MBS optometry items from 1 July 2024

The following details have been extracted and compiled by Optometry Australia from Medicare Benefits Schedule Book, published by **Australian Government Department of Health.**

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A10. OPTOMETRICAL SERVICES — 1. GENERAL

	Group A10. Optometrical Services
Item number	**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.10.1 of explanatory notes to this Category) Fee: 100% = $76.00 Benefit: 85% = $64.60
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.10.1 of explanatory notes to this Category) Fee: 100% = $38.10 Benefit: 85% = $32.40
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.10.1 of explanatory notes to this Category) Fee: 100% = $76.00 Benefit: 85% = $64.60
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.10.1 of explanatory notes to this Category) Fee: 100% = $76.00 Benefit: 85% = $64.60
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.10.1 of explanatory notes to this Category) Fee: 100% = $76.00 Benefit: 85% = $64.60
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.10.1 of explanatory notes to this Category) Fee: 100% = $76.00 Benefit: 85% = $64.60

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A10. OPTOMETRICAL SERVICES	1. GENERAL
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.10.1 of explanatory notes to this Category) Fee: 100% = $76.00 Benefit: 85% = $64.60
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.10.1 of explanatory notes to this Category) Fee: 100% = $76.00 Benefit: 85% = $64.60
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.10.1 of explanatory notes to this Category) Fee: 100% = $38.10 Benefit: 85% = $32.40
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.10.1 of explanatory notes to this Category) Fee: 100% = $38.10 Benefit: 85% = $32.40
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: 100% = $188.90 Benefit: 85% = $160.60
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: 100% = $188.90 Benefit: 85% = $160.60
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: 100% = $188.90 Benefit: 85% = $160.60
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: 100% = $238.35 Benefit: 85% = $202.60

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A10. OPTOMETRICAL SERVICES	1. GENERAL
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: 100% = $188.90 Benefit: 85% = $160.60
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: 100% = $188.90 Benefit: 85% = $160.60
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: 100% = $238.35 Benefit: 85% = $202.60
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: 100% = $188.90 Benefit: 85% = $160.60
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: 100% = $238.35 Benefit: 85% = $202.60
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: 100% = $188.90 Benefit: 85% = $160.60

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A10. OPTOMETRICAL SERVICES	1. GENERAL
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 (See para AN.10.1 of explanatory notes to this Category) Fee: 100% = $26.55 Benefit: 85% = $22.60
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) 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.10.1 of explanatory notes to this Category) Fee: 100% = $13.25 Benefit: 85% = $11.30
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.10.1 of explanatory notes to this Category) Fee: 100% = $8.75 Benefit: 85% = $7.45
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.10.1, DN.1.6 of explanatory notes to this Category) Fee: 100% = $72.55 Benefit: 85% = $61.70
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.10.1, DN.1.6 of explanatory notes to this Category) Fee: 100% = $43.80 Benefit: 85% = $37.25

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A10. OPTOMETRICAL SERVICES	1. GENERAL
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.10.1 of explanatory notes to this Category) Fee: 100% = $38.10 Benefit: 85% = $32.40
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.10.1 of explanatory notes to this Category) Fee: 100% = $38.10 Benefit: 85% = $32.40
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: 100% = $82.20 Benefit: 85% = $69.90

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. Fee: 100% = $38.10 Benefit: 85% = $32.40
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. Fee: 100% = $76.00 Benefit: 85% = $64.60

Members, need guidance on Medicare billing?

Download our MBS Item Use Guide.

Or contact us for support.

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Updates to MBS explanatory notes

The following details have been extracted from the full Medicare Benefits Schedule Book published by the **Australian Government Department of Health.** Download here: http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/downloads.

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:

a) Check that they will be providing optometry services on behalf of a participating optometrist i.e. their employer has a current Undertaking.

b) 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.

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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.

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:

a) 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.

b) 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 Attracting

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.

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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 non-clinically 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:

d) a service has been performed and a clinical record of the service has been made;
e) a significant consultation or examination procedure has been carried out;
f) the service has been performed at premises to which the Undertaking relates;
g) the service has involved the personal attendance of both the patient and the optometrist; and
h) the service is "clinically relevant" (as defined in the *Health Insurance Act 1973*).

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.

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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:
b) 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
c) 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.0.12 Billing Procedures

There are three ways benefits may be paid for optometric services:

a) the claimant may pay the optometrist's account in full and then claim benefits from the Department of Human Services office by submitting the account and the receipt;
b) the claimant may submit the unpaid account to the Department of Human Services who will then send a cheque in favour of the optometrist, to the claimant; or
c) the optometrist may bill Medicare instead of the patient for the consultation. This is known as bulk billing. If an optometrist direct-bills, they undertake to accept the relevant Medicare benefit as full payment for the consultation. Additional charges for that service (irrespective of the purpose or title of the charge) cannot be raised against the patient.

Claiming of benefits

The patient, upon receipt of an optometrist's account, has two options open for paying the account and receiving benefits.

Paid accounts

If the account has been paid in full a claimant can claim Medicare benefits in a number of ways:

a) Electronically if the claimant's doctor offers this service and the claimant has completed and lodged a Bank account details collection form with Medicare.
b) Online through Medicare Online Services.
c) At the claimant's local Department of Human Services Service Centre.
d) By mail by sending a completed Medicare claim form with the original accounts and/or receipts to: *Department of Human Services GPO Box 9822 (in the claimant's capital city).*
e) Over the phone by calling 132 011 and giving the claim details and then sending the accounts and/or receipts to: *Telephone Claiming Department of Human Services GPO Box 9847 (in the claimant's capital city).*

Practitioners seeking information regarding registration to allow EFT payments and other E-Business transactions, can do so by viewing the Health Professionals section at the Department of Human Services at www.humanservices.gov.au.

Unpaid accounts

Where the patient has not paid the account in full, the unpaid account may be presented to the Department of Human Services with a completed Medicare claim form. In this case the Department of Human Services will forward to the claimant a benefit cheque made payable to the optometrist.

It is the patient's responsibility to forward the cheque to the optometrist and make arrangements for payment of the balance of the account, if any.

"Pay optometrist" cheques involving Medicare benefits must (by law), not be sent direct to optometrists, or to the claimant at an optometrist's address (even if requested by the claimant to do so). "Pay optometrist" cheques are required to be forwarded to the claimant's last known address as recorded with the Department of Human Services.

When issuing a receipt to a patient for an account that is being paid wholly or in part by a Medicare "pay optometrist" cheque the optometrist should indicate on the receipt that a "Medicare cheque for $..... was involved in the payment of the account". The receipt should also include any money paid by the claimant or patient.

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Itemised accounts

When an optometrist bills a patient for a service, the patient should be issued with a correctly itemised account and receipt to enable the patient to claim Medicare benefits. Where both a consultation and another service, for example computerised perimetry occur, these may be itemised on the same account.

Medicare benefits are only payable in respect of optometric services where it is recorded on the account setting out the fee for the service or on the receipt for the fee in respect of each service to each patient, the following information:

a) patient's name;

b) date on which the service(s) was rendered;

c) a description of the service(s) (e.g. "initial consultation," "subsequent consultation" or "contact lens consultation"and/or "computerised perimetry" in those cases where it is performed);

d) Medicare Benefits Schedule item number(s);

e) the name and practice address or name and provider number of the optometrist who actually rendered the service(s). Where the optometrist has more than one practice location, the provider number used should be that which is applicable to the practice location where the service(s) was given;

f) the fee charged for the service(s); and

g) the time each service began if the optometrist attended the patient on more than one occasion on the same day and on each occasion rendered a professional service relating to an optometric item, except where a perimetry item is performed in association with a consultation item, where times do not need to be specified.

The optometrist billing for the service bears responsibility for the accuracy and completeness of the information included on accounts, receipts and assignment of benefits forms even where such information has been recorded by an employee of the optometrist.

Payment of benefits could be delayed or disallowed if the account does not clearly identify the service as one which qualifies for Medicare benefits or that the practitioner is a registered optometrist practising at the address where the service was rendered. It is important to ensure that an appropriate description of the service, the item number and the optometrist's provider number are included on accounts, receipts and assignment of benefit forms.

Details of any charges made other than for services, e.g. a dispensing charge, a charge for a domiciliary visit, should be shown separately either on the same account or on a separate account. Patients must be eligible to receive Medicare benefits and must also meet the clinical requirements outlined in the relevant item descriptors.

Duplicate accounts

Only one original itemised account per service should be issued, except in circumstances where both a consultation and computerised perimetry occur, in which case these may be itemised on the same original account. Duplicates of accounts or receipts should be clearly marked "duplicate" and should be issued only where the original has been lost. Duplicates should not be issued as a routine system for "accounts rendered".

Assignment of benefit (bulk billed) arrangements

Under the *Health Insurance Act 1973* an Assignment of Benefit (bulk-billing) facility for professional services is available to all persons in Australia who are eligible for benefit under the Medicare program. This facility is **NOT** confined to pensioners or people in special need.

If an optometrist bulk-bills, they undertake to accept the relevant Medicare benefit as full payment for the service. Additional charges for that service (irrespective of the purpose or title of the charge) cannot be raised against the patient. Under these arrangements:

- the patient's Medicare number must be quoted on all bulk bill assignment of benefit forms for that patient;
- the assignment of benefit forms provided are loose leaf to enable the patient details to be imprinted from the Medicare Card;
- the forms include information required by Regulations under Section 19(6) of the *Health Insurance Act 1973*; and
- the optometrist must cause the particulars relating to the professional service to be set out on the assignment of benefit form, before the patient signs the form and cause the patient to receive a copy of the form as soon as practicable after the patient signs it.

Where a patient is unable to sign the assignment of benefit form, the signature of the patient's parent, guardian or other responsible person (other than the optometrist, optometrist's staff, hospital proprietor, hospital staff, residential aged care facility proprietor or residential aged care facility staff)) is acceptable.

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Where the signature space is either left blank or another person signs on the patient's behalf, the form must include:

- the notation "Patient unable to sign" and
- in the section headed 'Practitioner's Use', an explanation should be given as to why the patient was unable to sign (e.g. unconscious, injured hand etc.) and this note should be signed or initialled by the optometrist. If in the opinion of the optometrist the reason is of such a "sensitive" nature that revealing it would constitute an unacceptable breach of patient confidentiality or unduly embarrass or distress the recipient of the patient's copy of the assignment of benefits form, a concessional reason "due to medical condition" to signify that such a situation exists may be substituted for the actual reason. However, this should not be used routinely and in most cases it is expected that the reason given will be more specific.

Use of Medicare cards in bulk-billing

Where a patient presents without a Medicare card and indicates that they have been issued with a card but does not know the details, the optometrist may contact the Department of Human Services on 132 150 to obtain the number.

It is important for the optometrist to check the eligibility of their patients for Medicare benefits by reference to the card, as entitlement is limited to the "valid to" date shown on the bottom of the card. Additionally the card will show if a person is enrolled through a Reciprocal Health Care Agreement.

Assignment of benefit forms

Only the approved assignment of benefit forms available from the Department of Human Services website, www.humanservices.gov.au, can be used to bulk-bill patients for optometric services and no other form can be used without its approval.

a) **Form DB2-OP**
This form is designed for the use of optical scanning equipment and is used to assign benefits for optometrical services. It is loose leaf to enable imprinting of patient details from the Medicare card and comprises a throw away cover sheet (after imprinting), a Medicare copy, a Practitioner copy and a Patient copy.

b) **Form DB4**
This is a continuous stationery version of Form DB2 and has been designed for use on most office accounting machines.

The Claim for Assigned Benefits (Form DB1N, DB1H)

Optometrists who accept assigned benefits must claim from the Department of Human Services using either Claim for Assigned Benefits form DB1N or DB1H. The DB1N form should be used where services are rendered to persons for treatment provided out of hospital or day hospital treatment.

The DB1H form should be used where services are rendered to persons while hospital treatment is provided in a hospital or day hospital facility (other than public patients). Both forms have been designed to enable benefit for a claim to be directed to an optometrist other than the one who rendered the services. The facility is intended for use in situations such as where a short term locum is acting on behalf of the principal optometrist and setting the locum up with a provider number and pay group link for the principal optometrist's practice is impractical. Optometrists should note that this facility cannot be used to generate payments to or through a person who does not have a provider number. Each claim form must be accompanied by the assignment of benefit forms to which the claim relates.

Time limits applicable to lodgement of bulk bill claims for benefits

A time limit of two years applies to the lodgement of claims with the Department of Human Services under the bulk billed (assignment of benefits) arrangements. This means that Medicare benefits are not payable for any service where the service was rendered more than two years earlier than the date the claim was lodged with the Department of Human Services.

Provision exists whereby in certain circumstances (e.g. hardship cases), the Minister may waive the time limits. Special forms for this purpose are available, if required, from the Department of Human Services website at www.humanservices.gov.au or the processing centre to which bulk-bill claims are directed.

AN.0.14 Referrals (Read in Connection with the Relevant Paragraphs at O.6)

General

Optometrists are required to refer a patient for medical attention when it becomes apparent to them that the patient's condition is such that it would be more appropriate for treatment to be undertaken by a medical practitioner. Optometrists may refer patients directly to specialist ophthalmologists with the patient being able to claim benefits for the ophthalmologist's services at the referred specialist rate. Optometrists may refer patients directly to another optometrist, based on the clinical needs of the patient.

A referral letter or note must have been issued by the optometrist for all such services provided by specialist ophthalmologists or optometrists in order for patients to be eligible for Medicare benefits at the referred rate. Unless such a letter or note has been provided, benefits will be paid at the non-referred attendance rate, which has a lower rebate.Medicare benefits at the referred rate are not paid for patients referred by optometrists to consultant physicians or to specialists other than ophthalmologists. See relevant paragraph regarding emergency situations.

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What is a referral?

For the purposes of the optometric arrangements, a "referral" is a request to a specialist ophthalmologist or another optometrist for investigation, opinion, treatment and/or management of a condition or problem of a patient or for the performance of a specific examination(s) or test(s).

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

a) the referring optometrist must have turned their mind to the patient's need for referral and communicate relevant information about the patient to the specialist ophthalmologist or optometrist to whom the patient is referred (but this does not necessarily mean an attendance on the occasion of the referral);

b) the instrument of referral must be in writing by way of a letter or note and must be signed and dated by the referring optometrist; and

c) the practitioner to whom the patient is referred must have received the instrument of referral on or prior to the occasion of the professional service to which the referral relates.

The exceptions to the requirements in the above paragraph are that:

a) sub-paragraphs b) and c) do not apply to an emergency situation where the specialist ophthalmologist was of the opinion that the service be rendered as quickly as possible (see paragraph below on emergency situations); and

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

Period for which referral is valid

A referral from an optometrist to an ophthalmologist is valid for twelve months unless the optometrist specifies on the referral that the referral is for a different period (e.g. three, six or eighteen months or valid indefinitely).

The referral applies for the period specified in the referral from the date that the ophthalmologist provides the first service to the patient. If there is no period specified in the referral then the referral is valid for twelve months from the date of the first service provided by the ophthalmologist. Referrals for longer than twelve months should be made only when the patient's clinical condition requires continuing care and management.

An optometrist may write a new referral when a patient presents with a condition unrelated to the condition for which the previous referral to an ophthalmologist was written. In these circumstances Medicare benefits for the consultation with the ophthalmologist would be payable at initial consultation rates.

A new course of treatment for which Medicare benefits would be payable at the initial consultation rates will also be paid where the referring optometrist:

a) deems it necessary for the patient's condition to be reviewed; and

b) the patient is seen by the ophthalmologist outside the currency of the previous referral; and

c) the patient was last seen by the specialist ophthalmologist more than nine months earlier than the attendance following a new referral.

Self referral

Optometrists may refer themselves to specialist ophthalmologists or other optometrists and Medicare benefits are payable at referred rates.

Lost, stolen or destroyed referrals

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

Emergency situations

Medicare benefits are payable even though there is no written referral in an emergency situation (as defined in the Health Insurance Regulations 2018). The specialist or the consultant physician should be of the opinion that the service must be rendered as quickly as possible and endorses the account, receipt or assignment form as an "Emergency referral".

A referral must be obtained from a medical practitioner or, in the case of a specialist ophthalmologist, a medical practitioner or an optometrist if attendances subsequent to the emergency attendance are to attract Medicare benefits at the referred rate.

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AN.0.16 Provision for Review of the Schedule

Optometric Benefits Consultative Committee (OBCC)

The OBCC is an advisory committee established in 1990 by arrangement between the Minister and Optometry Australia.

The OBCC's functions are:

a) to discuss the appropriateness of existing Medicare Benefits Schedule items for the purposes of considering whether an approach to the Medical Services Advisory Committee may be needed;

b) to undertake reviews of particular services and to report on the appropriateness of the existing structure of the Schedule, having regard to current optometric practice;

c) to consider and advise on the appropriateness of the participating optometrists' arrangements and the Common Form of Undertaking (as specified in the *Health Insurance Act 1973* and related legislation) and the administrative rules and interpretations which determine the payment of benefits for optometric services or the level of benefits;

d) to investigate specific matters associated with the participating optometrists' arrangements and to advise on desirable changes.

The OBCC comprises two representatives from the Department of Health, two representatives from the Department of Human Services, and three representatives from Optometry Australia.

AN.0.18 Provision for Review of Practitioner Behaviour

Professional Services Review (PSR) Scheme

The Professional Services Review (PSR) Scheme is a scheme for reviewing and investigating the provision of services by a health practitioner to determine whether the practitioner has engaged in inappropriate practice in the rendering or initiating of Medicare services or in prescribing under the Pharmaceutical Benefits Scheme (PBS). 'Practitioner' is defined in Section 81 of the *Health Insurance Act 1973* and includes: medical practitioners, dentists, optometrists, chiropractors, midwives, nurse practitioners, physiotherapists, podiatrists and osteopaths.

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

The Department of Human Services monitors health practitioners' claiming patterns. Where an anomaly is detected, for which a satisfactory explanation cannot be provided, the Department of Human Services can request that the Director of PSR review the provision of services by the practitioner. On receiving the request, the Director must decide whether to conduct a review and in which manner the review will be conducted. The Director is authorised to require that documents and information be provided.

Following a review, the Director must:

a) decide to take no further action; or

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

c) refer the matter to a PSR Committee.

A PSR Committee consists of the Chairperson and two other panel members who must be members of the same profession as the practitioner under review. However, up to two additional Committee members may be appointed to provide a wider range of clinical expertise.

The Committee is authorised to:

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

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

c) require the production of documents (including clinical notes).

A PSR Committee may not make a finding of inappropriate practice unless it has given the person under review notice of its intention to review them, the reasons for its findings, and an opportunity to respond. In reaching their decision, a PSR Committee is required to consider whether or not the practitioner has kept adequate and contemporaneous patient records. It will be up to the peer judgement of the PSR Committee to decide if a practitioner's records meet the prescribed standards.

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

Continued over page.

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

a) clearly identify the name of the patient; and

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

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

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

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

The practitioner under review is permitted to make submissions to the PSR Committee before key decisions or a final report is made. If a PSR Committee finds that the person under review has engaged in inappropriate practice, the findings will be reported to the Determining Authority to decide what action should be taken:

a) a reprimand;

b) counselling;

c) repayment of Medicare benefits; and/or

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

Further information on the Professional Services Review is available at www.psr.gov.au and information on Medicare compliance is available at http:// www.humanservices.gov.au/health-professionals/subjects/compliance?utm_id=9.

Penalties

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

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

Medicare Participation Review Committee (MPRC)

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

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

b) has been found to have engaged in inappropriate practice under the Professional Services Review scheme.

The Committee can take no further action, counsel or reprimand the practitioner, or determine that the practitioner be disqualified from Medicare for a particular period or in relation to particular services for up to five years. Medicare benefits are not payable in respect of services rendered by a practitioner who has been fully disqualified, or partly disqualified in relation to relevant services under the *Health Insurance Act 1973* (Section 19B applies).

AN.0.18 Provision for Review of Practitioner Behaviour AN.0.20 Visiting Optometrists Scheme (VOS)

Special arrangements exist under the provisions of Section 129A of the *Health Insurance Act 1973* to ensure that people in rural and remote locations have access to optometry services. Optometrists are encouraged to provide outreach services to national priority locations, particularly remote and very remote locations, Aboriginal and Torres Strait Islander communities and rural locations with an identified need for optometry services.

Under these arrangements, financial assistance may be provided to cover costs associated with delivering outreach services, including travel, accommodation and meals and facility fees. Funding agreements are currently in place with optometrists for the delivery of services until 30 June 2015. Enquiries can be directed to vos@health.gov.au.

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AN.0.22 Telehealth Patient-end Support Services by Optometrists

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 and 10946 in Group A10.

Telehealth patient-end support services can only be claimed where:

a) a Medicare eligible specialist service is claimed;

b) the service is rendered in Australia; and

c) 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. 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.

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.

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.

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AN.10.1 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.

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.

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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 post-operative 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 non-vocationally 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) In 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) In 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. 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.

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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:

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

b) visual fields or previously undetected field loss

c) binocular vision

d) 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.

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".

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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:

a) the patient's home;

b) a residential aged care facility as defined by the Aged Care Act 1997; or

c) 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.

Domiciliary visit loading items cannot be claimed in conjunction with brief initial consultation item 10916, or with computerised perimetry items 10940 or 10941. 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 appropriate consultation item (excluding items 10916, 10932, 10933, 10940 or 10941). 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 appropriate 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 appropriate 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 appropriate 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.

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.

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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 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.

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.

MN.9.8 MBS Autism, Pervasive Developmental Disorder and Disability Allied Health Case Conferencing Items

For more information about MBS autism, pervasive developmental disorder and disability allied health case conferencing items, please refer to the Fact Sheet at:

https://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-Multidisciplinary%20case%20conference%20items%20for%20complex%20neurodevelopmental%20disorders%20and%20eligible%20disabilities

MN.10.1 Provision of Autism, Pervasive Developmental Disorder or Disability Services by Allied Health Professionals (Items 82000 to 82035)

Eligible patients

MBS items 82000 to 82035 provide Medicare-rebateable allied health services to children with autism or any other pervasive developmental disorder (PDD) through the Helping Children with Autism program, and to children with an eligible disability through the Better Start for Children with Disability program. Children with both autism/PDD and an eligible disability can access either program, but not both.

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The conditions classified as PDD in 2008 for the purposes of these services were informed by the American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV-TR), Washington, DC, American Psychiatric Association, 2000.

'Eligible disabilities' for the purpose of these services means any of the following conditions:

a) sight impairment that results in vision of less than or equal to 6/18 vision or equivalent field loss in the better eye, with correction.

b) hearing impairment that results in:

   i. a hearing loss of 40 decibels or greater in the better ear, across 4 frequencies; or

   ii. permanent conductive hearing loss and auditory neuropathy.

c) deaf/blindness

d) cerebral palsy

e) Down syndrome

f) Fragile X syndrome

g) Prader-Willi syndrome

h) Williams syndrome

i) Angelman syndrome

j) Kabuki syndrome

k) Smith-Magenis syndrome

l) CHARGE syndrome

m) Cri du Chat syndrome

n) Cornelia de Lange syndrome

o) microcephaly if a child has:

   i. a head circumference less than the third percentile for age and sex; and

   ii. a functional level at or below 2 standard deviations below the mean for age on a ***standard developmental test**, or an IQ score of less than 70 on a ****standardised test of intelligence.**

p) Rett's disorder

***Standard developmental test:**

a) the Bayley Scales of Infant Development or the Griffiths Mental Development Scales.

****Standardised test of intelligence:**

a) the Wechsler Intelligence Scale for Children (WISC) or

b) the Wechsler Preschool and Primary Scale of Intelligence (WPPSI).

It is up to the clinical judgement of the diagnosing practitioner if other tests are appropriate to be used.

Allied health services available under Medicare

Items are available for assessment/diagnosis services, the results of which can contribute to development of a treatment and management plan by the referring medical practitioner, and for treatment services.

The assessment/diagnosis items (82000, 82005, 82010, 82030) can be accessed when:

a) a child with autism/PDD is aged under 13 years and referred by an eligible consultant psychiatrist or paediatrician; or

b) a child with an eligible disability is aged under 13 years and referred by a specialist, consultant physician or GP.

The treatment items (82015, 82020, 82025 and 82035) can be accessed when:

a) A child with autism/PDD is aged under 15 years and a treatment and management plan has been put in place for them before their 13th birthday, and they have been referred by an eligible consultant psychiatrist or paediatrician.

b) A child with an eligible disability is aged under 15 years and a treatment and management plan has been put in place for them before their 13th birthday, and they have been referred by a specialist, consultant physician or GP.

The allied health assessment and treatment services can be provided by eligible audiologists, occupational therapists, optometrists, orthoptists, physiotherapists, psychologists and speech pathologists.

Number of assessment services

Medicare rebates are available for up to four services in total per eligible child, to assist with assessment and diagnosis and development of a treatment plan. The four services may consist of any combination of items 82000, 82005, 82010 and 82030. It is the responsibility of the referring practitioner to allocate these services in keeping with the child's individual needs and to refer the child to appropriate allied health professional(s) accordingly.

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These services will not attract a Medicare rebate unless a referral has been made by a consultant psychiatrist (using items 296-370) or paediatrician (using items 110-131) for a child with autism/PDD, or by a specialist or consultant physician (using items 104-131 or 296-370 excluding item 359) or GP (using items 3-51) for a child with a disability.

Number of treatment services

Medicare rebates are available for up to twenty allied health treatment services in total per eligible child. The twenty services may consist of any combination of items 82015, 82020, 82025 and 82035. It is the responsibility of the referring practitioner to allocate these services in keeping with the child's individual treatment needs and to refer the child to appropriate allied health professional(s) accordingly.

These services will not attract a Medicare rebate unless referral has been made by a consultant psychiatrist (using item 289) or paediatrician (using item 135) for children with autism/PDD, or by a specialist or consultant physician (using item 137) or a GP for disability (using item 139) for children with disability.

Service length and type

Services under these items must be for the time period specified within the item descriptor. The allied health professional must personally attend the child. A child may receive up to four Medicare eligible services from an allied health professional on the same day. It is anticipated that professional attendances at places other than consulting rooms would be provided where treatment in other environments is necessary to achieve therapeutic outcomes.

It is also expected that participating allied health providers will deliver treatment under these items that is consistent with the autism/PDD or disability treatment plan prepared by the medical practitioner, and is in keeping with commonly established autism/PDD or disability interventions as practised by their profession and appropriate for the age and particular needs of the child being treated.

Eligible allied health professionals

Allied health professionals providing services under these items must be registered with the Department of Human Services. To register with the Department of Human Services to provide these services, an allied health professional must meet the specific eligibility requirements detailed below:

a) Audiologist 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).

b) Occupational Therapist must be registered with the Occupational Therapy Board of Australia.

c) Optometrist must be registered as an optometrist or optician under a law of a State or an internal Territory that provides for the registration of optometrists or opticians, and be a participating optometrist.

d) Orthoptist must be registered with the Australian Orthoptic Board and have a Certificate of Currency; and be a member of Orthoptics Australia.

e) Physiotherapist must be registered with the Physiotherapy Board of Australia.

f) Psychologist must hold General Registration with the Psychology Board of Australia.

g) Speech Pathologist must be a 'Practising Member' of Speech Pathology Australia.

In addition to meeting the above mentioned credentialing requirements, it is expected that eligible providers will "self-select" for the autism/PDD and disability items (i.e. possess the skills and experience appropriate for provision of these services and be oriented to work with children with autism/ PDD or disability).

Referral requirements

An allied health professional wanting to provide any of the items 82000-82035 must be in receipt of a current referral provided by an eligible medical practitioner. Referrals are only valid when prerequisite MBS services have been provided.

An eligible allied health professional can provide assessment items (82000, 82005, 82010 and 82030) to a child under the Helping Children with Autism program when:

a) the child has previously been provided with any MBS service covering items 110 through 131 inclusive by a consultant paediatrician; or

b) the child has previously been provided with any MBS service covering items 296 through 370 (excluding item 359) inclusive by a consultant psychiatrist.

An eligible allied health professional can provide assessment items (82000, 82005, 82010 and 82030) to a child under the Better Start for Children with Disability program when:

a) the child has previously been provided with any MBS service covering items 104 through 131 inclusive, or items 296 through 370 (excluding item 359) inclusive by a specialist or consultant physician; or

b) the child has previously been provided with any MBS service covering items 3 through 51 by a GP.

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An eligible allied health professional can provide treatment items (82015-82025 and 82035) to a child under the Helping Children with Autism program when:

a) the child has previously been provided with a treatment plan (item 135) by a consultant paediatrician; or

b) the child has previously been provided with a treatment plan (item 289) by a consultant psychiatrist.

An eligible allied health professional can provide treatment items (82015-82025 and 82035) to a child under the Better Start for Children with Disability program when:

a) the child has previously been provided with a treatment plan (MBS item 137) by a specialist or consultant physician; or

b) the child has previously been provided with a treatment plan (MBS item 139) by a GP.

If the referring service has not yet been claimed, the Department of Human Services (DHS) will not be aware of the child's eligibility and Medicare benefits cannot be paid. DHS will be able to confirm whether a relevant MBS service has been claimed and/or the number of allied health services already claimed by the child. Allied health professionals can call the DHS provider line on 132 150. Parents and carers can call the patient information line on 132 011.

It is recommended that allied health professionals retain the referral for 24 months from the date the service was rendered for Medicare auditing purposes. Referring medical practitioners are not required to use a specific form to refer patients for these services. The referral may be a letter or note to an eligible allied health professional signed and dated by the referring practitioner.

Referral validity

Medicare benefits are available for up to four allied health assessment and diagnosis services and up to twenty allied health treatment services per patient in total. Patients will require a separate referral for each allied health professional they are referred to and they will also need new referrals for each new course of treatment.

A course of treatment for the allied health treatment services consists of the number of allied health services stated on the child's referral. This enables the referring practitioner to consider a report from the allied health professional(s) about the services provided to the child, and the need for further treatment.

Within the maximum service allocation of twenty services for the treatment items, the allied health professional(s) can provide one or more courses of treatment. Up to 4 services may be provided to the same child on the same day.

Reporting requirements

A written report must be provided to the referring medical practitioner by the allied health professional(s) after having provided the assessment and diagnosis and development of a treatment plan service(s) to the child.

On completion of a course of treatment, the eligible audiologist, occupational therapist, optometrist, orthoptist, physiotherapist, psychologist and speech pathologist must provide a written report to the referring medical practitioner which includes information on:

a) treatment provided;

b) recommendations on future management of the child's disorder; and

c) any advice provided to third parties (e.g. parents, schools).

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

Further Information

The above is an extract of notes in the Medicare Benefits Schedule that are of relevance to optometrists.

For the full document, visit: http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/downloads