



MEDICARE BENEFITS SCHEDULE ITEM USE GUIDE

An Optometry Australia guide for members

This document has been developed by Optometry Australia. It is not a legal document and, in case of discrepancy, the legislation will be the source of documents for payment of Medicare benefits. The document is intended to be read in conjunction with, and supplement the item descriptors and explanatory notes in the current version of the Medicare Benefits Schedule Book available at <http://www.mbsonline.gov.au/> The Department of Health can be contacted for further information and guidance.

Optometry Australia has made every effort to ensure that the information contained in this guide is accurate. It cannot accept responsibility for errors or omissions but invites notification of such for future reference.

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BILLING FOR OPTOMETRIC SERVICES

Provider numbers

Optometrists obtain provider numbers from the Department of Human Services (see <https://www.servicesaustralia.gov.au/hw093> for the application form, or register and apply via PRODA (<https://proda.humanservices.gov.au>) for subsequent applications.

Provider numbers are location specific. A separate provider number must be obtained for each practice location at which an optometrist practises. An optometrist cannot use another optometrist's provider number.

Locum Tenens

Where a locum tenens will be in a practice for more than two weeks **or** in a practice for less than two weeks but on a regular basis, the locum should apply for a provider number for the relevant location. If the locum will be in a practice for less than two weeks and will not be returning there, they should contact the Department of Human Services (provider liaison - 132 150) to discuss their options (for example, use one of the locum's other provider numbers). Locums can direct Medicare payments to a third party, for example the principal of the practice, by nominating the business details and bank account of the practice owner/ principal during the provider number application process.

Patient eligibility and Medicare Cards

Permanent residents of Australia must enrol with Medicare before they are eligible to receive Medicare benefits. A green Medicare card is the standard card for Australian citizens and permanent residents. A blue Medicare card is a visitor or interim card and has no restrictions apart from usually having a twelve month validity period.

Benefits for Services by Participating Optometrists

Benefits may be claimed only when:

- a service has been performed and a clinical record of the service has been made
- a significant consultation or examination procedure has been carried out
- the service has involved the personal attendance of both the patient and the optometrist; and
- the service is 'clinically relevant' (as defined in the Health Insurance Act 1973 as being generally accepted in the optometric profession as being necessary for the appropriate treatment of the patient to whom it is rendered).

Benefits are **not payable** for:

- Attendances for:
 - delivery, dispensing, adjustment or repairs of visual aids
 - filling of prescriptions written by other practitioners
- Optometric services associated with:
 - cosmetic surgery
 - refractive surgery
 - tests for fitness to undertake sporting, leisure or vocational activities
 - compulsory examinations or tests to obtain any commercial licence (for example, flying or driving)
 - entrance to schools or other educational facilities
 - compulsory examinations for admissions to aged care facilities
 - vision screening.
- Services in the following circumstances:
 - where the expenses for the service are paid or payable to a recognised (public) hospital
 - an attendance on behalf of teaching institutions on patients of supervised students of optometry
 - where the service is not 'clinically relevant' (see previous definition)

Unless the Minister otherwise directs, a benefit is not payable in respect of an optometric service where the service has been rendered by/on behalf of/under arrangement with the Commonwealth, a State or 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 the service was rendered in one or more of the following circumstances:

- the employer arranges or requests the consultation
- the results are provided to the employer by the optometrist
- the employer requires that the employee have their eyes examined
- the account for the consultation is sent to the employer
- the consultation takes place at the patient's workplace or in a mobile consulting room at the patient's workplace
- for services provided to an optometrist's dependants, spouse, employer or practice partner and their dependants

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 to the same optometrist, the time of each attendance should be stated on the account to assist with payment of benefits, except where a perimetry item is performed in association with a consultation item where the times need not be specified.

Examples of multiple attendances on the same day where benefits are payable include:

- A patient attends an initial consultation (item 10910/11) at 10.00am and returns to the original optometrist at 3.00pm the same day due to an injury to their eye. The patient requires examination to assess the injury, determine the need for referral and prescribe and necessary medications (which can be billed as item 10916 or 10913). The times of the different services are noted on the Medicare vouchers/account and can be billed separately.
- Where a patient undergoes a comprehensive eye examination and on the same day returns for a clinically necessary visual field test. In this instance times need not be stated on the patient's account.

*Examples of multiple attendances on the same day where benefits are **not** payable include:*

- An optometrist may need to check IOP on several occasions throughout a day to monitor diurnal variation of IOP to assess whether the patient is predisposed to developing glaucoma. The usual protocol is for the IOP to be measured at two-hourly intervals, on about four occasions during the same day.
Where there are multiple same day attendances for assessing diurnal variation in IOP, for the purpose of Medicare benefits, all consultations after the first one are considered to be a continuation of the first attendance. Therefore, only one claim can be lodged with Medicare.
- When a preliminary eye examination is concluded with the instillation of mydriatic or cycloplegic drops. Later that day, additional examination procedures, for example dilated fundus examination, take place. These sessions are regarded as being one attendance for Medicare benefit purposes.

Billing Procedures

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. Details of any charges made other than for (Medicare) 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.

The optometrist can bulk-bill the patient for the Medicare item **and** charge a separate fee for other procedures not covered by Medicare, recognising that they can only charge the schedule fee for the Medicare item that is bulk-billed.

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.

Patient Information, Records and Referrals

Maintaining adequate and contemporaneous records

Optometrists who provide or initiate a service for which a Medicare benefit is payable are required to maintain adequate and contemporaneous records.

To be *adequate* records must:

- clearly identify the name of the patient; and
- contain a separate entry for each attendance by the patient for a service and the date on which the service was rendered or initiated; and
- provide clinical information adequate to explain the type of service rendered or initiated for each entry; and
- be sufficiently comprehensible that another practitioner, relying on each entry in 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 in-patient care.

Optometry Australia guidelines on patient records and record keeping can be found at <https://www.optometry.org.au/practice-professional-support/patient-practice-management/clinical-advice-and-practice-notes>.

Referrals

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.

Referrals by optometrists to specialists

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. Referrals by a registered optometrist to a specialist other than an ophthalmologist will attract Medicare benefits at non-referred rates.

Referrals to other optometrists

Optometrists may also refer patients directly to another optometrist, based on the clinical needs of the patient.

Referral letters

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.

Medicare Compliance and Professional Services Review

Medicare practice audits are a part of the national compliance program and may occur routinely or when a practitioner is identified as having a claiming pattern different from those of their peers.



It is understood that optometrists with certain clinical interests will typically display different claiming patterns from those of their peers. Inappropriate practice is regarded as conduct in connection with rendering or initiating services that would be unacceptable to the general members of that profession.

The Department of Human Services conducts the Professional Services Review Scheme (PSR), which looks at a practitioner's Medicare claims (and also Pharmaceutical Benefits Scheme prescribing data) to determine if their practice data differ from their peers and if so, whether the difference may be due to inappropriate practice. A key principle of the PSR Scheme is a system where professionals are given the opportunity to explain their practice to a committee of peers; a peer is appointed after consultation with the relevant professional association as representing the general body of that profession.

The review process is outlined at <https://www.psr.gov.au>. Information to assist with Medicare compliance audits and reviews is available at <https://www.health.gov.au/topics/medicare-compliance/how-we-ensure-compliance>.

Guideline for substantiating optometry services

A guideline outlining what an optometrist can do to substantiate optometry services for Medicare Benefits Schedule (MBS) items 10912, 10913, 10914, 10915, 10942 and 10943 is available at <https://www.health.gov.au/resources/publications/guideline-for-substantiating-optometry-services>. The guideline is not exhaustive and optometrists may use any document they think substantiates any claim that is the subject of a Medicare compliance audit or review.

Any record or document provided should have been created during or as soon as practicable after the treatment occurred and should include the patient's name and the date the treatment was provided.

Optometric Medicare Items

Each patient and attendance should be considered on an individual basis and billed for the clinically relevant services.

When determining which item number to use optometrists should take into consideration:

- reason for the attendance
- presenting symptoms
- time since last eye examination (by you or another practitioner)
- general and ocular history
- the position of the consultation in a course of attention (first, second or subsequent)
- the necessity for a comprehensive re-evaluation rather than a continuing course
- the duration of an initial visit (more or less than 15 minutes)
- clinical relevance of special tests (for example, computerised perimetry)
- restrictions or requirements of the MBS for the use of a specific item.

10905: Referred Comprehensive Initial Consultation

Professional attendance of more than 15 minutes duration, being the first in a course of attention, if the patient has been **referred** by another optometrist who is not associated with the optometrist to whom the patient is referred.

Criteria for using item 10905

More than 15 minutes duration

If the consultation takes 15 minutes or less, item 10905 may not be billed.

The first in a course of attention

If the consultation is not the first in a course of attention, item 10918 (subsequent consultation) should be used. The MBS describes attendances provided by optometrists using the sequence of initial, second and subsequent, as visits occur in a course of attention.

If the patient has been referred by another optometrist ...

A referral in this instance is a request to an 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).

Referrals from medical practitioners do not attract benefit under item 10905.

The referral must:

- communicate all relevant information about the patient
- be dated and signed by the referring optometrist
- be received by the optometrist providing the service prior to the service
- be kept by the optometrist providing the service for a period of 24 months with the patient history

The obligation to substantiate the necessity for the item 10905 consultation lies with the referring optometrist.

The patient's account, receipt or bulk-billing form must contain the name and provider number of the referring optometrist.

... who is not associated with the optometrist to whom the patient is referred.

Referrals must be at 'arms length', that is, no commercial arrangements or connections should exist between the optometrists. This includes practitioners with the same employer. Optometrists should not be pressured to 'co-operate' with other optometrists or patients in providing retrospective referrals.

10907: Comprehensive Initial Consultation by Another Practitioner (within the initial consultation reset period)

Professional attendance of more than 15 minutes 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 of age – within the previous 12 months.

Criteria for using item 10907

Item 10910 may not be billed if the patient has been billed for any of the items 10905, 10907, 10910, 10912, 10913, 10914 or 10915 within the preceding 36 months. Item 10911 may not be billed if the patient has been billed for any of the items 10905, 10907, 10910, 10911, 10912, 10913, 10914 or 10915 within the preceding 12 months. The use of item 10907 is appropriate in these instances.

More than 15 minutes duration

If the consultation takes 15 minutes or less, item 10907 may not be billed.

The first in a course of attention

If the consultation is not the first in a course of consultation, item 10918 (subsequent consultation) should be used.

10910: Comprehensive Initial Consultation: Patient is less than 65 years of age

Professional attendance of more than 15 minutes 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.

10911: Comprehensive Initial Consultation: Patient is at least 65 years of age

Professional attendance of more than 15 minutes 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 applies; or
 - (ii) old item 10900 applied.

Criteria for using items 10910 and 10911

More than 15 minutes duration

If the duration of a consultation is 15 minutes or less, item 10910 (for those under the age of 65) or item 10911 (for those aged 65 and over) may not be billed. Consultations of not more than 15 minutes should normally be billed as item 10916 consultations.

Only the time during which a patient is receiving active attention from the optometrist should be counted. Periods spent completing information forms, or waiting for pupils to dilate after instillation of a mydriatic, should not be included in the time of the consultation.

The schedule does not provide for any averaging of the duration of initial consultations.

The first in a course of attention

In the case of items 10905–10916 a single course of attention relates to a specific episode of optometric care. Optometric visits in a single course of attention follow a sequence of initial, second and subsequent.

If the consultation is not the first in a course of attention, item 10918 (subsequent consultation) should be used.

If the patient is less than 65 years of age (10910); if the patient is at least 65 years of age (10911)

If the patient is under the age of 65 a 10910 can only be paid once every 36 months. Once the age of 65 is reached, item 10911 applies and this can be used once every 12 months.

If a patient under the age of 65 has been billed for any of the items 10905, 10907, 10910, 10912, 10913, 10914 or 10915 within the preceding 36 months, the item 10910 may not be used.

If a patient aged 65 or over has been billed for any of the items 10905, 10907, 10910, 10911, 10912, 10913, 10914 or 10915 within the preceding 12 months, the item 10911 may not be used.

Content of an item 10910 or 10911 consultation

The Medicare arrangements do not specify which procedures and services must be included in these consultations, but for benefits to be claimable, the consultation must be comprehensive, that is, contain all the elements that the profession would regard as being necessary and appropriate for the care of the patient.

What the profession would regard as necessary and appropriate may vary with the patient and the reasons for the patient attending the optometrist. For example, a patient attending an optometrist for routine preventative care would require a consultation of a different nature from that of a patient attending for assessment of an eye injury. The content of an examination of a child attending for the first time may be different from that of an elderly person who has been examined regularly over many years.

Optometrists who choose to include as routine some procedures that are performed by others on indication, must be prepared to do so within the limits of an item 10910 or 10911 consultation. Artificially splitting the consultation into two attendances is unacceptable.

On the other hand, those providers whose initial consultations are longer than 15 minutes duration but do not include a set of procedures, examinations and recordings considered minimal by the majority of their peers, should be prepared to defend the validity of a claim for a comprehensive consultation fee.

Optometrists may charge for additional services they provide such as retinal photography, pachymetry, visual fields etc not covered by Medicare, but they must be sure that the time taken for these procedures does not contribute to the 15 or more minutes required to be able to charge a 10910 or a 10911.

10912 to 10915: Other Comprehensive Consultations

10912

Professional attendance of more than 15 minutes 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.

Criteria for using item 10912

More than 15 minutes duration

If the consultation takes 15 minutes or less, item 10912 may not be billed.

The first in a course of attention

If the consultation is not the first in a course of consultation, item 10918 should be used.

Significant change in visual function requiring comprehensive reassessment

If the patient has attended the same practice for an initial consultation within the past 36 months (for those age under 65) or within the past 12 months (for those aged 65 and over), there must be a significant change in visual function to justify the charging of item 10912. This could include documented changes of:

- vision or visual acuity of two lines (0.2 logMAR) or more (corrected or uncorrected)
- visual fields or previously undetected field loss
- binocular vision
- contrast sensitivity or previously undetected contrast sensitivity loss.

The presence of new signs or symptoms alone is not necessarily enough to justify use of item 10913. The descriptor states that the new signs or symptoms must also be clinically significant enough to require comprehensive reassessment.

Item 10912 may not be used when a patient attends a practice for the first time; the previous initial consultation must have been provided at the same practice, at the same physical address.

Documentation used to substantiate item 10912 includes a copy or excerpt of recorded evidence of the patient's clinical file or patient records, clearly explaining any significant changes in visual function (see <https://www.health.gov.au/resources/publications/guideline-for-substantiating-optometry-services>).

When a patient who has had a comprehensive consultation at a different practice within the last 36 months (for those age under 65) or within the past 12 months (for those aged 65 and over) presents with a significant change in visual function that did not exist at the time of the last consultation, the appropriate item to be used for the ensuing comprehensive reassessment is 10907. (Note that this consultation then resets the clock).

10913

Professional attendance of more than 15 minutes 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.

Criteria for using item 10913

More than 15 minutes duration

If the consultation takes 15 minutes or less, item 10913 may not be billed.

The first in a course of attention

If the consultation is not the first in a course of consultation, item 10918 (subsequent consultation) should be used.

New signs or symptoms unrelated to the earlier course of attention, requiring comprehensive reassessment

When charging item 10913, the optometrist must document the new signs or symptoms on the patient's record card.

The presence of new signs or symptoms alone is not necessarily enough to justify use of item 10913. The descriptor states that the new signs or symptoms must also be clinically significant enough to require comprehensive reassessment.

Item 10913 may not be used when a patient attends a practice for the first time; the previous initial consultation must have been provided at the same practice, at the same physical address.

Documentation used to substantiate item 10913 includes a copy or excerpt of recorded evidence of the patient's clinical file or patient records, clearly explaining any new signs or symptoms suffered (see <https://www.health.gov.au/resources/publications/guideline-for-substantiating-optometry-services>).

When a patient who has had a comprehensive consultation at a different practice within the past 36 months (for those age under 65) or within the past 12 months (for those aged 65 and over) presents with new signs and symptoms that did not exist at the time of the last consultation, the appropriate item to be used for the ensuing comprehensive reassessment is 10907. (Note that this consultation then resets the clock).

10914

Professional attendance of more than 15 minutes 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.

Criteria for using item 10914

More than 15 minutes duration

If the consultation takes 15 minutes or less, item 10914 may not be billed.

The first in a course of attention

If the consultation is not the first in a course of consultation, item 10918 (subsequent consultation) should be used.

Item 10914 may be used for patient's first attendance at a particular practice.

Progressive disorder requiring comprehensive reassessment

A progressive disorder is a disease or health condition that gets worse over time, resulting in a general decline in health or function. When charging item 10914, the optometrist must 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 or diabetic

retinopathy), cataract, keratoconus, corneal dystrophies, or glaucoma. Item 10914 specifically excludes presbyopia from 'progressive disorders'. The progressive condition does not necessarily have to progress at each visit.

The presence of a progressive disorder alone is not necessarily enough to justify use of item 10914. The progressive disorder must also be clinically significant enough as at the date of service so as to require comprehensive reassessment.

It is inappropriate to use item 10914 for a patient with a simple refractive condition, especially in the case where a practitioner uses the item for myopia when a patient presents for the first time, to avoid providing the service as an item 10907 attendance.

The '10914 exception' to the 'same practice' requirement enables patients with progressive disorders and who require comprehensive reassessment at an interval of less than 12/36 months (depending on their age), to attend at a different practice and still be eligible for the 10914 rebate.

Documentation used to substantiate item 10914 includes a copy or excerpt of recorded evidence of the patient's clinical file or patient records, clearly explaining the nature of the progressive disorder (see <https://www1.health.gov.au/internet/main/publishing.nsf/Content/hpg-substan-optometry-services>).

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.

Criteria for using item 10915

More than 15 minutes duration

If the consultation takes 15 minutes or less, item 10915 may not be billed.

The first in a course of attention

If the consultation is not the first in a course of consultation, item 10918 (subsequent consultation) should be used.

Patient with diabetes mellitus

A medical practitioner must have diagnosed the patient as suffering from diabetes mellitus. In most cases, the optometrist's knowledge of this will be based on the patient reporting the diagnosis. If the optometrist suspects that the patient may have diabetes, but a medical practitioner has not confirmed this, then item 10915 should not be used.

Where an examination of the eyes with the instillation of a mydriatic of a patient with diabetes mellitus is being conducted, where possible item 10915 should be billed rather than item 10914 to assist in identifying whether such patients are receiving appropriate eye care.

The instillation of a mydriatic

A mydriatic must be instilled and a dilated (ocular) fundus examination (DFE) performed. The fundus must be examined at the consultation being billed as item 10915.

If a DFE is not possible at the initial consultation, do not use item 10915. Instead, use the initial consultation item that is appropriate and then use 10918 for the subsequent consultation at which the DFE is performed.

Frequency of use of item 10915

Item 10915 may be provided to new as well as returning patients. This initial examination of a diabetic patient starts the '36-month clock' or the '12-month clock' — your patients aged under 65 will be ineligible for item 10910 in the following 36 months whilst patient aged 65 and over will be ineligible for item 10911 in the following 12 months.



Optometry Australia has published guidelines on the optometric care of people with diabetes, which may be viewed at https://www.optometry.org.au/wp-content/uploads/Professional_support/Guidelines/clinical_guideline_diabetes_revised_sept_2018_final_designed.pdf.

The National Health and Medical Research Council also publishes clinical practice guidelines, which may be viewed at https://www.optometry.org.au/wp-content/uploads/Professional_support/Guidelines/nhmrc_diabetic_guidelines.pdf.

Patients with diabetes mellitus require comprehensive assessment including a retinal examination under mydriasis at least every two years, although some may require more frequent examination.

If further examination is required, the reason for this should be documented in the clinical notes, and the patient's GP or other health-care provider should be informed.

Record keeping for 10915

Records should include documentation of the following:

- the fact that the patient has been diagnosed with diabetes mellitus (see <https://www.health.gov.au/resources/publications/guideline-for-substantiating-optometry-services>).
- the time since the patient's previous dilated fundus examination
- the findings of the fundus examination
- any communications with other practitioners involved in the patient's care.

Optometry Australia guidelines on patient records and record keeping can be found at <https://www.optometry.org.au/practice-professional-support/patient-practice-management/clinical-advice-and-practice-notes>.

It is important that the patient's GP or other health-care provider is informed of the results of the examination, although this is not a requirement of the MBS item descriptor.

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.

Criteria for using item 10916

The first in a course of attention

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

Item 10916 enables a more appropriate fee to be charged when an optometrist attends a patient for the first time, in circumstances other than when 'traditional' vision-related reasons drive the attendance.

If the consultation is not the first in a course of consultation, item 10918 (subsequent consultation) should be used.

Of not more than 15 minutes duration

The consultation should take 15 minutes or less.

Frequency of use

Unlike other items covering sole or first attendances, item 10916 is not restricted to once only in 36 months for those aged under 65 years or once in 12 months for those aged 65 and over, nor is it limited to patients whose visual or ocular conditions meet specified descriptions—as necessary for items 10912, 10913, 10914 or 10915.

The item can be the only consultation in a course of attention, or it can be followed by a subsequent consultation to be billed as item 10918.

The consultation should be complete in itself, not part of a longer consultation staged over two attendances to avoid the item 10907 arrangements. Appropriate clinical reasons for using item 10907 or 10916 are different, and when item 10916 is used, optometrists should be sure their decision to deliver a short consultation of less than 15 minutes would be supported by the body of the profession. Utilisation patterns of item 10916 followed a short time later by 10918 are closely monitored by Medicare.

If another course of attention is commenced for a patient whose last attendance was item 10916, the new course can begin with either item 10910 (for those aged 65), 10911 (for those aged 65 and over) or 10916, depending on whether the duration of attendance is more than 15 minutes or 15 minutes or less.

The use of item 10910 or 10911 in these circumstances is subject to the usual restriction of once only in a period of 36 and 12 months respectively.

If an item 10910 or 10911 (or 10912, 10913, 10914, or 10915) has been billed within the preceding 36 months for those aged under 65, or 12 months for those age 65 and over, and the most recent attendance is item 10916, then a claim for a subsequent comprehensive consultation—items 10912, 10913 or 10914—must be based on fulfilling the specific item requirements of significant change, new signs or symptoms, or reassessment of a progressive disorder, as is always required. If these conditions are not met the appropriate item to follow 10916 is 10918. If in any of these situations the duration of the consultation does not exceed 15 minutes, it should be itemised as 10916.

Example—Ocular injury and subsequent care

- Patient presents for the first time with a sore eye. Corneal abrasion requiring short term review is diagnosed. Duration: 10 minutes. Item 10916 billed.
- Three days later, patient presents for review of corneal abrasion. Item 10918 billed.
- Two weeks later, patient decides to have vision examination 'now that eye has cleared up'. Comprehensive visual examination performed. Duration: 28 minutes. Item 10910 billed if the patient is aged under 65 or item 10911 billed if the patient is aged 65 or over.

Other examples

- Where patients are referred to optometrists by ophthalmologists, general medical practitioners or other optometrists for specific procedures such as IOP measurement, biomicroscopy or refraction.
- Acute red eye scenarios where history taking, assessment and management or referral are carried out within 15 minutes. Remember item 10916 can be followed by item 10918 when there are further consultations in the course of attention, or by item 10910, 10911, 10912, 10913 or 10914 as appropriate when a new course of attention is commenced.
- Recurrent eyelash epilation services where the first epilation attendance in a course of attention would be billed as 10916, and repeated subsequent epilation attendances after a short interval (weeks rather than months or years) billed as 10918.
- Refraction only patients are those either referred directly by an ophthalmologist or those where the optometrist is aware that the patient has very recently been examined by an ophthalmologist and does not require comprehensive examination. In such circumstances it would be difficult to support the necessity to repeat much of the examination, so it is the view of Medicare Australia that the necessary consultation would be completed in less than 15 minutes and therefore billed as item 10916.

NOTE: There have been occasions when an optometrist diagnosed something at a post-ophthalmological consultation, which had either been overlooked or developed since the earlier consultation. When a patient has recently seen or is under the regular care of an ophthalmologist, the attending optometrist must decide the appropriate clinical tests to be performed. Decisions relating to

appropriate clinical care should not be dictated by the ability or inability to bill a particular Medicare item number.

The Optometry Board of Australia Guidelines on the prescription of optical appliances notes that “Before issuing a prescription, optometrists should normally perform an examination of the patient including addressing ocular health, the need for referral or review, and determination of whether it is appropriate to issue a prescription”. If a practitioner elects to perform a refraction-only exam it would be prudent to record the name of the patient’s ophthalmologist, date of last test and date of next test to assist in justifying the practitioner’s decision.

If an optometrist is uncomfortable with performing a ‘refraction-only’ consultation and provides a comprehensive consultation (item 10910/10911/10912/10913/10914), they should be prepared to support the appropriateness of such action to a panel of their peers. There is also the option of advising the referring ophthalmologist that they do not perform refraction-only consultations.

NOTE: a Medicare service should not be claimed when a patient presents with a valid optical prescription issued by another practitioner and the second practitioner elects to check the first practitioner’s prescription before dispensing the spectacles (as this is unlikely to be considered a clinically relevant” service).

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.

Criteria for using item 10918

Second or subsequent in a course of attention

Item 10918 must be subsequent to a claimable and clinically relevant service and not be the initial attendance in a course of attention.

Not related to the prescription and fitting of contact lenses

Item 10918 may not be used for any part of the contact lens prescription and fitting process. (In these instances items 10921-29 should be used where applicable, or alternatively the billing should be arranged privately between the optometrist and their patient.)

Not being a service to which item 10940 or 10941 applies

Item 10918 may not be billed in conjunction with a visit where item 10940 or 10941 is billed for perimetry. See Medicare descriptor for items 10940 and 10941.

Digital imaging and item 10918

Item 10918 may not be billed for digital imaging nor may it be billed following an attendance for any digital imagery for the sole purposes of discussing the imaging results. This is because the digital imaging is not considered clinically relevant with regards to Medicare billing. Item 10918 must be subsequent to a clinically relevant attendance.

For clarity: item 10918 may not be billed when a patient attends a practice to collect spectacles, or for repairs or adjustments.

Medicare compliance audits can identify when consultations are mistakenly ‘up-coded’—billed as item 10912-5 when item 10918 should be used.

Multiple attendances

Information concerning Medicare billing and multiple attendances can be found at [Multiple attendances](#) above. This includes enquiries concerning repeated IOP measurements and same-day visits for a patient regarding unrelated issues.

CONTACT LENS ITEMS

10921-10930: Contact Lenses for Specified Classes of Patients—Bulk Items for all Subsequent Consultations

For the contact lens items, an account for Medicare contact items or a bulk-billing form should not normally be issued until the prescribing and fitting process is complete and the contact lenses are delivered to the patient.

Items 10921 to 10929

Each of these items includes different wording after 'Payable once in a period of 36 months for' (see below):

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

- 10921 patients with myopia of 5.0 dioptres or greater (spherical equivalent) in one eye.
- 10922 patients with manifest hyperopia of 5.0 dioptres or greater (spherical equivalent) in one eye.
- 10923 patients with astigmatism of 3.0 dioptres or greater in one eye.
- 10924 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.
- 10925 patients with anisometropia of 3.0 dioptres or greater (difference between spherical equivalents).
- 10926 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.
- 10927 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.
- 10928 patients who, by reason of physical deformity, are unable to wear spectacles.
- 10929 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, where 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 in MBS guide.

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.

Items 10921 to 10929: All professional attendances after the first

Each of the items 10921 to 10929 generally follows a service to which item 10910, 10911, 10905, 10907, 10912, 10913, 10914, 10915 or 10916 applies.

Criteria for using items 10921-10930

The descriptions for contact lens consultations are the most detailed in the Optometric Schedule. There is no use of terms such as 'significant' or 'progressive', which allow a wider interpretation, but rather, very specific descriptions of magnitude of ametropia. The responsibility of assigning a particular item falls to the optometrist and there is virtually no room for discretion or interpretation where this item is concerned.

Eligibility based on refractive error is determined through calculation of a spherical equivalent adding half the cylindrical power to the spherical power of the patient's distance spectacle prescription. The use of a patient's near add to determine the spherical equivalent is inappropriate.

In a single course of attention

A course of attention in relation to items 10921-10930 includes all associated attendances, by one or more optometrists, for the purpose of prescribing and fitting contact lenses.

All attendances for contact lens after-care consultations are covered by the bulk item. This interpretation is unaltered by the frequency of after-care visits associated with various lens types, including extended wear lenses.

Involving the prescription and fitting of contact lenses

The consultation procedure must include both prescribing (frequently including the use of trial lenses) and fitting which includes lens verification, delivery and patient tuition as well as a number of after-care visits as appropriate for the particular patient.

This bulk item includes those after-care visits necessary to ensure the satisfactory performance of the lenses. This interpretation is unaltered by the frequency of after-care visits associated with various lens types including extended wear lenses. Consultations during the after-care 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).

The date of service

The date of service is regarded as the date on which the contact lenses are delivered to the patient. If the patient is purchasing the lenses elsewhere after the conclusion of the prescription and fitting process, then the date of service is regarded as the date that the contact lens prescription is finalised and provided to the patient.

There is no Medicare rebate available for 'part' of the prescribing and fitting process. Item 10918 is specifically excluded from these procedures. .

The contact lens item may not be charged unless the contact lens prescription is finalised. In some cases, where the patient decides not to proceed with contact lenses, the patient may be charged a non-rebateable (private) fee for a 'part' service.

Items 10921 to 10929: payable only once in a period of 36 months

A benefit under items 10921-10929 is payable once only in any 36-month period. If the conditions attached to item 10930 are met, a second contact lens benefit may be payable in a shorter period.

These considerations mean that the number of patients whose contact lens consultation fees are rebateable is about 30 percent of all contact lens patients. Ethnicity and practice demographics can

affect this figure and optometrists report wide variations between practices, ranging between 10 per cent and 40 per cent of total contact lens patients.

The passage of 36 months is not an automatic trigger for charging another service. The content of the service and its appropriateness for the patient are the paramount considerations.

Where previously fitted patients present at a practice for the first time, certifying a contact lens attendance is legitimate only if the full prescribing and fitting process is carried out to solve the problem of a lost, damaged or otherwise unsatisfactory lens—consultations that result in disposable lens wearers being dispensed duplicate lenses, or lenses with altered power, do not meet MBS requirements.

Private billing of contact lens consultation fees

Any consultation associated with prescribing and fitting contact lenses where the requirements of the MBS are not met may be charged at any fee negotiated between the patient and the provider.

Accounts and receipts issued to the patient should clearly indicate the service is non-rebateable using terminology such as ‘Medicare benefits not payable for this service’.

As for other consultations covered under Medicare, since January 2015 optometrists may charge more than the schedule fee for contact lens consultations but patients must be advised of costs prior to the commencement of the process.

Other Medicare billing within this period

Consultations during the after-care period that are unrelated to the prescription and fitting of contact lenses or that are not part of the normal after-care may be billed under other appropriate items (not items 10921 to 10930). This includes visits such as dilated fundus examination or perimetry.

10921

- patients with **myopia of 5.0 dioptres or greater** (spherical equivalent) in one eye.

A myopic patient must exhibit a spherical equivalent of 5.0 dioptres or more of myopia in their distance spectacle prescription in either eye to be eligible.

10922

- patients with **manifest hyperopia of 5.0 dioptres or greater** (spherical equivalent) in one eye

A hyperopic patient must exhibit a spherical equivalent of 5.0 dioptres or more in their distance spectacle prescription in either eye. The use of a patient’s near add to determine the spherical equivalent is unacceptable.

10923

- patients with **astigmatism of 3.0 dioptres or greater** in one eye

An astigmatic patient must exhibit 3.0 or more dioptres of astigmatism in their distance spectacle prescription in either eye.

10924

- 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

Irregular astigmatism is where the refraction varies in different parts of the same meridian or where refraction in successive meridians differs irregularly. In irregular astigmatism the principal meridians are not perpendicular.

Optometrists should keep records of keratometric findings, spectacle correction, visual acuities and acuities with prescribed contact lenses.

... and if that corrected acuity would be improved by an additional 0.1 logMAR by the use of a contact lens

0.1 logMAR improvement is equivalent to the gain of one line on a Snellen acuity chart. The use of contact lenses must offer this benefit over the use of spectacles for the patient.

10925

- patients with **anisometropia of 3.0 dioptres or greater** (difference between spherical equivalents).

The difference between the spherical equivalents of the patient's distance spectacle correction of the two eyes must be 3.0 dioptres or more. The use of the resultant prescription in monovision or multifocal prescriptions is unacceptable.

10926

- 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**

Patients with a corrected visual acuity of 0.7 logMAR (6/30) or worse in both eyes

The patient's corrected visual acuities (i.e. with spectacle correction) must not be better than 6/30 in either eye for this item to apply.

Telescopic system

The use of a (high plus) contact lens as the eyepiece of a Galilean telescopic system, associated with an objective in the form of a (negative) spectacle correction.

10927

- patients for whom a wholly or segmentally opaque contact lens is prescribed for the alleviation of dazzle, distortion or diplopia caused by:
 - pathological mydriasis; or
 - aniridia; or
 - coloboma of the iris; or
 - pupillary malformation or distortion; or
 - significant ocular deformity or corneal opacity
 whether congenital, traumatic or surgical in origin.

There is little room for misinterpretation of the conditions of item 10927. Patient information and findings must be clearly documented. Medicare benefits are not payable for contact lens consultations when the lenses are prescribed for reasons of appearance.

10928

- patients who, by reason of **physical deformity**, are unable to wear spectacles

Physical deformity

Examples of use include where a patient may be missing an ear or nose.

10929

- 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, where 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.

Medical or optical condition

Any remaining medical or optical condition that necessitates the use of contact lenses is covered by item 10929 and this is generally limited to such situations as the use of bandage lenses—generally a soft contact lens used to temporarily protect the cornea and allow it to heal. An example of such a condition is recurrent corneal erosion.

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

- reasons of appearance (because they do not want to wear spectacles)
- sporting purposes
- work purposes
- psychological reasons (because they cannot cope with spectacles)

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.

Item 10930 may be charged only when the contact lens prescription and fitting has taken place within 36 months of the payment of Medicare benefits for another contact lens item.

For providers refitting their own patients, the new fitting must involve the use of a different lens material or a changed design, which are necessary because the eye has experienced a structural or functional change, or an allergic response.

Changing from spherical to toric lens design in the absence of a change in the eye, solely as a result of dissatisfaction with a spherical correction, does not warrant charging item 10930.

Examples of use

- Progression of keratoconus
- Change in corneal graft profile
- Refit for infant
- Corneal hypoxia requiring change in lens material
- Giant papillary conjunctivitis

10931-10933: Domiciliary Visits

10931

An optometric service to which an item in Group A10 of this table (other than this item or item 10916, 10932, 10933, 10940 or 10941) applies (the applicable item) if the service is:

a) rendered at a place other than consulting rooms, being at:

- (i) a patient's home: or
- (ii) residential aged care facility: or
- (iii) an institution; and

b) performed on **one patient** at a single location on one occasion, and

c) either:

- (i) bulk-billed in respect of the fees for both:
 - this item; and
 - the applicable item; or

- (ii) not bulk-billed in respect of the fees for both:
 - this item; and
 - the applicable item

(See para O6 of explanatory notes to this Category)

10932

An optometric service to which an item in Group A10 of this table (other than this item or item 10916, 10931, 10933, 10940 or 10941) applies (the applicable item) if the service is:

- a) rendered at a place other than consulting rooms, being at:
 - (i) a patient's home: or
 - (ii) residential aged care facility: or
 - (iii) an institution; and
- b) performed on **two patients** at the same location on one occasion, and
- c) either:
 - (i) bulk-billed in respect of the fees for both:
 - this item; and
 - the applicable item; or
 - (ii) not bulk-billed in respect of the fees for both:
 - this item; and
 - the applicable item

(See para O6 of explanatory notes to this Category)

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 O6 of explanatory notes to this Category)

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, transporting the necessary equipment.

Items 10931–10933 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 domiciliary loading, acceptable places of residence for domiciliary visits are:

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

The items are add-ons. They are intended to be billed in addition to the regular consultation items. These items may not be billed without billing a consultation item.

The items are structured so that the additional fee is distributed between the first one, two or three patients seen at one visit. The fees for the items are set so that the total fee is the same in all cases except for a slight rounding effect.

Hospital visits

The domiciliary items are *not* payable for examinations provided at other locations such as hospitals (or workplaces). Where a visit to a hospital is provided at the patient's request, an extra fee in addition to the schedule fee may be charged providing the service is not bulk-billed. Benefits are not payable in respect of the private charge. If the optometrist does not bulk-bill the consultation, they can charge their own fee for the consultation (since the fee cap has been removed) or a consultation fee that is rebateable plus a domiciliary visit fee that is not rebateable. In either case the additional costs are not covered by Medicare.

Exclusions

The normal rules concerning eligibility for Medicare benefits apply, so patients must satisfy the requirements for the consultation item before the domiciliary loading may be charged. In particular, Medicare specifically excludes paying benefits for compulsory examinations for admission to aged-care facilities.

Using the items

At each visit to a location:

- If one patient is seen, bill the appropriate consultation item plus item 10931.
- If two patients are seen, bill each patient the appropriate consultation item plus item 10932.
- If three patients are seen, bill each patient the appropriate consultation item plus item 10933.
- If four or more patients are seen, bill each of the first three patients the appropriate consultation item plus item 10933, then bill the other patients only the appropriate consultation item. In this scenario, do not bill the fourth and subsequent patients item 10933, only the first three.

Where more than three patients are seen at the same location, additional benefits for domiciliary visits are not payable for the fourth, fifth et cetera 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 be billed only 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.

The difference in fees for each item means the total Medicare benefit paid (per visit) once three or more patients are seen is the same, regardless of the number of patients seen during the visit.

If the optometrist then attends another single patient at a different location, that patient can also be billed an item 10931 plus the consultation item.

Domiciliary visits do not have to be bulk-billed and the optometrist may charge their own consultation fee and their own domiciliary fee. However, after the first three patients at a given location, the domiciliary fee should not be itemised with a Medicare number as no rebate will apply.

To bulk-bill or not

You are free to decide whether to bulk-bill any patient.

Under the terms of the Medicare agreement, you may not bulk-bill part of a service and charge the patient for other parts of the service.

When you bill items 10931, 10932 or 10933, you may choose to either bulk-bill both the consultation item and the domiciliary visit item, OR charge the patient directly for both. You MAY NOT bulk-bill one item and not the other.

If you choose to bulk-bill the items, you may not charge any additional fee to the patient.

If you choose not to bulk-bill, you may determine your own charges.

You do not have to use the same billing method for all patients seen during one domiciliary visit.

Private billing and additional fees

Domiciliary visit loading items may not be claimed in conjunction with brief initial consultation item 10916, or with computerised perimetry items 10940 or 10941.

Compliance with Medicare

Medicare compliance audits investigate high levels of daily servicing in aged-care facilities.

Benefits may be claimed only when a significant consultation or examination procedure has been carried out. In aged-care settings, an optometrist may be asked to investigate or assess a patient's living environment to identify and eliminate potential hazards or risks for falls or accidents. Services of this nature are not covered by Medicare, however the optometrist may bill a private fee for these services. For Medicare benefits to be claimed for an optometric attendance, the consultation or service must be necessary for the patient's health care.

The opinion of what constitutes a comprehensive consultation varies widely and may depend on the patient's presenting signs, symptoms, history, and health; however optometrists should ensure that when conducting domiciliary visits the consultation is as complete as possible in the circumstances.

10940 and 10941: Computerised Perimetry

10940

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 two examinations (including examinations to which item 10941 applies) in any twelve month period, not being a service associated with a service to which item 10916, 10918, 10931, 10932 or 10933 applies.

(See para O6 of explanatory notes to this Category)

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 two examinations (including examinations to

which item 10940 applies) in any twelve month period, not being a service associated with a service to which item 10916, 10918, 10931, 10932 or 10933 applies.

(See para O6 of explanatory notes to this Category)

Optometrists should be aware that there will be occasions when visual field assessment is indicated but will not be covered by Medicare. In these cases a private fee may be charged.

Criteria for using items 10940 and 10941

Full quantitative computerised perimetry (automated absolute static threshold)

The test must be quantitative, that is, determine thresholds.

To qualify for items 10940/10941, the test must determine an absolute threshold for each point tested. It is not necessary to test the entire visual field. Optometrists should use their clinical judgement to determine the areas of the visual field to be tested in each case, whether it is a central, peripheral or full threshold test.

Most of the common automated perimeters can be used to measure a full threshold field, and can be used to provide an examination that qualifies for item 10940/10941. These include the Humphrey Visual Field Analyzer (HFVA), the Medmont perimeter, the Octopus perimeter, and the Humphrey Matrix perimeter.

Many of the perimeters in current use offer a range of different testing algorithms that provide the ability to determine a threshold more quickly than was possible with the earlier algorithms. Examples of these algorithms include the Medmont 'fast threshold' and the HVFA 'SITA' and 'SITA Fast'. Each of these algorithms determines an absolute threshold for each point tested, and qualifies for items 10940/10941.

The Humphrey FDT screener, for example, does not qualify for items 10940/10941. This is because it is a screening device and tests a very limited number of points. The items 10940/10941 may not be used for supra-threshold screenings, where the perimeter presents a stimulus at each point that the patient would normally be expected to see, based on their age. The Esterman test is one such test, and therefore does not qualify for items 10940/41.

If a visual field screening is performed, the optometrist can bill only for an attendance item (for example, 10918). A private fee may be charged if any tests not covered by Medicare are performed (e.g. pachymetry, OCT).

Not multifocal multichannel objective perimetry

The exclusion of multifocal multichannel objective perimetry means that these items cannot be used for examinations with the AccuMap perimeter.

Performed by an optometrist

Under the Health Insurance Act 1973 all optometry services including perimetry must be performed by an optometrist, or performed by an optometrist on behalf of another optometrist, but not by a technician acting 'on behalf of' an optometrist, for Medicare benefits to be claimed.

For purposes of items 10940 and 10941 this means the optometrist, having determined the need for a visual field examination, is required to take full professional responsibility for the perimetry service and to personally perform the following essential elements of the service:

- Explain the procedure to the patient, select the appropriate computer program for the perimetry and ensure that the patient is correctly positioned
- Be available at the practice throughout the procedure to respond to computer prompts that suggest the test is not proceeding correctly
- Consider the results of the examination and, based on those results, determine the appropriate course of action required to manage the patient's condition
- Complete the report of the service on the patient record, and provide the printed results of the perimetry in cases where the patient is being referred for further treatment.

The above requirements apply regardless of whether the optometrist is claiming items 10940/10941 or when claiming item 10918 in those cases where it is essential to perform perimetry more than twice in a 12-month period and the quota of perimetry items has already been used or when the patient is ineligible for a 10940/10941 in the absence of diagnosed glaucoma or suspected optic nerve pathway disease.

The optometrist must determine the need for a visual field examination, select the protocols for the examination, consider the results of the examination, and determine the appropriate course of action required to manage the patient's condition in light of the results.

It is acceptable for the optometrist to have assistance with physically operating the equipment and ensuring that the patient is maintaining correct posture, comfortable and reassured, as this is not in any way interpreted as acting 'on behalf of' the optometrist.

It is not necessary for the optometrist to physically operate the computerised perimeter, or to personally observe the entire visual field examination. While it is acceptable for the optometrist to have an assistant operate the perimeter, the optometrist must take full professional responsibility for the performance of the examination and should be present in the practice during the examination.

Where indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain

There must be a clear indication for performing the visual field examination and this should be noted in the patient record. Simply, the patient must have ocular disease that is relevant to the measurement of their visual field, or there must be suspicion of the existence of pathology of the visual pathway or brain.

A Clinical Guideline on Visual Field Testing has been published by Optometry Australia, and includes indications for assessing a patient's visual field. The guideline is available at http://www.optometry.org.au/media/274936/clinical_guideline_visual_field_testing_v2_02.03.16.pdf. Optometrists should note that there will be occasions when visual field assessment is indicated but will not be covered by Medicare. For further guidance, the following lists clinically relevant indications for perimetry with regards to Medicare billing for items 10940 and 10941. The list is not definitive.

Examples of indications for computerised perimetry that attract Medicare rebates include:

- Confrontation indicates the possibility of a visual field loss, or there is a presenting positive scotoma or known visual field defect or patient
- History indicates there may be a visual field defect (for example, patient bumps into things or has frequent falls)
- Patient displays risk of developing conditions likely to be associated with visual field loss (for example, first degree relative with glaucoma) and clinical signs of risk factors for glaucoma as noted in eye examination, for example, pigment dispersion or pseudoexfoliation syndromes
- Anomalies of the optic disc(s)
- Intraocular pressure is greater than 22 mmHg (CCT corrected) or significant asymmetric intraocular pressure
- Patients with unexpected loss of visual acuity in one or both eyes
- Symptoms of cerebral aneurysm, pituitary tumour, occipital tumour
- Newly documented visual aura not associated with clearly demonstrated/known and recorded history of migraine aura
- Investigation of head injury or trauma (for example, closed head injury, neuro- and vascular surgery), acute blunt trauma to the globe, other ocular injury where visual field loss is suspected
- Afferent pupil defect or other significant pupil anomalies
- Known or suspected carotid artery insufficiency
- Investigation of macular disorders and age-related macular degeneration together with assessment using Amsler charts (for example, disciform degeneration, central serous retinopathy, other significant degenerative or dystrophic disease) for the detection of small central scotomas and metamorphopsia in macular diseases

- Choroidal disease and choroidal melanoma
- Retinal disease including retinal dystrophies
- Presence or suspicion of optic nerve disease, chiasmal lesions, posterior chiasmal lesions, lesions in the visual pathways, psychogenic disorders
- Investigation of cranial nerve or gaze palsies (for example, presence of diplopia or sudden onset of ocular motility disturbance)
- Intracranial pathological conditions, for example, intracranial mass, increased intra-cranial pressure
- Proven acquired colour vision loss
- Use of systemic drug/s that may have effects on the visual fields, for example, Plaquenil (hydroxychloroquine sulphate), Chloroquin (chloroquine phosphate), Sabril (vigabatrin). There are recommendations on the frequency of visual field testing for patients on Plaquenil and a guideline on recommended frequency and timing of perimetry in children prescribed Sabril.

Examples of indications for computerised perimetry that do not attract Medicare rebates include:

- Visual field assessment for occupational purposes
- To determine the fitness of a patient to meet visual standards such as commercial driving licences
- Baseline documentation of patient history.
- Isolated, single measurements or test results that do not, alone, provide a sufficient clinical justification to satisfy the requirement for a diagnosis of ocular disease or suspicion of pathology of the visual pathway.

Medicare rebates are not payable when visual field testing is conducted for:

- Routine testing when patients report a symptom of headache
- Visual field screenings based solely on patient's age or general family history
- Repeat testing performed due to inadequate procedures when test was first carried out
- Perimetry carried out by another staff member with no optometrist present
- Perimetry performed without documented presence or suspicion of relevant ocular disease or pathology of the visual pathway or brain.

With assessment and report

The optometrist must consider the results of the visual field examination, determine the course of action required to manage the patient's ocular disease or suspected pathology, and communicate these findings to the patient. The report can be made verbally to the patient but the disease or suspected pathology that prompted the test, the results and interpretation of the test, and the management plan, should also be documented in the clinical record.

Bilateral or unilateral

The appropriate item should be billed, depending on whether the examination is unilateral or bilateral. Item 10940 for bilateral procedures may not be claimed for patients who are totally blind in one eye.

If it is necessary to split a bilateral examination (for example, where patient fatigue makes it impossible to examine the second eye in the same session), a single item 10940 should be used, rather than billing item 10941 twice.

Not in conjunction with items 10916, 10918, 10931, 10932 or 10933

Items 10940 and 10941 can be billed either in association with comprehensive consultation items 10905, 10907, 10910, 10911, 10912, 10913, 10914 or 10915, or independently, but they may not be billed with items 10916, 10918, 10931, 10932 or 10933.

For example, if a patient under 65 presents for an examination, and has not had an optometric examination in the previous 36 months, the optometrist would bill an item 10910 or if a patient aged

65 or over presents for an examination, and has not had an optometric examination in the previous 12 months, the optometrist would bill an item 10911. If the optometrist determines that the patient requires a bilateral visual field examination, the optometrist has the option of either performing it at the initial consultation, and billing an additional item 10940, or performing it at a later date, and billing an item 10940 (but not an item 10918) on that day.

Where a patient returns for the visual field examination at a subsequent consultation, the optometrist can bill either a visual field item (10940 or 10941) or a subsequent consultation item (10918), but not both.

Note that the use of item 10940 or 10941 does not preclude the provision of other services at the same consultation. For example, an optometrist who measured a patient's intraocular pressure at a subsequent consultation, in addition to assessing their visual fields, could bill an item 10940 and they could also bill a non-Medicare private fee for the pressure measurement. **Maximum of two examinations in any 12-month period**

Medicare will pay benefits for two visual field examination items in any 12-month period. If a third visual field examination is required within this period, items 10940 and 10941 may not be used. In this case, it would be appropriate to use item 10918 (subsequent consultation) for the consultation at which the third visual field examination was performed. Alternatively the optometrist can choose to charge a private (non-Medicare rebateable) fee for the third visual field service. Note that both visual field items (10940 and 10941) count towards the two-item limit, so that if a patient receives an item 10940 and an item 10941 within 12 months, they are then ineligible for either item until 12 months after the first visual field examination.

Perimetry performed by an ophthalmologist in the same period does not affect the limit for optometric claims.

Note: Optometrists may bill privately for perimetry on top of a private consultation fee if the performance of perimetry is not covered by the schedule.

Referrals

When a visual field examination is performed and the patient is subsequently referred to another practitioner, a copy of the visual field results should be sent to that practitioner to discourage repetition of perimetry unless clinically necessary.

Copies of relevant visual field results should also be provided on request when a patient consults another practitioner without referral, for example, when a patient has moved to another area.

Referrals to another optometrist

If an optometrist determines that a patient requires a visual field examination, but is unable to provide the service themselves, they should refer the patient to another practitioner who can provide the examination.

An optometrist receiving a referral from another optometrist for the purpose of providing a visual field examination can bill an item 10940 or 10941.

If an optometrist receives a referral from another optometrist for the purpose of providing assessment and management and this incorporates a visual field examination, then a 10905 and a 10940/10941 can be billed, assuming the requirements and descriptors for both items are met by the optometrist receiving the referral.

An optometrist receiving a referral from a (non-optometrist) health practitioner for the purpose of providing a visual field examination in relation to suspected pathology of the visual pathways or brain can bill a visual field examination item (10940 or 10941), and an appropriate initial consultation item (10900, 10907, 10914), depending on whether or not a significant consultation service has also been provided.

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 twelve month period.

(See para O6 of explanatory notes to this Category)

Criteria for using item 10942

The patient has low vision

The patient must have a best corrected distance visual acuity of 6/15 or worse or best corrected near acuity of N12 or worse in the better eye, or a horizontal (binocular) visual field restricted to less than 120 degrees within 10 degrees above and below the horizontal midline, or some combination of these. Note that while the visual field criterion is the same as that for a private drivers' licence, the visual acuity criterion is slightly higher (6/15 vs. 6/12²).

These findings should generally be permanent, for example, this item is not intended for patients who are likely to undergo cataract surgery in the near future who may temporarily meet the criteria for having low vision.

Testing of residual vision to provide optimum visual performance

A benefit is payable under item 10942 where one or more of the measurements 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.

- spectacle correction
- determination of contrast sensitivity (for example, Pelli Robson test, Melbourne Edge Test)
- determination of glare sensitivity (for example, glare Halometer)
- prescription of magnification aids.

The results should be clearly noted on the patient record.

Not being a service associated with a service to which item 10916 or 10921 to 10930 applies

Item 10942 is an add-on item allowing an additional fee to be charged when an optometrist carries out an assessment of a patient with low vision to cover additional examination procedures in low vision patients.

The item can be billed in association with any of items 10905 to 10915 or item 10918.

Item 10942 may not be billed in association with:

- Item 10916 (short initial consultation)
- Items 10921–10930 (contact lens items).

The patient (or Medicare) should be billed for the appropriate attendance item (10905–10915 or 10918), and item 10942. Their account should show both item numbers and the fees for each.

Payable twice in a twelve month period

Item 10942 can only be used twice in a 12-month period.

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 three to fourteen

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 twelve month period

(See para O6 of explanatory notes to this Category)

Criteria for using item 10943

To confirm diagnosis of, or establish a treatment regime for, a significant binocular or accommodative dysfunction

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 from three to 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.

The patient must have a significant binocular or accommodative dysfunction. This would generally be interpreted as a dysfunction that is symptomatic and/or requires treatment.

Note: If additional testing is performed and it is found that the patient does not have any significant binocular or accommodative dysfunction, the add-on item may not be billed.

Additional testing

Additional testing is performed, including one or more of the procedures listed in the item descriptor. These procedures are assessment of any or all of:

- accommodation
- ocular motility
- vergences
- fusional reserves
- cycloplegic refraction.

These procedures must be additional to the testing routinely performed by the optometrist. If an optometrist performs the listed procedure(s) routinely on all child patients, then item 10943 should not be claimed as the testing is not 'additional'. Results of the additional procedures, and a diagnosis or treatment regime, must be noted on the patient record.

In a patient aged from three to 14 years

A patient is eligible for this item only between their third birthday and the day before their 15th birthday.

If older or younger patients are examined (children aged from birth to two years or older than 15 years), you may bill only the relevant consultation items, not this add-on item.

Not to be used for the assessment of learning difficulties or learning disabilities

The item is intended to cover the assessment of vision problems, not learning problems.

Not being a service associated with a service to which item 10916 or 10921-30 applies

The item is an add-on item, similar to item 10942 (low vision assessment) and will normally be billed in addition to an initial or subsequent consultation item. Item 10943 may be claimed on the same day as either a comprehensive consultation or a subsequent consultation, but only where the additional assessment has been carried out on an eligible child. Item 10943 is not intended to be claimed with a brief initial consultation, or with any of the contact lens items.

Payable once only in a 12-month period

Item 10943 can only be claimed once in any 12-month period.

10944: Removal of Embedded Corneal Foreign Body

Complete removal of an embedded corneal foreign body – 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. Where the embedded foreign body has not been completely removed, benefits are only payable under item 10916.

Appropriate use of item

Item 10944 may only be billed when:

- The complete removal of the foreign body and removal of the rust rings from the cornea is undertaken. If not completely removed, then item 10916 may instead be the appropriate item to be billed.
- The foreign body is located either at the intraepithelial or sub-epithelial corneal layer
- It has not previously been billed by the same practitioner on the same day.

Restrictions on Item 10944:

- Medicare items 10905, 10907, 10910-10916 or 10918 cannot be billed in conjunction with item 10944.
- As a general reminder, Medicare rebates are not applicable to services arranged by an employer or where a workers compensation insurance claim is to be lodged.
- If the consultation involved a comprehensive re-assessment and takes more than 15 minutes, another item (e.g. 10910/10911/10913) may apply more appropriately.

Required equipment

The removal of the embedded corneal foreign body should be performed with:

- Hypodermic needle or foreign body gauge
- Slit Lamp biomicroscope with magnification or loupe

Record keeping

Practitioners are advised to document:

- The nature of the embedded corneal foreign body
- Location and depth of the foreign body
- Method of removal
- Slit lamp or loupe magnification used.

Similarly, the optometrist should document the method of removal and magnification used in removal of the rust rings.

10945 to 10946: Telehealth Attendance at Consulting Rooms, Home Visits or Other Institutions

10945

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

Criteria for using item 10945

- Less than 15 minutes in duration.
- If the consultation is divided and the component parts total 15 minutes or more, then item 10946 applies.

10946

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

Criteria for using item 10946

- At least 15 minutes in duration
- If the consultation takes less than 15 minutes, item 10946 may not be billed and 10945 is the appropriate item to bill. The time may or may not be continuous.

Items 10945 & 10946 Notes:

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

- a Medicare eligible specialist service is claimed;
- the service is rendered in Australia; and
- this is necessary for the provision of the specialist service.

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

- Benefits 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 – unless a smartphone is being used to conduct the consultation using a videoconferencing application.
- An MBS rebate will not apply for these items if the ophthalmologist is unable to establish both a video and audio link with the patient.
- There is no restriction on how many telehealth consultations an optometrist can bill in a period of time.
- 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

- Optometrists must keep contemporaneous clinical records of the consultation including documenting the following:
 - That the service was performed via video conference
 - The date, time and 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

- Patients are only eligible for two or more telehealth video consultations on the same day where the subsequent telehealth consultations are not a continuation of the initial or earlier video consultations. If a patient attends for a telehealth consultation at 10am for a glaucoma review and then at 3pm for a red eye, and both clinical presentations require ophthalmological consultation via telehealth, practitioners are advised to provide the times of each consultation on the patient's account or bulk billing voucher to avoid unnecessary rejection of Medicare claims.

82001-82003 Multidisciplinary Case Conferences

82001

Attendance by an eligible allied health practitioner, as a member of a multidisciplinary case conference team, to participate in a community case conference if the conference lasts for at least 15 minutes, but for less than 20 minutes (other than a service associated with a service to which another item in this Group applies)

82002

Attendance by an eligible allied health practitioner, as a member of a multidisciplinary case conference team, to participate in a community case conference if the conference lasts for at least 20 minutes, but for less than 40 minutes (other than a service associated with a service to which another item in this Group applies)

82003

Attendance by an eligible allied health practitioner, as a member of a multidisciplinary case conference team, to participate in a community case conference if the conference lasts for at least 40 minutes (other than a service associated with a service to which another item in this Group applies)

Criteria for using item 82001-3

The new items apply to non-admitted patients under the care of an eligible allied health practitioner for early diagnosis and treatment for children under 13 years diagnosed with, or suspected of having, a pervasive developmental disorder (including autism) or an eligible disability, under the care of a specialist, consultant physician or GP.

The patient must be aged under 13 years

The patient must have, or be suspected of having, a pervasive developmental disorder (including autism) or an eligible disability.

The optometrist must be invited to attend a case conference by the patient's treating medical practitioner (see below for more details), and the patient must agree to the allied health practitioner participating in the case conference. There is no requirement that the patient have a pre-existing relationship with the optometrist.

The case conference must be organised by the medical practitioner and involve at least two other persons providing different kinds of care to the patient. The patient and family members or carers can attend the case conference, but will not count towards the minimum of two other care providers. The optometrist can be counted as one of these other two persons and must be invited to attend by the organising medical practitioner.

In some instances, two optometrists may participate in the same case conference (and therefore claim the Medicare items), but only if both provide different aspects of care to the patient that cannot be provided by one practitioner alone.

For patients diagnosed with, or suspected of having, a **pervasive developmental disorder** (including autism), the optometrist must be invited to the case conference by the patient's treating **psychiatrist or paediatrician** for the disorder.

For patients diagnosed with, or suspected of having, an **eligible disability** (see below), the optometrist must be invited to the case conference by the patient's treating **specialist, consultant physician, or GP** for the disability.

Eligible disability means any of the following:

- 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;
- hearing impairment that results in:
 - a hearing loss of 40 decibels or greater in the better ear, across 4 frequencies; or
 - permanent conductive hearing loss and auditory neuropathy;
- deafblindness;
- cerebral palsy;
- Down syndrome;
- Fragile X syndrome;
- Prader-Willi syndrome;
- Williams syndrome;
- Angelman syndrome;
- Kabuki syndrome;
- Smith-Magenis syndrome;
- CHARGE syndrome;
- Cri du Chat syndrome;

- Cornelia de Lange syndrome;
- microcephaly, if a child has:
 - a head circumference less than the third percentile for age and sex; and
 - a functional level at or below 2 standard deviations below the mean for age on a standard development test or an IQ score of less than 70 on a standardised test of intelligence;
- Rett's disorder.

Service Duration

15-20 minutes in duration (item 81001)

20-40 minutes in duration (item 81002)

Over 40 minutes in duration (item 81003)

The full item descriptors can be found on the MBS Online website at www.mbsonline.gov.au

Record Keeping

Allied health practitioners claiming one of the MBS items must record the day, start and end times, the names of all participants and all matters discussed in the patient's medical record.

Mode of communication

- The new case conferencing items can be accessed in-person, via videoconference or telephone, using the same item number. There is no requirement that all participants use the same communication method.

Frequency / Number of Services

There are no frequency restrictions for case conferencing items for patients with or suspected of autism, a pervasive developmental disorder or an eligible disability.

Items 82001-3 Notes:

The new items are intended to increase uptake of multidisciplinary case conferences, improve care coordination and support the outcomes that matter most to patients and their families.

An optometrist who is registered with the Optometry Board of Australia (i.e. registered with AHPRA) and has a Medicare provider number is an "eligible allied health practitioner" for the purpose of these item numbers.

Besides optometrists, other eligible health practitioners for these item numbers are: Aboriginal and Torres Strait Islander health practitioners; Aboriginal health workers; audiologists; mental health nurses; mental health workers; occupational therapists; orthoptists; physiotherapists; psychologists; or speech pathologists. Other providers can continue to participate in case conferences, however they will not be able to access the new items.



82030, 82035 Diagnosis & Treatment of PDD or Eligible Disability

82030

Audiology, optometry, orthoptic or physiotherapy health service provided to a child, aged under 13 years, by an eligible audiologist, optometrist, orthoptist or physiotherapist where:

- the child is referred by an eligible practitioner for the purpose of assisting the practitioner with their **diagnosis** of the child;

or

- the child is referred by an eligible practitioner for the purpose of contributing to the child's pervasive developmental disorder (PDD) or disability treatment plan, developed by the practitioner; and
- for a child with PDD, the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; or for a child with disability, the eligible practitioner is a specialist, consultant physician or general practitioner; and
- the audiologist, optometrist, orthoptist or physiotherapist attending the child is registered with the Department of Human Services as meeting the credentialing requirements for provision of these services; and
- the child is not an admitted patient of a hospital; and
- the service is provided to the child individually and in person; and
- the service lasts at least **50 minutes** in duration.

82035

Audiology, optometry, orthoptic or physiotherapy health service provided to a child, aged under 15 years, for **treatment** of a pervasive developmental disorder (PDD) or eligible disability by an eligible audiologist, optometrist, orthoptist or physiotherapist where:

- the child has been diagnosed with PDD or eligible disability; and
- the child has received a PDD or disability treatment plan (while aged under 13 years) as prepared by an eligible practitioner; and
- the child has been referred by an eligible practitioner for the provision of services that are consistent with the PDD or disability treatment plan; and
- for a child with PDD, the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; or for a child with disability, the eligible practitioner is a specialist, consultant physician or general practitioner; and
- the audiologist, optometrist, orthoptist or physiotherapist attending the child is registered with the Department of Human Services as meeting the credentialing requirements for provision of these services; and
- the child is not an admitted patient of a hospital; and
- the service is provided to the child individually and in person; and
- the service lasts at least **30 minutes** in duration.

Criteria for using item 82030, 82035

Items 82030 and 82035 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.

Item 82030 Notes

The assessment/diagnosis item (82030) can be accessed when:



- a child with autism/PDD is aged under 13 years and referred by an eligible consultant psychiatrist or paediatrician; or
- a child with an eligible disability is aged under 13 years and referred by a specialist, consultant physician or GP.

Item 82035 Notes

The treatment items (82035) can be accessed when:

- 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.
- 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.

Co-Billing with Other Optometry Item Numbers

Generally, items 82030 and 82035 cannot be co-billed with other optometrist item numbers. To co-claim 82030 or 82035 with other optometry item numbers (for example 10910) on the same day, the services would have to be separate discreet services, meaning certain requirements would need to be met.

For example, an optometrist conducts comprehensive examination on a patient (10910) and, at a later time on the same day, the optometrist subsequently performs a different test or tests on the same patient to assist with a diagnosis of a pervasive developmental disorder (82030). In this circumstance it would be appropriate for the optometrist to claim item 10910 and item 82030 on the same day. However, if as part of a single attendance to conduct a comprehensive examination (10910) the results of the same test are also used to assist with a diagnosis of a pervasive developmental disorder (82030), it would not be appropriate to claim both items. This principle would apply to items 82030 and 82035 similarly.

For further clarity, an extract from Associated Note 10.1 on the multiple attendance rules for optometrists, is provided below:

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.

Eligible disability means any of the following:

- 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;
- hearing impairment that results in:
 - a hearing loss of 40 decibels or greater in the better ear, across 4 frequencies; or
 - permanent conductive hearing loss and auditory neuropathy;
- deafblindness;
- cerebral palsy;
- Down syndrome;
- Fragile X syndrome;
- Prader-Willi syndrome;
- Williams syndrome;
- Angelman syndrome;
- Kabuki syndrome;
- Smith-Magenis syndrome;
- CHARGE syndrome;
- Cri du Chat syndrome;
- Cornelia de Lange syndrome;
- microcephaly, if a child has:
 - a head circumference less than the third percentile for age and sex; and
 - a functional level at or below 2 standard deviations below the mean for age on a standard development test or an IQ score of less than 70 on a standardised test of intelligence;
- Rett's disorder.

Service Duration

The service must last at least 50 minutes in duration (for 82030), or at least 30 minutes in duration (for 82035).

Record Keeping

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.

Frequency / Number of Services

For assessment services (item 82030), 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. 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.

For treatment services (item 82035), Medicare rebates are available for up to twenty services in total per eligible child. 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.



Referral - Eligible Referring Practitioner

These services will not attract a Medicare rebate unless a referral has been made by a consultant psychiatrist or paediatrician for a child with autism/PDD, or by a specialist or consultant physician or GP for a child with a disability.

Eligible Optometrists

An optometrist who is registered with the Optometry Board of Australia (i.e. registered with AHPRA) and has a Medicare provider number is an "eligible allied health practitioner" for the purpose of these item numbers.

In addition, it is expected that eligible providers will "self-select" for the autism/PDD and disability items – that is, optometrists using these items should possess the skills and experience appropriate for provision of these services and be oriented to work with children with autism/PDD or disability.

Reporting Requirements

A written report must be provided to the referring medical practitioner by the optometrist 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 optometrist must provide a written report to the referring medical practitioner which includes information on:

- treatment provided;
- recommendations on future management of the child's disorder; and
- 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.

Billing Outside Medicare

The Government has advised that certain procedures are not eligible for Medicare rebates and as a consequence a private fee may be charged for these procedures. The fee charged for a non-Medicare service is a matter for the optometrist and the patient and is not subject to Medicare limits.

Patients should be informed that Medicare benefits are not payable in respect of private charges. Private charges should be shown separately on accounts issued by optometrists and not included in Medicare-billed service fees.

Among the services provided by optometrists for which Medicare rebates are not payable are:

- contact lens prescription & fitting examinations that do not meet schedule criteria
- consultations related to refractive surgery
- digital imaging
- testing and treatment for learning difficulties
- cataract surgery after-care examinations
- vision screenings and workplace assessments/visits
- examinations not conducted primarily by the optometrist
- where item numbers exist in the medical MBS, but not in the optometric MBS
- testing for commercial driving, boating or pilot licenses

Digital Imaging

For the purposes of the Medicare Benefits Schedule (MBS), digital imaging, including optical coherence tomography (OCT) and retinal photography, is not regarded as clinically relevant. Optometrists should not bill under the Medicare arrangements for digital imaging. In these cases a

private fee may be charged. Where no Medicare rebate is payable for a service, the patient should be advised that Medicare will not pay benefits so they can make an informed choice in deciding whether to receive the service.

A practitioner may charge a patient a private fee for digital imaging regardless of whether a consultation item is bulk-billed.

To ensure appropriate Medicare billing of the consultation item, the following points should be kept in mind:

- Retinal and optic nerve head imaging services should not be used as a prerequisite or 'gateway' to an MBS service, that is, a practitioner may not have a patient return for digital imaging and charge an attendance item at that visit purely to discuss results
- Time taken to perform a non-MBS service cannot count towards the length of an MBS consultation
- If Medicare is bulk-billed for a consultation at the same time as billing for digital imagery, no additional private fee may be charged in respect of the bulk-billed consultation service itself
- Accounts should be presented to show a clear separation between MBS and retinal and optic nerve head imaging services. Care should be taken that accounts for privately billed services should not be itemised as attracting Medicare benefits.

Pachymetry

Pachymetry is not listed as an eligible service in the [Health Insurance \(General Medical Services Table\) Regulation 2014](#) and so Medicare benefits are not payable for pachymetry. Pachymetry would not constitute a professional attendance (because it is a measurement only) and would not meet the requirements for an attendance item.

Payment for a service that is not eligible for benefits under Medicare is a private matter between the practitioner and the patient. Optometrists may charge a private fee for a pachymetry service without breaching the Common Form of Undertaking for Optometrists.

Refractive surgery

Irrespective of whether services are provided by an optometrist or an ophthalmologist, Medicare benefits are not claimable for:

- refractive surgery
- consultations in preparation for refractive surgery
- consultations in the aftercare period.

Optometric involvement can range from planned participation with ophthalmology in the delivery of an agreed treatment protocol, to the care of a new patient who has recently undergone refractive surgery. All visits associated with monitoring the recovery of the eye from refractive surgery are considered part of the surgery.

Optometrists may bill the patient directly for services they provide in connection with refractive surgery or bill the surgeon on behalf of the patient, depending on the arrangements made in advance with the surgeon and the patient. The fees may be paid by the patient to either or both practitioners as either a bulk-fee or a fee-for-service. Accounts and receipts issued to the patient should clearly indicate the fee is non-rebateable.

Patient-initiated attendances and services provided at any attendances that are not part of the normal after-care arrangements attract a Medicare rebate. For example, care provided to a patient for the treatment of an adverse eye reaction is not part of normal after-care, and the services involved attract Medicare benefits. When submitting a Medicare claim for such a consultation, the claim should be annotated with 'Not normal aftercare' to assist Medicare staff in processing the claim correctly.

Following the post-operative aftercare period, patients may develop visual or ocular symptoms that require optometric treatment. These visits are rebateable under Medicare.

Cataract surgery

Medicare schedule items that apply to surgery include all professional attendances necessary for the post-operative treatment of the patient. The after-care period includes all post-operative treatment, whether it is provided by a medical practitioner or an optometrist. The amount and duration of the after-care may vary but includes all attendances until recovery from the operation. Attendances provided by an optometrist in the after-care period do not attract a Medicare benefit.

Surgeons may recommend that a series of post-operative examinations be provided by the optometrist. Optometrists are advised to consider that the after-care period following cataract surgery is not defined in terms of days or weeks, but continues until the point where the eye is sufficiently stable to allow a post-operative spectacle prescription to be issued. Benefit is payable for the consultation at which the prescription is written.

The following guidelines may assist practitioners in billing correctly when they and an ophthalmologist share the care of a patient who receives cataract surgery.

Pre-operative consultations:

Optometric consultations resulting in referral to an ophthalmologist are Medicare rebateable. An ophthalmologist may bill Medicare for their resulting consultation and for any associated A-scan.

Surgery and after-care

The surgeon may make arrangements for some of the after-care to be provided by an optometrist, and in such cases the ophthalmologist and optometrist may share the fee paid by the patient and the Medicare rebate. The optometrist may not charge Medicare rebateable fees for performing this function.

Patient-initiated attendances and services provided at any attendances that are not part of the normal after-care arrangements attract a Medicare rebate. For example, care provided to a patient for the treatment of an adverse eye reaction is not part of normal after-care, and the services involved attract Medicare benefits. When submitting a Medicare claim for such a consultation, the claim should be annotated with 'Not normal aftercare' to assist Medicare staff in processing the claim correctly.

Post-operative visual assessment

When rehabilitation is complete, a complete post-operative reassessment at which a spectacle correction is prescribed attracts a Medicare benefit. Depending on the type of surgery used and the speed of the patient's recovery, such a consultation might typically occur around four weeks after the surgery. It is also likely that with no signs or symptoms of post-surgical complications, all of the required assessments could be done in fewer than 15 minutes, and an item 10916 could be billed.

Item 10913 may be billed when a patient presents with symptoms or signs indicative of a post-surgical retinal complication, provided that the optometrist carries out a comprehensive examination. If an unexpected two-line or more reduction in vision is found, then item 10912 may be used.

Task delegation and staff supervision

During a patient's consultation, certain eye examination procedures can be delegated to a suitably trained assistant in the practice. These procedures can include:

- initial measurement of vision
- intraocular pressure measurement
- retinal photography
- corneal mapping
- certain aspects of computerised perimetry (see items 10940/10941).

These tests should be performed under the supervision of the optometrist.

Benefits are payable for attendances only in a face-to-face consultation with a patient. While some tests may be supervised and some measurements made by assistants, the service must be primarily provided by the optometrist.

For the patient's attendance to be eligible for a Medicare rebate, the procedure must involve the personal attendance of the optometrist. If the Medicare item to be claimed is a time-based attendance (for example, item 10910: 'professional attendance of more than 15 minutes in duration'), the time attended by the assistant is not counted towards the duration of the professional attendance.

Student supervision

Section 3.1 (c) of the CFU states that the undertaking relates to any clinically relevant service ordinarily rendered by an optometrist in relation to consultation on ocular or vision problems, but does not include 'an attendance on behalf of teaching institutions on patients of supervised students of optometry'.

Medicare benefits are paid only for consultations rendered by a participating optometrist. Where students are observing and participating in a consultation under the direct supervision of an optometrist, from the perspective of Medicare the presence of the student is incidental. The primary purpose of the consultation is for the optometrist to deliver a health-care service to the patient, and that is the service for which Medicare benefits are payable.

For a Medicare benefit to be payable, the service must be performed personally by an optometrist participating in the undertaking. This precludes claims being made under Medicare where any part of the service claimed is provided solely by a student. Participating optometrists may choose to involve a student in the delivery of a service, but the service itself must be performed personally by the participating optometrist who must meet all the requirements described in the MBS items, irrespective of the assistance provided by the student.

Occupational assessments, vision screenings and Medicare

Under current Medicare arrangements, vision screening services do not attract Medicare benefits. Optometrists may charge private fees for vision screenings.

Screenings for sports persons, employees, students, VDU operators, applicants for commercial driving licences, or applicants for placement in aged persons' accommodation are examples of services not covered by Medicare. Fees for vision screening can be charged directly to the individual, the school, an organisation or an employer. Fees charged are a matter between the optometrist and the patient.

The [Health Insurance Act](#) states that:

'Unless the Minister otherwise directs, a Medicare benefit is not payable in respect of a professional service rendered to a person if

(b) the person to whom that professional service was rendered was employed in an industrial undertaking and that professional service was rendered to him or her for purposes connected with the operation of that undertaking.'

The wording of the legislation is confusing but is interpreted to mean that Medicare benefits are not payable when an examination is carried out for the purpose of assessing whether a person has vision of sufficient standard to perform their work or for correcting their vision so that they can carry out their work. In these circumstances the responsibility for the cost of the consultation is seen to lie with the employer or the person concerned.

The results of vision screenings may reveal the need for a follow-up consultation. Only when an individual makes an independent decision to seek a follow-up consultation from an optometrist of his or her choice, and is responsible for the payment of the fee, is the service covered by Medicare. When follow-up consultations are provided at the workplace (or in a mobile consulting room) no Medicare benefit is payable.

Scenario 1.

A company provides safety spectacles to its employees, usually under a contract agreement with an optometrist or optical dispenser, as part of its workplace health and safety arrangements.

If an employee requires prescription safety lenses and undergoes an optometric consultation to determine the prescription required, the consultation is considered to be part of the industrial undertaking and no Medicare benefit is payable.

The cost of the consultation is the employer's responsibility.

If it is the employee's responsibility to provide a prescription for his or her safety spectacles and a service is performed, like all services for which Medicare benefit is paid, it must be 'clinically relevant', that is, generally accepted in the profession as being necessary for the appropriate treatment of the patient. The employee must bear the cost and in these circumstances benefit is payable.

Scenario 2.

Consultations offered at the workplace, where an optometrist temporarily conducts their practice in an office or boardroom for the convenience of clients, are considered 'workplace visits'.

Regardless of whether the company makes any charge on the optometrist for the use of the room, and regardless of whether there is any compulsion to attend, these consultations are considered to be part of an industrial undertaking and do not attract a Medicare rebate.

Overall, where the employer is involved at any stage in the provision of an optometric consultation, no benefit is payable.

This is regardless of whether the employer's involvement includes arranging a vision screening, follow-up consultation, or provision/subsidy of spectacles.

Driving licences

Medicare benefits may be paid for examinations necessary to obtain or renew a licence to drive a private motor vehicle; however Medicare benefits are not payable for compulsory examinations to obtain commercial licences, such as flying or driving.

For private licences, your patients may be asked by their local roads and traffic authority to have a vision test and may request a report from you with details of the examination to determine if their vision is fit for driving.

Children's consultations

Medicare does not pay benefits for services that optometrists sometimes provide to children. Services provided to children that do not attract Medicare benefits include:

- testing and training of cognitive ability
- testing and training of learning ability
- psychological testing

Optometrists may charge for these tests and associated training and treatments in addition to any appropriate Medicare billing. There are no restrictions on the fee that may be charged for these additional services.

Other items not listed in the Optometric MBS

Optometrists can bill privately for 12 eye-related procedures listed on the Medicare Medical Benefits Schedule for use by medical practitioners but not by optometrists.

The department has confirmed that optometrists may charge privately for:

- lacrimal lavage (unilateral)
- lacrimal lavage (bilateral)
- punctal occlusion
- electroretinography
- pattern electroretinography
- corneal epithelial debridement
- dark adaptometry
- electro-oculography
- central nervous system evoked potentials



The patient must be informed that no MBS rebate is available for these services so the patient is able to make an informed financial decision on whether to have the services provided.

Accounts should clearly distinguish charges made for MBS and non-MBS services, and a statement saying that Medicare fees are not payable for the service should accompany any private fee.

The fees charged for non-MBS services are a matter between the optometrist and the patient.

Optometrists may charge a patient a private fee in addition to a Medicare consultation fee where a patient is billed for an MBS item, even when the two services occur during the same visit or on the same day.

A separate non-MBS service may not be used as a prerequisite for the MBS service, neither can the time taken to perform the non-MBS service count towards the length of the MBS consultation.

A practitioner may charge a patient privately for the separate non-MBS service, regardless of whether the MBS item is bulk-billed, as the restrictions in relation to private charging at the same time as bulk-billing relate to the bulk-billed service, that is, no additional private fee may be charged in respect of the bulk-billed service itself.

Members should note that if a Medicare attendance item is charged at the same visit as a non-Medicare service, clinically relevant services in relation to the Medicare attendance item must also be provided at that visit. For example, if a patient is recalled solely for lacrimal lavage, an item 10918 cannot also be billed.



ADDITIONAL INFORMATION AND ENQUIRIES

Medicare Australia

Mail Medicare, GPO Box 9822, in your capital city

Email medicare.prov@servicesaustralia.gov.au

Contacts <https://www.servicesaustralia.gov.au/contact-medicare?context=26266>

Online Services <https://www.servicesaustralia.gov.au/medicare-information-for-health-professionals>

- view dedicated health professional section
- make enquiries online
- instantly obtain Medicare eligibility information (date of service check)
- access information about PBS (also see <https://www.pbs.gov.au>)
- access Medicare's online eLearning for health professionals:
<https://www.servicesaustralia.gov.au/health-professional-education-resources>

Medicare Provider Enquiry Line

132 150 (local call rate applies)

Optometrist Interactive Voice Response (IVR) hotline

1300 652 752 (call charges apply)

9:00 am–9:00 pm Monday to Friday

9:00 am–6:30 pm Saturday AEST (except public holidays)

To enable patient 10910/10911 eligibility checks. This aids correct practitioner billing and reduces resubmitted claims to Medicare Australia. A provider number will be required.

To help protect the privacy of optometrists and patients, practitioners must:

- notify the patient of the need to confirm their eligibility
- obtain patient consent to call the Optometrist IVR
- record the consent on the patient's file.

Pharmaceutical Benefits Scheme

Telephone 1800 020 613

Mail Pharmaceutical Benefits Scheme, GPO Box 9826, in your capital city

Email Department of Health: pbs@health.gov.au

Online www.pbs.gov.au

PBS Authority Approvals

Telephone Authority prescription approvals, 1800 888 333 (free call: 24 hours, 7 days)

Mail Pharmaceutical Benefits Scheme, GPO Box 9857, in your capital city

Optometry Australia

National Office

Mail PO Box 1037, South Melbourne, VIC 3205

Telephone (03) 9668 8500

Facsimile (03) 9682 0928

Email national@optometry.org.au



State Offices

Online <http://www.optometry.org.au>

Follow links to state and territory websites and contacts

Optometry Australia material:

Practice Notes on [Electronic Medicare Billing, Setting consultation fees, and Private Billing](#)

[Optometry Australia 2022 Schedule of recommended consultation fees](#) (follow link on page)

Optometry Australia information on [understanding the rules of Medicare, Private billing and Health funds](#)

Medicare Provider Percentile charts

Provider percentile charts are no longer provided by the Department of Health, but raw data can still be viewed at http://medicarestatistics.humanservices.gov.au/statistics/mbs_item.jsp. To compare your item usage with your peers simply extract the data from your practice management software.