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Information about Medicare Australia

This reference guide has been developed to assist Aboriginal and Torres Strait Islander Health Services access Medicare, the Pharmaceutical Benefits Scheme (PBS) and other Medicare Australia administered programs.

Medicare Australia is keen to ensure that health services do not miss out on eligible Medicare payments because of rejected claims or lack of information. Helpful checklists for filling out vouchers and claims headers have also been included.

There is a range of programs, for example, the Practice Incentive Program and the Rural Retention Program, that health services can access. These programs work to enhance service provision by providing financial support. The guide will help you to find out how to access these programs.

Medicare Australia is committed to improving Indigenous access to Medicare and other programs with the implementation of the Indigenous communication strategy.

Across Australia, Medicare Liaison Officers for Indigenous access are available to support Aboriginal and Torres Strait Islander Health Services and provide information about Medicare, the PBS, the Australian Childhood Immunisation Register and other programs.

A major role of the Medicare Liaison Officers for Indigenous Access is to personally visit health services and spend time advising workers about how to administer Medicare in their own service. The Medicare Liaison Officer can help to set up systems to enable smooth Medicare claiming as well as organising Medicare enrolment drives and showing health services staff how they can help to enrol patients, locate missing card numbers and update patient contact details.

Your local Medicare Liaison Officer can be contacted via the Aboriginal and Torres Strait Islander Access line on free call 1800 556 955.

Medicare Australia administers large government health programs including Medicare, the PBS, the Australian Childhood Immunisation Register and the Australian Organ Donor Register.

The goal of Medicare Australia is to improve Australia’s health through payments and information. This is done by making sure we provide all our customers with timely and correct benefit payments, as well as information that will help them make important health decisions.

Medicare Australia is committed to protecting the privacy of the personal information we hold, as well as working to prevent and detect fraud by health service providers.

Access to all of our programs is the right of every Australian and Medicare Australia is working to ensure that there is equality of access for all people.

About the Indigenous communication activities

Medicare Australia has implemented national communication activities as part of a wider strategy to increase access to Medicare and other programs by Aboriginal and Torres Strait Islander people. These activities include a consumer information flier, fact sheet, poster and this reference guide.

Medicare Liaison Officers for Indigenous access are employed to work in the community to carry out enrolment drives, assist with general inquiries via the Aboriginal and Torres Strait Islander Access line and support health services to fully access Medicare. Medicare Australia has an Indigenous Access Program in each state with outreach to internal and external customers.

For more information call the Aboriginal and Torres Strait Islander Access line on 1800 556 955
Medicare enrolment

This section explains the processes and procedures required for the enrolment of consumers.

Medicare enrolment

Australians who live permanently in Australia are generally eligible to enrol in Medicare.

- Most Aboriginal and Torres Strait Islander primary health care services and some specific Queensland and Northern Territory health services, have been granted exemptions under subsection 19(2) of the *Health Insurance Act 1973* (HIA) which allows Medicare benefits to be paid for certain primary health care services. Aboriginal and Torres Strait Islander primary health care services that have been granted a subsection 19(2) exemption are also granted an exemption under subsection 19(5) which allows Medicare benefits to be paid for pathology tests as part of health screening for specified conditions.

- Your patients must be enrolled with Medicare before your health service can be paid a Medicare benefit.

- When your patients are travelling they will need their Medicare card in case they need to see a doctor or buy medicine.

- When providing prescription medicines, pharmacies need to record the Medicare number of the person buying the medicines. This means everyone needs to show a Medicare card. If someone doesn’t have their Medicare card and it’s an emergency, at the discretion of the pharmacist a special number provided by Medicare Australia can be used.

- A child’s Medicare enrolment sets up their immunisation record. Having no immunisation record may affect Centrelink payments to the parents and General Practice Immunisation Incentives (GPII) payments to the Health Service.

Reciprocal Health Care Agreements (RHCA) for visitors to Australia

RHCA provides cover to visitors to Australia for subsidised PBS medicines and necessary medical treatment for any ill health or injury. Australia has RHCA with the following countries for the stated periods:

- The United Kingdom, including Northern Ireland—duration of visit;
- Peoples Republic of Ireland (Southern Ireland)—duration of visit—(PBS and Public Hospital treatment only—may be billed for the service);
- Norway—duration of visit;
- Sweden—duration of visit;
- Netherlands—duration of visit;
- Finland—duration of visit;
- Italy—six months;
- Malta—six months; and
- New Zealand—duration of visit—(PBS and Public Hospital treatment only—may be billed for the service).

Visitors to Australia who are not eligible for Medicare can be treated by the health service and billed for the service. For further information, please contact the Aboriginal and Torres Strait Islander Access line.

For more information call the Aboriginal and Torres Strait Islander Access line on 1800 556 955
Medicare cards

1. Card number
2. Issue number (this number increases by one each time a card is replaced)
3. Patient identifier number
4. Patient’s first given name
5. Initial of second given name
6. Surname
7. Effective ‘valid to’ date (the month and year the card will expire)

Messages about Medicare cards

- Expired cards cannot be used to bulk bill so health services may miss out on funding.
- Medicare cards expire every seven years or when the patient’s details change.
- It is important that Medicare has current address details to be able to post out new Medicare cards.

Your patients can change their contact details by using the Aboriginal and Torres Strait Islander Medicare enrolment and amendment form or calling the Aboriginal and Torres Strait Islander Access line. Your help to keep your patients’ Medicare details up-to-date will assist your patients and your health service.

Procedures for expired Medicare cards

If the Medicare card expired more than six months ago, an Aboriginal and Torres Strait Islander Medicare enrolment and amendment form must be completed. Documentation to confirm that the person has resided in Australia during the expired period must accompany this form, for example, a letter from employer, tax documents or proof of identity form completed by an authorised referee.

Required documents to enrol a child under six months

Babies and children can be enrolled using the Aboriginal and Torres Strait Islander Enrolment and amendment form or general Medicare Claim form. Proof of identification for the child needs to be provided. These include:

- Birth certificate
- Extract of birth certificate
- Centrelink document
- Certification (on letterhead) provided by medical practitioner
- Hospital baby book (blue/yellow book) which has been certified by the hospital (hospital stamp or official sticker from the hospital)
- Proof of identity section on the Aboriginal and Torres Strait Islander enrolment and amendment form completed by an authorised referee.

Required documents to enrol children between six months and 15 years

If a child is being enrolled in Medicare for the first time and is aged between six months and 15 years, it will be necessary to prove the child’s identity as well as checking that the child is eligible to enrol in Medicare.
Required identification documents for enrolment

An Aboriginal and Torres Strait Islander Enrolment and amendment form completed by a parent, plus one document to prove identity and one document to prove eligibility are required.

Documents that prove the identity of a child include:

- Birth certificate
- Extract of birth certificate
- Centrelink document
- Document issued by a hospital certifying the birth
- Certification (on letterhead) provided by medical practitioner
- Passport
- Hospital baby book (blue/yellow book) which has been certified by the hospital (hospital stamp or official sticker from hospital)

Proof of identity section on the Aboriginal and Torres Strait Islander enrolment and amendment form completed by an authorised referee.

Documents that prove eligibility to Medicare benefits include:

- School exam report or letter from school
- Bank account statement
- Student identification card
- Financial institution card
- Proof of age card.

Please note: this list is not exhaustive and other documents may be acceptable.

Aboriginal and Torres Strait Islander Medicare Enrolment and amendment form
What can the form be used for?

- enrol with Medicare for the first time
- change of name
- change of address
- order a duplicate card
- order a replacement card (lost, stolen, damaged or expired)
- add a newborn baby to an existing Medicare card
- copy or transfer off an existing Medicare card.

The enrolment form has detailed instructions on how to complete the form.

Identification requirements

Identification (ID) needs to be provided to enrol in Medicare. One of the following pieces of ID can be shown or the proof of identity completed by an authorised referee:

- current passport
- photographic driver’s licence
- birth certificate or birth extract
- Australian armed services papers.

If original document cannot be provided, a certified photocopy of the ID or a completed proof of identity section is required for each person enrolling with Medicare.

An Aboriginal Health Worker, a community Elder, School Principal or Centrelink Officer can certify a form of ID by sighting the original document, then photocopying it and noting on the photocopy ‘this is a true copy of the original document’ and signing it.

If a person does not have any of the forms of identification listed, an approved referee is to complete the proof of identity on the Aboriginal and Torres Strait Islander Enrolment and amendment form.

An approved referee can be a community Elder, a school principal, a Centrelink Officer, a council chairperson, a medical or health service manager or nurse, a minister of religion or a welfare organisation worker.
Proof of identity section

Completing the proof of identity (section 7 on the back of the form)

All of the following sections need to be completed by the referee:

• name of the referee

• applicant (the person who requires proof of identity) details—including their name and address—the name should be the name they are most commonly known as—you should also write any other names that the applicant is or has been known by

• declaration—to be signed and dated by the referee

• the name of the organisation the referee represents, for example, community council or local school.

The referee must have known the applicant for a period of six months or more or confirm the applicant’s identity by using official records such as medical records or school records.
**Prisoners and inmates of State institutions**

Generally, a prisoner will be an eligible person for Medicare purposes as they will be an Australian resident and will probably be an Australian citizen or fit one of the other groups of eligible persons. For an initial enrolment, it is necessary that they meet the usual requirements.

Even though a prisoner may be an eligible person, subsection 19(2) of the HIA provides that:

‘Unless the Minister otherwise directs, a Medicare benefit is not payable in respect of a professional service that has been rendered by or on behalf of, or under an agreement with:

- the Commonwealth
- a State
- a local governing authority or
- an authority established by a law of the Commonwealth, a law of a State or a law of an internal territory.’

This means that medical services provided to prisoners or those on remand would generally be regarded as services provided by a State and, as a result, Medicare benefits would not be payable.

**Documents required when ordering a replacement card:**

- completed Aboriginal and Torres Strait Islander Enrolment and amendment form
- Release papers.

**Day release**

If a prisoner seeks medical treatment while on approved day release and that medical treatment is not provided, arranged or required to be provided by the prison authorities, Medicare benefits are payable as the service has been provided outside the arrangement under which the State cares for the prisoner.

**Documents required to order a replacement card when on day release:**

- completed Aboriginal and Torres Strait Islander Enrolment and amendment form
- Document/letter from the prison stating the prisoner is on day release.

**Home detention**

Home detention services provide for a prisoner to reside in a normal residential home under the control of a supervisor. The prisoner’s movements are subject to approval by the supervisor of the home. Medical services are not arranged by the State and inmates are expected to arrange their own medical care with the approval of their supervisor. Medicare benefits are payable for these services. However, in instances when inmates are subject to drug counselling, these services may be provided by the State and the costs covered by the State authorities.

**Documents required when ordering a replacement card when on home detention:**

- completed Aboriginal and Torres Strait Islander Enrolment and amendment form
- Document/letter from the prison stating the prisoner is on home detention.

**Inmates of other State institutions**

Inmates are a State responsibility and are not entitled to Medicare benefits for medical services rendered on behalf of the State. However, there will be instances where individuals who attend an institution on a daily or short-term basis, arrange and receive medical treatment outside the institution. Provided the person is eligible, Medicare benefits are payable for these services.
Aboriginal and Torres Strait Islander identifier question
An Aboriginal and Torres Strait Islander identifier question has been included on all Medicare enrolment forms. Answering this question is voluntary.

- Statistical data on the usage of Medicare by Aboriginal and Torres Strait Islander people will be given to the Department of Health and Ageing (DoHA) and Department of Immigration and Multicultural Affairs.
- There are strict requirements to ensure that information provided to the government is 'de-identified'. Data that is de-identified means that there is no way the data can be used to specify or identify any individual.
- This information may be used to improve government services, health programs and general outcomes for Indigenous people.
- If at any time an individual no longer wishes to be identified as Aboriginal or Torres Strait Islander, they can have the information removed from their Medicare records by calling the Aboriginal and Torres Strait Islander Access line.

Enrolment—questions and answers

What can I do if a patient comes to our health service without a Medicare card?

- If the patient is enrolled with Medicare, call the Aboriginal and Torres Strait Islander Access line and provide the patient's details to see if a card number can be located.
- If a patient needs to be enrolled with Medicare, complete the Aboriginal and Torres Strait Islander enrolment and amendment form and post or fax it to your local Medicare Liaison Officer for Indigenous Access with a certified copy of one of the approved forms of identification, or the completed proof of identity section completed by an authorised referee.
- A certified copy of a form of identification or a proof of identity is required for each person enrolling with Medicare.

Who can be an approved referee for the proof of identity section?
An approved referee can be a community Elder, a school principal, a Centrelink Officer, a council chairperson, a medical or health service manager or nurse, a minister of religion or a welfare organisation worker.

How can the referee authorise the proof of identity?
The referee needs to have known the applicant for a period of six months or more, or confirm the applicant's identity by using official records, such as medical records or school records.

What if a child, who is enrolled with Medicare is brought in to see a doctor and is being looked after by a family member?

- If the child has been brought in by a family member who is only looking after the child for the day or a short period of time and they don't have the child's Medicare number with them, call the Aboriginal and Torres Strait Islander Access line with the child's details to see if the child's card number can be located.
- A child cannot be transferred from one card to another without the approval of the adults enrolled on both cards. For further information and assistance call the Aboriginal and Torres Strait Islander Access line.

Why should Medicare cardholders tell Medicare about address changes?
Cardholders should tell Medicare about address changes so that when their card expires, the new card or a reminder letter can be sent to their new address. It also means that any Medicare letters or information will be sent to the right address. People are able to change their address by calling the Aboriginal and Torres Strait Islander Access line. Your help to keep your patients’ Medicare details up-to-date will assist your patients.
What if a parent comes in with a baby who is not yet enrolled with Medicare and needs to see a doctor—can we bill Medicare for seeing the baby?

If a baby, up to six months old needs to see a doctor and the baby’s name is not on the parent’s Medicare card, Medicare can still be bulk billed for services for the baby by:

- asking the parent to complete a Medicare enrolment form for the baby;
- imprinting the parent’s card on the assignment (DB2) voucher and writing the baby’s name under the imprinted names;
- attaching the completed enrolment form to the assignment voucher; and
- sending them to Medicare with the claim.

However, if your health service is using Medicare Australia online claiming you would need to contact Medicare Liaison Officer for Indigenous Access to arrange an enrolment of the baby.

How old must a child be before they can have their own Medicare card?

- With parental or guardian consent, a child can have their own Medicare card at any age.
- Usually a child will need to be 15 years of age or older before they can ask for their own Medicare card. If there is a case where a child is under the age of 15 but is not living at home, call the Aboriginal and Torres Strait Islander Access line to discuss.

What should I do if a patient’s Medicare card has expired?

- If the card expired less than six months ago the patient can call the Aboriginal and Torres Strait Islander Access line to have the card replaced. However if the patient is unable to do so, then with permission of the patient, it may be more appropriate for health centre staff to liaise directly with Medicare.
- If the card expired more than six months ago, an Aboriginal and Torres Strait Islander Medicare enrolment and amendment form must be submitted, with documentation to confirm that the person has resided in Australia during the expired period, for example a letter from employer, tax documents or proof of identify form competed by an authorised referee.
Provider registration

This section relates to requirements for medical practitioners and allied health professionals for registration and claiming of services provided to clients from service providers who have exemption under subsection 19(2).

Medicare provider numbers

What is a provider number?

Provider numbers are issued to doctors by Medicare for each location at which they see patients. These are referred to as location specific numbers. These numbers are used to identify the different places from which doctors are providing services and making Medicare claims.

- All doctors at your health service will need to complete the Application for Provider Number for a Medical Practitioner form (3136).
- A provider number is required for each location at which the doctor provides services.
- It is up to the doctor to apply for any new provider numbers they may need.
- This number must be used only at the specific location for which it is issued when billing Medicare.
- If a doctor does not have a provider number for a location, claims made from that location will be rejected.
- The provider number consists of eight characters eg. 999000AB.
  1) The first six digits are unique to the doctor and remain the same regardless of where the doctor practices.
  2) The last two characters can be a combination of a number and a letter, or two letters (these identify the practice location where the doctor works).

For more information call the Aboriginal and Torres Strait Islander Access line on 1800 556 955
What is subsection 19(2)?

Aboriginal and Torres Strait Islander primary health care services are usually funded by either Commonwealth or State/Territory funding arrangements. Under subsection 19(2) of the HIA, unless the Minister directs otherwise, Medicare benefits cannot be paid for services provided by salaried doctors who work for a health service funded in this way.

An exemption to subsection 19(2) has been granted to some Aboriginal and Torres Strait Islander primary health care services and certain remote communities in Queensland and the Northern Territory where services are provided by the State/Territory. This exemption allows Medicare benefits to be paid for GP type services.

This means that doctors who are paid a salary by an Aboriginal and Torres Strait Islander primary health care service can bill Medicare for the primary health care services they provide.

Approval for Medicare benefits to be paid is granted on the following conditions:

- The health service accepts the Medicare benefit as full payment for the service.
- The medical practitioner, allied health or dental professional has a formal agreement with the health service in relation to Medicare benefits, and uses a pay group link or electronic funds transfer link to transfer Medicare benefits to the Aboriginal and Torres Strait Islander primary health care service.
- The Aboriginal and Torres Strait Islander primary health care service uses all Medicare funds received from bulk billing under the subsection 19(2) Arrangements specifically for the provision of additional primary health care services to Aboriginal and Torres Strait Islander people.
- The Aboriginal and Torres Strait Islander primary health care service provides Medicare Australia or DoHA, when asked, with information on the provider numbers of medical practitioners/allied health/dental professionals employed by the health service, including their start and finish dates, pay group link and electronic funds transfer links.

For more information call the Aboriginal and Torres Strait Islander Access line on 1800 556 955
At least once a year Medicare Australia will send a survey form to all Aboriginal and Torres Strait Islander primary health care services that have been granted a subsection 19(2) exemption. You will be asked to confirm or amend the details held by Medicare Australia about the doctors, allied health professionals and dental professionals who work at your health service including those who have started working at your service or who have left since the previous survey. This information is used by DoHA to estimate the total Medicare expenditure associated with the subsection 19(2) exemptions.

**What is subsection 19(5)?**

Under subsection 19(5) of the HIA, unless the Minister directs otherwise, Medicare benefits are not payable for pathology tests associated with health screening. All Aboriginal and Torres Strait Islander primary health care services that have been granted a subsection 19(2) exemption have also been granted a subsection 19(5) exemption for specific conditions.

If your Aboriginal and Torres Strait Islander primary health care service conducts health screening for the detection and management of sexually transmissible infections, diabetes, renal or cardiovascular disease, Medicare can be claimed by the pathologist for the pathology test. (The health service can claim the consultation item for this service).

If you are not sure whether your Aboriginal and Torres Strait Islander primary health care service has been granted approval under subsection 19(2) or 19(5), call the Aboriginal and Torres Strait Islander Access line.

**What is a pay group link?**

Pay group links tell Medicare who and where to pay the money for Medicare claims. This link enables a doctor to have Medicare benefits made payable to the Aboriginal and Torres Strait Islander primary health care service.

- All doctors employed by a subsection 19(2) approved Aboriginal and Torres Strait Islander primary health care service or identified as a QLD or NT health hospital or clinic on a salary or contract basis, must have a pay group link established with Medicare Australia. This ensures that Medicare benefits are paid directly to the clinic or State/Territory health department under the subsection 19(2) arrangements.
- This is because the doctors are already paid by the Aboriginal and Torres Strait Islander primary health care service.
- All doctors at your health service will need to complete the Application for Provider Number for a Medical Practitioner form (3136) and the Request for Pay Group Link form (3137).
- All doctors who are salaried Medical Officers of the Queensland or Northern Territory Governments who bill Medicare for services to health services and communities approved under subsection 19(2), must have a pay group link established with Medicare Australia. This ensures that Medicare benefits are paid to the State/Territory Government to use in providing additional primary health care services for agreed Aboriginal and Torres Strait Islander communities.
Medicare Australia

Request for Pay Group Link

1. Request for Pay Group Link
Medicare benefit cheques are usually made payable to the practitioner at their practice address. A pay group link enables a practitioner to have Medicare benefit cheques made payable to another payee associated with the practice and/or another address. Cheques can only be sent to the requested pay group link from the date the application has been processed.

2. Personal details
Family name: ___________________________ First name: ___________________________ Date of birth: ___________________________ Tax number: ___________________________
Please quote provider number for which the Pay Group Link will be established:
Contact telephone number (during business hours): ___________________________

3. Mailing address (used for correspondence about provider number information, vocational registration, practice placements):

4. Practice address for which Pay Group Link sought:

5. Replaced payee (if different to applicant):

Address of payee (for mailing of payments):

6. Where the payee is a third party, the payee (or person properly authorised in the case of a body corporate or other entity) must agree to the arrangement by signing below:

Signature of payee: ___________________________ Date: ___________________________

7. Declaration
I declare that, to the best of my knowledge and belief, all the information provided on this form is true and correct.

Signature of applicant: ___________________________ Date: ___________________________

Please note: Medicare Australia policy concerning pay group links is that where a pay group to a third party is terminated by the practitioner, the third party will be routinely advised of the termination.

After date of termination of pay group link any outstanding claims processed will be payable to the “payee” recorded at the time of processing.

A pay group link can be overridden where the “payee provider” section of the Direct Bill claim form (DB1) is completed.

Temporary resident doctors
For a temporary resident doctor (TRD) specific documentation is required when applying for a provider number. They must submit:

1) a completed application form for a Medicare provider number for a medical practitioner;
2) evidence of current medical registration held with the state medical registration authority in the state in which they will be working;
3) certified copies of pages from their passport including the information page, Australian entry visa and entry stamp;
4) a letter of support from the employer outlining why the practitioner requires access to a Medicare provider and prescriber number, the location the services will be rendered from and the dates the practitioner will be employed (i.e. start and end date of employment); and
5) a certified copy of their employment contract (if there is one).

Most TRD applications are forwarded to the DoHA for approval under section 19AB of the HIA. Exemptions will specify where and for how long the doctor can have access to Medicare benefit for services they render. These applications can take up to 28 days to be processed.

Overseas Trained Doctors
The provisions of sections 19AB and 19AA of the HIA apply to overseas trained doctors (OTDs). An OTD first registered with an Australian medical registration authority on or after 1 January 1997 is generally subject to provisions of section 19AB (ten year moratorium). However, as an Australian permanent resident or Australian citizen, the provisions of section 19AA of the HIA must also be considered. Under section 19AA, for a practitioner to obtain access to a Medicare benefit for their services they must:

• hold a recognised post graduate qualification; or
• be a Fellow of the Royal Australian College of General Practitioners; or
• be an Australian vocationally registered medical practitioner; or
• be in an approved specialist or GP training program; or
• be in an approved placement under section 3GA of the HIA.

An OTD must meet the criteria of section 19AA before an application for a 19AB exemption is made to DoHA.

Again the following documentation is to be submitted:

1) a completed application form for a Medicare provider number for a medical practitioner;
2) evidence of current medical registration held with the state medical registration authority in the state in which they will be working;
3) certified copies of pages from their passport including the information page, Australian permanent residency visa and/or Australian citizenship certificate;
4) letter of support from the employer outlining why the practitioner requires access to a Medicare provider and prescriber number, the location the services will be rendered from and the dates the practitioner will be employed (i.e. start and end date of employment) (this is not required when the practitioner submits 3GA placement approval documents);
5) a certified copy of their employment contract (if there is one); and
6) if a recognised post graduate qualification is not held, 3GA placement approval advice.

Applications for OTDs subject to 19AB are forwarded to DoHA for approval. A time and location specific section 19AB exemption alone will not give OTDs access to a Medicare benefit for services they render; they must also meet the criteria of section 19AA. Again, these applications can take up to 28 days to be processed.

Section 19AB exemptions cannot be backdated under any circumstances. It is an offence under section 19CC of the HIA for a practitioner to knowingly render a service prior to the issuance of a 19AB exemption without advising the patient prior to the consultation that a Medicare benefit will not be payable.

Once a section 19AB exemption is issued, it is faxed to the Provider Liaison section in the relevant state for processing.
Medicare Benefits Schedule (MBS)

This section contains information on professional services covered by Medicare. It also has notes to explain the Medicare program and each part of the Schedule in detail.

Understanding the MBS
The MBS is written by DoHA and is administered by Medicare Australia. The MBS is updated annually on the 1 November and the supplement is issued annually on the 1 May. For further enquiries please call the Aboriginal and Torres Strait Islander Access line.

Each professional service contained in the MBS has been allocated a unique item number.
The MBS is supplied as a book to all registered doctors. It is also on DoHA’s website at www.health.gov.au.

Outline of coloured information sections in the MBS

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<th>Colour</th>
<th>Section</th>
</tr>
</thead>
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<td>Introduction and General Notes</td>
</tr>
<tr>
<td>Buff</td>
<td>Professional Attendances</td>
</tr>
<tr>
<td>Ochre</td>
<td>Services provided by Nurses Allied and Dental Health Professionals</td>
</tr>
<tr>
<td>Blue</td>
<td>Diagnostic Procedures and Investigations</td>
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<tr>
<td>Red</td>
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<tr>
<td>Teal (Aqua)</td>
<td>Relative Value Guide (anaesthetic services)</td>
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<td>Oral and Maxillofacial Services by approved Dental Practitioners</td>
</tr>
<tr>
<td>Purple</td>
<td>Diagnostic Imaging Services</td>
</tr>
<tr>
<td>Yellow</td>
<td>Pathology Services</td>
</tr>
</tbody>
</table>

Further advice and information can be obtained by contacting the Aboriginal and Torres Strait Islander Access line.

Multiple consultations
Payment of benefit may be made for several attendances with a patient on the same day by the same medical practitioner, provided the subsequent attendances are not a continuation of the initial or earlier attendances.

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

Where two or more attendances are made on the one day by the same medical practitioner, the time of each attendance should be stated on the account (for example 10.30am and 3.15pm) in order to assist in the assessment of benefits.

For more information call the Aboriginal and Torres Strait Islander Access line on 1800 556 955
Services that do not attract Medicare benefits

Services that do not attract Medicare benefits include:
- telephone consultations
- the issue of repeat prescriptions when the patient is not in attendance
- post mortem examinations
- the issue of death or cremation certificates
- health education, weight reduction or fitness classes
- health screening.

For a more comprehensive list of services that do not attract Medicare benefits refer to the MBS.

MBS item—73840

In recognition of the higher incidence of diabetes in Indigenous communities, approved health services are able to monitor diabetic control with a blood test for glycosylated haemoglobin and bill Medicare for the service.

Description

Quantitation of glycosylated haemoglobin performed in the management of established diabetes—each test to a maximum of 4 tests in a 12 month period where:
- the health service is provided in a Commonwealth funded Aboriginal and Torres Strait Islander health and medical service; and
- the Aboriginal and Torres Strait Islander health and medical service participates in a recognised quality assurance program.

Doctors are required to have the speciality code added to their provider number in order to qualify to bill for this item number.

MBS—information for doctors

Itemisation

Extra charges

Extra costs cannot be charged for the supply of any other service or item (for example, bandages or dressings) when bulk billing is used for a consultation—however, certain vaccines can be charged when supplied with a bulk bill consultation.

Consultations with procedures

If you ask a patient to return for a pre-determined procedure, a further consultation should not be billed in addition to the procedure for that particular problem—however, if the doctor performs the procedure during the initial consultation, both the consultation and the procedure can be billed.

Home visits and residential aged care facility (nursing home) visits

Where a doctor attends to a patient in a self-contained unit, within a residential aged care facility complex, the consultation is billed under the appropriate home visit item.

Where a patient living in a self-contained unit attends a doctor at consulting rooms situated within the grounds of the residential aged care facility, or at free standing consulting rooms within the residential aged care facility complex, the appropriate surgery consultation item applies.

If a patient who is accommodated in the residential aged care facility visits a doctor at consulting rooms situated within the residential aged care facility complex, whether free standing or situated within the residential aged care facility grounds, benefits would be attracted under the appropriate residential aged care facility attendance item.
Administrative tasks, such as completing medication charts undertaken separate to consultations do not attract Medicare benefits.

**Medical records**

Legislation states that ‘adequate and contemporaneous medical records’ need to be maintained for all consultations and procedures itemised under Medicare.

**Multiple operation rule**

Where two or more operations (other than amputations) are performed on a patient on the one occasion, the fees are calculated as follows: 100% for the item with the highest schedule fee, plus 50% for the item with the second highest schedule fee, plus 25% each other items.

**Seborrheic keratoses (removal of)**

No matter how you remove a seborrheic keratosis (excision, cryotherapy) you can only bill a consultation item. There is not an appropriate procedural item.

**Signing on behalf of a patient**

If the patient is unable to sign the voucher, the signature of the patient’s parent, guardian or other responsible person is acceptable. The doctor or health service staff cannot sign on behalf of a patient.

**The reason the patient is unable to sign (medical reason only) should also be stated in the practitioner use section of the voucher.**

In the absence of a ‘responsible person’ the patient signature section should be left blank and in the section headed ‘Practitioner’s Use’ an explanation should be given as to why the patient was unable to sign, for example ‘unconscious’.

**Skin lesions and histopathology**

Some items for treatment of skin lesions can only be billed if the diagnosis has been confirmed by histopathology or by specialist opinion. These should not be billed prior to confirmation of diagnosis, for example Basal Cell Carcinoma (BCC) and Squamous Cell Carcinoma (SCC). The patient should not sign the voucher until the item number is determined and included on the voucher.

**Skin lesions and premalignant**

Item 30192 covers this but 10 or more lesions must be removed by ablative techniques. Attendance items only can be billed for less than 10 lesions.

**Warts (removal of)**

Warts and molluscum contagiosum where treated by any means attract benefits on an attendance basis except where definitive removal of palmar or plantar warts is undertaken. In these circumstances, where less than 10 palmar or plantar warts are treated, by methods other than ablative techniques alone, benefits are paid under item 30186, with fees progressively reducing as for multi operations. Where 10 or more palmar or plantar warts are treated, by methods other than ablative techniques alone, benefits are paid as a flat fee under item 30185.

**Wound repair**

To claim items 30026—30049 the repair must be undertaken by suture, tissue adhesive resin or clips. To claim a deep wound item number, the management should involve deeper tissue or repair of structures beneath the subcutaneous fat layer, for example muscle, ligament or tendon.

**Wound repairs and consultations**

An assessment of the wound prior to any procedure could warrant a separate consultation.
Aftercare

What is aftercare?
After an operation the surgeon or another doctor routinely attends the patient to check the patient’s progress, general condition, the healing of the wound, removal of sutures, etc. These routine attendances are referred to as ‘aftercare’. Aftercare includes all routine post-operative treatment rendered by medical practitioners. As a guide, aftercare includes all normal post-operative attendances up to the healing of a wound or normal union of a fracture. The schedule fee for most operations/procedures, fractures and dislocations listed in the MBS includes a component of aftercare.

The aftercare period
Most operations have an aftercare period assigned to them—this is a guide and the doctor is to determine each individual aftercare period depending on the needs of the patient. The length of an aftercare period varies depending on the operation/procedures involved. Any consultations rendered during an aftercare period will not normally be paid. Details regarding the relevant aftercare period for each service is automatically applied by Medicare to aftercare claims and guides a claims approval or rejection.

Notation on account documents
Consultations rendered during the aftercare period for a condition not related to the operation can be paid providing the direct bill voucher is endorsed with one of the following phrases: ‘Not normal aftercare’, ‘NNAC’, ‘NNA’, ‘Unrelated to operation’, or ‘Complication— infection’.

Medicare Australia Medical Advisers
Medicare Australia employs experienced medical practitioners as Medical Advisers. Their role is to provide a high standard of medical advice to all areas of Medicare Australia and to maintain communication with doctors in the community. Medical Advisers also:

• review claims sent to the Medicare Claims Review Panel
• help with the assessment of complicated claims
• provide advice on Medicare or the PBS
• are available to talk with groups of practitioners
• liaise with practitioners who may be engaging in inappropriate practice.

Round the clock Medicare—higher Medicare rebates for after-hours GP services
On 1 January 2005, Medicare items were introduced for after-hours GP consultations.

The Medicare benefit for these items is higher than the corresponding items used during non-after-hours periods. From 1 January 2005, the existing emergency after-hours items will continue to apply, but the Medicare benefit for these items will also be increased.
Claiming from Medicare

This section contains information relating to claiming processes for service providers who bulk bill manually or via online claiming.

Bulk billing

Bulk billing is the process where the doctor and health service accepts a Medicare benefit as full payment for medical services provided to a patient.

Aboriginal and Torres Strait Islander Health Services granted an exemption under subsection 19(2) of the HIA must bulk bill medical services so there is no cost to the patient.

- The information on the assignment form (DB2) voucher is a regulation requirement under subsection 19(6) of the HIA.
- The patient’s Medicare number and name must be on all vouchers for that patient.
- The item numbers and benefit must be included on the voucher before the patient signs it.
- The patient copy of the voucher must be given to the patient after they have signed it.
- If your service is using online claiming all relevant information will be on your computerised printout of the Medicare voucher.

Further information about the requirements to bulk bill Medicare can be found in the MBS—Assignment of Benefit (Direct Billing) Arrangements section. It is important that all staff understand and meet the above requirements for bulk billing Medicare.

What can be billed?

- The Direction issued under subsection 19(2) of the HIA specifies the services that Medicare benefits can be paid for. They are non referred professional services provided by salaried medical practitioners and services provided by allied health and dental professionals as part of a Chronic Disease Management care plan.
- Item numbers and descriptions for medical services and allied health services are listed in the MBS.

Who can bill?

- Medical practitioners and eligible allied health and dental professionals can bill Medicare for services.
- Services provided by practice nurses on behalf of a medical practitioner, such as wound management, immunisation and pap smears can be billed by the medical practitioner if the criteria for the item are met.

Who can complete the assignment form (DB2) voucher?

The doctor, receptionist, Aboriginal Health Worker or nurse can fill out the assignment form. If it is not the doctor, he/she must tell the staff member completing the assignment form which item or items are to be billed for the service.
A completed DB2 voucher must include the following:
1. Medicare card imprint
2. The patient’s card reference number
3. An X to indicate the card has not expired
4. Date of service
5. An X to indicate the service provided
6. Patient’s signature and date
7. Name and provider number or address of doctor
8. Listed items not on form and the additional Medicare benefit payable
9. Add the amount of Medicare benefit payable for the service
10. Number of patients seen on the one occasion—used for home consultations at nursing homes
11. Practitioner “use” section to be completed when patients are unable to sign for medical reasons.

General information checklist for manual bulk billing
- Use a black ballpoint pen to fill out the form—this makes the carbon copies easy to read.
- Complete a voucher for each patient on each occasion.
- The voucher is to be completed in full, including item numbers and benefit amounts, before the patient signs it.
- Send the red copy to Medicare, keep the black copy for your records and give the green copy to the patient.
- Fill out an enrolment amendment form if a replacement card is needed or to update enrolment details.
- If a Medicare card is not available, write in the patient’s name, address, date of birth, Medicare card number and patient’s card reference number. If you do not know the Medicare card number, call the Aboriginal and Torres Strait Islander Access line and give the patient’s details to see if a card number can be located.
Before the patient signs, fill in all the required information, including:

- The imprint of the patient’s Medicare card or
  - hand written Medicare number, name, date of birth and address details or
  - where the Medicare number is not known, call the Aboriginal and Torres Strait Islander Access line and give the patient’s details to see if a number can be found

- The patient’s card reference number
- An X to indicate the card has not expired
- Date of the service
- An X to indicate the service provided and the Medicare benefit payable
- The name and provider number of the doctor.

AFTER the patient signs, send the red copy to Medicare with a completed DB1I batch header signed by the doctor and witnessed. Keep the black copy for your records and give the green copy to the patient.

Remember:

- The Aboriginal and Torres Strait Islander Medicare enrolment and amendment form can be used if a patient is not enrolled in Medicare, if a replacement card is needed or to update enrolment details—attach the enrolment form to the voucher or call the Aboriginal and Torres Strait Islander Access line.

Filling out an assignment form (DB4) voucher

The DB4 voucher is a computerised version of the DB2.

All sections need to be filled out following the software instructions.

Bulk billing claims

When sending a claim to Medicare for payment, fill out one claim header for each doctor and attach no more that 50 assignment of benefit form vouchers (DB2s or DB4s) per claim.
Filling out and sending in a DB1I—claims header

A completed DB1I claims header must include the following:
1. Doctor's name and address
2. Doctor's provider number
3. Date of claim
4. Number of assignment forms (vouchers) attached
5. Signature of doctor
6. Signature of witness
7. Total benefit amount claimed
8. Name of witness and date.

General information
• Use a black ballpoint pen to fill out the form—this makes the carbon copies easy to read.
• All parts of the claims header must be completed for payment to occur. It is a requirement that the witness prints and signs their name and writes the date on the form.

Send to
Medicare Australia
Indigenous Access
GPO Box 9822
Details of the Capital City in your state

Medclaims and Online Claiming
Medclaims and Online Claiming are electronic ways to submit bulk bill claims and receive claims status reports.

Medclaims
Medclaims is a system that enables practitioners to transmit bulk bill and Department of Veterans' Affairs claims via electronic data interchange to Medicare Australia using an approved supplier of communication services. All hard copies of the claim must be received by Medicare Australia before any payment can be made, so it is recommended that these copies be sent to Medicare Australia daily.

For further information call the Medclaims help desk on 1300 788 008.
Online Claiming

Medicare Australia's online claiming enables medical practitioners to have a direct online computer connection to Medicare and extends Medicare claiming options to allow bulk bill and private accounts to be lodged with Medicare Australia using the internet and an integrated management system.

Online claiming does not replace Medicare offices. It simply provides patients with another way to claim Medicare benefits, and offers increased edit checking, improved claim accuracy and reduces the chance of claim rejections.

For further information call the online claiming helpdesk on 1800 700 199.
<table>
<thead>
<tr>
<th>Error Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>106</td>
<td>Provider requesting/providing service cannot be identified</td>
</tr>
<tr>
<td>107</td>
<td>Benefit paid on item number other than that claimed</td>
</tr>
<tr>
<td>108</td>
<td>Benefit is not payable for the service claimed</td>
</tr>
<tr>
<td>111</td>
<td>No benefit payable—claims/s over 2 years old</td>
</tr>
<tr>
<td>113</td>
<td>Total charge shown on account apportioned over all items</td>
</tr>
<tr>
<td>120</td>
<td>Age restriction applies to this item</td>
</tr>
<tr>
<td>122</td>
<td>Associated referral/request line not required</td>
</tr>
<tr>
<td>123</td>
<td>Benefit paid on radiology item other than service claimed</td>
</tr>
<tr>
<td>124</td>
<td>Item is restricted to persons of opposite sex to patient</td>
</tr>
<tr>
<td>131</td>
<td>Individual dates of service required—refer to provider</td>
</tr>
<tr>
<td>141</td>
<td>Benefits not payable for service performed by this provider</td>
</tr>
<tr>
<td>142</td>
<td>Letter of explanation is being sent separately</td>
</tr>
<tr>
<td>154</td>
<td>Diagnostic imaging multiple service rule applied to service</td>
</tr>
<tr>
<td>157</td>
<td>Service possibly aftercare—refer to provider</td>
</tr>
<tr>
<td>159</td>
<td>Item associated with other service on which benefit payable</td>
</tr>
<tr>
<td>160</td>
<td>Maximum number of services for this item already paid</td>
</tr>
<tr>
<td>161</td>
<td>Adjustment to benefit previously paid</td>
</tr>
<tr>
<td>162</td>
<td>Benefit has been previously paid for this service</td>
</tr>
<tr>
<td>179</td>
<td>Benefit not payable—associated service already paid</td>
</tr>
<tr>
<td>206</td>
<td>Item number does not attract a benefit at date of service</td>
</tr>
<tr>
<td>208</td>
<td>Card number used has expired</td>
</tr>
<tr>
<td>211</td>
<td>Patient not covered by this card number at date of service</td>
</tr>
<tr>
<td>212</td>
<td>Date of service used is in the future</td>
</tr>
<tr>
<td>217</td>
<td>Patient cannot be identified from information supplied</td>
</tr>
<tr>
<td>226</td>
<td>Date of service is prior to patients date of birth</td>
</tr>
<tr>
<td>227</td>
<td>Date of service prior to date eligible for Medicare benefit</td>
</tr>
<tr>
<td>233</td>
<td>Provider not entitled to Medicare benefits</td>
</tr>
<tr>
<td>241</td>
<td>Total charge and benefit for multiple procedure</td>
</tr>
<tr>
<td>242</td>
<td>Service is part of a multiple procedure</td>
</tr>
<tr>
<td>243</td>
<td>Apportioned charge and total benefit for multiple procedure</td>
</tr>
<tr>
<td>245</td>
<td>Benefit paid on service other than that claimed</td>
</tr>
<tr>
<td>246</td>
<td>Patient cannot be identified from information supplied</td>
</tr>
<tr>
<td>250</td>
<td>Explanation/voucher will be forwarded separately</td>
</tr>
<tr>
<td>252</td>
<td>Service possibly aftercare</td>
</tr>
<tr>
<td>255</td>
<td>Benefit assigned has been increased</td>
</tr>
<tr>
<td>280</td>
<td>Description of service insufficient to identify item number</td>
</tr>
<tr>
<td>Error Code</td>
<td>Description</td>
</tr>
<tr>
<td>------------</td>
<td>-------------</td>
</tr>
<tr>
<td>306</td>
<td>Card# not valid at date of service—future claims may reject</td>
</tr>
<tr>
<td>307</td>
<td>Claim not paid—card number not valid for date of service</td>
</tr>
<tr>
<td>320</td>
<td>Quoted Medicare card number is incorrect</td>
</tr>
<tr>
<td>322</td>
<td>Provider not approved for this Medicare pathology benefit</td>
</tr>
<tr>
<td>333</td>
<td>Provider must claim time-based items</td>
</tr>
<tr>
<td>337</td>
<td>Provider must claim content-based items</td>
</tr>
<tr>
<td>338</td>
<td>Provider not registered to claim benefit at date of service</td>
</tr>
<tr>
<td>370</td>
<td>Benefit paid on item number other than that claimed</td>
</tr>
<tr>
<td>371</td>
<td>Future claims quoting old style card no. will be rejected</td>
</tr>
<tr>
<td>372</td>
<td>Old style card number quoted—benefit not payable</td>
</tr>
<tr>
<td>373</td>
<td>Expired card—benefit not payable</td>
</tr>
<tr>
<td>374</td>
<td>Old card issue used—benefit not payable—also refer @</td>
</tr>
<tr>
<td>377</td>
<td>Number of patients attended not indicated in the claim</td>
</tr>
<tr>
<td>390</td>
<td>Documentation not received</td>
</tr>
<tr>
<td>391</td>
<td>Service provider on db1 differs from transmitted data</td>
</tr>
<tr>
<td>392</td>
<td>Benefit amount changed</td>
</tr>
<tr>
<td>401</td>
<td>Benefit not payable—charge amount missing or invalid</td>
</tr>
<tr>
<td>402</td>
<td>Benefit not payable—number of patients attended required</td>
</tr>
<tr>
<td>403</td>
<td>Subsequent consultation—referral details required</td>
</tr>
<tr>
<td>409</td>
<td>Card number for this enrolment needs to be verified</td>
</tr>
<tr>
<td>410</td>
<td>Age restriction applies for this item—verify details</td>
</tr>
<tr>
<td>418</td>
<td>Item cannot be claimed more than once in one attendance</td>
</tr>
<tr>
<td>514</td>
<td>Required equipment type code not on LSPN register</td>
</tr>
<tr>
<td>528</td>
<td>RRMA classification is not 3–7 or Tasmania</td>
</tr>
<tr>
<td>529</td>
<td>Bulk bill additional item claimed incorrectly</td>
</tr>
<tr>
<td>530</td>
<td>Patient not under 16 or concessional</td>
</tr>
<tr>
<td>536</td>
<td>Location specific practice number not supplied</td>
</tr>
<tr>
<td>537</td>
<td>Location specific practice number invalid</td>
</tr>
<tr>
<td>538</td>
<td>Location specific practice number not recognised</td>
</tr>
<tr>
<td>539</td>
<td>Location specific practice number not valid at date of service</td>
</tr>
<tr>
<td>540</td>
<td>Enhanced primary care plan not evident</td>
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<tr>
<td>542</td>
<td>Allied health referral form not present</td>
</tr>
<tr>
<td>603</td>
<td>Newborn not yet enrolled</td>
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<tr>
<td>604</td>
<td>Service over 6 months old—late lodgement form required</td>
</tr>
<tr>
<td>609</td>
<td>Service cancelled at providers request</td>
</tr>
<tr>
<td>610</td>
<td>Provider specialty not consistent with item claimed</td>
</tr>
<tr>
<td>613</td>
<td>Card number cannot be identified from information supplied</td>
</tr>
<tr>
<td>Error Code</td>
<td>Description</td>
</tr>
<tr>
<td>------------</td>
<td>-------------</td>
</tr>
<tr>
<td>614</td>
<td>No benefit payable—please notate time of each visit</td>
</tr>
<tr>
<td>615</td>
<td>Multiple procedures—notate times and area of treatment</td>
</tr>
<tr>
<td>619</td>
<td>Provider location number closed at date of service</td>
</tr>
<tr>
<td>620</td>
<td>Duplicate transmission—no further payment made</td>
</tr>
<tr>
<td>621</td>
<td>Item not claimable electronically</td>
</tr>
<tr>
<td>630</td>
<td>Item paid-patient may be over 16 or not concessional at dos</td>
</tr>
</tbody>
</table>

A complete list of the reason codes and their explanations can be found at:

http://www.medicareaustralia.gov.au/providers/programs_services/medicare/reason_codes.htm, or you can call Medicare Australia on 132 150.
Resubmitting a rejected bulk bill claim

In each state and territory there are different ways to resubmit a rejected bulk bill claim. In all cases the reason for the rejection must be addressed, for example reason 374—old style cards used, therefore the benefits are not payable. The Medicare bulk bill voucher should be resubmitted with the correct card number.

Call the Aboriginal and Torres Strait Islander Access line to talk to your Medicare Liaison Officer for Indigenous Access to work out the best way for your health service to resubmit these claims.

Completing a late lodgement form

A late lodgement form must be used to submit a bulk bill claim that is over six months old. This can also include resubmitted bulk bill claims over six months old from the date of the service. The form must be signed by the doctor and the reason for the late lodgement must be included in section 3 of the form for approval.

![Late lodgement form](image)

A completed late lodgement form must include the following:

1. Doctor’s provider number
2. Doctor’s name and address
3. Reason for the late lodgement of claim
4. Claim number
5. Doctor’s signature and date.

For further information and copies of the form, call the Aboriginal and Torres Strait Islander Access line.
Bulk billing and claiming—questions and answers

What if a patient leaves our health service before signing the bulk-bill voucher?

All vouchers need to be signed by the patient before they are sent to Medicare to be claimed. If the patient has left before signing, call them to come back to the health service or hold onto the voucher until they come back and ask them to sign the voucher then. If appropriate, perhaps a health worker could visit the patient. The voucher may then be submitted with the next claim batch.

How often should I submit bulk bill claims?

It is important to submit your claims on a regular basis, even if the batch does not contain many vouchers, so that your payments are regular. This is particularly important if your health service is registered for the Practice Incentive Program or the General Practice Immunisation Incentives Scheme (GPII) as the amount of money your Service will be paid depends on your Medicare claims being up to date.

For a health service that is using online claiming we suggest that you transmit claims on a daily basis. For a health service using medclaims we also suggest that you forward the claim summary report on a daily basis to enable payment. If Medicare doesn’t receive the claims summary report required to process the claim you will be required to retransmit the claim.

I have some claims that are over six months old, can I submit these now?

In order to submit a bulk bill claim or a resubmission of a bulk bill claim that is older than six months from the date of service, you will need to have the doctor who provided the services to complete a Late Lodgement form. The Late Lodgement form must then be submitted with your claim to Medicare for approval. One Late Lodgement form must be completed per bulk bill claim. If you need any of these forms, call the Aboriginal and Torres Strait Islander Access line, or access the forms on our website at www.medicareaustralia.gov.au/providers/forms.

If we are using online claiming and I have not received an exception report after four days, what should I do?

Call the Aboriginal and Torres Strait Islander Access line to ask about the status of the claim. There may be various reasons why the claim has not yet been processed.

If we are using medclaims and I have not received a payment report 10 days after the hard copy of the claim has been submitted to Medicare, what should I do?

Call the medclaims help desk on 1300 788 008 or the Aboriginal and Torres Strait Islander Access line to ask about the status of the claim. There may be various reasons why you have not received a payment report.

If you are using medclaims, do not re-transmit a claim a second time unless Medicare asks you to.

Medicare stationery order forms

Medicare stationery order forms can be obtained by calling 1800 067 307. The completed form can be faxed to 02 6230 0477.
Strengthening Medicare—incentive payments

This section details the incentive items introduced as part of the Government’s Strengthening Medicare initiative. These incentive items have been introduced to support service providers who are bulk billing.

When a patient is bulk billed and is either under 16 years of age or holds a concession card, an additional item can be claimed from Medicare because the services were bulk billed.

The amount of the additional bulk bill payment and the bulk bill item numbers are different depending on the location of your health service. If your health service is in a metropolitan or urban region you can claim item 10990, 64990 or 74990. If your health service is in a regional, rural or remote area i.e. an area classified as Rural Remote and Metropolitan Area (RRMA), Tasmania or in an eligible metropolitan area you can claim item 10991 or 64990 or 74991.

For information on how to claim these items see the explanatory note in the MBS.

Additional payment for bulk billing concessional patients and children aged under 16 years

NEW MBS ITEM NUMBERS: 10990, 64990 and 74990

How will medical practitioners claim the additional bulk bill payment?

To receive the additional bulk bill incentive payment, medical practitioners will need to claim a MBS item in addition to the relevant item for the professional service provided to the patient. There is no separate process of registration with Medicare Australia for medical practitioners to be able to claim the additional payment.

What are the MBS items for claiming the additional bulk bill payment?

There are three MBS items for claiming the additional bulk bill payment, although for the majority of eligible patients, medical practitioners will only need to use the new item 10990.

ITEM 10990—to be used where a medical practitioner provides a medical service (other than a diagnostic imaging or pathology service). Item 10990 is only to be used in conjunction with items in the General Medical Services Table of the MBS.

ITEM 64990—to be used where a medical practitioner (other than a specialist or consultant physician) provides an unreferred diagnostic imaging service under the MBS. Item 64990 is only to be used in conjunction with items in the Diagnostic Imaging Table of the MBS.

ITEM 74990—to be used where a medical practitioner (other than a specialist or consultant physician) provides an unreferred pathology service under the MBS. Item 74990 is only to be used in conjunction with items in the Pathology Services Table of the MBS.

These three items operate in a similar manner with some minor differences for diagnostic imaging and pathology services.
When can medical practitioners claim these items?

Items 10990, 64990 and 74990 can only be claimed where all of the following conditions have been met:

• The service must be provided to a Commonwealth concession card holder or child under 16 years of age; and
• The service must be unreferred (that is, not referred by another practitioner); and
• The service must not be provided in a hospital or day-hospital facility where the person is an admitted patient; and
• Both the service and the bulk bill incentive item must be bulk billed.

Which medical practitioners are eligible to claim the additional bulk bill payment?

Generally, any medical practitioner who provides an unreferred service to an eligible patient is able to claim the bulk bill incentive item provided the conditions of the item description are met.

All GPs, whether vocationally registered or not, are eligible to claim the bulk bill incentive item. GPs working in Aboriginal Medical Services are able to claim the new items as long as they are eligible to receive Medicare benefits.

Specialists and consultant physicians who provide diagnostic imaging or pathology services are not able to claim items 64990 or 74990 unless, for the purposes of the HIA, the medical practitioner is also a general practitioner and the service provided by the medical practitioner has not been referred to him/her by another practitioner.

What if more than one Medicare service is provided during the same patient visit?

Medical practitioners may claim a bulk bill incentive item for each item of service claimable under the MBS (including attendance and procedural items) provided the conditions of the items are met. See examples below. Where a Medicare benefit is not payable for a particular service (because the patient has exceeded the number of allowable services in a period of time for example), the bulk bill incentive item will not be paid for that service.

Who is responsible for determining whether a patient is a concession patient or under 16 years of age?

To claim the additional bulk bill payment, the medical practitioner (or the practice staff on behalf of the medical practitioner) must be satisfied that the patient is within one of the eligible groups. The medical practitioner or the practice staff may need to ask the patient to show some evidence of their concession status, for example a concession card.

Which types of concession cards attract the bulk bill incentive items?

The following Commonwealth concession cards issued by either Centrelink or the Department of Veterans’ Affairs attract the bulk bill incentive item:

• Pensioner cards
• Health Care cards
• Commonwealth Seniors Health cards

Veterans or spouses and dependents of veterans holding Gold or White cards will generally continue to be treated under the Local Medical Officer (LMO) Scheme. Gold and White cards issued by the Department of Veterans’ Affairs do not attract the bulk bill incentive item, unless the recipient also holds a recognised concession card and is treated under the Medicare arrangements.
How will Medicare Australia verify a patient's concession status?

Medicare Australia will undertake post payment auditing to ensure that the bulk bill incentive items are being claimed correctly. Centrelink data will be used to verify concession status and Medicare records will be used to confirm patient age.

Medicare Australia will take into account that medical practitioners and patients will need to adjust to the arrangements and that some initial errors may occur. Medicare Australia may contact medical practitioners where there appear to be significant anomalies or problems in the claims being made. However, medical practitioners will not be penalised for genuine errors. The concession status will be verified with Centrelink’s system information and the item will be rejected if the patient is found to be not eligible for the concession.

Does the practice need to be using medclaims or online claiming to make claims in order to claim the bulk bill incentive items?

No, although payments will be made faster if a medical practitioner submits claims via online claiming.

How to submit a claim for the bulk bill incentive items

These MBS items are claimable together with any other associated non referred service within the corresponding MBS tables. The bulk bill incentive items must be itemised on the bulk billing voucher and/or within an electronic transmission forwarded to Medicare Australia for payment. A bulk bill incentive item will be payable only once for each corresponding MBS item paid.

Example

A medical practitioner bulk bills an attendance item along with a pathology item for a child under 16 years of age. The medical practitioner can claim two additional bulk bill incentive items

Item 23 + item 10990.

Item 73805 + item 74990.

In some instances where multiple services are performed at the one time, there may be insufficient space within the DB2-GP or DB2-OT bulk bill voucher to indicate all items to be claimed. In this situation, a separate voucher must be used ensuring the corresponding items are on the same voucher and signed by the patient.

Example—DB2-GP voucher

Attendance item 23 + bulk bill incentive item 10990 = first voucher.

Pathology item 73805 + bulk bill incentive Additional pathology item 74990 = second voucher.

Changes to the bulk billing forms will be made in the near future to accommodate these additional items.

Please note DB4 forms will not be affected.

How will the medical practitioner receive the payment for the bulk bill incentive item once claims have been submitted?

Payments will be received as part of the current bulk bill payment process, for example via cheque or EFT and will be notated on the statement of benefit.
Payment for bulk billing concession patients and children aged under 16 years in regional, rural and remote areas, and in Tasmania.

**MBS ITEM NUMBERS: 10991, 64991 and 74991**

Medical practitioners in regional, rural and remote areas, an area classified as Rural Remote and Metropolitan Area (RRMA), Tasmania or in an eligible metropolitan area are eligible to claim an additional amount for each bulk billed MBS service provided to a Commonwealth concession card holder or child aged under 16 years.

To receive the higher additional payment, medical practitioners will need to claim MBS items 10991, 64991 or 74991.

These items operate in the same way as the items 10990, 64990 and 74990. The only difference is that to claim the items, the service must be provided at, or from, a practice location in an area classified as RRMA 3-7 (explained on page 40), or anywhere in Tasmania.

**Circumstances in which items 10991, 64991 and 74991 can be claimed**

These items can only be claimed where all of the following conditions have been met:

(a) the service is an unreferred service; and

(b) the service is provided to a person who is under the age of 16 or is a Commonwealth concession card holder; and

(c) the person is not an admitted patient of a hospital or day-hospital facility; and

(d) the service is bulk billed in respect of the fees for:
   (i) item 10991, 64991 or 74991; and
   (ii) the relevant medical service, diagnostic imaging service or pathology service; and

(e) the service is provided at, or from, a practice location in:
   (i) a regional, rural or remote area; or
   (ii) Tasmania; or
   (iii) A geographical area included in any of the Statistical Subdivision (SSD) spatial units in the explanatory notes in the General Medicare Services Table (GMST), Diagnostic Imaging Services Table (DIST) and Pathology Services Table (PST); or
   (iv) the geographical area included in the Statistical Local Area (SLA) spatial unit of Palm Island (AC).

**What is a practice location?**

A practice location is the place associated with the medical practitioner’s provider number from which the service has been provided.

“At or from a practice location” means services performed either at the medical practitioner’s surgery, or services performed away from the surgery using the provider number for that surgery (for example home visits or visits to aged care facilities).

**Which regional, rural or remote areas are eligible for the higher bulk bill payment?**

For the purposes of items 10991, 64991 and 74991 “regional, rural or remote area” means an area classified as RRMA 3, 4, 5, 6 or 7 under the Rural Remote and Metropolitan Areas (RRMA) classification system.

**Which areas in Tasmania are eligible for the bulk bill incentive items?**

All areas in Tasmania, including Hobart, are eligible areas for these items.

**Checking whether your practice location is in an eligible area.**

If you are not sure whether your practice location is in an eligible area, you can call Medicare Australia on 132 150.
Which types of concession cards attract the higher bulk bill payment?
The following Commonwealth concession cards issued by either Centrelink or the Department of Veterans’ Affairs attract the bulk billing incentive items:
- Pensioner cards
- Health Care cards
- Commonwealth Seniors Health cards

Veterans or spouses and dependents of veterans holding Gold or White cards will generally continue to be treated under the Local Medical Officer (LMO) Scheme. Gold and White cards issued by the Department of Veterans’ Affairs do not attract the additional payment, unless the recipient also holds a recognised concession card and is treated under the Medicare arrangements.

Can the bulk bill incentive items be used where the patient is being treated under the Local Medical Officer (LMO) Scheme, for instance under the DVA arrangements?
No. If a veteran holding a Gold or White card is being treated under the LMO Scheme, then the additional bulk bill incentive item cannot be claimed by the medical practitioner. In this case, the LMO will continue to receive 100% of the schedule fee plus an additional nominated amount for each item of service provided to the veteran. However, if a Gold or White card holder is also the holder of a Commonwealth concession card and they choose to be treated under the Medicare arrangements, then the medical practitioner can claim the bulk bill incentive items provided the conditions of those items are satisfied.

Do the bulk bill incentive items only apply to attendance items?
No. The bulk bill incentive items apply to each item of service for which a Medicare benefit is payable (including attendance, procedural items and practice nurse services covered by items 10993 and 10996), provided the conditions of the relevant bulk bill incentive items are satisfied.

If a medical practitioner in an eligible area mistakenly claims item 10990, 64990 or 74990 instead of item 10991, 64991 or 74991, will the medical practitioner be automatically paid the higher amount?
No. At present, it is not legally or technically possible to pay an amount higher than the level of the rebate for the item being claimed. In this case, the medical practitioner will still receive the benefit for item 10990, 64990 or 74990.

However, if the medical practitioner wishes to receive the correct payment, they must re-submit a correctly rendered claim for the correct item. The re-submitted claim must be signed by the patient to assign the increased benefit to the medical practitioner.

What happens if a medical practitioner claims item 10991, 64991 or 74991 from a practice location that is not in an eligible area?
Medicare Australia will reject claims for item 10991, 64991 or 74991 made from a practice location that is not in an eligible area. If this occurs, the medical practitioner will need to re-submit a claim using a correct item 10990, 64990 or 74990 in order to receive the bulk bill incentive payment. Again the re-submitted claim must be signed by the patient to assign the benefit to the medical practitioner.

Can item 10990, 64990 or 74990 and item 10991, 64991 or 74991 be claimed for the same service?
No. Only one of these items can be claimed in respect of each item of service.

What if a medical practitioner has practice locations in both metropolitan and rural areas?
If a medical practitioner has practice locations in both metropolitan and rural areas, items 10991, 64991 or 74991 can only be claimed in respect of services provided at or from the eligible rural location/s.

For further information on claiming these items, including whether you are practising in an eligible area, please call the Aboriginal and Torres Strait Islander Access line.
Pathology and Diagnostic Imaging

This section refers to processes relating to service providers requesting pathology and diagnostic imaging services for their clients.

Pathology

Writing requests for pathology services

In accordance with section 23DK of the HIA requests for pathology services may be made either verbally or in writing, but verbal requests must be confirmed in writing within 14 days from the date of the verbal request.

Please note: requests for pathology services can only be made by a medical practitioner, a dental practitioner or another approved pathology practitioner.

Include all of the following details when writing a request or combined pathology request/offer to assign form for pathology services:

• the individual pathology services or recognised groups of pathology tests that are being requested;
• the patient’s name, date of birth, sex, address and Medicare number. If the service is being bulk billed, the patient’s signature must also be obtained and if the patient is unable to sign, the practitioner needs to note the reason on the request;
• the requesting practitioner’s signature and date of request;
• the surname, initials of given names, practice address and provider number of the requesting practitioner;
• details of the hospital status of the patient—whether a private or public patient (if relevant); and
• details of the person to whom the request is directed—Approved Pathology Practitioner or Approved Pathology Authority.

Prostate specific antigen (PSA) ordering

The MBS indicates that a Medicare benefit will be paid for this test for three categories, but still not as a screening—criteria apply as follows: quantitation, monitoring of previously diagnosed prostatic disease and equivocal range tests.

Thyroid function testing

When investigating a patient for thyroid dysfunction, order Thyroid Stimulating Hormone (TSH) first, except for the specific circumstances outlined under item 66719 in the MBS.

Urine microscopy/catalase or using a ‘dipstick’ to test urine

A dipstick catalase test can be claimed under 73805. The dipstick/multistix label must state “catalase test”. Dipsticks/multistix using “leukocyte esterase reaction” (for example Bayer Multistix 10sg) do not qualify for payment under this item.

For more information call the Aboriginal and Torres Strait Islander Access line on 1800 556 955
Copy of the pathology request form.

Checklist—combined pathology request/offer to assign forms

Make sure:

☐ All of your patients have a Medicare card
☐ The patient’s Medicare number is written on all pathology request forms
☐ The patient signs the form

BEFORE the patient signs, fill in all the required information, including:

☐ The pathology service or group of tests required
☐ The date of the request
☐ The requesting doctor’s:
  • provider number
  • signature
  • surname and initials
  • practice address
☐ The patient’s:
  • name
  • address
  • Medicare number
☐ Details of the patient’s hospital status (if relevant)
☐ Details of the pathology service provider, if not already printed on the form.

AFTER the patient signs, give them a copy of the form.
Diagnostic imaging

X-rays for comparison
When you request both limbs, you need to specify whether the x-ray is for purposes of comparison or not.

Requests for diagnostic imaging services
There are two different groups of diagnostic imaging services:
• services that do not require a written request—indicated by ‘NR’ in the MBS; and
• services that do require a written request—indicated by ‘R’ in the MBS.

Please note: requests for ‘R-type’ diagnostic imaging services can only be made in writing (verbal requests are not acceptable) and in most cases must be requested by a medical practitioner. To see who else can request diagnostic imaging services, refer to the Diagnostic Imaging Services Overview in the purple section of the MBS.

Include all of the following information when writing a request for a diagnostic imaging service:
• name, date of birth, address and Medicare number of the patient;
• name and provider number of the requesting practitioner;
• description or item number of the service being requested;
• signature of requesting practitioner, and
• date of request.

Please note: a request for a diagnostic imaging service does not have to be addressed to a particular practitioner, however if a request identifies a particular practitioner and is provided by another practitioner the request is still valid for Medicare purposes.

Remote area exemptions for diagnostic imaging services
Where a medical practitioner provides an ‘R-type’ diagnostic imaging service in a remote area, a written request is not required if the following requirements are met:
• there is no corresponding ‘NR-type’ service listed in the MBS, and
• the medical practitioner providing the diagnostic imaging service has applied and been granted a remote area exemption for that service. A remote area exemption application is required to be completed and forward to the Provider Section in your state/territory for approval.
Enhanced Primary Care (EPC) Services

This section contains information on the health assessment, care planning and case conferencing services on the Medicare Benefits Schedule. It also contains information on the Allied Health and Dental Care rebates scheme (which is related to the EPC care planning services).

Overview of Enhanced Primary Care services

Enhanced Primary Care (EPC) services aim to improve the health and quality of life of older Australians, adult Aboriginal and Torres Strait Islander people and people of any age with a chronic or terminal condition.

EPC services cover five categories of General Practitioner (GP) activity:
1. annual older age health assessments for Aboriginal and Torres Strait Islander people aged 55 years and over, and other people aged 75 years and over;
2. two-yearly adult health checks for Aboriginal and Torres Strait Islander people aged 15 to 54 (inclusive);
3. comprehensive medical assessments for permanent residents of residential aged care facilities;
4. care planning for people with chronic conditions and for those who may also have complex (team) care needs; and
5. case conferencing for people with chronic conditions and complex care needs.

GPs should consult the relevant explanatory notes in the Medicare Benefits Schedule Book before providing any EPC service.

How your health service can benefit from EPC services

There are several ways your service may be able to benefit from EPC services:

- Your service employs a doctor who directly bills Medicare, the doctor will be able to bill Medicare directly for CDM services.
- If your clients go to other doctors or allied health professionals in your area, the CDM items provide the opportunity for your service to work together with these providers to give better care to your clients.

A Medicare benefit is only payable for a GP’s involvement in EPC services, although doctors may be assisted by other health professionals, including Aboriginal Health Workers, in the provision of most EPC services.
How you can build Enhanced Primary Care into your service

There are several steps you can take to incorporate EPC items into your service and ensure that the EPC services you provide meet Medicare requirements:

1. Make sure that staff are aware of the EPC services and how they operate by distributing this and other information about them;
2. Encourage staff to read distributed information and adapt it to your local needs and circumstances;
3. Talk to your client groups and patients about EPC services and how they can benefit from them;
4. Promote awareness of EPC services in the community by displaying available posters;
5. Make sure that doctors who work with your service are aware of EPC services, who can benefit from them, and what is involved in providing them;
6. If your service does not have a doctor, you may want to talk to doctors in the area about how you can work together to make sure patients get appropriate care. For example, Aboriginal health workers can be involved by contributing to care plans, taking part in case conferences or helping doctors get information for a health assessment.

Annual Older Age Health Assessments

There are four services on the Medicare Benefits Schedule for older age health assessments: two for Aboriginal and Torres Strait Islander people aged 55 years and over and two for other Australians aged 75 years and over.

Item number 704 is for an older age health assessment conducted for an Aboriginal and Torres Strait Islander person at a GP’s consulting rooms. Item 706 is for the same service conducted at somewhere other than a GP’s consulting rooms, a hospital or a residential aged care facility.

How are Indigenous status and age identified for an annual older age health assessment?

To be eligible for an older age Indigenous health assessment, a person must identify themselves as being of Aboriginal or Torres Strait Islander descent and state their age. Some patients may give this information without being asked. However, other patients will need to be asked. An appropriate way to ask this question is “Do you identify as an Aboriginal and/or Torres Strait Islander person?”

Information provided by the patient about their Indigenous status and age should be accepted, as stated by the patient, for the purposes of having a health assessment.

Who can do an annual older age health assessment?

An older age health assessment should be done by the patient’s usual GP. Providing certain conditions are met, the GP can arrange for another person under his or her supervision to collect information needed for the health assessment, with the patient’s agreement. The health assessment must include the GP seeing the patient.

What are the steps in an annual older age health assessment?

There are five main components:

1. seeking and gaining patient agreement to the service;
2. collecting specific information about the patient;
3. assessing the information to make recommendations for care/treatment;
4. talking to the patient about outcomes and recommendations; and
5. placing a copy of the assessment in the patient’s record and offering a copy to the patient.

Note that the information collecting part of the check can be done by an Aboriginal Health Worker, nurse or other qualified health professional if certain conditions are met (see the relevant explanatory notes in the Medicare Benefits Schedule Book).
What are the benefits of annual older age health assessments?
Health assessments can help prevent sickness or help the patient and doctor manage a health problem better by finding health or other problems early.

Health assessments give the doctor and health workers up-to-date information about a patient’s medical condition and health care needs. This can be very important in deciding how to care for a patient, and may mean better health outcomes.

Two-Yearly Aboriginal and Torres Strait Islander Adult Health Check
There is one service on the Medicare Benefits Schedule for a health check for Aboriginal and Torres Strait Islander people aged 15 to 54 (inclusive) who have not had the check in the previous 18 months. The relevant item number is 710.

How are indigenous status and age identified?
See the answer to this question for older age health assessments (above), noting that age range for the adult health check service is 15 to 54 (inclusive).

Who can do an adult health check?
The patient’s usual GP should normally do the adult health check.

What are the steps in an adult health check?
1. deciding whether the patient should have an adult health check;
2. explaining the health check to the patient;
3. gaining and noting patient agreement to the service;
4. taking a patient history;
5. examining the patient (mandatory activities);
6. arranging or undertaking any investigations;
7. assessing the patient’s health;
8. initiating interventions;
9. developing a strategy for the good health of the patient;
10. recording the health check;
11. offering the patient a written report (including the simple strategy); and
12. keeping a copy of the health check in the patient record.

Note that the information collecting part of the check can be done by an Aboriginal Health Worker, nurse or other qualified health professional if certain conditions are met (see the relevant explanatory notes in the Medicare Benefits Schedule Book).

What are the benefits of an adult health check?
The adult health check encourages early detection, diagnosis and intervention for common and treatable conditions.
**Comprehensive Medical Assessments (CMAs)**

There is one service on the MBS for a Comprehensive Medical Assessment (CMA) for permanent residents of residential aged care facilities who have not had a CMA in the previous twelve months. The relevant item number is 712. This service can be provided to a new resident on admission or to a continuing resident on an “as required” basis (with a maximum of one CMA Per resident in any twelve month period).

**Who can do a Comprehensive Medical Assessment?**

The patient’s usual GP should normally do the CMA. However, GPs who provide services on a facility-wide contract basis or who are registered to provide services to residential aged care facilities as a part of aged care panel arrangements may also provide CMAs as part of their services.

**What are the steps in a Comprehensive Medical Assessment?**

1. seeking and obtaining consent to the service;
2. taking a detailed medical history;
3. conducting a comprehensive medical examination;
4. developing a list of diagnoses or problems based on the medical history and medical examination; and
5. providing a written summary of the outcomes of the CMA.

**What are the benefits of a Comprehensive Medical Assessment?**

Listing diagnoses and problems helps provide better care for the resident. It also assists pharmacists who provide medication management review services for the resident.

**Care Planning (Chronic Disease Management services)**

There are six care planning or Chronic Disease Management (CDM) services on the MBS.

The two main services are:

(a) **preparation by a GP of a GP Management Plan** (Item 721) for a patient with at least one chronic or terminal condition; and

(b) **coordination by a GP of Team Care Arrangements** (Item 723), involving collaboration with at least two other service providers for a patient who has at least one chronic or terminal condition and complex (team) care needs.

A patient who has at least one chronic or terminal condition and complex (team) care needs will be eligible for both services.

There are two review services:

(a) **review by a GP of a GP Management Plan** (Item 725); and

(b) **coordination by a GP of a team review of Team Care Arrangements** (Item 727).

There is a service for a contribution by a GP to a multidisciplinary care plan by another provider, for example a hospital on discharge (Item 729).

There is also a service for a contribution by a GP to a multidisciplinary care plan for a resident of an aged care facility (Item 731).

There are restrictions on where the CDM services can be provided, who can provide them and on the frequency of provision. (See the relevant explanatory notes MBS Book.)
What are the steps in preparation of GP Management Plans (GPMPs)?
1. explaining the service to the patient and obtaining agreement to proceed;
2. assessing the patient to identify/confirm all of their health care needs, problems and relevant conditions;
3. agreeing management goals with the patient;
4. identifying actions to be taken by the patient;
5. identifying treatment and services that the patient is likely to need;
6. making arrangements for treatment/services and on-going management;
7. documenting the above (the plan) and offering it to the patient; and
8. including the plan in the patient’s medical record.

What are the steps in coordinating Team Care Arrangements (TCAs)?
1. explaining the service to the patient and obtaining agreement to proceed;
2. explaining any likely out-of-pocket costs arising from the involvement of the other members of the TCA team;
3. discussing with the patient which treatment/service providers should be asked to collaborate with the GP in completing the plan;
4. gaining patient agreement to share their medical history, diagnoses and GPMP (with or without restrictions) with the proposed providers;
5. contacting the proposed providers and obtaining their agreement to participate;
6. collaborating (two-way communication) with the agreed providers to discuss the potential treatment/services they will provide to achieve the management goals for the patient;
7. documenting the goals, the collaborating providers, the treatment/services they have agreed to provide, patient actions and a review date.
8. providing relevant parts of the TCA to the collaborating providers and other service providers;
9. offering the plan to the patient; and
10. including the plan in the patient’s medical record.

Note that for GPMPs and TCAs the GP may be assisted by a practice nurse, Aboriginal Health Worker or other health professional in the GP’s medical practice or health service. However, the GP must see the patient and review and confirm all assessments and elements of the GPMP or TCA.

The TCA team must include the coordinating GP and at least two other health service providers, who must contribute to the plan, and who must be providing a different kind of service to the patient. These core members of the team may include a specialist medical practitioner but not two specialists. However, if the team consists of more than three members a second specialist could be included. The core members would not usually include a second GP or a practice nurse who is providing general practice services on behalf of the patient’s GP.

Medicare provides a rebate for the GP’s coordinating work or participation but does not provide a rebate for specialist medical practitioners or allied health professionals to contribute to a TCA. Examples of health or care providers, apart from specialist medical practitioners, who can work with the GP as part of the TCA team include (but are not restricted to):

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<th>Allied Health Professionals</th>
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<td>Asthma educators</td>
<td>Education Providers</td>
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<td>Orthoptists</td>
<td>Meals on Wheels</td>
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<td>Audiologists</td>
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<td>Orthotists or Prosthetists</td>
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For more information call the Aboriginal and Torres Strait Islander Access line on 1800 556 955
Information on the circumstances in which a practice nurse and/or Aboriginal health worker can be included on the TCA team can be found on the chronic disease items web page.

**What are the benefits of care planning (CDM) services?**
These services make it easier for GPs to manage the care of patients with chronic or terminal conditions, including patients with complex (team) care needs.

**Case Conferencing**
There are eighteen GP case conferencing services on the Medicare Benefits Schedule for patients with at least one chronic or terminal condition and complex (team) care needs. The services are for GPs to organise/coordinate case conferences or to participate in case conferences organised by others.

The rebates for these services are based on the length of the conference: (a) at least 15 minutes but less than 30 minutes; (b) at least 30 minutes but less than 45 minutes and (c) at least 45 minutes. Item numbers for claiming purposes depend on the circumstances of the conference eg on discharge, in a residential aged care facility or in the community. See the MBS Book for individual item numbers.

A case conference must include a minimum of three participants (the GP plus two others) and the three participants must be present for all of the claimed conference period.

**Who can participate in a case conference?**
The GP case conferencing items on the Medicare Benefits Schedule provide rebates for GPs to organise/coordinate or participate in a case conference.

See material on TCA team members (earlier in this segment) for information on who, other than the patient's usual GP, can be a participant in a case conference, noting that Medicare does not provide a rebate for allied health professionals to participate.

**What is the difference between an EPC case conference and a Team Care Arrangements care planning service?**
A case conference is a meeting to look at the immediate needs of a patient. The meeting allows the GP and other care providers to discuss the immediate treatment and services needed by the patient.

A Team Care Arrangements service looks at the long term health and care needs of a patient. It allows the GP and other care and service providers to prepare a written plan on how the treatment and other services needed by the patient will be managed.

**What are the steps in organising/coordinating a case conference?**
1. explaining to the patient the nature of the conference;
2. recording the patient's agreement to the case conference;
3. conferring with the other conference participants and recording the relevant details (date, starting and finishing times, and names of participants);
4. recording identified multidisciplinary care needs, tasks to achieve specified outcomes and whether any previously specified outcomes have been achieved;
5. putting a copy of the record created in steps 3 and 4 on the patient's medical record;
6. offering the patients and participants a summary of the conference; and
7. discussing the results of the conference with the patient.
What are the steps in participating in a case conference?

Participation must be at the request of the person who is organising the case conference.
1. explaining to the patient the nature of the conference;
2. recording the patient’s agreement to the GP’s participation in the conference;
3. participating and recording the relevant details (date, starting and finishing times, and names of participants);
4. recording multidisciplinary care needs etc (see 4 above) as they relate to the GPs participation;
5. putting a copy of the record created in steps 3 and 4 in the patient’s medical record; and
6. offering the patient and participants a summary of the conference.

Does the patient have to attend the case conference?

The patient may attend but is not required to.

What are the benefits of case conferencing?

CDM care planning and case conferencing allow the doctor, the patient and other people who care for the patient to discuss, plan and manage the treatment, health care and other services the patient needs.

Allied health and dental care services

Care plans developed using the new EPC chronic disease management (CDM) items or the former EPC multidisciplinary care planning items are referred to in a generic way as ‘EPC plans’.

Patients who are being managed by their GP using EPC Plans are eligible for Medicare rebates for certain allied health and dental care services.

When is a patient considered to be managed under an EPC plan?

Patients are considered to be managed under an EPC plan if, during the last two years:
- their GP has prepared an EPC plan for them and claimed:
  - former MBS item 720—preparation of an EPC multidisciplinary care plan; or
  - former MBS item 722—preparation of an EPC multidisciplinary discharge care plan; or
  - new MBS items 721 and 723 together—CDM items for preparation of a GP Management Plan and coordination of Team Care Arrangements; or
- their GP has contributed to a plan prepared for them as a resident of an aged care facility and claimed former MBS item 730 or new MBS item 731; or
- their GP has reviewed their existing EPC plan and claimed former MBS item 724 or new MBE items 725 or 727.

How many rebates can eligible patients claim each year?

Eligible patients can claim rebates for a maximum of 5 allied health and 3 dental care services each calendar year (1 January–31 December) on referral from their GP for services recommended in their EPC plan.

Are rebates payable for services provided in government funded Indigenous services?

Services funded by other Commonwealth or State programs are not usually eligible for Medicare rebates. However, where an exemption under subsection 19(2) of the HIA has been granted to an ACCHS or State/Territory clinic, the allied health and dental care items can be claimed for services provided by eligible providers salaried by, or contracted to, the service.

How do patients access rebates for allied health services?

Patients need to be referred by their GP for services recommended in their care plan on the EPC Program Referral form for Allied Health Services under Medicare. Where the GP is referring a patient to more than one allied health professional, s/he will need to use a separate form for each referral.
The form can be found on the DoHA website at: www.health.gov.au/strengtheningmedicare or ordered by faxing (02) 6289 7120.

Who can provide allied health services?
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.
These services must be provided to individual patients, and last at least 20 minutes.
Eligible providers need to be registered with Medicare Australia. The list of eligibility criteria for allied health professionals is provided below.

How do patients access rebates for dental care services?
To be eligible for rebates for dental care services, patients must also have a dental condition that is making their chronic condition worse.
All patients must have a dental assessment (item 10975) prior to dental treatment (item 10976 or 10977).
A dentist, who provides a dental assessment under item 10975 and decides that the patient needs a further assessment or treatment from a dental specialist, needs to fill in the appropriate section of the EPC referral form to refer the patient. The item used by dental specialists is 10977.
Patients need to be referred to a dentist or dental specialist by their GP using the EPC Program Referral form for Dental Care under Medicare. Dentists and dental specialists must be registered with Medicare Australia.
The form can be found on the DoHA website at: www.health.gov.au/strengtheningmedicare or ordered by faxing (02) 6289 7120.

If a dentist or dental specialist supplies and fits a dental prosthesis using dental care item 10976 or 10977, does the cost attract a Medicare rebate?
The cost of making or supplying prostheses such as, an inlay, crown, bridge, implant, denture, obturator, veneer or a combination of these, are NOT covered by Medicare. Dentists and dental specialists should separately itemise any costs associated with the making or supply of prostheses when billing patients for a dental treatment using item 10976 or 10977.
However, costs associated with fitting prostheses can be included under these items.

Must Medicare items for relevant GP services be claimed before a Medicare rebate can be paid for allied health or dental services?
Yes. Allied health and dental care services will not attract a Medicare rebate unless they are provided after the relevant GP service(s) are complete and the appropriate item(s) have been claimed.
Where GPs bulk-bill patients for care planning, it may sometimes happen that a patient will have their first referred allied health or dental care service before the GP has actually lodged a Medicare claim for direct payment. When this happens, Medicare will be unable to process the patient’s claim (or allied health professional/dentist’s claim for direct payment) until after the GP’s claim is submitted.

Further information
Detailed information on the allied health and dental care items is available at:
- www.medicareaustralia.gov.au/providers/incentives_allowances/medicare_initiatives/allied_health.htm, and
Eligibility criteria for allied health professionals providing new Medicare services

**Aboriginal Health Workers** practising in the Northern Territory (NT) must be registered with the Aboriginal Health Workers Board of the NT. In other States and the Australian Capital Territory they must have been awarded a Certificate Level III (or higher) in Aboriginal and Torres Strait Islander Health from a Registered Training Organisation that meets training standards set by the Australian National Training Authority's Australian Quality Training Framework.

**Audiologists** must be either a ‘Full Member’ of the Audiological Society of Australia Inc (ASA), who holds a ‘Certificate of Clinical Practice’ issued by the ASA; or an ‘Ordinary Member—Audiologist’ or ‘Fellow Audiologist’ of the Australian College of Audiology (ACAud).

**Chiropractors** must be registered with the Chiropractors (or Chiropractors and Osteopaths) Registration Board in the State or Territory in which they are practising.

**Diabetes Educators** must be a Credentialled Diabetes Educator (CDE) as credentialed by the Australian Diabetes Educators Association (ADEA).

**Dietitians** must be an ‘Accredited Practising Dietician’ as recognised by the Dieticians Association of Australia (DAA).

**Exercise Physiologists** must be an ‘Accredited Exercise Physiologist’ as accredited by the Australian Association for Exercise and Sports Science (AESS).

**Mental Health Workers** ‘Mental health’ can include services provided by members of five different allied health professional groups. ‘Mental health workers’ are drawn from the following:

- psychologists;
- mental health nurses;
- occupational therapists;
- social workers; and
- Aboriginal health workers.

**Psychologists, occupational therapists and Aboriginal health workers** are eligible in separate categories for these items.

A **mental health nurse** may qualify if they are—

- a registered mental health nurse in Tasmania or the Australian Capital Territory (ACT), if providing mental health services in Tasmania or the ACT; or
- a ‘Credentialled Mental Health Nurse’ as certified by the Australian and New Zealand College of Mental Health Nurses (ANZCMHN), if providing mental health services in other States or the Northern Territory.

To be eligible to provide mental health services for the purposes of this item, a **social worker** must be a ‘Member’ of the Australian Association of Social Workers (AASW); and be certified by AASW as meeting the standards for mental health set out in AASW’s ‘Standards for Mental Health Social Workers 1999’.

**Occupational Therapists** in Queensland, Western Australia, South Australia and the Northern Territory must be registered with the Occupational Therapists Board in the State or Territory in which they are practising; in other States and the Australian Capital Territory, they must be a ‘Full-time Member’ or ‘Part-time Member’ of OT AUSTRALIA, the national body of the Australian Association of Occupational Therapists.

**Osteopaths** must be registered with the Osteopaths (or Chiropractors and Osteopaths) Registration Board in the State or Territory in which they are practising.

**Physiotherapists** must be registered with the Physiotherapists Registration Board in the State or Territory in which they are practising.
Podiatrists/Chiropodists in all States and the Australian Capital Territory must be registered with the Podiatrists Registration Board in the State or Territory in which they are practising. If practising in the Northern Territory, Podiatrists/Chiropodists must be registered with the Podiatrists Registration Board in any other State or the Australian Capital Territory, or be a “Full Member” of the Australian Podiatry Association (APodA) in any other State or the Australian Capital Territory.

Psychologists must be registered with the Psychologists Registration Board in the State or Territory in which they are practising.

Speech Pathologists practising in Queensland must be registered with the Speech Pathologist Board of Queensland. In all other States, the Australian Capital Territory and the Northern Territory, they must be a ‘Practising Member’ of Speech Pathology Australia.

Allied Health professionals need to register with Medicare Australia to obtain a provider number.

Combining EPC and Other Services

In some cases patients with chronic conditions and complex care needs may require a combination of EPC and other services, in addition to ongoing medical care through normal consultation items. Some possible combinations of services that may be beneficial for some Aboriginal and Torres Strait Islander people are listed below.

Eligibility for individual services should be checked before proceeding with sequences of services, and the Medicare requirements of each of the services should be fully met.

- For an Aboriginal and Torres Strait Islander person aged 55 or over with a chronic condition and complex care needs: Older age health assessment + General Practice Management Plan + Team Care Arrangements + Allied Health Program.
- For an Aboriginal and Torres Strait Islander person aged 55 or over with a chronic condition and complex care needs, and who is at risk of medication problems: Older age health assessment + General Practice Management Plan + Team Care Arrangements + Allied Health Program + Home Medicines Review.
- For an Aboriginal and Torres Strait Islander person aged between 15 and 54 with a chronic condition and complex care needs: Adult Health Check + General Practice Management Plan + Team Care Arrangements + Allied Health Program.
- For an Aboriginal and Torres Strait Islander person aged between 15 and 54 with a chronic condition and complex care needs and who is at risk of medication misadventure: Adult Health Check + General Practice Management Plan + Team Care Arrangements + Allied Health Program + Home Medicines Review.

Patients with chronic conditions and complex needs may also benefit from EPC multidisciplinary case conferences.

Patients with a chronic medical condition but without complex care needs may benefit from the relevant health check/health assessment items and from a GP Management Plan.
Practice nurse items

This section relates to those items that can be claimed by nurse practitioners and explains the relevant procedures.

Item 10993: Immunisation

Item 10993 can be claimed by a general practitioner where an immunisation is provided by a practice nurse on behalf of a general practitioner in any of the following locations:

• the consulting rooms of a general practice; or
• a residential aged care facility; or
• a home visit to a patient; or
• an institution (other than a hospital or day hospital facility).

This excludes locations typically associated with mass immunisations, such as schools, workplaces, shopping centres etc. Subsection 19(4) of the HIA prevents the payment of Medicare benefits in relation to mass immunisations.

What types of immunisations can be claimed?

This item can be claimed where a practice nurse administers any vaccine registered under the Therapeutic Goods Act 1989. The practice nurse must be appropriately qualified and trained to provide the immunisation. This includes compliance with any State or Territory requirements. See explanatory notes in the MBS M.2 for further information.

The vaccine may be administered to either an adult or a child.

When is the immunisation item not claimable?

This item cannot be claimed if the practice nurse is administering the vaccine to the patient under a Commonwealth or State funded immunisation program.

Must the general practitioner be present to claim the immunisation item?

As the immunisation service is being provided on behalf of, and under the general supervision of the general practitioner, the general practitioner retains responsibility for the health, safety and clinical outcomes of the patient.

The general practitioner does not need to be present at the time of the immunisation.

It is up to the general practitioner to decide whether they need to see the patient prior to the immunisation being administered by the practice nurse. Where this does occur, the general practitioner will still be able to claim for the professional service they provide to the patient.

Can I claim more than one immunisation item?

No. Item 10993 can be claimed only once per patient visit, even if more than one vaccine is administered during the same patient visit.
**Will item 10993 affect existing immunisation payments?**
No. Service incentive payments currently received as part of the GPII Scheme and notification payments received through the Australian Childhood Immunisation Register are unaffected by the new immunisation item.

**Item 10996: Wound management**

**Circumstances in which item 10996 can be claimed**
Item 10996 can be claimed by a general practitioner where wound management is administered by a practice nurse on behalf of a general practitioner.

The wound management can be provided in any location, except where the patient has been admitted to a hospital or day-hospital facility.

**What type of wound management can be claimed under this item?**
This item can be claimed for the treatment of any wound, except for normal post-operative aftercare.

**Must the general practitioner be present to claim item 10996?**
As the wound management service is being provided on behalf of, and under the general supervision of, the general practitioner, the general practitioner retains responsibility for the health, safety and clinical outcomes of the patient.

The medical practitioner does not need to be present during the treatment of the wound. However, the general practitioner must conduct an initial assessment of the patient in order to give instruction in relation to the treatment of the wound. Where a practice nurse provides ongoing wound management, the general practitioner is not required to see the patient during each subsequent visit.

**Common elements for items 10993 and 10996**

**Who can claim items 10993 and 10996?**
Items 10993 and 10996 can only be claimed by a general practitioner for services provided by a practice nurse.

All GPs whether vocationally registered or not are eligible to claim the items.

The items can be claimed in any general practice where general practitioners are eligible to receive Medicare benefits. This includes Aboriginal Community Controlled Clinics and Qld/NT Health identified hospitals/clinics that have approval under exemption to subsection 19(2) which gives them approval to bulk bill Medicare.

**What is a practice nurse for the purposes of items 10993 and 10996?**
A practice nurse must be either a registered or an enrolled nurse and employed by, or their services retained by, a general practice.

The practice nurse must also be appropriately qualified and trained, including compliance with any State or Territory requirements, to provide the relevant service for the particular item.
Can items 10993 and 10996 be claimed in conjunction with the bulk billing incentive items?

Yes. Item 10990 can be claimed as long as the immunisation or wound management service is provided to a Commonwealth concession card holder or child under 16 years and the service is bulk billed, unreferral and provided out-of-hospital.

Item 10991 can be claimed as long as the immunisation or wound management service is provided to a Commonwealth concession card holder or child under 16 years and the service is bulk billed, unreferral and provided out-of-hospital and the service is provided at, or from, a practice location in:

(i) a regional, rural or remote area; or

(ii) Tasmania; or

(iii) A geographical area included in any of the SSD spatial units in the explanatory notes in the GMST, DIST and PST; or

(iv) the geographical area included in the SLA spatial unit of Palm Island (AC).

If these conditions are met, the medical practitioner can claim both the bulk bill incentive items plus item 10993 and/or 10996.

For example, item 10993 (and/or item 10996) + item 10990 or 10991.

Item 10998 for pap smears taken by a practice nurse in a regional, rural or remote area.

Item 10998

Service provided by a practice nurse, being the taking of a cervical smear from a person, if:

a. the service is provided on behalf of, and under the supervision of, a medical practitioner; and

b. the service is provided at, or from, a practice location in a regional, rural or remote area; and

c. the person is not an admitted patient of a hospital or approved day hospital facility.

Item 10998 only applies where:

• the practice nurse is appropriately qualified and trained to take a cervical smear; and

• the medical practitioner under whose supervision the smear is taken retains responsibility for the health, safety and clinical outcomes of the person.

Item 10998 will operate in a similar way to the immunisation and wound management items (10993 and 10996). Further information on these items can be found in the explanatory notes (M.2) of the MBS book.

Who can claim item 10998?

Item 10998 can only be claimed by a general practitioner for a pap smear that is taken by a practice nurse on behalf of the general practitioner.

All vocationally registered and non-vocationally registered GPs are eligible to claim the item.

What qualifications and training are required for a practice nurse to take a pap smear?

It is a requirement of the item that the practice nurse must be appropriately qualified and trained to take a pap smear. This means that, where credentialing arrangements are in place; the practice nurse should be credentialled as qualified and trained to take pap smears.

All practice nurses taking pap smears should have undertaken an accredited course. Accredited training courses are now or will soon be available in all States and Territories. For information about accredited training for nurse pap smear providers, you should contact the Royal College of Nursing, Australia on 1800 061 660, or the Cervical Screening Program in your State or Territory on 131 556.

In all cases, the general practitioner (who is responsible for the health, safety and clinical outcomes of the patient) must be satisfied that the practice nurse is appropriately qualified and trained to take pap smears.

The practice nurse must also comply with any relevant legislative or regulatory requirements, including those applying to state and territory cervical cytology registers or laboratories.
Quality assurance and continuing professional development

Quality assurance is an important part of cervical screening. Continuing professional development is a compulsory part of the credentialing arrangements and is recommended for all nurses taking Pap smears in jurisdictions where there are currently no credentialing arrangements.

General practices, where nurses take pap smears, should also have a written clinical risk management strategy covering issues like clinical roles, pathology follow-up and patient consent.

DoHA will continue to work with general practices and nursing professions on issues about quality assurance such as credentialing, practice protocols and continuing professional development for nurses working in this role.

National and State and Territory cervical screening policies

When providing services covered by item 10998, the practice nurse should be aware of national, State and Territory cervical screening policies for the prevention of cervical cancer.

Questions and answers

Must the general practitioner see the patient first, or be present, in order to claim item 10998?

As the service is being provided on behalf of, and under the supervision of the general practitioner, the general practitioner retains responsibility for the health, safety and clinical outcomes of the patient.

However, this does not mean that the general practitioner is required to see the patient first, or be present with the practice nurse during the service, to claim item 10998.

It is up to the general practitioner to decide whether they need to initially see the patient. Where a consultation has taken place with the patient first, the general practitioner is entitled to claim for that professional service.

What level of medical indemnity insurance is required?

The general practitioner who claims item 10998 will need to ensure that their medical indemnity insurance covers circumstances where a practice nurse takes a pap smear on their behalf.

Can a practice nurse order the pathology for a pap smear?

Where pathology services are claimed through Medicare, the pathology can only be ordered by a general practitioner. In some jurisdictions, and in specific circumstances, a practice nurse may be able to order pathology through public pathology laboratories.

The practice nurse must also comply with any relevant legislative or regulatory requirements, including those applying to state and territory cervical cytology registers or laboratories.

Which practice locations are considered to be regional, rural and remote?

For the purposes of item 10998, a practice location in a regional, rural or remote area means a practice location in an area classified as RRMA 3–7 under the Rural Remote and Metropolitan Areas (RRMA) classification system.

A practice location is the place associated with the general practitioner's provider number from which the service has been provided. If you are unsure whether you are practising in an eligible area, you can call Medicare Australia on 132 150.
What is the level of the Medicare rebate for item 10998?

Item 10998, along with items 10993 and 10996 for practice nurse services, will attract a 100% Medicare rebate from 1 January 2005.

This means that the Medicare rebate will be the same as the schedule fee.

Can item 10998 be claimed in conjunction with the bulk billing incentive item 10991?

Yes, as long as the pap smear service is provided to a Commonwealth concession card holder or person under the age of 16, and the service is bulk billed. In this case, the general practitioner would be able to claim item 10998 and item 10991.

Will item 10998 affect the outcomes component under the Practice Incentives Program (PIP) cervical screening initiative?

No. The PIP cervical screening outcomes payment will not be affected by item 10998.

Can the PIP items for unscreened or significantly under screened women still be claimed where the practice nurse takes the pap smear?

Yes. Where the general practitioner provides a consultation before the practice nurse takes the pap smear, and the conditions of both item 10998 and the relevant PIP items have been satisfied, the PIP items (2501–2509 and 2600–2616) and item 10998 can both be claimed.

In claiming the PIP item, the general practitioner is only eligible to claim for the length of time that they spend with the patient. This does not include the time that the practice nurse spends with the patient to take the pap smear.
Pharmaceutical Benefits Scheme (PBS)

This section explains the Pharmaceutical Benefits Scheme under normal arrangements and under special arrangements for Remote area Aboriginal communities.

Normal arrangements under the PBS

About the PBS

The PBS gives all Australian residents and eligible overseas visitors access to prescription medicine in a way that is affordable, reliable and timely. Through the PBS, the Australian Government subsidises the cost of prescription medicine, making them more affordable for all Australians.

PBS medicine, under normal arrangements, is prescribed by doctors who will give a customer a prescription to take to the pharmacy. The Government subsidises the cost of the medicine and the customer pays less.

To receive the best Government subsidy, a customer should show their current Medicare card, Concession card (from Centrelink and/or Department of Veterans’ Affairs - DVA health card) if they have one, and/or their PBS Safety Net entitlement or concession card, if they have one, each time they have a prescription filled.

The amount a customer is required to pay (the patient co-payment) for a PBS prescription varies depending on the customer’s level of entitlement and the medicine required. As the co-payment increases annually, the pharmacist can advise a patient how much a PBS medicine will cost them.

If a doctor prescribes a medicine which is not listed under the PBS or the customer does not meet the restrictions for a particular medicine, they will need to pay the full price.

For more information call the PBS information line on 1800 020 613.

PBS Safety Net Scheme

The PBS Safety Net scheme exists to protect people and families who need to spend large amounts of money on prescription medicine in a calendar year. The Safety Net sets a maximum amount these people pay for PBS prescription medicine.

- To access Safety Net arrangements, patients are required to keep a record of the PBS medicine supplied for themselves or their family. To do this they will need to ask their pharmacist for a Prescription Record Form (PRF) and every time a PBS prescription is filled hand the PRF to the pharmacist to record the medicine supplied.
- If a patient always uses the same pharmacy, they can ask them to keep a record on their computer.
- Once the Safety Net threshold is reached, a person can apply for a Safety Net card. Further PBS medicine for the remainder of the calendar year will then be available at concessional co-payment for general patients and at no charge for concessional patients.
- There are joint arrangements with public hospitals, so the outpatient medicine costs are considered for the PBS Safety Net.

For more information call the Aboriginal and Torres Strait Islander Access line on 1800 556 955
Schedule of Pharmaceutical Benefits

The Schedule of Pharmaceutical Benefits is produced by DoHA and lists medicine available under the PBS. The Explanatory Notes in the Schedule provide information to help doctors, dentists and pharmacists work within the PBS. It contains information about maximum quantities, repeats, authority prescriptions, restrictions and other procedural details. The Schedule is also available in prescribing and dispensing software and on the Internet at http://www1.health.gov.au/pbs/index.htm.

PBS prescriptions

Doctors should use their own personalised PBS prescription pads and authority forms. Computer stationery must be approved by Medicare Australia.

All prescriptions need to include the following information:

- Name and residential address of the patient being treated
- Date
- Name of the medicine (either generic or brand named) the patient is to receive including strength, form, quantity expressed as a number and number of repeats
- Instructions about the dose and frequency to be printed on the label by the pharmacist
- Doctor’s signature

Including the patient’s Medicare number, Centrelink concession number or DVA White, Gold or Orange card number helps to ensure pharmaceutical benefits are provided only to those eligible to receive them.

Some PBS prescriptions are for authority required items and require prior approval from Medicare Australia or DVA before a prescription can be written. These are called authority prescriptions. Prior approval from Medicare Australia and DVA is also needed when a doctor requires an increase to the maximum quantity or number of repeats as listed in the Schedule of Pharmaceutical Benefits.

Home Medicines Review (HMR)

Home Medicines Review (HMR) is also known as Domiciliary Medication Management Review (DMMR). HMR sees GPs and pharmacists working together to review the use of medicine by patients living in the community. HMR aims to reduce medication-related problems, improve medication outcomes and reduce medication costs.

More detailed information about HMR (including relevant forms, a patient information sheet and answers to commonly asked questions) can be found at www.health.gov.au/epc/dmmr

Queries about HMR can be sent to epc.items@health.gov.au

Program review

Medicare Australia manages the prevention, detection and investigation of fraud and abuse of Medicare Australia administered programs. Medicare Australia has developed many methods to ensure benefits are paid correctly. One of those is to ensure people who claim the benefits understand how to claim correctly. As most claims are submitted by doctors or pharmacists, Medicare Australia works with these professionals and the broader health industry to help them claim for their services appropriately.

If inappropriate or incorrect claims are made inadvertently, Medicare Australia will discuss and resolve the problem while maintaining a monitoring activity. Medicare Australia uses advanced technology to identify irregularities in claiming behaviour and to monitor payment patterns—this helps us to detect and investigate fraud, as well as inappropriate claiming practices.
Special arrangements for Remote area Aboriginal communities

Remote area Aboriginal communities have improved access to PBS medicine through the special ‘section 100’ arrangements.

These arrangements enable approved Aboriginal Health Services (AHS) in remote areas to order PBS medicine in bulk from local pharmacies and supply them to patients directly from a dispensary at the health service, without a formal prescription (provided State law can be met) and without charge.

Remote ACCHS’s wishing to gain access to section 100 arrangements should contact the Pharmaceutical Access and Quality Branch, Medical and Pharmaceutical Services Division, DoHA by calling (02) 6289 8311, to determine eligibility prior to applying. If appropriate, services can then request an ‘Application for approval for the purpose of obtaining Pharmaceutical Benefits under the provisions of section 100 of the National Health Act 1953’ form by:

- Post to MDP 38, GPO Box 9848, Canberra City ACT 2601; or
- Telephone on (02) 6289 8897; or
- Website at pbs-indigenous@health.gov.au

Remote State and Territory Government operated Health Services must apply for approval to obtain Pharmaceutical Benefits under section 100 through their respective health department.

Incentive Payments for providing support services to a remote area AHS

When a community pharmacist supplies medicine to a remote area AHS, an allowance per annum plus a component for GST may be paid to the pharmacist for providing a range of services to support the AHS in its implementation of the Section 100 supply arrangements.

Examples of services that a pharmacy may provide in order to receive financial support include:

- medication management
- training of Aboriginal Health Workers in the handling of medication and supervision of medication held by rural and remote Aboriginal communities, such as out of date stock, etc.

Pharmacist payment for the delivery of services to remote area AHSs has been made possible through the Third Community Pharmacy Agreement (Guild/Government Agreement).

How can health workers help?

- Health workers can explain how the PBS works (under both normal and special arrangements) to customers, including reminding them to ‘take your Medicare card and other concession cards with you when you travel’.
- If required under normal arrangements, current Medicare card details could be included on medical records so that the details are available to the doctor during consultations and can be included on prescriptions.
Other programs

This section provides information for service providers on the Australian Childhood Immunisation Register and recording client’s immunisations.

Australian Childhood Immunisation Register (ACIR)
The Australian Childhood Immunisation Register (the Register/Immunisation Register) records details of vaccinations given to children under the age of seven who live in Australia. The Register and other initiatives were introduced to increase immunisation rates.

Submitting data to the Immunisation Register
- When an immunisation provider (including GPs, some hospitals and local councils) vaccinates a child, they should record the details and send them to the Immunisation Register. Providers will receive a notification payment for information about a vaccination that completes one of the individual immunisation schedules. Please note, unless alternative arrangements have been made providers in Queensland and the Northern Territory should send immunisation details to their State/Territory Health Department.
- Information can be sent to the Immunisation Register by manually completing an IMMU2 form. It can also be done electronically either through Electronic Data Interchange (EDI) or by accessing the professional link on Medicare Australia’s website at www.medicareaustralia.gov.au—for further information call the Immunisation Register internet helpline on 1300 650 039. Information can also be sent via online claiming software, if this is offered to the provider by an approved software vendor—for further information call the Medicare Australia eBusiness Service Centre on 1800 700 199.
- When sending information to the Immunisation Register, children should be identified by their Medicare number whenever possible. If the Medicare number is not available, the child’s full name, address, date of birth and gender need to be included to allow the child to be identified.
- Order forms for stationery and brochures for patients can be obtained by calling 1800 067 307.

Immunisation records and history statements
- Information on the Immunisation Register is available to providers to help determine the immunisation status of a particular child. If you have parental consent, providers can call 1800 653 809 for this information.
- Immunisation history statements are available to parents and guardians. These statements provide useful up-to-date information in a certificate format and can be used by parents as evidence that their child is immunised.
General Practice Immunisation Incentives Scheme

The General Practice Immunisation Incentives Scheme (GPII) provides financial incentives to GPs who monitor, promote and provide age appropriate immunisation services to children under the age of seven in their practice. Aboriginal Medical Services claiming Medicare benefits are welcome to apply. To check the eligibility requirements please call the GPII information number listed below.

The GPII Scheme is made up of three components:

- A Service Incentive Payment (SIP) to GPs and other medical practitioners who notify ACIR of a vaccination that completes an immunisation schedule according to the National Immunisation Program.
- An Outcomes Payment—a payment made to practices that achieve 90% or greater proportions of full immunisation of children under seven years of age attending their practices.
- Immunisation Infrastructure Funding—this provides funds to Divisions of General Practice, state-based organisations and a National GP Immunisation Coordinator to improve the proportion of children who are immunised at local, state and national levels. (Administered by DoHA).

The GPII scheme aims to encourage at least 90 per cent of practices to fully immunise 90 per cent of children under seven years of age attending their practices.

For further information about the GPII Scheme call 1800 246 101 or the Aboriginal and Torres Strait Islander Access line.

Practice Incentive Program

Overview

The Practice Incentives Program (PIP) provides a range of incentives that aim to support general practices and improve the quality of care provided to patients. This includes service providers that have general practitioners providing services through Medicare. Practices must be accredited or working towards accreditation against the Royal Australian College of General Practitioners Standards for General Practices, to participate in the program.

The PIP is part of a blended payment approach for general practice. Payments made through the program are in addition to other income earned by the GPs and the practice, such as patient payments and Medicare rebates. In May 2005 there were around 4,680 general practices participating in the PIP. These practices provide 4 out of every 5 GP patient services in Australia.

Medicare Australia assesses all applications from general practices and administers the program on a day-to-day basis. DoHA has overall policy responsibility for the PIP including determination of eligibility criteria.

Payments received through the PIP can also help fund the changes required for accreditation. A service provider claiming Medicare benefits can receive PIP payments as soon as it is registered for accreditation with an accreditation provider (Australian General Practice Accreditation Ltd or General Practice Accreditation Plus—contact details below). The service must obtain accreditation within 12 months to continue to participate in the program.
Types of payments
There are eleven PIP components and practices may qualify for any or all of these.

- **Information management**—payments to practices for providing data to the Australian Government, using electronic prescribing software to generate scripts, and for having the capacity to send and receive data electronically.
- **After-hours care**—payments to practices for ensuring that patients have access to 24-hour care including the provision of after-hours home visits where necessary and appropriate.
- **Teaching**—payments to practices for teaching medical students.
- **Quality Prescribing Initiative**—payments to practices that participate in the quality use of medicines program endorsed by the National Prescribing Service.
- **Practice nurses**—payments to practices in RRMAs 3-7 and eligible urban areas of workforce shortage and to service providers with Indigenous clients to assist them to employ or retain the services of a practice nurse, Aboriginal health worker and/or allied health worker.
- **Cervical screening**—payments to practices that achieve targets in cervical screening and payments to GPs who screen women aged 20 to 69 years who have not had a pap smear for 4 years or more.
- **Diabetes**—payments to practices that achieve targets in providing care for their patients with diabetes and payments to GPs for providing diabetes care according to best practice guidelines.
- **Asthma**—payments to practices for providing the Asthma 3+ Program and payments to GPs who complete an Asthma 3+ plan for patients with moderate to severe asthma.
- **Mental health**—payments to GPs for using the 3 Step Mental Health Process with their patients.
- **Procedural GP payment**—payments to practices with procedural GPs to support the provision of procedural services such as surgery, anaesthetics and obstetrics in rural and remote areas.
- **Rurality**—a rural loading is applied to the PIP payments of practices where the main location is situated outside a capital city or other major metropolitan area.

More information

- Medicare Australia operates a PIP Enquiry line 1800 222 032 to provide support to practices and providers and operates from 8.30am—5.00pm central time.
- The PIP website displays general program information, application forms and PIP statistics which can be downloaded by providers and Divisions of General Practice at www.medicareaustralia.gov.au/pip.
- Providers are kept up-to-date on changes to the PIP by the PIP News Update, a quarterly information sheet about current and future program activities and incentives, posted to practices and also accessible on the PIP website.
- Information on accreditation is available through the accreditation providers:
  - Australian General Practice Accreditation Ltd (AGPAL), phone 1300 362 111
  - Quality Assurance Services (QAS) via General Practice Accreditation Plus (GPA Plus), phone 1800 188 088.

General Practice Registrars Rural Incentive Payments Scheme (RRIPS)
The General Practice Registrars Rural Incentive Payments Scheme (RRIPS) is designed to boost general practice training in rural and remote areas and provides financial incentives to encourage general practice registrars to take up the rural training initiative.

- These incentives are offered to general practice registrars who undertake the majority of their general practice training in training practices located in Rural, Remote and Metropolitan Area (RRMA) 4-7 locations.
- Registrars can receive payments over three years for general practice training.
- To be eligible for rural training incentive payments, registrars must be formally registered in the Rural Training Pathway.
- For further information about RRIPS and to obtain a registration form call Medicare Australia RRIPS helpline on 1800 700 050.
Rural Retention Program
The Rural Retention Program works to strengthen the rural health workforce and aims to improve the level of health care for people in rural and remote areas of Australia through a system of incentive payments to medical practitioners working in these areas.

The program encourages doctors to remain in rural and remote practices beyond the current average of two years and rewards those who do.

The two components of the program are:
• a central payments system financially recognising doctors based on their Medicare service data in rural and remote locations over a number of years; and
• a flexible payments system that financially recognises long serving doctors who do not receive a fair and equitable level of support under the central payments systems because their services are not captured by Medicare or their locations are not adequately taken into account.

The payments vary depending on the qualifying period, the location classification and the length of service of the doctor.

For further information call the Rural Retention Program on 1800 010 550.

Higher Education Contribution Scheme (HECS) Reimbursement Scheme
The HECS Reimbursement Scheme was announced in the 2000-2001 Federal Budget as part of the Regional Strategy: More Doctors, Better Services. This initiative aims to promote careers in rural medicine and increase the number of doctors in rural and regional areas in the longer term.

Participants in the Scheme will have one fifth of their HECS fees for the study of medicine reimbursed for each year of training undertaken or service provided in rural and remote areas of Australia.

Through the Scheme, communities will gain improved access to health services as more doctors move to work in rural areas.

For the purposes of the HECS Reimbursement Scheme, Rural, Remote and Metropolitan Area (RRMA) classifications 3-7 will be used for determining eligible areas.

For further information about the HECS Reimbursement Scheme or to obtain a registration from call Medicare Australia HECS Reimbursement Scheme helpline on 1800 700 177.

Training for Rural and Remote Procedural GPs Program
The Australian Government launched a new Medicare Package—a program to strengthen Medicare now and for future generations. One of the initiatives included in this package is the Training for Rural and Remote Procedural GPs Program.

This program will support procedural GPs in rural and remote areas (RRMAs 3-7) to attend relevant training, which is focussed on both skills maintenance and up skilling. This support is in the form of a grant for the cost of up to two weeks training, including the cost of the required locum relief to a maximum of $15 000 per GP per annum. This is based in the financial year in which the training is completed.

The program commenced in July 2004 with the Australian College of Rural and Remote Medicine (ACRRM), the Royal Australian College of General Practitioners (RACGP) and Medicare Australia assisting the Department of Health and Aging to administer the program. Eligible GPs who have undertaken approved training from 1 March 2004 will be considered for payment of the grant.

Medicare Australia will maintain a register of eligible GPs and will be in constant communication with ACRRM and RACGP to enable payment to the GP.

For further information please contact either ACRRM on 1800 223 226 or RACGP on 1800 636 764.
The Rural Other Medical Practitioners (ROMP) Program

The Rural Other Medical Practitioners (ROMP) Program provides access to the higher A1 Medicare rebate for services provided in Rural, Remote and Metropolitan Area (RRMA) 4-7 locations and defined ‘areas of consideration’ by non-vocationally recognised medical practitioners who express an interest in achieving vocational recognition.

Areas of consideration are areas that are not classified as RRMA 4-7 locations but exhibit the characteristics of rural areas.

The Rural OMPs Program recognises the value of services provided in rural areas by non-vocationally recognised medical practitioners and provides substantial financial benefits for their patients.

The program provides an incentive to encourage non-vocationally recognised medical practitioners to provide general practice services in RRMA 4–7 locations.

Medicare Australia administers the ROMP Program on behalf of DoHA.

Medical practitioners are required to complete an application form and receive notification from Medicare Australia that they are approved under the program before they begin to bill the A1 items.

For further information about the program contact the GP helpline on 1800 667 677.

Australian Organ Donor Register (AODR)

The Australian Organ Donor Register (AODR/the Donor Register) provides a national and coordinated way for Australians to record their decision regarding organ and/or tissue donation for transplantation. The purpose of the Donor Register is to increase awareness of organ and tissue donation, supporting a national strategy to improve donation rates in Australia.

Only people aged 18 years or more can register their consent (or objection) on the Donor Register.

- If you are 16 or 17 years old you can register your intention (or objection) on the Donor Register.
- Entry onto the Donor Registry is voluntary.

Registration forms are available from Medicare offices or by calling the Donor Register on 1800 777 203. Registration can also be completed via the Medicare Australia website at www.medicareaustralia.gov.au. Additionally, you can call the Aboriginal and Torres Strait Islander Access line to discuss the program.

Health services can promote the Donor Register to their patients and supply registration forms.
## Contact details

Medicare Australia website: [www.medicareaustralia.gov.au](http://www.medicareaustralia.gov.au)

<table>
<thead>
<tr>
<th>Contact</th>
<th>Phone</th>
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<tr>
<td>Indigenous Access Program (Hours 8:30 a.m. to 4:30 p.m.)</td>
<td>1800 556 955</td>
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<tr>
<td>Aboriginal and Torres Strait Islander Access Line</td>
<td>1800 556 955</td>
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<tr>
<td>Medicare—general public enquiries</td>
<td>132 011</td>
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<td>Medicare—provider enquiries</td>
<td>132 150</td>
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<tr>
<td>Medclaims helpdesk—electronically transmitted claims</td>
<td>1300 788 008</td>
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<tr>
<td>Medicare/DVA form enquiries</td>
<td>1800 067 307</td>
</tr>
<tr>
<td>Medicare stationery order forms</td>
<td>1800 067 307</td>
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<tr>
<td>Authority prescription approvals</td>
<td>1800 888 333</td>
</tr>
<tr>
<td>Online Claiming</td>
<td>1800 700 199</td>
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<td>IME Hotline</td>
<td>1300 302 122</td>
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<td>PBS information line</td>
<td>1800 020 613</td>
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<tr>
<td>DVA authority prescription approvals</td>
<td>1800 552 580</td>
</tr>
<tr>
<td>PBS general and stationary enquiries</td>
<td>132 290</td>
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<tr>
<td>Australian Childhood Immunisation Register</td>
<td>1800 653 809</td>
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<tr>
<td>Australian Childhood Immunisation Register—internet helpline</td>
<td>1300 650 039</td>
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<td>Australian Organ Donor Register</td>
<td>1800 777 203</td>
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<td>Practice Incentives Program</td>
<td>1800 222 032</td>
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<td>General Practice Immunisation Incentive Scheme</td>
<td>1800 246 101</td>
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<td>Rural Retention Program</td>
<td>1800 010 550</td>
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<td>General Practice Registrars Rural Incentive Payments Scheme HECS Reimbursement Scheme</td>
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<td>Training for Rural and Remote Procedural GPs</td>
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<td>Rural OMPs program</td>
<td>1800 667 677</td>
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<tr>
<td>Team Leader, Indigenous Access</td>
<td>(02) 6124 7937</td>
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1300 numbers—local call rates (normal mobile and public phone charges apply)

1800 numbers—free call (normal mobile and public phone charges apply)
Department of Human Services (DHS) contacts

Information for Aboriginal and Torres Strait Islander People

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<td>Centrelink</td>
<td>131 021</td>
<td><a href="http://www.centrelink.gov.au">www.centrelink.gov.au</a></td>
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<td>CRS Australia</td>
<td>1800 624 824</td>
<td><a href="http://www.crsaustralia.gov.au">www.crsaustralia.gov.au</a></td>
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<td>Child Support Agency</td>
<td>131 272</td>
<td><a href="http://www.csa.gov.au">www.csa.gov.au</a></td>
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<td>Australian Hearing</td>
<td>131 797</td>
<td><a href="http://www.hearing.com.au">www.hearing.com.au</a></td>
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<tr>
<td>Health Services Australia</td>
<td>1300 361 046</td>
<td><a href="http://www.healthoz.com.au">www.healthoz.com.au</a></td>
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# Acronyms

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<td>Audiological Society of Australia Inc</td>
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<td>Comprehensive Medical Assessment</td>
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<td>Department of Health and Ageing</td>
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For more information call the Aboriginal and Torres Strait Islander Access line on 1800 556 955
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