Updates to MBS optometry items

The following details have been extracted from pages of the full Medicare Benefits Schedule Book, operating from 1 July 2020 and published by the Australian Government Department of Health.

A10. OPTOMETRICAL SERVICES — 1. GENERAL

Item number	Group A10. Optometrical Services Subgroup 1. General
10905	REFERRED COMPREHENSIVE INITIAL CONSULTATION Professional attendance of more than 15 minutes duration, being the first in a course of attention, where the patient has been referred by another optometrist who is not associated with the optometrist to whom the patient is referred (See para AN.0.10 of explanatory notes to this Category) **Fee:** $68.85 **Benefit:** 85% = $58.55
10907	COMPREHENSIVE INITIAL CONSULTATION BY ANOTHER PRACTITIONER Professional attendance of more than 15 minutes in duration, being the first in a course of attention if the patient has attended another optometrist for an attendance to which this item or item 10905, 10910, 10911, 10912, 10913, 10914 or 10915 applies, or to which old item 10900 applied: (a) for a patient who is less than 65 years of age-within the previous 36 months; or (b) for a patient who is at least 65 years or age-within the previous 12 months (See para AN.0.10 of explanatory notes to this Category) **Fee:** $34.50 **Benefit:** 85% = $29.35
10910	COMPREHENSIVE INITIAL CONSULTATION - PATIENT IS LESS THAN 65 YEARS OF AGE Professional attendance of more than 15 minutes in duration, being the first in a course of attention, if: (a) the patient is less than 65 years of age; and (b) the patient has not, within the previous 36 months, received a service to which: (i) this item or item 10905, 10907, 10912, 10913, 10914 or 10915 applies; or (ii) old item 10900 applied (See para AN.0.10 of explanatory notes to this Category) **Fee:** $68.85 **Benefit:** 85% = $58.55
10911	COMPREHENSIVE INITIAL CONSULTATION - PATIENT IS AT LEAST 65 YEARS OF AGE Professional attendance of more than 15 minutes in duration, being the first in a course of attention, if: (a) the patient is at least 65 years of age; and (b) the patient has not, within the previous 12 months, received a service to which: (i) this item, or item 10905, 10907, 10910, 10912, 10913, 10914 or 10915 (ii) old item 10900 applied (See para AN.0.10 of explanatory notes to this Category) **Fee:** $68.85 **Benefit:** 85% = $58.55
10912	OTHER COMPREHENSIVE CONSULTATIONS Professional attendance of more than 15 minutes in duration, being the first in a course of attention, if the patient has suffered a significant change of visual function requiring comprehensive reassessment: (a) for a patient who is less than 65 years of age-within 36 months of an initial consultation to which: (i) this item, or item 10905, 10907, 10910, 10913, 10914 or 10915 at the same practice applies; or (ii) old item 10900 at the same practice applied; or (b) for a patient who is at least 65 years of age-within 12 months of an initial consultation to which: (i) this item, or item 10905, 10907, 10910, 10911, 10913, 10914 or 10915 at the same practice applies; or (ii) old item 10900 at the same practice applied (See para AN.0.10 of explanatory notes to this Category) **Fee:** $68.85 **Benefit:** 85% = $58.55

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Optometry AUSTRALIA

A10. OPTOMETRICAL SERVICES — 1. GENERAL

10913	Professional attendance of more than 15 minutes in duration, being the first in a course of attention, if the patient has new signs or symptoms, unrelated to the earlier course of attention, requiring comprehensive reassessment: (a) for a patient who is less than 65 years of age-within 36 months of an initial consultation to which: (i) this item, or item 10905, 10907, 10910, 10912, 10914 or 10915 at the same practice applies; or (ii) old item 10900 at the same practice applied; or (b) for a patient who is at least 65 years of age-within 12 months of an initial consultation to which: (i) this item, or item 10905, 10907, 10910, 10911, 10912, 10914 or 10915 at the same practice applies; or (ii) old item 10900 at the same practice applied (See para AN.0.10 of explanatory notes to this Category) **Fee:** $68.85 **Benefit:** 85% = $58.55
10914	Professional attendance of more than 15 minutes in duration, being the first in a course of attention, if the patient has a progressive disorder (excluding presbyopia) requiring comprehensive reassessment: (a) for a patient who is less than 65 years of age-within 36 months of an initial consultation to which: (i) this item, or item 10905, 10907, 10910, 10912, 10913 or 10915 applies; or (ii) old item 10900 applied; or (b) for a patient who is at least 65 years of age-within 12 months of an initial consultation to which: (i) this item, or item 10905, 10907, 10910, 10911, 10912, 10913 or 10915 applies; or (ii) old item 10900 applied (See para AN.0.10 of explanatory notes to this Category) **Fee:** $68.85 **Benefit:** 85% = $58.55
10915	Professional attendance of more than 15 minutes duration, being the first in a course of attention involving the examination of the eyes, with the instillation of a mydriatic, of a patient with diabetes mellitus requiring comprehensive reassessment. (See para AN.0.10 of explanatory notes to this Category) **Fee:** $68.85 **Benefit:** 85% = $58.55
10916	BRIEF INITIAL CONSULTATION Professional attendance, being the first in a course of attention, of not more than 15 minutes duration, not being a service associated with a service to which item 10931, 10932, 10933, 10940, 10941, 10942 or 10943 applies (See para AN.0.10 of explanatory notes to this Category) **Fee:** $34.50 **Benefit:** 85% = $29.35
10918	SUBSEQUENT CONSULTATION Professional attendance being the second or subsequent in a course of attention not related to the prescription and fitting of contact lenses, not being a service associated with a service to which item 10940 or 10941 applies (See para AN.0.10 of explanatory notes to this Category) **Fee:** $34.50 **Benefit:** 85% = $29.35
10921	CONTACT LENSES FOR SPECIFIED CLASSES OF PATIENTS - BULK ITEMS FOR ALL SUBSEQUENT CONSULTATIONS All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which: (a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or (b) old item 10900 applied Payable once in a period of 36 months for - patients with myopia of 5.0 dioptres or greater (spherical equivalent) in one eye (See para AN.0.2 of explanatory notes to this Category) **Fee:** $171.00 **Benefit:** 85% = $145.35
10922	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which: (a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or (b) old item 10900 applied Payable once in a period of 36 months for - patients with manifest hyperopia of 5.0 dioptres or greater (spherical equivalent) in one eye (See para AN.0.2 of explanatory notes to this Category) **Fee:** $171.00 **Benefit:** 85% = $145.35

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A10. OPTOMETRICAL SERVICES — 1. GENERAL

10923	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which: (a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or (b) old item 10900 applied Payable once in a period of 36 months for - patients with astigmatism of 3.0 dioptres or greater in one eye (See para AN.0.2 of explanatory notes to this Category) **Fee:** $171.00 **Benefit:** 85% = $145.35
10924	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which: (a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or (b) old item 10900 applied Payable once in a period of 36 months for - patients with irregular astigmatism in either eye, being a condition the existence of which has been confirmed by keratometric observation, if the maximum visual acuity obtainable with spectacle correction is worse than 0.3 logMAR (6/12) and if that corrected acuity would be improved by an additional 0.1 logMAR by the use of a contact lens (See para AN.0.2 of explanatory notes to this Category) **Fee:** $215.75 **Benefit:** 85% = $183.40
10925	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which: (a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or (b) old item 10900 applied Payable once in a period of 36 months for - patients with anisometropia of 3.0 dioptres or greater (difference between spherical equivalents) (See para AN.0.2 of explanatory notes to this Category) **Fee:** $171.00 **Benefit:** 85% = $145.35
10926	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which: (a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or (b) old item 10900 applied Payable once in a period of 36 months for - patients with corrected visual acuity of 0.7 logMAR (6/30) or worse in both eyes, being patients for whom a contact lens is prescribed as part of a telescopic system (See para AN.0.2 of explanatory notes to this Category) **Fee:** $171.00 **Benefit:** 85% = $145.35
10927	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which: (a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or (b) old item 10900 applied Payable once in a period of 36 months for - patients for whom a wholly or segmentally opaque contact lens is prescribed for the alleviation of dazzle, distortion or diplopia caused by: i. pathological mydriasis; or ii. aniridia; or iii. coloboma of the iris; or iv. pupillary malformation or distortion; or v. significant ocular deformity or corneal opacity - whether congenital, traumatic or surgical in origin (See para AN.0.2 of explanatory notes to this Category) **Fee:** $215.75 **Benefit:** 85% = $183.40

A10. OPTOMETRICAL SERVICES — 1. GENERAL

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10928	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which: (a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or (b) old item 10900 applied Payable once in a period of 36 months for - patients who, because of physical deformity, are unable to wear spectacles (See para AN.0.2 of explanatory notes to this Category) **Fee:** $171.00 **Benefit:** 85% = $145.35
10929	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which: (a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or (b) old item 10900 applied Payable once in a period of 36 months for - patients who have a medical or optical condition (other than myopia, hyperopia, astigmatism, anisometropia or a condition to which item 10926, 10927 or 10928 applies) requiring the use of a contact lens for correction, if the condition is specified on the patient's account *Note: Benefits may not be claimed under Item 10929 where the patient wants the contact lenses for appearance, sporting, work or psychological reasons - see paragraph O6 of explanatory notes to this category.* (See para AN.0.2 of explanatory notes to this Category) **Fee:** $215.75 **Benefit:** 85% = $183.40
10930	All professional attendances regarded as a single service in a single course of attention involving the prescription and fitting of contact lenses where the patient meets the requirements of an item in the range 10921-10929 and requires a change in contact lens material or basic lens parameters, other than a simple power change, because of a structural or functional change in the eye or an allergic response within 36 months of the fitting of a contact lens covered by item 10921 to 10929 **Fee:** $171.00 **Benefit:** 85% = $145.35
10931	DOMICILIARY VISITS An optometric service to which an item in Group A10 of this table (other than this item or item 10916, 10932, 10933, 10940 or 10941) applies (the applicable item) if the service is: a) rendered at a place other than consulting rooms, being at: (i) a patient's home: or (ii) residential aged care facility: or (iii) an institution; and b) performed on one patient at a single location on one occasion, and c) either: (i) bulk-billed in respect of the fees for both: - this item; and - the applicable item; or (See para AN.0.10 of explanatory notes to this Category) **Fee:** $24.00 **Benefit:** 85% = $20.40
10932	An optometric service to which an item in Group A10 of this table (other than this item or item 10916, 10931, 10933, 10940 or 10941) applies (the applicable item) if the service is: a) rendered at a place other than consulting rooms, being at: (i) a patient's home: or (ii) residential aged care facility: or (iii) an institution; and b) performed on two patients at the same location on one occasion, and c) either: (i) bulk-billed in respect of the fees for both: - this item; and - the applicable item; or (ii) not bulk-billed in respect of the fees for both: - this item; and - the applicable item (See para AN.0.10 of explanatory notes to this Category) **Fee:** $12.00 **Benefit:** 85% = $10.20

A10. OPTOMETRICAL SERVICES 1. GENERAL

Continued over page.

10933	An optometric service to which an item in Group A10 of this table (other than this item or item 10916, 10931, 10932, 10940 or 10941) applies (the applicable item) if the service is: a) rendered at a place other than consulting rooms, being at: (i) a patient's home: or (ii) residential aged care facility: or (iii) an institution; and b) performed on three patients at the same location on one occasion, and c) either: (i) bulk-billed in respect of the fees for both: - this item; and - the applicable item; or (ii) not bulk-billed in respect of the fees for both: - this item; and - the applicable item (See para AN.0.10 of explanatory notes to this Category) **Fee:** $7.90 **Benefit:** 85% = $6.75
10940	COMPUTERISED PERIMETRY Full quantitative computerised perimetry (automated absolute static threshold) not being a service involving multifocal multichannel objective perimetry, performed by an optometrist, where indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain with assessment and report, bilateral - to a maximum of 2 examinations (including examinations to which item 10941 applies) in any 12 month period, not being a service associated with a service to which item 10916, 10918, 10931, 10932 or 10933 applies (See para AN.0.10, DN.1.6 of explanatory notes to this Category) **Fee:** $65.70 **Benefit:** 85% = $55.85
10941	Full quantitative computerised perimetry (automated absolute static threshold) not being a service involving multifocal multichannel objective perimetry, performed by an optometrist, where indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain with assessment and report, unilateral - to a maximum of 2 examinations (including examinations to which item 10940 applies) in any 12 month period, not being a service associated with a service to which item 10916, 10918, 10931, 10932 or 10933 applies (See para AN.0.10, DN.1.6 of explanatory notes to this Category) **Fee:** $39.65 **Benefit:** 85% = $33.75
10942	LOW VISION ASSESSMENT Testing of residual vision to provide optimum visual performance involving one or more of spectacle correction, determination of contrast sensitivity, determination of glare sensitivity and prescription of magnification aids in a patient who has best corrected visual acuity of 6/15 or N.12 or worse in the better eye, or horizontal visual field of less than 120 degrees within 10 degrees above and below the horizontal midline, not being a service associated with a service to which item 10916 or 10921 to 10930 applies, payable twice in a 12 month period (See para AN.0.10 of explanatory notes to this Category) **Fee:** $34.50 **Benefit:** 85% = $29.35
10943	CHILDREN'S VISION ASSESSMENT Additional testing to confirm diagnosis of, or establish a treatment regime for, a significant binocular or accommodative dysfunction, including assessment of one or more of accommodation, ocular motility, vergences, or fusional reserves and/or cycloplegic refraction, in a patient aged 3 to 14 years, not to be used for the assessment of learning difficulties or learning disabilities, not being a service associated with a service to which item 10916 or 10921 to 10930 applies, payable once only in a 12 month period (See para AN.0.10 of explanatory notes to this Category) **Fee:** $34.50 **Benefit:** 85% = $29.35
10944	CORNEA, complete removal of embedded foreign body from - not more than once on the same day by the same practitioner (excluding aftercare) The item is not to be billed on the same occasion as MBS items 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915, 10916 or 10918. If the embedded foreign body is not completely removed, this item does not apply but item 10916 may apply. **Fee:** $74.40 **Benefit:** 85% = $63.25

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A10. OPTOMETRICAL SERVICES	2. TELEHEALTH ATTENDANCE
	Group A10. Optometrical Services
	Subgroup 2. Telehealth Attendance
Item number	TELEHEALTH ATTENDANCE AT CONSULTING ROOMS, HOME VISITS OR OTHER INSTITUTIONS
10945	A professional attendance of less than 15 minutes (whether or not continuous) by an attending optometrist that requires the provision of clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist practising in his or her speciality of ophthalmology; and (b) is not an admitted patient; and (c) either: (i) is located within a telehealth eligible area and, at the time of the attendance, is at least 15 kilometres by road from the specialist mentioned in paragraph (a); or (ii) is a patient of an Aboriginal Medical Service, or an Aboriginal Community Controlled Health Service, for which a direction under subsection 19(2) of the Act applies (See para AN.0.22 of explanatory notes to this Category) **Fee:** $34.50 **Benefit:** 85% = $29.35
10946	A professional attendance of at least 15 minutes (whether or not continuous) by an attending optometrist that requires the provision of clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist practising in his or her speciality of ophthalmology; and (b) is not an admitted patient; and (c) either: (i) is located within a telehealth eligible area and, at the time of the attendance, is at least 15 kilometres by road from the specialist mentioned in paragraph (a); or (ii) is a patient of an Aboriginal Medical Service, or an Aboriginal Community Controlled Health Service, for which a direction under subsection 19(2) of the Act applies (See para AN.0.22 of explanatory notes to this Category) **Fee:** $68.85 **Benefit:** 85% = $58.55
10947	A professional attendance (not being a service to which any other item applies) of less than 15 minutes (whether or not continuous) by an attending optometrist that requires the provision of clinical support to a patient who: a) is participating in a video conferencing consultation with a specialist practising in his or her speciality of ophthalmology; and b) at the time of the attendance, is located at a residential aged care facility (whether or not at consulting rooms situated within the facility); andc) is a care recipient in the facility; and d) is not a resident of a self-contained unit; for an attendance on one occasion-each patient (See para AN.0.22 of explanatory notes to this Category) **Fee:** $34.50 **Benefit:** 85% = $29.35
10948	A professional attendance (not being a service to which any other item applies) of at least 15 minutes (whether or not continuous) by an attending optometrist that requires the provision of clinical support to a patient who: a) is participating in a video conferencing consultation with a specialist practising in his or her speciality of ophthalmology; and b) at the time of the attendance, is located at a residential aged care facility (whether or not at consulting rooms situated within the facility); andc) is a care recipient in the facility; and d) is not a resident of a self-contained unit; for an attendance on one occasion-each patient (See para AN.0.22 of explanatory notes to this Category) **Fee:** $68.85 **Benefit:** 85% = $58.55

Updates to MBS explanatory notes detailed over page.

Updates to MBS explanatory notes

The following details have been extracted from the full Medicare Benefits Schedule Book, operating from 1 July 2020 and published by the Australian Government Department of Health.

Notes AN.0.2, AN.0.10, AN.0.22 and DN.1.6 are explicitly referred to in the MBS items listed on previous pages of this summary document.

Professional Attendances Notes

AN.0.1 Personal Attendance by Practitioner

The personal attendance of the medical practitioner upon the patient is necessary, before a "consultation" may be regarded as a professional attendance. In itemising a consultation covered by an item which refers to a period of time, only that time during which a patient is receiving active attention should be counted. Periods such as when a patient is resting between blood pressure readings, waiting for pupils to dilate after the instillation of a mydriatic, or receiving short wave therapy etc., should not be included in the time of the consultation. Similarly, the time taken by a doctor to travel to a patient's home should not be taken into consideration in the determination of the length of the consultation. While the doctor is free to charge a fee for "travel time" when patients are seen away from the surgery, benefits are payable only in respect of the time a patient is receiving active attention.

AN.0.2 Benefits For Services

All Australian residents and certain categories of visitors to Australia can claim Medicare benefits for services by optometrists. The Health Insurance Act 1973 contains legislation covering the major elements of the Medicare program.

Responsibility for regulating the Medicare program lies with the Australian Government through the Department of Health. The Department of Human Services is responsible for consideration of applications and for the day to day operation of Medicare and the payment of benefits. Contact details of the Department of Health and the Department of Human Services are located at the end of these Notes.

AN.0.3 Professional Attendances

Professional attendances by medical practitioners cover consultations during which the practitioner: evaluates the patient's health-related issue or issues, using certain health screening services if applicable; formulates a management plan in relation to one or more health-related issues for the patient; provides advice to the patient and/or relatives (if authorised by the patient); provides appropriate preventive health care; and records the clinical detail of the service(s) provided to the patient. (See the General Explanatory Notes for more information on health screening services.)

AN.0.4 Provider Numbers

To ensure that benefits are paid only for services provided by optometrists registered with the Optometry Board of Australia, each optometrist providing services for which a Medicare benefit is payable requires an individual provider number.

Provider numbers will be issued only to registered optometrists. Corporations, other business entities and individuals who are not registered optometrists will not be issued with provider numbers.

Provider numbers are allocated to enable claims for Medicare benefits to be processed. The number may be up to eight characters. The second last character identifies the practice location, the last being a check character.

Optometrists can obtain a provider number from the Department of Human Services. A separate provider number is issued for each location at which an optometrist practises and has current registration. Provider numbers for additional practice locations may also be obtained from the Department of Human Services following confirmation of registration. Optometrists cannot use another optometrist's provider number.

Locum Tenens

An optometrist who has signed an Undertaking and is to provide services at a practice location as a locum for more than two weeks or will return to the practice on a regular basis for short periods should apply for a provider number for that location.

If the locum is to provide services at a practice for less than two weeks, the locum can use their own provider number or can obtain an additional provider number for that location.

Normally, Medicare benefits are payable for services rendered by an optometrist only when the optometrist has completed an Undertaking. However, benefits may be claimed for services provided by an optometrist who has not signed the Undertaking if the optometrist has provided them on behalf of an optometrist who has signed the Undertaking.

To ensure benefits are payable when a locum practises in these circumstances, the locum optometrist should:

– Check that they will be providing optometry services on behalf of a participating optometrist i.e. their employer has a current Undertaking.
– Complete the Schedule which is available on the Department of Human Services' website http://www.humanservices.gov.au/, before commencing the locum arrangement of the name and address of the participating optometrist on whose behalf they will be providing services.

Locums can direct Medicare payments to a third party, for example the principal of the practice, by either arranging a pay group link and/or by nominating the principal as the payee provider on bulk-bill stationery.

AN.0.5 Services not Attracting Medicare Benefits

Telephone consultations, letters of advice by medical practitioners, the issue of repeat prescriptions when the patient is not in attendance, post mortem examinations, the issue of death certificates, cremation certificates, counselling of relatives (Note - items 348, 350 and 352 are not counselling services), group attendances (other than group attendances covered by items 170, 171, 172, 342, 344 and 346) such as group counselling, health education, weight reduction or fitness classes do not qualify for benefit.

Although Medicare benefits are not payable for the issue of a death certificate, an attendance on a patient at which it is determined that life is extinct can be claimed under the appropriate attendance item. The outcome of the attendance may be that a death certificate is issued, however, Medicare benefits are only payable for the attendance component of the service.

Continued over page.

AN.0.6 Patient Eligibility

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

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

Medicare Cards

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

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

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

Visitors to Australia and temporary residents

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

Reciprocal Health Care Agreements

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

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

– Visitors from Ireland and New Zealand are entitled to public hospital care and PBS drugs only, and should present their passports before treatment as they are not issued with Medicare cards.

– Visitors from Italy and Malta are covered for a period of six months only.

The RHCAs do not cover treatment as a private patient in a public or private hospital. People visiting Australia for the purpose of receiving treatment are not covered. Visitors from New Zealand and the Republic of Ireland are NOT entitled to optometric treatment under a RHCA.

AN.0.7 Multiple Attendances on the Same Day

Payment of benefit may be made for each of several attendances on 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.

However, 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 (eg 10.30 am and 3.15 pm) in order to assist in the assessment of benefits.

In some circumstances a subsequent attendance on the same day does in fact constitute a continuation of an earlier attendance. For example, a preliminary eye examination may be concluded with the instillation of a mydriatic and then an hour or so later eye refraction is undertaken. These sessions are regarded as being one attendance for benefit purposes. Further examples are the case of skin sensitivity testing, and the situation where a patient is issued a prescription for a vaccine and subsequently returns to the surgery for the injection.

AN.0.8 Benefits For Optometrists

What services are covered?

The Health Insurance Act 1973 stipulates that Medicare benefits are payable for professional services .The professional services coming within the scope of the optometric benefit arrangements are those clinically relevant services ordinarily rendered by the optometrist in relation to a consultation on ocular or vision problems or related procedures. The Health Insurance Act 1973 defines a 'clinically relevant service' as a service rendered by an optometrist that is generally accepted in the optometrical profession as being necessary for the appropriate treatment of the patient to whom it is rendered.

From 1 January 2015, optometrists will be free to set their own fees for their professional service. However, the amount specified in the patient's account must be the amount charged for the service specified. The fee may not include a cost of goods or services which are not part of the MBS service specified on the account. A non-clinically relevant service must not be included in the charge for a Medicare item. The nonclinically relevant service must be separately listed on the account and not billed to Medicare. Where it is necessary for the optometrist to seek patient information from the Department of Human Services in order to determine appropriate itemisation of accounts, receipts or bulk-billed claims, the optometrist must ensure that:

(a) the patient is advised of the need to seek the information and the reason the information is required; (b) the patient's informed consent to the release of information has been obtained; and (c) the patient's records verify the patient's consent to the release of information.

Benefits may only be claimed when:

(a) a service has been performed and a clinical record of the service has been made;

(b) a significant consultation or examination procedure has been carried out;

(c) the service has been performed at premises to which the Undertaking relates;

(d) the service has involved the personal attendance of both the patient and the optometrist; and (e) the service is "clinically relevant" (as defined in the Health Insurance Act 1973).

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Where Medicare benefits are not payable

Medicare benefits may not be claimed for attendances for: (a) delivery, dispensing, adjustment or repairs of visual aids; (b) filling of prescriptions written by other practitioners.

Benefits are not payable for optometric services associated with:

(a) cosmetic surgery;
(b) refractive surgery;
(c) tests for fitness to undertake sporting, leisure or vocational activities;
(d) compulsory examinations or tests to obtain any commercial licence (e.g. flying or driving);
(e) entrance to schools or other educational facilities;
(f) compulsory examinations for admissions to aged care facilities; (g) vision screening.

Medicare benefits are not payable for services in the following circumstances:

(a) where the expenses for the service are paid or payable to a recognised (public) hospital;
(b) an attendance on behalf of teaching institutions on patients of supervised students of optometry; (c) where the service is not "clinically relevant" (as defined in the *Health Insurance Act 1973*).

Unless the Minister otherwise directs, a benefit is not payable in respect of an optometric service where:

(a) the service has been rendered by or on behalf of, or under an arrangement with, the Commonwealth, a State or a local governing body or an authority established by a law of the Commonwealth, a law of a State or a law of an internal Territory; or
(b) the service was rendered in one or more of the following circumstances -
(i) the employer arranges or requests the consultation
(ii) the results are provided to the employer by the optometrist
(iii) the employer requires that the employee have their eyes examined
(iv) the account for the consultation is sent to the employer
(v) the consultation takes place at the patient's workplace or in a mobile consulting room at the patient's workplace.

Services rendered to an optometrist's dependants, employer or practice partner or dependants

A condition of the participating arrangement is that the optometrist agrees not to submit an account or a claim for services rendered to any dependants of the optometrist, to his or her employer or practice partner or any dependants of that employer or partner. A 'dependant' person is a spouse or a child. The following provides definitions of these dependant persons: a *spouse*, in relation to a dependant person means:

(a) a person who is legally married to, and is not living, on a permanent basis, separately and apart from, that person;

and (b) a de facto spouse of that person. a child, in relation to a dependant person means:

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

(b) a person who:

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

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

(iii) is not being paid a disability support pension under the Social Security Act 1991; and (iv) is wholly or substantially dependent on the person or on the spouse of the person.

AN.0.9 Attendances by General Practitioners (Items 3-4, 23-24, 36-37, 44, 47, 193, 195, 197, 199, 585, 594, 599, 2095, 2144, 2180, 2193, 2497-2559, 5000-5067 and 90020-90051)

Attendances by General Practitioners (Items 3-4, 23-24, 36-37, 44, 47, 193, 195, 197, 199, 585, 594, 599, 2497-2559, 5000-5067 and 90020-90051)

Items 3-4, 23-24, 36-37, 44, 47, 193, 195, 197, 199, 585, 594, 599, 2095, 2144, 2180, 2193, 2497-2559, 5000-5067 and 90020-90051 relate to attendances rendered by medical practitioners who are:

– listed on the Vocational Register of General Practitioners maintained by the Department of Human Services; or
– holders of the Fellowship of the Royal Australian College of General Practitioners (FRACGP) who participate in, and meet the requirements of the RACGP for continuing medical education and quality assurance as defined in the RACGP Quality Assurance and Continuing Medical Education program; or
– holders of the Fellowship of the Australian College of Rural and Remote Medicine (FACRRM) who participate in, and meet the requirements of the Australian College of Rural and Remote Medicine (ACRRM) for continuing medical education and quality assurance as defined in ACRRM's Professional Development Program; or

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– undertaking an approved placement in general practice as part of a training program for general practice leading to the award of the FRACGP or training recognised by the RACGP as being of an equivalent standard; or
– undertaking an approved placement in general practice as part of a training program for general practice leading to the award of the FACRRM or training recognised by ACRRM as being of an equivalent standard.

To assist general practitioners in selecting the appropriate item number for Medicare benefit purposes the following notes in respect of the various levels are given.

LEVEL A

A Level A item will be used for obvious and straightforward cases and this should be reflected in the practitioner's records. In this context, the practitioner should undertake the necessary examination of the affected part if required, and note the action taken.

LEVEL B

A Level B item will be used for a consultation lasting less than 20 minutes for cases that are not obvious or straightforward in relation to one or more health related issues. The medical practitioner may undertake all or some of the tasks set out in the item descriptor as clinically relevant, and this should be reflected in the practitioner's record. In the item descriptor singular also means plural and vice versa.

LEVEL C

A Level C item will be used for a consultation lasting at least 20 minutes for cases in relation to one or more health related issues. The medical practitioner may undertake all or some of the tasks set out in the item descriptor as clinically relevant, and this should be reflected in the practitioner's record. In the item descriptor singular also means plural and vice versa.

LEVEL D

A Level D item will be used for a consultation lasting at least 40 minutes for cases in relation to one or more health related issues. The medical practitioner may undertake all or some of the tasks set out in the item descriptor as clinically relevant, and this should be reflected in the practitioner's record. In the item descriptor singular also means plural and vice versa.

Creating and Updating a Personally Controlled Electronic Health Record (PCEHR)

The time spent by a medical practitioner on the following activities may be counted towards the total consultation time:

– Reviewing a patient's clinical history, in the patient's file and/or the PCEHR, and preparing or updating a Shared Health Summary where it involves the exercise of clinical judgement about what aspects of the clinical history are relevant to inform ongoing management of the patient's care by other providers; or
– Preparing an Event Summary for the episode of care.

Preparing or updating a Shared Health Summary and preparing an Event Summary are clinically relevant activities. When either of these activities are undertaken with any form of patient history taking and/or the other clinically relevant activities that can form part of a consultation, the item that can be billed is the one with the time period that matches the total consultation time.

MBS rebates are not available for creating or updating a Shared Health Summary as a stand alone service.

Counselling or Advice to Patients or Relatives

For items 23-24, 36-37, 44, 47 and 5020 to 5067 'implementation of a management plan' includes counselling services.

Items 3-4, 23-24, 36-37, 44, 47, 193, 195, 197, 199, 585, 594, 599, 2497-2559, 5000-5067 and 90020-90051 include advice to patients and/or relatives during the course of an attendance. The advising of relatives at a later time does not extend the time of attendance.

Recording Clinical Notes

In relation to the time taken in recording appropriate details of the service, only clinical details recorded at the time of the attendance count towards the time of consultation. It does not include information added at a later time, such as reports of investigations.

Other Services at the Time of Attendance

Where, during the course of a single attendance by a general practitioner, both a consultation and another medical service are rendered, Medicare benefits are generally payable for both the consultation and the other service. Exceptions are in respect of medical services which form part of the normal consultative process, or services which include a component for the associated consultation (see the General Explanatory Notes for further information on the interpretation of the Schedule).

The Department of Human Services (DHS) has developed an Health Practitioner Guideline for responding to a request to substantiate that a patient attended a service which is located on the DHS website.

AN.0.10 Schedule Fees and Medicare Benefits

Medicare benefits are based on fees determined for each optometrical service. The services provided by participating optometrists which attract benefits are set out in the *Health Insurance (General Medical Services Table) Regulations* (as amended).

If the fee is greater than the Medicare benefit, optometrists participating in the scheme are to inform the patient of the Medicare benefit payable for the item, at the time of the consultation and that the additional fee will not attract benefits. Medicare benefits are payable at 85% of the Schedule fee for services rendered. **Medicare Safety Nets**

The Medicare safety net provides families and singles with an additional rebate for out-of-hospital Medicare services, once annual thresholds are reached. There are two safety nets: the original Medicare safety net and the extended Medicare safety net (EMSN).

Under the original Medicare safety net, the Medicare benefit for out-of-hospital services is increased to 100% of the Schedule Fee (up from 85%) once an annual threshold in gap costs is reached. Gap costs refer to the difference between the Medicare benefit (85%) and the Schedule Fee.

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Under the EMSN, once an annual threshold in out-of-pocket costs for out-of-hospital Medicare services is reached, Medicare will pay for 80% of any future out-of-pocket costs for out-of-hospital Medicare services for the remainder of the calendar year. However, where the item has an EMSN benefit cap, there is a maximum limit on the EMSN benefit that will be paid for that item. Further explanation about EMSN benefit caps is provided at www.mbsonline.gov.au.

The thresholds for the Medicare safety nets are indexed on 1 January each year.

Individuals are automatically registered with the Department of Human Services for the safety nets, however couples and families are required to register in order to be recognised as a family for the purposes of the safety nets. In most cases, registered families have their expenses combined to reach the safety net thresholds. This may help to qualify for safety net benefits more quickly. Registration forms can be obtained from the Department of Human Services offices, or completed at www.humanservices.gov.au. If you have already registered it is important to ensure your details are up to date.

Further information on the Medicare safety nets is available at http://www.humanservices.gov.au/customer/services/medicare/medicare-safety-net. **Limiting rule for patient claims**

Where a fee charged for a service is less than the Medicare benefit, the benefit will be reduced to the amount of the fee actually charged. In no case will the benefit payable exceed the fee charged. **Multiple attendances**

Payment of benefit may be made for several attendances on a patient on the same day by the same optometrist provided that the subsequent attendances are not a continuation of the initial or earlier attendances. However, there should be a reasonable lapse of time between the services before they can be regarded as separate attendances.

Where two or more attendances are made on the one day by the same optometrist the time of each attendance should be stated on the account (e.g. 10.30 am and 3.15 pm) in order to assist in the payment of benefits. Times do not need to be specified where a perimetry item is performed in association with a consultation item.

In some circumstances a subsequent consultation on the same day may be judged to be a continuation of an earlier attendance and a second benefit is not payable. For example, a preliminary eye examination may be concluded with the instillation of mydriatic or cycloplegic drops and some time later additional examination procedures are undertaken. These sessions are regarded as being one attendance for benefit purposes.

Release of prescription

Where a spectacle prescription is prepared for the patient, it becomes the property of the patient, who is free to have the spectacles dispensed by any person of the patient's choice. The optometrist will ensure that the patient is made aware that he or she is entitled to a copy of the spectacle prescription.

Contact lens prescriptions are excluded from the above provision, although the prescription remains the property of the patient and should be available to the patient at the completion of the prescription and fitting process. **Reminder notices**

The optometrist will ensure that any notice sent to a patient suggesting re-examination is sent solely on the basis of the clinical needs of the patient.

Aftercare period following surgery

Medicare schedule items that apply to surgery include all professional attendances necessary for the post-operative treatment of the patient, other than attendances provided by vocationally or non-vocationally trained general practitioners. The aftercare period includes all postoperative treatment, when provided by a medical specialist, consultant physician or optometrist. The amount and duration of the aftercare may vary but includes all attendances until recovery from the operation. Attendances unrelated to the operation provided by a vocationally or nonvocationally registered general practitioner in the aftercare period can also attract Medicare benefits. Attendances provided by an optometrist in the aftercare period do not attract a Medicare benefit.

The rebate for cataract surgery includes payment for aftercare attendances so payment for aftercare services provided by an optometrist on behalf of a surgeon should be arranged with the surgeon. The optometrist should not charge the patient. In the case of cataract surgery, the first visit following surgery for which the optometrist can charge a rebatable fee is generally the attendance at which a prescription for spectacles or contact lenses is written.

Medicare benefits are not available for refractive surgery, consultations in preparation for the surgery or consultations in the aftercare period. Charges for attendances by optometrists may be made directly to the patient or to the surgeon depending on the arrangements made prior to surgery. Accounts and the receipt issued to the patient should clearly indicate the fee is non-rebatable.

Single Course of Attention

A reference to a single course of attention means:

(a) I n the case of items 10905 to 10918, and old item 10900 - a course of attention by one or more optometrists in relation to a specific episode of optometric care.

(b) I n relation to items 10921 to 10930 - a course of attention, including all associated attendances, by one or more optometrists for the purpose of prescribing and fitting of contact lenses. This includes those after-care visits necessary to ensure the satisfactory performance of the lenses.

Referred comprehensive initial consultations (item 10905) - Read in conjunction with 08 Referrals

For the purposes of item 10905, the referring optometrist, having considered the patient's need for the referred consultation, is required to provide a written referral, dated and signed, and setting out the patient's condition and the reason for the referral.

Benefits will be paid at the level of item 10905 providing the referral is received before the provision of the service, and providing the account, receipt or bulk-billing form contains the name and provider number of the referring optometrist. Referrals from medical practitioners do not attract benefits under item 10905.

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The optometrist claiming the item 10905 service is obliged to retain the written referral for a period of twenty-four months.

Referrals must be at "arms length". That is to say, no commercial arrangements or connections should exist between the optometrists.

Second comprehensive initial consultation, within 36 months for a patient who is less than 65 years of age and once every 12 months for a patient who is at least 65 years of age, of a previous comprehensive consultation (item 10907)

A patient can receive a comprehensive initial consultation by another optometrist within 36 months if the patient is less than 65 years of age, and once every 12 months if the patient is at least 65 years of age, if the patient has attended another optometrist for an attendance to which item 10905, 10907, 10910, 10911, 10912, 10913, 10914 or 10915 applies, or old item 10900 applied.

Comprehensive initial consultations (items 10910 and 10911)

There are two new MBS items for comprehensive initial consultation that have been introduced. Item 10910 has been introduced for a professional attendance of more than 15 minutes for a patient who is less than 65 years of age. This item is payable once only within a 36 month period, and if the patient has not received a service in this timeframe to which item 10905, 10907, 10910, 10912, 10913, 10914 or 10915 applies, or old item 10900 applied.

Item 10911 has been introduced for a professional attendance of more than 15 minutes for a patient who is at least 65 years of age. This item is payable once only within a 12 month period, and if the patient has not received a service in this timeframe to which item 10905, 10907, 10910, 10911, 10912, 10913, 10914 or 10915 applies, or old item 10900 applied.

However, a benefit is payable under item 10912, 10913, 10914 or 10915 where the patient has an ocular condition which necessitates a further course of attention being started within 36 months for a patient who is less than 65 years of age (item 10910) and within 12 months for a patient who is at least 65 years of age (item 10911) of the previous initial consultation. The conditions which qualify for a further course of attention are contained in the descriptions of these items.

Where an attendance would have been covered by item 10905, 10907, 10910, 10911, 10912, 10913, 10914, or 10915 but is of 15 minutes duration or less, item 10916 (Short consultation) applies.

Significant change in visual function requiring comprehensive re-evaluation (item 10912)

Significant changes in visual function which justify the charging of item 10912 could include documented changes of:

– vision or visual acuity of 2 lines (0.2 logMAR) or more (corrected or uncorrected)

– visual fields or previously undetected field loss

– binocular vision

– contrast sensitivity or previously undetected contrast sensitivity loss.

New signs or symptoms requiring comprehensive re-evaluation (item 10913)

When charging item 10913 the optometrist should document the new signs or symptoms suffered by the patient on the patient's record card.

Progressive disorder requiring comprehensive re-evaluation (item 10914)

When charging item 10914, the optometrist should document the nature of the progressive disorder suffered by the patient on the patient's record card. Progressive disorders may include conditions such as maculopathy (including age related maculopathy) cataract, corneal dystrophies, glaucoma etc.

Examination of the eyes of a patient with diabetes mellitus (item 10915)

Where an examination of the eyes, with the instillation of a mydriatic, of a patient with diabetes mellitus is being conducted, where possible this item should be billed rather than item 10914 to assist in identifying whether such patients are receiving appropriate eye care.

Second or subsequent consultations (item 10918)

Each consultation, apart from the initial consultation, in a single course of attention, other than a course of attention involving the fitting and prescription of contact lenses, is covered by item 10918. **Contact lens consultations (items 10921 to 10930)**

In the case of contact lens consultations, benefit is payable only where the patient is one of the prescribed classes of patient entitled to benefit for contact lens consultations as described in items 10921 to 10929.

For claims under items 10921,10922,10923,10925 and 10930, eligibility is based on the patient's distance spectacle prescription, determining the spherical equivalent by adding to the spherical prescription, half the cylindrical correction.

Medicare benefits are not payable for item 10929 in circumstances where a patient wants contact lenses for:

(a) reasons of appearance (because they do not want to wear spectacles);

(b) sporting purposes;

(c) work purposes; or

(d) psychological reasons (because they cannot cope with spectacles).

All attendances subsequent to the initial consultation in a course of attention involving the prescription and fitting of contact lenses are collectively regarded as a single service under items 10921 to 10930, as appropriate. The date of service is deemed to be the date on which the contact lenses are delivered to the patient. In some cases, where the patient decides not to proceed with contact lenses, no Medicare fee is payable because the patient has not taken delivery of the lenses. In such instances, the patient may be charged a non-rebatable (private) fee for a 'part' service.

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Any visits related to the prescribing and fitting of lenses are regarded to be covered by the relevant item in the range 10921 to 10930. The bulk item includes those aftercare visits necessary to ensure the satisfactory performance of the lenses. This interpretation is unaltered by the frequency of aftercare visits associated with various lens types including extended wear lenses.

Consultations during the aftercare period that are unrelated to the prescription and fitting of contact lenses or that are not part of normal aftercare may be billed under other appropriate items (not items 10921 to 10930).

For patients not eligible for Medicare rebates for contact lens care, fees charged for contact lens consultations are a matter between the practitioner and the patient. Any account for consultations involving the fitting and prescription of contact lenses issued to a patient who does not fall into the specified categories should be prepared in such a way that it cannot be used to obtain benefits. No Medicare item should be attached to any service that does not attract benefits and the optometrist should annotate the account with wording such as “Medicare benefits not payable”.

Where an optometrist wishes to apportion the total fee to show the appropriate optometric consultation benefit and the balance of the fee, he or she should ensure that the balance is described in such a way (e.g. balance of account) that it cannot be mistaken as being a separate consultation. In particular no Medicare item number should be shown against the balance.

When a patient receives a course of attention involving the prescription and fitting of contact lenses an account should not be issued (or an assignment form completed) until the date on which the patient takes delivery of the lenses.

Benefit under items 10921 to 10929 is payable once only in any period of 36 consecutive months except where circumstances are met under item 10930 within a 36 month period. **Domiciliary visits (items 10931 - 10933)**

Where patients are unable to travel to an optometrist’s practice for treatment, and where the request for treatment is initiated by the patient, a domiciliary visit may be conducted, which involves the optometrist travelling to the patient’s place of residence, and transporting the necessary equipment. Where possible, it is preferable that the patient travel to the practice so that the full range of equipment is available for the examination of the patient.

Benefits are payable under items 10931 - 10933 to provide some financial assistance in the form of a loading to the optometrist, in recompense for travel costs and packing and unpacking of equipment. The loading is in addition to the consultation item. For the purposes of the loading, acceptable places of residence for domiciliary visits are:

– the patient’s home;
– a residential aged care facility as defined by the Aged Care Act 1997; or
– an institution which means a place (other than a residential aged care facility or hospital) at which residential accommodation and/or day care is made available to any of the following categories: disadvantaged children, juvenile offenders, aged persons, chronically ill psychiatric patients, homeless persons, unemployed persons, persons suffering from alcoholism, persons addicted to drugs, or physically or intellectually disabled persons.

Visits to a hospital at the patient’s request are not covered by the loading and instead, an extra fee in addition to the Schedule fee can be charged, providing the service is not bulk-billed. Medicare benefits are not payable in respect of the private charge.

Items 10931 - 10933 may be used whether or not the optometrist chooses to bulk-bill but it is important that if the consultation is bulk-billed the loading is also, and no private charge can then be levied. If the consultation is not bulk-billed, the loading should also not be bulk-billed and a private charge may be levied. The usual requirement that the patient must have requested the domiciliary visit applies.

The choice of appropriate item in the range 10931 - 10933 depends on how many patients are seen at the one location. Benefits are payable under item 10931 where the optometrist travels to see one patient at a single location.

Item 10931 can be billed in addition to the consultation item. If the optometrist goes on to see another single patient at a different location, that patient can also be billed an item 10931 plus the consultation. However, if two patients are visited at a single location on the same occasion, each of the two patients should be billed item 10932 as well as the consultation item applying to each patient. Similarly, if three patients are visited at a single location on the same occasion, each of the three patients should be billed item 10933 as well as the consultation item applying to each patient.

Where more than three patients are seen at the same location, additional benefits for domiciliary visits are not payable for the fourth, fifth etc patients. On such occasions, the first three patients should be billed item 10933 as well as the appropriate consultation item, and all subsequent patients may only be billed the appropriate consultation item. Where multiple patients are seen at one location on one occasion, there is no provision for patients to be ‘grouped’ into twos and threes for billing purposes.

Where a private charge is levied for a domiciliary visit, bulk-billing is precluded. Medicare benefits are not payable in respect of the private charge and the patient should be informed of this. Private charges should be shown separately on accounts issued by optometrists and must not be included in the fees for the service. Domiciliary visit loading items cannot be claimed in conjunction with brief initial consultation item 10916, or with computerised perimetry items 10940 or 10941.

Computerised Perimetry Services (items 10940 and 10941)

Benefit under items 10940 and 10941 is payable where full quantitative computerised perimetry (automated absolute static threshold but not including multifocal multichannel objective perimetry) has been performed by an optometrist on both eyes (item 10940) or one eye (item 10941) where indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain. Item 10940 for bilateral procedures cannot be claimed for patients who are totally blind in one eye. In this instance, item 10941 for unilateral procedures should be claimed, where appropriate.

These items can be billed either in association with comprehensive consultation items 10905, 10907, 10910, 10911, 10912, 10913, 10914, or 10915, or independently, but they cannot be billed with items 10916, 10918, 10931, 10932 or 10933. An assessment and report is required and, where referral to an ophthalmologist for further treatment is required, the printed results of the perimetry should be provided to the

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ophthalmologist to discourage repetition of perimetry unless clinically necessary. If Medicare benefits are to be claimed, a maximum of two perimetry services in any twelve month period may be provided. **Low Vision Assessment (item 10942)**

A benefit is payable under item 10942 where one or more of the tests outlined in the item description are carried out on a patient who has already been established during a comprehensive consultation as having low vision, as specifically defined in the item. This item is not intended for patients expected to undergo cataract surgery in the near future who may temporarily meet the criteria for having low vision.

Item 10942 may be claimed on the same day as either a comprehensive initial consultation (items 10905 - 10915) or a subsequent consultation (item 10918), but only where the additional low vision testing has been carried out on an eligible patient. Item 10942 is not intended to be claimed with a brief initial consultation (item 10916), or with any of the contact lens items (items 10921-10930).

Children's vision assessment (item 10943)

Children aged 0 to 2 years, and 15 years and over, are not eligible for item 10943 and may be treated under appropriate attendance items.

A benefit is payable under item 10943 where one or more of the assessment and testing procedures outlined in the item description are carried out on a patient aged 3 - 14 years inclusive, and where a finding of significant binocular or accommodative dysfunction is the outcome of the consultation and assessment/testing. The conditions to be assessed under this item are primarily amblyopia and strabismus, but dysfunctions relating to vergences are also covered, providing well established and evidence based optometry practice is observed.

A benefit is not payable under item 10943 for the assessment of learning difficulties or learning disabilities.

Item 10943 may be claimed on the same day as either a comprehensive consultation (items 10905 - 10915) or a subsequent consultation (item 10918), but only where the additional assessment/testing has been carried out on an eligible child. Item 10943 is not intended to be claimed with a brief initial consultation (item 10916), or with any of the contact lens items (items 10921-10930).

Removal of an embedded corneal foreign body (item 10944)

Item 10944 has been introduced for the complete removal of an embedded corneal foreign body that is sub-epithelial or intra-epithelial and the removal of rust rings from the cornea.

The removal of an embedded foreign body should be performed using a hypodermic needle, foreign body gouge or similar surgical instrument, with magnification provided by a slit lamp biomicroscope, loupe or similar device.

The optometrist should document the nature of the embedded foreign body (sub-epithelial or intra-epithelial), method of removal and the magnification. Similarly, with rust ring removal, the optometrist should document the method of removal and the magnification.

Where complexity of the procedure is beyond the skill of the optometrist, or if other complications are present (e.g. globe perforation, penetration >25%, or patient unable to hold still due to pathological anxiety, nystagmus, or tremor etc, without some form of systemic medication), the patient should be referred to an ophthalmologist.

This item cannot be billed on the same occasion as items 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915, 10916 or 10918. If the embedded foreign body or rust ring has not been completely removed, benefits are only payable under item 10916.

AN.0.22 Telehealth Patient-end Support Services by Optometrists

These notes provide information on the telehealth MBS attendance items for optometrists to provide clinical support to their patients, when clinically relevant, during video consultations with ophthalmologists under items 10945, 10946, 10947 and 10948 in Group A10. Telehealth patient-end support services can only be claimed where:

– a Medicare eligible specialist service is claimed;

– the service is rendered in Australia; and

– this is necessary for the provision of the specialist service.

A video consultation will involve a single optometrist attending to the patient, with the possible participation of another medical practitioner, a participating nurse practitioner, a participating midwife, practice nurse, Aboriginal and Torres Strait Islander health practitioner or Aboriginal health worker at the patient end. The above time-tiered items provide for patient-end support services in various settings, including consulting rooms, other than consulting rooms, eligible residential aged care services and Aboriginal Medical Services.

Clinical indications

The ophthalmologist must be satisfied that it is clinically appropriate to provide a video consultation to a patient. The decision to provide clinically relevant support to the patient is the responsibility of the ophthalmologist.

Telehealth specialist services can be provided to patients when there is no patient-end support service provided.

Collaborative Consultation

The optometrist who provides assistance to the patient where this is necessary for the provision of the specialist service, may seek assistance from a health professional (e.g. a medical practitioner, practice nurse, Aboriginal or Torres Strait Islander health practitioner or Aboriginal health worker) but only one item is billable for the patient-end support service. The optometrist must be present during part or all of the consultation in order to bill an **appropriate time**-tiered MBS item. Any time spent by another health professional called to assist with the consultation may not be counted against the overall time taken to complete the video consultation.

Restrictions

The MBS telehealth attendance items are not payable for services to an admitted hospital patient (this includes Hospital in the Home patients). Benefits are not payable for telephone or email consultations. In order to fulfil the item descriptor there must be a visual and audio link between the patient and the ophthalmologist. If the ophthalmologist is unable to establish both a video and audio link with the patient, a MBS rebate for a telehealth attendance is not payable. *Eligible Geographical Areas*

Geographic eligibility for telehealth services funded under Medicare are determined according to the Australian Standard Geographical Classification Remoteness Area (ASGC-RA) classifications. Telehealth Eligible Areas are areas that are outside a Major City (RA1) according to

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ASGC-RA (RA2 - 5). Patients and providers are able to check their eligibility by following the links on the MBS Online website (www.mbsonline.gov.au/telehealth).

There is a requirement for the patient and specialist to be located a minimum of 15km apart at the time of the consultation. Minimum distance between specialist and patient video consultations are measured by the most direct (ie least distance) route by road. The patient or the specialist is not permitted to travel to an area outside the minimum 15 km distance in order to claim a video conference. This rule will not apply to specialist video consultations with patients who are a care recipient in an eligible residential care service; or at an eligible Aboriginal Medical Service or Aboriginal Community Controlled Health Service for which a direction, made under subsection 19(2) of the Health Insurance Act 1973, as these patients are able to receive telehealth services anywhere in Australia. Telehealth Eligible Service Areas are defined at: http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/connectinghealthservices-eligible-geo.

Record Keeping

Telehealth optometrists must keep contemporaneous notes of the consultation including documenting that the service was performed by video conference, the date, time and the people who participated.

Only clinical details recorded at the time of the attendance count towards the time of the consultation. It does not include information added at a later time, such as reports of investigations. *Multiple attendances on the same day*

In some situations a patient may receive a telehealth consultation and a face-to-face consultation by the same or different practitioner on the same day.

Medicare benefits may be paid for more than one video consultation on a patient on the same day by the same practitioner, provided the second (and any following) video consultations are not a continuation of the initial or earlier video consultations. Practitioners will need to provide the times of each consultation on the patient's account or bulk billing voucher.

Also, if a patient has an initial consultation via telehealth, they cannot also claim an initial face-to-face consultation as part of the same course of treatment.

Aftercare Rule

Video consultations are subject to the same aftercare rules as face-to-face consultations.

Referrals

The referral procedure for a video consultation is the same as for conventional face-to-face consultations.

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Technical requirements

In order to fulfil the item descriptor there must be a visual and audio link between the patient and the ophthalmologist. If the ophthalmologist is unable to establish both a video and audio link with the patient, a MBS rebate for a specialist video consultation is not payable.

Individual clinicians must be confident that the technology used is able to satisfy the item descriptor and that software and hardware used to deliver a videoconference meets the applicable laws for security and privacy.

Duration of attendance

The optometrist attending at the patient end of the video consultation does not need to be present for the entire consultation, only as long as is clinically relevant - this can be established in consultation with the ophthalmologist. The MBS fee payable for the supporting optometrist will be determined by the total time spent assisting the patient. This time does not need to be continuous.

DN.1.6 Computerised Perimetry Printed Results - (Items 11221 and 11224)

Computerised perimetry performed by optometrists is covered by MBS items 10940 and 10941. Items 11221 and 11224 should not be used to repeat perimetry unless clinically necessary - such as where the results of the perimetry have been provided by the optometrist referring the patient to an ophthalmologist.

The above is an extract of those notes in the Medicare Benefits Schedule operating from 1 July 2020 that are of relevance to optometrists, and is not a complete list. For the full list of notes, please download the complete Medicare Benefits Schedule operating from 1 July 2020 here: