage the process using a

GP consultation item, depending on the patient's circumstances and needs.

NOTE: It is not necessary to have a new EPC plan prepared every 12 months just to access a new set of allied health referrals. Patients continue to be eligible for rebates for eligible allied health services while they are being managed under an EPC plan, as long as the need for the eligible services continues to be recommended in their plan.

How do patients get a rebate for these services?

When the allied health professional has provided the service s/he may then:

1. seek payment for the service from the patient. The patient then takes the itemised receipt from the allied health professional to Medicare to claim the Medicare rebate. Out of pocket costs will count toward the Medicare safety net; or
2. seek payment for the service directly from Medicare. The patient must first sign an assignment of benefit form and the allied health professional will send that to Medicare for payment. To claim direct payment from Medicare in this way, the allied health professional accepts the value of the Medicare rebate in full payment for the service and will not be able to charge the patient a gap.

The following information must be shown on patients' itemised accounts/receipts:

- patient's name and date of service;
- MBS item number and/or description of service;
- name and practice address or name and provider number of servicing allied health professional;
- name and practice address or name and provider number of referring GP and date of referral; and
- amount charged, total amount paid, and any amount outstanding in relation to the service.

Note: Before a rebate can be paid for the allied health service provided on referral from a GP, either the patient must have already claimed a rebate, or the GP must have already lodged a claim for direct payment from Medicare for the relevant EPC planning item(s).

Allied health professionals may wish to check their responsibilities for Medicare claiming and payment processes with Medicare Australia on **132 150**.

A copy of the MBS booklet *Medicare Benefits for allied health and dental care services provided to people with chronic conditions and complex care needs* is sent to all registered allied health professionals. Updated annually, it contains item descriptors and explanatory notes including information on billing and claiming the items.

Alternatively the Medicare Australia website: www.medicareaustralia.gov.au is a useful resource.

What about patients with private health insurance cover?

Patients need to decide if they will use Medicare or their private health insurance ancillary cover to pay for these services.

Patients with such insurance can either:

1. access rebates from Medicare under the allied health items by following the claiming processes; or
2. see allied health professionals of their choice and claim on their insurance's ancillary benefits. No referral form is required in this case.

Patients cannot use their private health insurance ancillary cover to 'top up' the Medicare rebate.

It is important for patients to check with their health fund which ancillary services are covered and what their out of pocket expenses are likely to be.

Other publicly funded programs

Allied health services funded by other Commonwealth or State programs are not eligible for Medicare rebates. Examples include State government hospital outpatient clinics, the More Allied Health Services (MAHS) program, Commonwealth Hearing

Services Scheme or Department of Veterans' Affairs services for veterans.

Where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or State/Territory clinic, the allied health items can be claimed for services provided by eligible allied health professionals salaried by, or contracted to, the service.

Example of the how the Medicare allied health items work

The GP completes a GP Management Plan (GPMP), coordinates Team Care Arrangements (TCA) and bills the relevant EPC CDM items for Ms Jones.

In finalising her TCA, the GP refers her to an eligible podiatrist for 5 services using the 'EPC referral form for allied health services under Medicare'. This enables her to access Medicare rebates for eligible podiatry services recommended under her TCA.

Ms Jones takes the form to the podiatrist who must retain it for Medicare Australia auditing purposes. The podiatrist provides Ms Jones with her first service.

If Ms Jones' podiatrist accepts the value of the Medicare rebate as full payment for this service, s/he will not be able to charge Ms Jones a gap. Ms Jones must first sign an assignment of benefit form and the podiatrist will send that to Medicare for payment.

If the podiatrist charges a fee higher than the Medicare rebate and Ms Jones elects to pay the full amount up front, she will then need to take/send the itemised receipt from the podiatrist to Medicare to claim the Medicare rebate and have her out of pocket costs counted toward the Medicare safety net.

This billing/claiming process is repeated for Ms Jones's 4 subsequent visits under the same referral.

**For more information call Medicare Australia on 132 150
or go to www.medicareaustralia.gov.au**