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Introduction

This is the eleventh edition of Medicare Australia’s flagship publication for doctors and practice staff, Mediguide.

Mediguide will give you a quick and easy guide to the Medicare claiming system and other health programs administered by Medicare Australia. It can also be used as a source of information in conjunction with the Medicare Benefits Schedule Book and Medicare Australia newsletters, Forum and Bulletin Board.

There are a number of initiatives currently under consideration that highlight the changing environment in which Medicare Australia is operating. These initiatives will change the way doctors and patients interact with Medicare Australia in the future.

They include a range of online options in relation to Medicare and the Pharmaceutical Benefits Scheme. In the second half of 2007, Medicare Australia will introduce Medicare Easyclaim. Medicare Easyclaim is a new electronic Medicare claiming channel that allows medical practitioners and patients to lodge Medicare claims using the existing EFTPOS network. Bulk bill claims lodged using Medicare Easyclaim will be entirely paperless and your rebate will be paid into the practice’s nominated bank account, usually on the next working day. For more information about Medicare Easyclaim visit the Medicare Australia web site.

Another initiative attracting attention is the proposed implementation of the Australian Government’s health and social services Access card which will be introduced in 2008. By 2010, subject to the passage of legislation through parliament, the card will be required by everyone who needs to access health or social services benefits. Details about the Access card are available from www.humanservices.gov.au and updates will also be provided in Medicare Australia publications.

As these initiatives are implemented, information will be included in Mediguide online, which is now available at www.medicareaustralia.gov.au

In the meantime Mediguide will answer most of your questions to help you with your business. Medicare Australia welcomes your feedback and suggestions via email to editor.mediguide@medicareaustralia.gov.au
Section 1
Medicare—the basics

Background
Administration
Schedules
Fees
Benefits for non-hospital services
Safety Net
Benefits for private in-hospital services
Benefits for Medicare public hospital patients
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Online claiming
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Confidentiality
Medicare—the basics

Background
Medicare was introduced in 1984 to provide eligible Australian residents with affordable, accessible and high-quality health care.

Medicare is based on the understanding that all Australians should contribute to the cost of health care according to their ability to pay. It is financed through progressive income tax and an income-related Medicare levy.

Health care is funded by the Australian Government through:

- grants to state governments towards the operation of public hospitals
- Medicare benefits to patients on fees paid to private practitioners
- grants to government and non-government providers for a range of health research and promotion
- health support services (for example, the National Public Health Program).

Administration
Medicare Australia is responsible for administering government health programs including:

- Medicare
- Pharmaceutical Benefits Scheme (PBS)
- Australian Childhood Immunisation Register (ACIR)
- General Practice Immunisation Incentives Scheme (GPII)
- Practice Incentives Program (PIP)
- 30% Private Health Insurance Rebate
- Hearing Services
- Compensation Recovery Program
- Australian Organ Donor Register
- Special Assistance Scheme—special health care benefits for Balimed, Tsunami, London Bombing Assist and Bali 2005
- Rural Retention Program
- General Practice Registrars’ Rural Incentive Payments Scheme
- Family Assistance Office in partnership with Centrelink, the Australian Taxation Office (ATO) and the Department of Families, Community Services and Indigenous Affairs (FaCSIA)
- claims processing and payments for the Department of Veterans’ Affairs (DVA) treatment accounts.

Medicare Australia’s functions include payment of benefits in accordance with statutory requirements and auditing claims and services to protect against any abuse of the programs it administers.

The Department of Health and Ageing (DoHA) is responsible for health portfolio policy. DoHA assists the government with portfolio legislation, setting benefits payable for government programs, determining Medicare hospital arrangements and negotiating with professional
associations, colleges and related/relevant groups. DoHA also assists Medicare Australia with interpretation of the Medicare Benefits Schedule (MBS).

DoHA produces the *Medicare Benefits Schedule Book* and the *Schedule of Pharmaceutical Benefits* for approved pharmacists and medical practitioners.

### Schedules

The professional services that attract Medicare benefits are listed in four schedules. These schedules are:

- Medicare benefits (includes oral and maxillofacial surgery)
- optometrical
- cleft lip and cleft palate
- allied health and dental services.

The oral and maxillofacial, and cleft lip and cleft palate items cover defined procedures in restricted schemes. The optometrical services relate to attendances and the fitting of contact lenses by optometrists.

### Fees

The schedule fees for items are uniform across Australia and are determined by the Department of Health and Ageing in consultation with professional bodies.

Medicare benefits are based on a percentage of the schedule fee for each service as listed in the Medical Benefits Schedule. Practitioners are able to charge fees they consider suitable for the services they provide.

Practitioners may elect to bill the patient or bulk bill Medicare (see Section 5, “Billing and claiming”).

Because of the undertaking optometrists make with the Minister for Health and Ageing, they cannot charge an additional fee above the schedule fee. Exceptions to this rule are detailed in the *Schedule of Medical Benefits for Consultations by Optometrists*.

### Benefits for non-hospital services

Medical services rendered to patients outside a hospital are payable at either 85 per cent of the schedule fee, or at the schedule fee for all fees up to $426.00 (indexed 1 November each year) less a maximum gap amount, whichever is greater. The gap amount paid by the patient is the difference between the 85 per cent benefit and the schedule fee for out of hospital services plus the difference between the schedule fee and the practitioner’s charge. The gap payable is limited to a maximum amount indexed annually. The 100 per cent rate of benefit is payable for non-referred attendances by a General Practitioner to non-admitted patients, and for services provided by a practice nurse on behalf of a General Practitioner.

### Safety Net

The Medicare Safety Net is designed to help protect individuals and families from high medical costs for out-of-hospital medical services. There are three Safety Net thresholds.
**Gap threshold**

The Gap threshold is a dollar amount ($358.90 in 2007) which is adjusted annually. It is reached by accumulating the difference between the schedule fee and the Medicare benefit for an individual or family’s claims.

When the Gap threshold is reached the individual or family may be entitled to higher Medicare benefits. If entitled, Medicare benefits will increase to 100 per cent of the schedule fee for any further out-of-hospital services in that calendar year.

**Concessional and Family Tax Benefit (Part A) threshold**

The Concessional and Family Tax Benefit (Part A) (FTB(A)) threshold is a dollar amount ($519.00 in 2007) which is adjusted annually. It is reached by accumulating out-of-pocket costs (difference between the Medicare benefit and what a doctor charges for each service).

To be eligible the individual or family must have an eligible concession card, or be a registered Safety Net family in receipt of an FTB(A) payment.

When the Concessional and FTB(A) threshold is reached the individual or family may be entitled to higher Medicare benefits. If entitled, Medicare will refund the Medicare benefit plus 80 per cent of the difference between the Medicare benefit and the doctor’s charge for any further out-of-hospital services in that calendar year.

**General threshold**

The General threshold is a dollar amount ($1039.00 in 2007) which is adjusted annually. It is reached by accumulating out-of-pocket costs (difference between the Medicare benefit and what a doctor charges for each service).

All individuals and registered Safety Net families enrolled in Medicare are eligible.

When the General threshold is reached the individual or family may be entitled to higher Medicare benefits. If entitled, Medicare will refund the Medicare benefit plus 80 per cent of the difference between the Medicare benefit and the doctor’s charge for any further out-of-hospital services in that calendar year.

It is important to remind families and couples to register for the Medicare Safety Net. They can do this:

- online—visit [www.medicareaustralia.gov.au](http://www.medicareaustralia.gov.au)
- in person—at your local Medicare office
- over the phone—phone 132 011*.

**Benefits for private in-hospital services**

Medicare pays 75 per cent of the schedule fee for medical services provided to private patients in public or private hospitals or approved day hospital facilities. The gap for in-hospital services may be covered by private health insurance. Any gap amounts paid by the patient for in-hospital services do not count towards the Medicare Safety Net.

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* Local call rates. Normal mobile and public phone charges apply.
Benefits for Medicare public hospital patients

Medicare patients are entitled to free treatment in a public hospital. Free treatment includes accommodation and medical treatment as an in-patient or outpatient (as well as accident and emergency services) provided by doctors allocated by the hospital. No medical or hospital accounts are raised.

Optometrical services

Medicare pays a benefit for eye examinations performed by participating optometrists. Contact lens fitting (when necessary) is also covered, but the cost of the contact lenses or glasses is not covered. Cover for the cost of glasses and contact lenses may be provided by private health insurance funds.

Online claiming

Online claiming brings many Medicare Australia services to medical practitioners and their staff through the Internet and may be integrated with their practice management system. Online claiming has evolved from Medicare Australia’s Medclaims product to take full advantage of the latest developments in Internet technology including:

- lodging Medicare patient (private) and bulk bill claims
- confirming a patient’s Medicare eligibility before deciding to bulk bill
- requesting the deletion of a transmitted patient claim from the Medicare Australia system
- lodging Department of Veterans’ Affairs medical claims and submitting Australian Childhood Immunisation Register information.

The online claiming application:

- builds a claim from information already stored in the practice management system
- transmits the patient claim data either by a real-time or store-and-forward method, or bulk bill claim data by store-and-forward method
- works over the Internet and uses Public Key Infrastructure for online encryption and security
- reduces reliance on paper forms.

Medicare Easyclaim

Medicare Easyclaim is a new claiming channel that will be available in the second half of 2007. It allows you and your patients to lodge Medicare claims using the existing EFTPOS terminals already in most practices. Medicare Easyclaim offers:

- paperless bulk bill claiming—no need to store, forward or batch any paperwork
- faster bulk bill rebates, which are paid directly into your practice’s nominated bank account, usually on the next working day
- instant confirmation of a patient’s concessional entitlement
- generation of a “pay document via claimant” cheque by swiping a patient’s Medicare card through the EFTPOS terminal to lodge their claim when they have taken a patient account
• almost instant Medicare rebates for paying patients, who can swipe their Medicare card and their bank debit card through the practice’s EFTPOS terminal to have their Medicare rebate paid into their bank account.

**Issuing Medicare cards**

Medicare cards are issued when an enrolment application is processed. Each card has a unique number (the Medicare number) which may cover an individual or a family. Up to five people may be listed on one card, and up to nine people under a single enrolment. A unique identifying number for each person (individual reference number) appears before each name on the card.

**Card issue number**

Medicare cards are periodically replaced due to a change in patient details or because the card is due to expire. When a new card is produced it is given a new issue number (the last digit in the Medicare number) and an expiry date. In certain situations Medicare benefits will be refused if an expired Medicare issue number is used.

It is important that patients have their Medicare card when:

• visiting a doctor
• claiming a cash benefit at a Medicare office
• making enquiries when claiming
• choosing to be treated as a public (Medicare) patient for treatment or admission to hospital
• having a prescription filled.

**Medicare card replacement**

Medicare cards have a life expectancy of up to seven years and all cards are given an expiry date. When Medicare Australia is confident the enrolment address is accurate, cards are automatically replaced. They are replaced both for security reasons and wear and tear. A letter is sent two months before the card is due to expire inviting the cardholder to renew the card.

Bulk bill statements identify cards that are due to expire within three months. Expired cards may create a problem for practices if they go unnoticed. If a card has expired, the first bulk bill claim lodged by a practitioner, and any further claims that are processed by Medicare Australia for that practitioner, will be paid for 75 days. After that time, bulk bill claims will be rejected until the patient provides their updated card to the practitioner.

Medicare Australia does not always have the correct address for bulk billed patients, so unless patients advise Medicare Australia of a change of address they may not receive their new card.

To get copies of change of address forms contact Medicare Australia’s stationery contractor Leigh-Mardon (see page 114) or visit Medicare Australia’s web site.

**Confidentiality**

Medicare Australia staff are bound by strict privacy and confidentiality requirements under Australian Government law and are prevented from disclosing information to a third party. For more information visit Medicare Australia’s web site.
Section 2
Patient eligibility

Background
Applicants for permanent residency
Translated information
Eligible overseas visitors
Medicare services overseas
Special Assistance Scheme
Patient eligibility

Background

Medicare benefits are payable to Australian citizens and permanent resident visa holders who reside in Australia. Foreign diplomats and their families are not covered unless they are from countries, which have a Reciprocal Health Care Agreement with Australia (excluding New Zealand diplomats). Australian residents must be enrolled in Medicare before benefits can be paid. Enrolment application forms are available at Medicare offices in all states and online from the Medicare Australia web site.

Applicants for permanent residency

If a person from overseas has been granted permanent residency in Australia and is residing in Australia, they are eligible for enrolment in the Medicare program and will be issued with a Medicare card.

If a person has lodged an application for Australian permanent residency, is residing in Australia and meets other criteria, they may be eligible for Medicare. This includes those applying for a parent Visa. Those applicants who are assessed as eligible will be issued with a blue interim Medicare card with the words “INTERIM CARD” in the top left corner. Their eligibility for Medicare benefits is not limited; however, their coverage is limited to a specified period of time. The date to which eligibility is valid is shown in the bottom right corner of the card.

Some visitors to Australia are entitled to Medicare benefits through a Reciprocal Health Care Agreement (RHCA). Citizens of an RHCA country who do not reside in that country are not eligible. Visitors to Australia who receive or require medical and/or hospital treatment can check their eligibility by calling the Medicare enquiry number 132 011*.

Translated information

The Medicare Australia Information Kit, which is especially useful for new arrivals to Australia, has information about our main health programs—Medicare, the Pharmaceutical Benefits Scheme (PBS), the Australian Childhood Immunisation Register, the Australian Organ Donor Register as well as the Family Assistance Office and the Charter of Care.

The kit also contains a translated organ donor registration form.

The kit is translated into 18 community languages and has useful information for everyone, even if they have lived in Australia for some time.

Kits can be printed from the Medicare Australia web site and given to your patients.

* Local call rates. Normal mobile and public phone charges apply.
Eligible overseas visitors

Eligible visitors applying for a Medicare card need to complete a Medicare enrolment application form and present it with their passport and another form of identification to a Medicare office. Proof of residency may be requested for Reciprocal Health Care Agreement (RHCA) visitors.

A Medicare card with the words “RECPROCAL HEALTH CARE” and a date at the lower right corner shows the person is entitled to Medicare benefits for any medical treatment needed while visiting Australia.

Reciprocal Health Care Agreements

RHCAs provide visitors to Australia with cover equivalent to the health cover an Australian resident receives when visiting the overseas country concerned. Length of treatment depends on the time period specified in the agreement. Currently, Australia has RHCAs with the following countries for the stated periods:

- United Kingdom—duration of visit
- Sweden—duration of visit
- Netherlands—duration of visit
- Finland—duration of visit
- Italy—six months from date of arrival
- Malta—six months from date of arrival
- Republic of Ireland—public hospital treatment and Pharmaceutical Benefits Scheme (PBS) medicines only, for length of stay
- New Zealand—public hospital treatment and PBS medicines only, for length of stay
- Norway—duration of visit.

Information sheets are available for visitors from these countries. They can be printed from the Medicare Australia web site and given to patients.

RHCA cover and restrictions

These arrangements cover any medical treatment required for any ill health or injury which may occur while in Australia (eligible diplomats are entitled to full Medicare benefits). RHCA cover does not include Medicare benefits for:

- treatment arranged before arrival in Australia or hospital treatment that is not medically necessary
- elective or plastic surgery treatment
- medical treatment (or accommodation charges) if admitted as a private patient in a public or private hospital
- dental work and chiropractic services—except referred patients being managed by their General Practitioner under an Enhanced Primary Care plan
- vaccinations for overseas travel
- medicines not subsidised under the PBS
- treatment that is not medically necessary.
Medicare benefits for services in Australia

With the exception of visitors from the Republic of Ireland and New Zealand, visitors from RHCA-covered countries are eligible for Medicare benefits for out-of-hospital medical treatment required for any ill health or injury during their visit.

Visitors from the Republic of Ireland and New Zealand

Visitors from the Republic of Ireland and New Zealand are entitled to free public hospital treatment when treated as public patients in Australia and to subsidised PBS medicines on production of their passport. These visitors are not eligible for Medicare benefits and will not be issued with a Medicare card.

Medicare enrolment for visitors

Visitors to Australia from countries with which Australia has an RHCA (other than those from the Republic of Ireland and New Zealand) who wish to claim Medicare benefits should enrol with Medicare. Eligible visitors who enrol with Medicare are issued with a RHCA Medicare card valid to the date marked on the card.

Medicare services overseas

Medicare benefits are not paid to Australian residents for services provided overseas. Australian residents are entitled to assistance with the cost of medical treatment in New Zealand, the United Kingdom, the Republic of Ireland, Sweden, the Netherlands, Finland, Italy, Malta and Norway. Australia's RHCAs with these countries cover any medically necessary treatment Australian residents require.

These agreements do not replace the need for private travel health insurance, which is available to cover the costs of medical treatment overseas. It is advisable for intending travellers to arrange travel insurance.

Special Assistance Scheme

The Special Assistance Scheme was developed by the Australian Government in recognition of Australian and eligible foreign nationals requiring assistance as a direct result of an adverse event or disaster. Medicare Australia administers healthcare assistance as part of the Special Assistance Scheme. The Scheme was originally developed to cover all out-of-pocket expenses for the treatment of injuries received by those in the Bali bombings on 12 October 2002 (Balimed).
The Scheme currently includes:

- Balimed—from the Bali bombings disaster on 12 October 2002
- Tsunami Healthcare Assistance—from the Indian Ocean tsunami disaster on 26 December 2004
- London Assist—from the London bombings disasters on 7 July 2005
- Bali 2005—from the Bali bombings disaster on 1 October 2005
- Dahab Egypt Bombing Health Care Costs Assistance—from the Egypt bombing disaster on 24 April 2006.

Medicare Australia’s role in administering the Special Assistance Scheme includes:

- processing registrations from eligible victims and their families
- assessing claims
- processing payments.

For further details of the Medicare Australia Special Assistance Scheme, please visit the Medicare Australia web site.
Section 3
Medicare Benefits Schedule

Medicare Benefits Schedule (MBS) Book

Services attracting Medicare benefits

Excluded services

Health screening

Identifying a suitable item number

Proposed surgery

Services requiring clinical and/or photographic information

Restricted items

Listing a new procedure or diagnostic test

Review of services in the MBS
Medicare Benefits Schedule

Medicare Benefits Schedule Book

The Medicare Benefits Schedule (MBS) Book contains information on professional services covered by Medicare. It also has notes to explain the Medicare program and each part of the Schedule in detail. It is published by the Department of Health and Ageing and is available in printed format and on the Department's web site at www.health.gov.au

Services attracting Medicare benefits

Medicare benefits are paid for professional services provided by doctors, some dentists, optometrists and eligible allied health professionals. A professional service must be necessary for the management of the patient’s medical condition and must be clinically relevant. A clinically relevant service is a service provided by a doctor, approved dentist, optometrist or eligible allied health professional that is generally accepted in the medical, dental, optometrical or the relevant allied health profession as being necessary for appropriate treatment of the patient.

For benefits to be payable, practitioners must have face-to-face consultations with their patients. Most services must be performed personally by a medical practitioner to attract benefits. Notable exclusions are telepsychiatry consultations, some diagnostic tests, pathology tests and diagnostic imaging services. These services are listed in the General Explanatory Notes of the Medicare Benefits Schedule Book.

Excluded services

Some services do not attract Medicare benefits including:

- transplantation of a thoracic or abdominal organ other than a kidney
- removal from a cadaver of kidneys for transplantation
- removal of tattoos
- chelation therapy (other than for the treatment of heavy metal poisoning)
- injection of Human Chorionic Gonadotrophin in the management of obesity
- hyperbaric oxygen therapy in the treatment of multiple sclerosis
- services such as physiotherapy, occupational therapy, speech pathology, chiropractic services, and podiatry (except referred patients being managed by their General Practitioner under an Enhanced Primary Care plan)
- services by a salaried practitioner in a hospital (other than a private hospital) except when the practitioner is in private practice
- telephone consultations, referrals or repeat prescriptions which do not involve an attendance by the patient
- group counselling (except in limited circumstances), health education, weight reduction or fitness classes
- cosmetic surgery for non-medical reasons
• body piercing
• medical examinations for life insurance, superannuation, provident account scheme or admission to membership of a friendly society
• service rendered by, or on behalf of, Australian, state or local government, or one of their authorities
• service where the medical expense is the responsibility of the patient’s employer
• mass immunisation programs
• health screening
• compensation-related medical service where there is a reimbursement agreement between a compensation claimant and the insurer
• self-treatment by practitioners or treatment of their immediate family
• treatment of a partner or partner’s dependants unless there is provision for a charge to be made for such treatment within the partnership agreement
• laser vision correction or other refractive eye surgery
• vision screening
• compulsory eye examinations to obtain any commercial licence (for example flying or driving)
• eye examination required by an employer (for example to obtain safety glasses).

Practitioners providing these services should bill the patient and write on the account “does not attract Medicare benefits”.

**Health screening**

Health screening is a test or examination that is not reasonably necessary for the management of the patient’s medical condition. Under the *Health Insurance Act 1973*, these services are excluded from payment of benefits.

A practitioner is not precluded from providing such services, however accounts for the service should be marked to indicate that a Medicare benefit is not payable.

Services in this category include:
• screening for osteoporosis
• multiphasic health screening
• testing to determine fitness for weight reduction classes, fitness programs, scuba diving or other sporting activities
• examinations for pilot, driving or other commercial licences, excepting medical assessment for private driver licences due to age or medical condition
• mammography (breast screening), except as provided in items 59300 and 59303
• examinations for entrance to educational establishments
• examination of a potential employee for a proposed employer (unless the candidate is currently unemployed and the potential employer requires the examination)
• pathology tests for a person occupationally exposed to the sexual transmission of disease
• pathology services associated with clinical ecology (previously referred to as orthomolecular medicine).

Complete details are set out in the General Explanatory Notes of the Medicare Benefits Schedule Book.

**Identifying a suitable item number**

Item numbers used in billing must accurately reflect the service. If an item which accurately describes the service cannot be found, call the Schedule Interpretation Section or a Medicare Australia medical adviser on 132 150*.

**Proposed surgery**

Medicare Australia can offer an opinion on whether proposed surgery might attract Medicare benefits for augmentation mammoplasty, meloplasty, blepharoplasty, rhinoplasty, liposuction, varicose veins and laser photocoagulation. Applications should be forwarded directly to:

Medicare Australia
Medicare Claims Review Panel
PO Box 1001
Tuggeranong ACT 2901

Applications should include full clinical and/or photographic evidence to demonstrate the medical reasons for the proposed surgery.

**Services requiring clinical and/or photographic information**

Specific items in the Medicare Benefits Schedule (MBS) need Medicare Australia approval where the item descriptor includes the phrase “where it can be demonstrated”. Claims for these services should be accompanied by full clinical details, including pre-operative colour photographs where applicable, and sent to:

Medicare Australia
Medicare Claims Review Panel
PO Box 1001
Tuggeranong ACT 2901

The claim will be reviewed by the review panel for a recommendation to be made. Clinical details and/or photographs accompanying the claim should be in an envelope marked “Medical-in-confidence”. Where digital photographs are supplied, the practitioner must sign and certify that the digital photograph has not been altered.

Following the repeal of sections 11 and 12 of the Health Insurance Act 1973 a panel was established to review and make recommendations on claims where clinical and/or photographic information is required for benefit determination. The panel does not have the legislative power to approve benefits for any other items in the MBS or to overrule existing item descriptors. The panel consists of three medical practitioners: two from Medicare Australia and one from the Department of Health and Ageing.

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* Local call rates. Normal mobile and public phone charges apply.
**Restricted items**

Some services are “restricted” when provided with other services. A benefit may not be paid when these services are provided in conjunction with each other. In general, where a restriction exists between items, benefits are payable for the service attracting the higher benefit only. The Medicare statement will identify the service for which benefits are not payable and provide a reason for this. For further details see the Medicare Benefits Schedule.

**Listing a new procedure or diagnostic test**

If a practitioner wishes to have a new procedure, diagnostic test or pathology service recognised in the Medicare Benefits Schedule (MBS), they should contact the Medical Services Advisory Committee (MSAC). This committee advises the Minister for Health and Ageing on the strength of evidence relating to the safety, effectiveness and cost-effectiveness of new and emerging medical services and technologies and under what circumstances public funding, including listing on the MBS, should be supported.

Membership of the committee comprises a mix of clinical expertise covering pathology, surgery, internal medicine and general practice, plus clinical epidemiology and clinical trials, health economics, consumers, and health administration and planning. Further information relating to MSAC can be found at [www.msac.gov.au](http://www.msac.gov.au)

**Review of services in the Medicare Benefits Schedule**

Review of a particular service or group of services within the Medicare Benefits Schedule is undertaken by the Medicare Benefits Consultative Committee.

This informal advisory committee has been established by agreement between the Minister for Health and Ageing and the Australian Medical Association (AMA). The committee consists of representatives of the Department of Health and Ageing, Medicare Australia, the AMA and relevant medical profession groups.

Pathology services are dealt with on a similar basis by the Pathology Services Table Committee.
Section 4
What every practitioner should know

Medicare and Pharmaceutical Benefits schedules
Provider eligibility
Claiming guide
General information
Charter of Care for Providers
What every practitioner should know

Medicare and Pharmaceutical Benefits schedules

The Department of Health and Ageing (DoHA) develops and distributes these schedules.

Practitioners should access current versions of the Medicare Benefits Schedule (MBS) and the Schedule of Pharmaceutical Benefits (the Schedule). These schedules contain details of items as well as rules relating to Medicare and the Pharmaceutical Benefits Scheme (PBS).

The Medicare Benefits Schedule (MBS)

Currently this publication is available in hard copy, distributed in November each year.

DoHA updates the MBS as required and current versions are available at www.health.gov.au

Enquiries concerning the distribution of the MBS should be directed to:

Department of Health and Ageing
Director
MBS Interpretation and Development
Medicare Benefits Branch
GPO Box 9848
Canberra ACT 2601
Freecall 1800 020 103

The Schedule of Pharmaceutical Benefits

Since 1 December 2006 the Schedule has been updated monthly to include new listings and the latest changes (effective on the first day of each month).

Users can view, download to CD and/or print their own copies of the Schedule free of charge every month from DoHA’s comprehensive user-friendly, online schedule www.pbs.gov.au

The option is also available to subscribe to a “print on demand” service. A printed version or a CD of the complete Schedule, the Dental Book only, or the relevant Summary of Changes will be available for a fee.

Returned mail

Where mail is returned from a practice which appears to be inactive, the provider number for that practice is closed on the Medicare Provider Directory. Where there is some level of Medicare activity, Medicare Australia contacts the practitioner to determine if the location is still required and if the address is still valid.
Provider eligibility

Providers

The *Health Insurance Act 1973* provides that in order to be eligible to render services that attract Medicare benefits, one of the following conditions must apply:

- the person was a medical practitioner before 1 November 1996 (this does not include a medical practitioner who, on or after 1 November 1996, was undertaking a period of internship or a period of supervised training imposed by a state or territory registration authority; or who was not an Australian citizen or permanent resident on 1 November 1996)
- the person is a recognised specialist or consultant physician or is a General Practitioner
- the person is in an approved placement authorised by the Royal Australian College of General Practitioners (RACGP), General Practice Education and Training Limited, specialist college or an approved placement under a program specified under section 3GA of the *Health Insurance Act 1973*
- the person is a temporary resident practitioner (including New Zealand citizens) who has been issued with an exemption under section 19AB of the *Health Insurance Act 1973*, while working in accordance with that exemption.

Services provided by a medical practitioner who does not satisfy one of these conditions are not eligible for Medicare benefits. This does not affect the practitioner’s ability to prescribe pharmaceutical benefits, refer patients to specialists or consultant physicians, or order pathology and diagnostic imaging services.

In addition, Medicare benefits are not payable in respect of services rendered by a practitioner who has been fully disqualified, or partly disqualified in relation to relevant services under the *Health Insurance Act 1973*. (Section 19B of the *Health Insurance Act 1973* provides details of the circumstances in which Medicare benefits are not payable in respect of services rendered by disqualified practitioners).

Where a medical practitioner is not eligible to provide services which attract Medicare benefits, under section 19CC of the *Health Insurance Act 1973* it is an offence to render a service without first informing a patient that Medicare benefits are not payable for that service.

It is also illegal for a medical practitioner to use another practitioner’s provider number or to claim Medicare benefits when working on behalf of another practitioner (including locums).

For overseas-trained doctors or former overseas medical students, an exemption to section 19AB of the *Health Insurance Act 1973* must be obtained before being able to access Medicare benefits. Section 19AB effectively precludes these practitioners from being eligible to attract Medicare benefits for services they provide for a period of 10 years from their first recognition as a medical practitioner as defined under the *Health Insurance Act 1973* (for those doctors registered before 18 October 2001) or from when they were first granted permanency (for those doctors registered after 18 October 2001).
Practitioners from overseas—Section 19AB exemptions

Any doctor who has been trained overseas, or who was not a permanent resident or Australian citizen at the time of undertaking medical training in Australia, is subject to the provisions of section 19AB of the Health Insurance Act 1973. The Department of Health and Ageing (DoHA) approves and issues exemptions under section 19AB, in accordance with stipulated guidelines. Applicants should not assume they will be granted approval for a 19AB exemption and must not practise until an exemption has been granted.

Section 19AB exemptions are time and location specific, cannot be backdated and take effect from the date specified. Medicare Australia and DoHA will write to the practitioner advising them of the approved 19AB exemption dates and location/s.

A request for an exemption can be made through Medicare Australia at the time of application for a provider number. Enquiries can be directed to Medicare Australia Provider Eligibility on 132 150* or the Workforce Distribution Section, DoHA on (02) 6289 5903.

Applications for section 19AB exemptions must include supporting documentation to show entitlement to work in Australia, details of residency status and employment contract, medical registration and any restrictions imposed by either the Department of Immigration and Multicultural Affairs or medical authorities.

Vocational Register

Medicare Australia maintains the Vocational Register of General Practitioners. Practitioners who are certified as eligible and included on the register are able to access certain items on the Medicare Benefits Schedule (MBS) which provide a higher rate of Medicare benefits for consultation services (including Group A attendance items).

To apply for inclusion on the register, a practitioner must have their eligibility certified by the Royal Australian College of General Practitioners (RACGP) or the General Practice Recognition Eligibility Committee (GPREC).

Contact addresses are as follows:

National Membership/GP Recognition Coordinator
RACGP
1 Palmerston Crescent
South Melbourne VIC 3205

Secretary
General Practice Recognition Eligibility Committee
Medicare Australia
PO Box 1001, Tuggeranong DC ACT 2901

* Local call rates. Normal mobile and public phone charges apply.
Application forms can be obtained from the RACGP on (03) 8699 0414 or Medicare Australia’s web site. The RACGP or GPREC consider applications for inclusion on the register and advise Medicare Australia when eligibility is determined.

To maintain their eligibility, vocationally registered practitioners are also obliged to satisfy the RACGP’s quality assurance and continuing professional development requirements, and to remain predominantly in general practice.

**Approvals for GP registrars, RACGP fellows and specialist/consultant physicians**

**General practice registrars**

General practice registrars can use Group A1 items (as outlined in the MBS Book) for services provided at practice placements approved by the authorising body and notified to Medicare Australia. These practice placements are for a set period and permit the payment of Group A1 items for services provided at the approved placement for the duration of the placement.

When a registrar wishes to extend a practice placement, it is very important the necessary approvals are obtained and given to Medicare Australia before the expiry of the current placement period.

The legislation does not allow back-dating of applications or extensions.

**RACGP fellows**

RACGP fellows can use their fellowship qualification to access Group A1 items by lodging an application with Medicare Australia. Once approval is granted, fellows should use Group A1 items at each practice where they provide medical consultations, in the same way as vocationally registered practitioners.

RACGP fellows are also obliged to satisfy the RACGP requirements for quality assurance and continuing professional development to maintain eligibility to use Group A1 items. Application forms are also available from Medicare Australia’s web site.

**Specialist/consultant physician recognition**

To attract higher Medicare benefits, practitioners must seek recognition in their specialty. For fellows of Australasian specialist medical colleges, recognition takes effect upon formal notification by the relevant college.

Applications for recognition as specialists (without Australasian qualifications) or as consultant physicians are considered by the Specialist Recognition Advisory Committee (SRAC) from the state in which the applicant lives.

The SRAC considers the applicant’s qualifications, experience, nature of practice and standing in the medical profession.
Applications for recognition as a specialist/consultant physician should be made to:

Secretary
SRAC
PO Box 1001
Tuggeranong DC ACT 2901

The prescribed fee should accompany the application.

Application forms can be downloaded from Medicare Australia’s web site.

**Rights of private practice for salaried practitioners**

Medicare benefits are not payable for services where medical expenses are met or provided without charge to a patient under an agreement between the provider of the service and the government (includes Australian Government, state or territory or local governing body) or employer. For example, benefits are generally not payable for services by a salaried practitioner at a public hospital or employer’s workplace.

Salaried practitioners in public hospitals may have a “right of private practice” which allows them to treat private patients outside their salaried employment and charge for their services. When this occurs, a Medicare benefit is payable.

**Claiming guide**

**Referral of patients**

A referral is intended to relate to a single course of treatment. For the patient to receive a benefit at the referred rate, a referral letter is required before the specialist/consultant physician service is provided, for initial consultation. This does not apply if the referral is requested in an emergency; however, written referral is required for ongoing treatment or consultation.

Referrals issued by a General Practitioner are valid for 12 months, unless the General Practitioner indicates a shorter, longer or indefinite period. Referrals for longer than 12 months should only be used where the patient’s clinical condition requires continuing care and management of a specialist or a consultant physician for a specific condition or specific conditions.

Where a referral originates from a specialist or a consultant physician, the referral is valid for three months, except where the referred patient is an in-patient. For in-patients, the referral is valid for three months or the duration of the admission, whichever is longer.

Referrals are to be made to a specialist or consultant physician. Referral letters should include the referring practitioner’s name, practice address and/or provider number, the date and period of referral if applicable, and must be signed by the practitioner.

Full details are provided in the General Explanatory Notes of the *Medicare Benefits Schedule* (MBS). If there is a need for a patient to see the same specialist or consultant for a different condition, another initial consultation may be claimed provided there is a new referral.
**Attendance items**

Attendance items can only be claimed if the practitioner personally attends the patient. Telephone consultations do not attract a benefit. Explanatory notes on attendance items are set out in the beige Professional Attendances section of the MBS Book.

Medicare benefits are not payable where a practitioner attends a deceased person for the issue of a death certificate, post-mortem examination or to certify life is extinct for the purposes of removing a body.

Benefits are payable where a practitioner:
- attends a patient who dies in their presence, with or without resuscitation attempts, or
- attends a person who may or may not be dead and the practitioner has either to verify death or institute treatment if the patient is alive.

In general, if a procedure listed in the MBS is performed during a consultation, both items may be claimed. The item description in the MBS will indicate if this does not apply.

**General Practitioner attendance items**

General Practitioners are eligible to use General Practitioner attendance items listed in Group A1 in the beige Professional Attendances section of the MBS Book. A General Practitioner, for the purposes of the MBS, is a medical practitioner who is:
- vocationally registered
- a Fellow of the Royal Australian College of General Practitioners (RACGP)
- an RACGP or General Practice Education and Training (GPET) registrar.

If, during a consultation, a procedure that has its own MBS item is performed, the time taken for the procedure should not be included in the Group A2 item.

**Note:** Medical practitioners in rural and remote areas who are not in the above categories may be eligible for the Group A1 items by registering under the Rural Other Medical Practitioners (ROMPs) program. Call 1800 667 677 for details.

**Other non-referred attendance items**

Other non-referred attendance (Group A2) items are available to other medical practitioners.

**Anaesthesia**

*Anaesthesia—pre-operative examination*

The item listed as “Anaesthesia—pre-operative examination” (item number 17603) applies when the examination is performed before the patient is brought to the theatre, and may be done up to a week or more before the operation.
**Anaesthesia Relative Value Guide**

The Relative Value Guide (RVG) is based on an anaesthesia unit system reflecting the difficulty of the service and the total time taken for the service. Each unit has been assigned a dollar value.

Under the RVG, the Medicare benefit for anaesthesia in connection with a procedure has up to three components:

(a) the basic units allocated to each anaesthetic procedure, reflecting the degree of difficulty of the procedure (an item in the range 20100–21997), for example:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
<th>Benefit 75%</th>
<th>Benefit 85%</th>
</tr>
</thead>
<tbody>
<tr>
<td>20702</td>
<td>INITIATION AND MANAGEMENT OF ANAESTHESIA</td>
<td>$68.60</td>
<td>$51.45</td>
<td>$58.35</td>
</tr>
<tr>
<td></td>
<td>for percutaneous liver biopsy (4 basic units)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(b) the time unit allocation reflecting the total time of the anaesthesia (an item in the range 23010–24136), for example:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
<th>Benefit 75%</th>
<th>Benefit 85%</th>
</tr>
</thead>
<tbody>
<tr>
<td>23033</td>
<td>41 MINUTES TO 45 MINUTES (3 units)</td>
<td>$51.45</td>
<td>$38.60</td>
<td>$43.75</td>
</tr>
</tbody>
</table>

Plus, where appropriate:

(c) modifying units recognising certain added complexities in anaesthesia (items in the range 25000–25020), for example:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
<th>Benefit 75%</th>
<th>Benefit 85%</th>
</tr>
</thead>
<tbody>
<tr>
<td>25015</td>
<td>ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA where the patient’s age is 1 year or less or 70 years or greater (1 unit)</td>
<td>$17.15</td>
<td>$12.90</td>
<td>$14.60</td>
</tr>
</tbody>
</table>

See the Explanatory Notes in the red Therapeutic Procedures section of the MBS Book for further information on anaesthesia.

**Surgery**

**Multiple operation rule**

When two or more operations are performed on a patient on the one occasion, the schedule fee is calculated as follows:

<table>
<thead>
<tr>
<th>Item description</th>
<th>Schedule Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item with the highest schedule fee plus</td>
<td>100%</td>
</tr>
<tr>
<td>Item with the next highest schedule fee plus</td>
<td>50%</td>
</tr>
<tr>
<td>Each other item</td>
<td>25%</td>
</tr>
</tbody>
</table>
For payment of benefit purposes, a multiple operation is regarded as one service. Only one patient gap applies for benefit calculation. The total benefit payable is calculated on the total schedule fee for the operations. The Medicare statement of benefit for multiple procedures will only show the total charge and benefit against the major procedure. Appropriate explanation codes will identify when this occurs.

The multiple operation rule applies to all operations in Group T8 of the MBS with the exception of amputations and some obstetric items.

Where two or more operations performed on the same occasion have schedule fees that are equal, simply treat one as having a higher schedule fee than the other on the account.

For example, if both items have a fee of $250.00, the benefit will be based on 100 per cent of the schedule fee for the first item and 50 per cent of the schedule fee for the other. All operative procedures provided to a patient by the same practitioner on one occasion are affected by this rule.

Some items refer to a recognised combination operation, for example, Manchester repair. The components cannot be claimed separately.

**Two surgeons operating together**

If two surgeons operate on a patient under the same anaesthetic and do not assist one another, each is entitled to benefits calculated on the full schedule fee. This usually occurs with two surgeons of different disciplines, for example, plastic surgeons and neurosurgeons operating together.

There are a few items for combined synchronous operations. Abdomino-perineal resection is an example. There is an item for a solo surgeon and two others (one for the abdominal surgeon and the other for the perineal surgeon). However, if the surgeons assist one another, the multiple operation rule is applied to all the operations performed by the surgeons.

**Assistance at operations**

Items covering operations that are eligible for benefits for surgical assistance have been identified by the inclusion of the word “Assist” in the item description. Medicare benefits are not payable for the surgical assistance associated with procedures that have not been so identified.

**Aftercare**

The schedule fee for surgical items in Category 3 of the MBS includes a component to cover routine post-operative treatment (except where specifically excluded). The aftercare period is the duration of the normal healing process. The amount and duration of aftercare following an operation may vary between different operations and, in all cases, covers routine post-operative visits.

Benefits are not payable for routine post-operative attendances provided during the period. The aftercare rule applies whether the patient is in hospital or at home and applies to all practitioners, not just the surgeon.
Attendance items may be charged for aftercare attention after the patient’s discharge if the patient had the operation as a public patient, subject to the public hospital meeting its responsibilities under the 2003–2008 Australian Health Care Agreements.

See the Explanatory Note T8.7 for guidance in the red Therapeutic Procedures section of the MBS Book.

**Attendances not related to aftercare**

Attendances for a condition not related to an operation (but provided during the normal aftercare period) do attract benefits. To ensure payment, the accounts, receipts or assignment forms for such treatment should be clearly endorsed “not normal aftercare”.

A claim for treatment of an unrelated illness during an aftercare period, which does not have the above endorsement, will be returned to you with the question, “Is this aftercare management?”.

This may happen if the treating practitioner is not aware the patient is in the aftercare period for a procedure performed elsewhere. In this situation, you should resubmit the claim to Medicare with the endorsement “not normal aftercare”.

**Shared aftercare**

A surgeon may arrange for another practitioner to supervise the aftercare of a patient. This may occur, for example, in country areas where the patient has to travel for an operation and it may not be feasible for that patient to remain at, or return to, the place of surgery to receive aftercare. Where aftercare has been delegated in this way, benefits are generally apportioned on a basis of 75 per cent for the operation and 25 per cent for the aftercare comprising attendance services. Where the benefit has been apportioned, no more than 100 per cent of the MBS benefit will be paid.

**Obstetrics**

**Obstetric consultations**

Consultation items should not be used for antenatal attendances. There is no limit to the number of antenatal attendances claimed during a pregnancy using item 16500. Refer to the red Therapeutic Procedures section of the MBS Book. During labour, a practitioner may find it necessary to call in another practitioner to complete the delivery. The first practitioner can claim the item for incomplete delivery (item 16518).

**Antenatal care involving more than one practitioner**

If antenatal care is performed by a General Practitioner, and the delivery is performed by a specialist, a benefit is available for the services of both practitioners under the appropriate MBS item.

**Antenatal complications**

There are items for antenatal complications and the wording of these items clearly explains their use. See the obstetrics explanatory notes listed in T4 in the red Therapeutic Procedures section of the MBS Book.
Psychiatric consultations

Medicare benefits are limited to 50 attendances for items in the range of 300 to 308 and 353 to 370 for psychiatric consultations in a calendar year. Where a patient exceeds 50 of any combination of these services in a calendar year, benefits are paid under the appropriate equivalent second level item, 310, 312, 314, 316 or 318. There is no limit to the number of second level items a patient may claim during the remainder of the year.

Item 319 has a limit of 160 services in a calendar year. The 160 attendances can include items in the range of 300 to 308 and 353 to 370, provided they do not exceed 50. This item can only be claimed where the patient has been diagnosed as having severe personality disorder, anorexia nervosa, bulimia nervosa, dysthymic disorder, substance-related disorder, somatoform disorder or a pervasive development disorder; and for patients 18 years and over, has been related to a level of functional impairment within the range of 1 to 50 according to the Global Assessment of Functioning Scale.

Optometric consultations

Medicare benefits are payable for most types of eye examinations conducted by optometrists. A Medicare benefit for a comprehensive eye examination is payable under item 10900 once every 24 months. Under certain conditions (items 10912, 10913 or 10914), a comprehensive eye examination that is performed within 24 months is eligible for the same benefit. Patients who receive a comprehensive eye examination within 24 months from a different practitioner, at a different practice, are able to claim a partial benefit under item 10907.

Pathology

Pathology ordering

Medicare benefits are only payable for individual pathology tests listed in the yellow Pathology section of the MBS Book and determined necessary by the treating practitioner.

If an Approved Pathology Practitioner (APP), who is a specialist pathologist, performs a service in response to a request by a practitioner, the APP cannot self-determine additional tests.

However, tissue pathology items 72846, 72847 and 72848 and cytology items 73059, 73060, and 73061 and electronmicroscopy items 72851 and 72852 are designated as pathologist-determinable services.

Items 69364 and 69365 are pathologist determinable services, and the specialist pathologist is required to record the reasons for determining the need for the service. (Rule 26, MBS 1 November, 2005.)
Items 72846, 72847 or 72848 can be performed without the need for a specific request, following an initial request for tissue examination items 72813 to 72836. Similarly, items 73059, 73060 or 73061 can be performed without the need for a specific request following an initial request for cytology items 73045 to 73051.

Pathology services have approved abbreviations, which can be found in the index of the yellow Pathology Services section of the MBS Book. These abbreviations prevent ambiguity when requesting pathology services and enable accurate identification of the services on a pathologist’s accounts.

Some pathology tests are commonly grouped together. The groups that are acceptable are detailed in the yellow Pathology Services section of the MBS Book.

A benefit is only payable for a test described sufficiently to identify the item in the MBS, or its approved abbreviation, on a correctly completed request form.

Restrictions for Medicare benefits for pathology

There is an upper limit on the number of pathology items for which Medicare benefits are payable in a patient episode.

The limit:
• applies to out-of-hospital pathology services requested by General Practitioners
• limits benefit to the three services with the highest schedule fee requested in a patient episode.

Exemptions are:
• Group P9 services (simple basic pathology tests)
• episode initiation items (Group P10)
• the specimen referred item (Group P11)
• management of bulk billed services (Group P12)
• pap smear testing (items 73053 and 73055)
• designated pathology services (items 66713, 66737, 66809, 66818 and 69402)
• supplementary test for Hepatitis C (item 69484).

Definition of a patient episode

A patient episode consists of pathology services determined on the same day, provided for a single patient by one or more APPs on one or more days, requested by one or more treating practitioners. A limited exemption applies for seriously or chronically ill patients.

For more information, refer to Explanatory Notes under Definitions in the yellow Pathology Services section of the MBS Book.

Pathology requests

Written requests are necessary for pathology services. Verbal requests must be confirmed in writing within 14 days from the date the verbal request was made. Pathology request forms or combined pathology request/offer to assign forms provided by the pathologist must be approved by Medicare Australia.
Written pathology requests do not need to be made on forms provided by the pathologist. However, all written requests for pathology services should contain certain particulars. Full details of these can be found in the yellow Pathology section of the MBS Book.

Pathology requests are directed either to a specific APP or an Approved Pathology Authority (APA). If the request specifies an APP, name and place of practice should be included on the request with the letters “APP” appearing after the name. If the request is directed to an APA, the full name and address of the pathology centre must be included on the request with the letters “APA” appearing after the name.

Medicare benefits are not payable for a pathology service if the request was made as a result of a consideration or promise by the APP or APA to the requesting practitioner or to someone associated with the practitioner. Similarly, it is an offence under the Health Insurance Act 1973 for a medical practitioner to enter into an arrangement with the supplier of a pathology service under which the practitioner obtains any benefit or advantage from the pathologist.

Specimen collection
Medicare benefits are only payable for a pathology service where the specimen is collected by the patient themselves or from the patient at:
- an Approved Collection Centre
- the treating practitioner’s surgery or rooms
- the patient’s place of residence
- a public hospital
- a private hospital, day hospital facility, nursing home or other institution in which the person is a patient.

For a collection centre to become approved, the APA needs to apply to Medicare Australia. For more information, call the Diagnostic Accreditation section on 02 6124 6800.

Pathology tests
There are some basic pathology tests that can be claimed by any practitioner—see Group P9 in the yellow Pathology Services section of the MBS Book. Other than these, Medicare benefits are only payable when the test is performed by an APP in an Accredited Pathology Laboratory (which is accredited for the category of services claimed) and where the proprietor of the laboratory is an APA. Further, the APP must be the APA or have a written agreement (such as an employment contract) with the APA.

To become an APP or APA, or to have a laboratory accredited or collection centre approved, application must be made to Medicare Australia. Contact the Pathology section on 02 6124 6800 or download a form from the Medicare Australia web site.
Patient Episode Initiation (PEI)

A PEI fee is paid with pathology service items to cover the costs associated with the collection of pathology specimens by an APA. Each PEI item (see items 73901 to 73915) has a different schedule fee. For further details on PEIs refer to the yellow Pathology Services section of the MBS Book.

In-built multiple services rule

Where two or more pathology services are requested in the same patient episode and these services are listed under one item number, they are counted as one item number and payment is only payable once. For further details regarding this rule, refer to PD—Multiple Services Rule in the yellow Pathology Services section of the MBS Book.

Imaging

Magnetic Resonance Imaging

Arrangements for the payment of Medicare benefits for Magnetic Resonance Imaging (MRI) came into effect on 1 September 1998 in response to recommendations by the Australian Health Technology Advisory Committee. The arrangements include detailed itemisation and a number of eligibility criteria relating to MRI provision.

MRI services can only be requested by a specialist or consultant physician. A referral must be in writing and must identify the clinical indications for the service. Oral and maxillofacial surgeons may request items 63007 and 63334. For further details, refer to section D1O in the purple Diagnostic Imaging section of the MBS Book.

Diagnostic imaging

Diagnostic imaging services identified in the MBS with the symbol “(R)” are subject to a written request. Those identified with the symbol “(NR)” are not subject to request requirements.

Written requests do not have to be in any specific form, but they must contain sufficient information to identify the item in the Schedule. They must also contain certain particulars that are detailed under DID Requests for Diagnostic Imaging Services in the purple Diagnostic Imaging section of the MBS Book.

In relation to diagnostic radiology, there are two points to note:
• where comparison films of the opposite limb are required, no extra benefit is payable
• mammography items apply when the requirements of the wording of the items are met.

See Explanatory Notes in the purple Diagnostic Imaging section of the MBS Book.

Remote Area Exemption

Practitioners working in a remote area who are expected to perform diagnostic radiology services that are normally provided by a specialist radiologist and who wish to be exempted from the referral requirements associated with R-type diagnostic imaging services, will need to complete a Remote Area Exemption application form. Forms are available from Medicare.
Australia by calling 132 150*. A separate application form must be completed for each practice location that qualifies for a Remote Area Exemption. To access a Medicare benefit under a Remote Area Exemption you must also be participating in a quality assurance and continuing medical education radiology program administered by the Australian College of Rural and Remote Medicine (ACRRM) or the Royal Australian College of General Practitioners (RACGP).

For further information please contact RACGP on (03) 9214 1510 or ACRRM on (07) 3352 8600.

For further information on “R” type diagnostic imaging services, refer to the MBS Book under Explanatory Notes, paragraph DID in the purple Diagnostic Imaging section.

**Ultrasound**

Ultrasound cross-sectional echography is covered by items 55028 to 55085, 55700 to 55774, and 55800 to 55854. As a rule, a benefit is payable once only for ultrasonic examination at attendance, irrespective of the areas involved. However, there are some exceptions where, for example, separate attendances are involved or where the additional service relates to a non-contiguous body area. Refer to the purple Diagnostic Imaging section of the MBS Book.

**Professional supervision for ultrasound services**

A professional supervision requirement was introduced for ultrasound services from 1 September 1999, with the exception of items 55600 and 55603.

Ultrasound services marked with the symbol “R” are not eligible for a Medicare benefit unless the service is performed:

a) under the professional supervision of a specialist or a consultant physician in the practice of his or her specialty who is available to monitor and influence the conduct and diagnostic quality of the examination and, if necessary, to personally attend the patient, or

b) under the professional supervision of a practitioner who is not a specialist or consultant physician who meets the requirements of A or B hereunder, and who is available to monitor and influence the conduct and diagnostic quality of the examination and, if necessary, to personally attend the patient.

A. Between 1 September 1997 and 31 August 1999, at least 50 services were rendered by or on behalf of the practitioner at the location where the service was rendered and the rendering of those services entitled the payment of a Medicare benefit.

B. Between 1 September 1997 and 31 August 1999, at least 50 services were rendered by or on behalf of the practitioner to a patient in a nursing home or at the patient’s residence and the rendering of those services entitled the payment of a Medicare benefit.

If paragraph (a) or (b) cannot be complied with, ultrasound services are eligible for a Medicare rebate:

(i) in an emergency, or

(ii) in a location that is not less than 30 kilometres by the most direct road route from another practice where services that comply with paragraph (a) or (b) are available.

**Note:** Practitioners do not have to apply for a Remote Area Exemption in these circumstances.

* Local call rates. Normal mobile and public phone charges apply.
Nuclear medicine imaging services

Medicare benefits are available only to patients of practitioners who are recognised as credentialled specialists in nuclear medicine. This ensures appropriate standards for the provision of nuclear medicine imaging services.

Payment of Medicare benefits for nuclear medicine imaging services is limited to medical specialists who are credentialled by the Joint Nuclear Medicine Credentialling and Accreditation Committee (JNMCAC) of the Royal Australian College of Physicians and the Royal Australian and New Zealand College of Radiologists. Re-credentialling occurs every two years.

The scheme has been developed by the profession in consultation with government to ensure that specialists in nuclear medicine are appropriately trained and licensed, provide appropriate personal supervision of procedures and are involved in ongoing medical education.

Practitioners wanting information and/or application forms regarding the scheme should call the Secretary of the JNMCAC on (02) 9818 4824.

Sonographer accreditation

From 1 November 2001, sonographers performing ultrasounds on behalf of medical practitioners must be suitably qualified and involved in a relevant and appropriate continuing professional development program. In addition, sonographers must be registered on Medicare Australia's Register of Accredited Sonographers. This reflects the Government’s desire to ensure the provision of high quality diagnostic imaging services under the MBS.

To monitor compliance with this requirement medical practitioners must include the sonographer’s name on the diagnostic imaging report.

For further information, call Medicare Australia, Provider Eligibility section on 132 150 or the Australasian Sonographer Accreditation Registry on (02) 8850 1144, or visit the web site at www.asar.com.au

Diagnostic imaging ordering

Except in certain circumstances, Medicare benefits are payable only for a diagnostic imaging service if it is provided following a written request from another medical practitioner. For x-rays of the head and some other services, the requesting practitioner may also be a dental practitioner, prosthodontist or oral and maxillofacial surgeon. For x-rays of the spine and pelvic region, the requesting practitioner may also be a chiropractor, physiotherapist or osteopath. For specified x-rays of the foot, the requesting practitioner may also be a podiatrist.

Generally, services designated with an “(R)” in the MBS must be requested. However, there are some situations where this does not apply. If a practitioner provides radiology services in response to a request, the practitioner can, on the basis of results obtained from the requested service, self-determine that additional tests are necessary.

A specialist practitioner (except a specialist radiologist) can also self-determine imaging services when practising in the course of their specialty.
In the case of an emergency, a request is not required if the practitioner providing the service determines that the need arose in an emergency and the service should be performed as quickly as possible. The purple Diagnostic Imaging section of the MBS Book outlines details required on accounts in these situations.

Other exceptions to the request requirements include services provided by practitioners in remote areas and the exemption for pre-existing diagnostic imaging practices.

**Computed tomography**

Since 1 March 1999, a reduced schedule fee has applied to computed tomography “(CT)” services provided on equipment 10 years old or older. A range of additional items have been introduced to cover services provided on older equipment. These items are identified by the letters “(NK)” at the end of the item. An exception applies for old equipment located in remote areas where “under 10 years old” “(K)” items may be used.

**Diagnostic imaging multiple services rules**

Additional rules affecting diagnostic imaging services, for example, x-rays and ultrasounds, were introduced from 20 January 1997. Where a diagnostic imaging service and other imaging, consultation and procedural-type services are provided to a patient by the same practitioner on the same day, the Medicare benefit payable may be reduced.

It should be noted that more than one rule, and in some cases all rules, may apply in certain circumstances.

**Situations where the schedule fee for diagnostic imaging services will be reduced**

Where more than one diagnostic imaging service is provided to the same patient, on the same day, the diagnostic imaging service with the highest schedule fee will have a benefit based on the full schedule fee amount. For each additional diagnostic imaging service, the schedule fee will be reduced by $5.00 before calculating the benefit.

Where a consultation and any “R-type” (requested diagnostic imaging) service is provided to the same patient on the same day by the same practitioner, one of the following applies before calculating the benefit:

- where the schedule fee for the consultation is $40.00 or more, the schedule fee for the diagnostic imaging service with the highest schedule fee will be reduced by $35.00 (or by the actual schedule fee amount where this is less than $35.00)
- where the schedule fee for the consultation is less than $40.00, the schedule fee for the diagnostic imaging service with the highest schedule fee will be reduced by $15.00 (or by the actual schedule fee amount where it is less than $15.00)
- where a procedural-type service and any “R-type” diagnostic imaging service are provided to the same patient on the same day by the same practitioner, the schedule fee for the diagnostic imaging service with the highest schedule fee will be reduced by $5.00.
**Audiology tests**

Some audiology tests attract a benefit only if they are performed in a sound-attenuated room that meets the Australian standard. For details, see the Explanatory Notes in section D1.13 in the blue Diagnostic Procedures and Investigations section of the MBS Book.

**Electrocardiogram**

Electrocardiograms (ECGs) are covered in the blue Diagnostic Procedures and Investigations section of the MBS Book. The services include:

- 12-lead ECG
- monitoring of an ambulatory patient
- exercise ECG.

For ECG items 11708, 11709 and 11713 the recording must be interpreted and reported upon by a specialist or consultant physician.

**Allied health and dental care initiative**

The Medicare allied health and dental care initiative provides rebates for certain allied health and dental care services for patients with a chronic condition and complex care needs who are being managed by their General Practitioner under an Enhanced Primary Care plan. Medicare rebates are available to eligible patients for a maximum of five allied health and three dental care services each calendar year. To access these rebates, patients need to be referred by their General Practitioner to an allied health professional or dentist who is registered with Medicare Australia.

Providers included under the measure are Aboriginal health workers, audiologists, chiropodists, chiropractors, dentists (through the dental care plan), diabetes educators, dietitians, exercise physiologists, mental health workers, occupational therapists, physiotherapists, podiatrists, psychologists, osteopaths and speech pathologists.

Further information is available in the *Medicare Benefits Schedule: Allied Health and Dental Services* supplement, which is published by the Department of Health and Ageing.

**General information**

**Provider numbers**

To process benefit claims efficiently and pay Medicare benefits to practitioners, Medicare Australia identifies practitioners by a unique provider number for each physical location.

To apply for a provider number, call Medicare Australia’s Provider Eligibility section on 132 150* to obtain an application form. The form can also be downloaded from Medicare Australia’s web site.

The form should be submitted at least 14 working days before the commencement date. Please include provider numbers on accounts and receipts to ensure patients’ claims are processed promptly. Provider numbers are also used to identify practitioners for referral and diagnostic test request purposes. Public hospital practitioners need a provider number for referral purposes.

* Local call rates. Normal mobile and public phone charges apply.
You should let Medicare Australia know in writing if the location of your practice changes so that the provider number can be closed and a new provider number issued.

**Provider cards**

For some forms of bulk billing, a provider card embossed with the practitioner’s name, address and provider number will help in the preparation of claims. A card can be obtained by writing to:

Provider Eligibility Section  
Medicare Australia  
GPO Box 9822 in each capital city

or by calling the Provider Eligibility section on 132 150*. Provider cards are issued within three weeks. Imprint machines for provider cards can be obtained by calling 1800 067 307 or faxing (02) 6230 0477.

**Prescriber numbers**

A prescriber number can be obtained by writing to the address above.

Prescriber numbers should be included on prescriptions (including authority prescriptions) when prescribing PBS medicines.

Where practicable, the practitioner is encouraged to attend an information session usually held at Medicare Australia offices in capital cities. More information about these sessions, or about prescribing in general, can be found on the Medicare Australia web site, or by calling 132 150*.

**Locum provider numbers**

A medical practitioner providing services as a locum (even for short periods) should have a provider number for that location and must use their own provider number on any document used to claim Medicare benefits. It is an offence for a medical practitioner to use another practitioner’s provider number. It is the practitioner’s responsibility to ensure that the practice staff do not inadvertently show the practice owner’s provider number as the rendering provider if the service has been rendered by an employee or a locum. For more information call 132 150*.

Where a locum requests Medicare benefits be paid directly to the principal of the practice or the employer, a pay group link can be established to redirect Medicare payments. Bulk bill stationery allows the rendering practitioner to direct the Medicare benefit to another medical practitioner.

**Locum requirements for optometrists**

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

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

* Local call rates. Normal mobile and public phone charges apply.
Locums must either sign an undertaking, or ensure that their employer has an undertaking in place. Locums not using their own undertaking must notify Medicare Australia in writing before starting at the practice and must also provide details of the participating optometrists for whom locums are providing services. Medicare Australia has a form specifically for this purpose. Not having an appropriate undertaking may affect eligibility for Medicare benefits.

Medicare Australia will pay Medicare benefits to the optometrist performing the service unless advised otherwise. If a locum wants payment to be made to a third party, a pay group link must be set up or the appropriate section on the DB1 form filled out. The DB1 facility can only direct payments to an optometrist who has a provider number. These requirements also apply to all electronic claiming.

For more information please contact the optometrical adviser in your state or territory on 132 150*.

Locums and the Practice Incentives Program

If a locum works at a practice that is eligible to participate in the Practice Incentives Program (PIP) (see section 9 for more details on the PIP), a provider number should be obtained specifically for that practice location. This ensures all services provided by the locum at that practice are included for the purposes of calculating the practice incentives payment.

Closing of practices

If a practitioner ceases to practise at a particular practice location for which a provider number has been allocated, it is important they advise the Provider Eligibility section so the practice record can be closed. For more information call 132 150*.

Practice nurse and Aboriginal health worker services

Medicare benefits are payable for certain services provided by practice nurses and Aboriginal health workers on behalf of medical practitioners. Please refer to the Medicare Benefits Schedule for more information.

Medicare Australia medical advisers

Medicare Australia employs experienced medical practitioners as medical advisers. Their role is to provide a high standard of medical advice to all areas of Medicare Australia and to maintain communication with the profession.

Medical advisers also review claims sent to the Medicare Claims Review Panel, help with the assessment of complicated claims, provide advice on Medicare or the PBS, and are available to talk with groups of practitioners.

If there is concern a practitioner may be engaged in inappropriate practice, a medical adviser will draw it to the attention of the practitioner. These discussions may resolve the matter or it may be necessary to refer the matter to the director of Professional Services Review who may establish a Professional Services Review Committee.

* Local call rates. Normal mobile and public phone charges apply.
Medicare Australia also has consultants in optometry, general practice and many of the medical specialties. These consultants are highly regarded by their peers and provide Medicare Australia medical advisers with access to the best possible advice about various disciplines.

**Program review**

Medicare Australia manages the prevention, detection and investigation of fraud and abuse of Medicare Australia administered programs.

Medicare Australia has made payments to the Australian public for more than 25 years and has an important role in protecting public health funds from fraudulent or inappropriate claims.

Medicare Australia has developed many methods to ensure benefits are paid correctly. One of those is to ensure people who claim the benefits understand how to claim correctly.

As most claims are submitted by doctors and pharmacists, Medicare Australia works with these professionals and the broader health industry to help them claim for their services appropriately.

Inappropriate or incorrect claims are often made inadvertently. Once the problem has been discussed and resolved, Medicare Australia monitors the situation to ensure that it does not happen again. However, incorrect claims are not all made through misunderstanding, and Medicare Australia uses advanced technology to identify irregularities in claiming behaviour and monitor payment patterns. This helps Medicare Australia to detect and investigate fraud, as well as inappropriate claiming practices.

**Inappropriate practice**

Inappropriate practice is conduct that could reasonably be considered to be unacceptable to the general body of members of the specialty in which the practitioner was practising when he or she provided the services. For the purposes of this definition, general medical practice is considered to be a specialty.

**Payment arrangements**

Medicare can arrange for benefit cheques to be made payable to any payee nominated by the practitioner who provided the service, for example, cheques may be made payable to the principal of the practice. Further information on pay group links can be obtained from the Provider Eligibility section on 132 150*.

**Mail-outs**

Medicare Australia distributes information periodically to medical practitioners. This information is usually sent to the principal practice address because it is considered the most reliable. The preferred mailing address held on Medicare records is used for some communications, for example vocational register matters for particular groups of practitioners, and these addresses should be regularly updated.

Medicare Australia also produces Forum—a quarterly newsletter posted to practices and available via the Medicare Australia web site.

* Local call rates. Normal mobile and public phone charges apply.
**Charter of Care for Providers**

Medicare Australia's *Charter of Care for Providers* sets out standards that we aim to meet when providing services to you. We are committed to quickly and efficiently responding to your needs and developing our services to meet your diverse requirements.

The *Charter of Care for Providers* also sets out your rights when dealing with us and ways that you can help us serve you better. Your feedback is also important, it helps us to continuously improve our service to you.

You can obtain a copy of our *Charter of Care for Providers* from Medicare offices or by contacting **132 011**. A PDF version can also be found on the Medicare Australia web site.

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* Local call rates. Normal mobile and public phone charges apply.
Section 5
Billing and claiming

Billing
Claiming from Medicare—patient

Bulk billing
Submitting bulk bill claims electronically
Submitting hard copy bulk bill claims for pathology

Obtaining stationery, imprinters, plastic cards, brochures and posters

Forms
Billing and claiming

Billing

Practitioners have two choices for billing services. They can bill patients privately or bulk bill Medicare (assignment of benefit).

Required details

Regardless of which billing method is chosen, the following details are required on each account, receipt or bulk bill voucher submitted to Medicare:

- practitioner’s name, address and/or provider number
- patient’s name (in the case of family names indicate senior/junior)
- Medicare Benefits Schedule (MBS) item number and a description of the service or a description of the service sufficiently detailed to enable the correct MBS item to be identified
- date of service
- the amount charged
- identification of in-hospital services
  - patient account: an asterisk (*) or the word “admitted patient” beside the appropriate item number
  - bulk bill: attach the vouchers to a DB1H claim header (see Form DB1N).

The following details may also need to be shown on the account.

- Accounts from consultant physicians and specialists
  - referral details (name, address and/or provider number of the referring practitioner)
  - date of referral and the period of referral, preferably in months or “indefinite” if applicable.
- Diagnostic imaging services
  - name, address and/or provider number of the practitioner who provided the report.
- Diagnostic imaging where exemption is claimed from request requirements
  - the account should be annotated “SD” (self-determined).
- “R-type” diagnostic imaging services
  - name, address and/or provider number of the requesting practitioner and the date of request.
- Requested pathology services
  - name of the requesting provider, provider number and the date of request. If the service is self-determined for the practitioner’s own patient, the account should be annotated “SD”.
• Administration of an anaesthetic or assistance at an operation
  – name of the surgeon and the item number relating to the operation.

• Patient is attended on more than one occasion in any day
  – time when each attendance occurred on separate vouchers (if bulk billed), each signed
    by patient.

• Category 1 attendance items endorsement
  – notification of “not normal aftercare” – NNAC.

• Category 5 diagnostic imaging items endorsement
  – notification of “not for comparison” – NFC along with description i.e. L foot, R foot etc.
    (For example, online claiming = HX1)

• Category 6 pathology items endorsement
  – notification of “Rule 3 Exemption” or S4B3.

• Specialist/consultant referrals or diagnostic imaging services where the referral/request
  was lost or destroyed or the service was provided in an emergency
  – notification of “lost referral” or “emergency referral”.

Claiming from Medicare—patient

The settlement of a private account is the responsibility of the patient (claimant). When you
bill a claimant they can either:

• pay the full amount of the consultation and use their detailed receipt to claim a
  Medicare benefit

• pay the difference between the Medicare benefit and the total account amount, and then
  claim the benefit from Medicare to forward to the doctor later

• claim from Medicare using their unpaid account.

Please ensure the account clearly indicates whether or not it has been paid.

Paid account

If the account has been paid, claimants can obtain a cash benefit (up to certain limits) from a
Medicare office. Alternatively they can lodge a claim by post, by Medicare claiming facilities
available in some rural locations, or telephone (also in rural areas throughout Australia) for a
payment by electronic funds transfer (EFT) or cheque.

From the second half of 2007, patients who pay their account can use Medicare Easyclaim
to receive their Medicare benefit directly into a nominated bank account, through the
EFTPOS terminal at participating practices. After they have paid their account, patients can
lodge their Medicare claim by swiping their Medicare card through the surgery’s EFTPOS
terminal. The rebate will be paid into the patient’s bank account almost instantly.

For more information about Medicare Easyclaim visit the Medicare Australia web site.
Unpaid account

If the account is unpaid, the claimant can submit the claim for a cheque benefit made payable to the medical provider and posted to the claimant. This can be done using the same methods as for paid accounts. The claimant is then responsible for settling the practitioner’s account.

These cheques are mailed in accordance with the Australian Government’s minimum payment times. Allowances must also be made for time taken by the claimant to lodge the claim, the time in which the claim and the cheque are in the mail system, and any delays by the claimant in finalising payment after the cheque has been received.

From the second half of 2007, patients who have an unpaid account can use Medicare Easyclaim to submit the claim for a cheque benefit made payable to the provider through the EFTPOS terminal at participating practices. After the consultation, the patient’s Medicare card is swiped through the surgery’s EFTPOS terminal and a claim is lodged. A cheque is then posted directly to the patient, speeding up the process and providing certainty that the patient has lodged the claim.

For more information about Medicare Easyclaim visit the Medicare Australia web site.

Where the claimant has been given a “pay doctor via claimant” cheque, Medicare Australia can release claims information relating to the services connected with the cheque to the provider. The provider must be able to identify the service(s) that the cheque relates to.

If there is a dispute between the claimant and the provider regarding the payment of an account Medicare Australia can release the presentation date, account name, financial institution and the cheque amount to the provider if the cheque has been banked.

Note: Medicare Australia cannot disclose the account number to the provider.

It is important that patients keep their address details up-to-date with Medicare, as the cheque will be posted to the address recorded. Patients can update their address details:

- online—www.medicareaustralia.gov.au
- in person—at any Medicare office
- over the phone—phone 132 011*.

Submitting private (patient) claims electronically

If your practice has online claiming, claimants are able to lodge their Medicare claims electronically from your practice. Online claiming uses demographic billing information already stored in your practice management system to create an electronic claim. With permission, the claim is forwarded to Medicare Australia via the Internet.

If the claim is error free, it is processed and payment is made according to the minimum payment timeframes. The system can be used in real-time or store-and-forward mode. Any errors found in transactions will be returned for correction and retransmission.

* Local call rates. Normal mobile and public phone charges apply.
Online claiming same day deletion for Medicare patient claims

If you become aware that an error was made while entering or submitting a patient claim using the online claiming channel on the day it is transmitted and processed, the Medicare system will allow you to request the deletion of the claim using your desktop.

The 90-day cheque scheme

The 90-day cheque scheme was introduced in July 2001 to guarantee General Practitioners payment of the Medicare scheduled fee for patient claims. If a claimant does not present the cheque made in favour of the doctor to the practice within 90 days of its issue, Medicare Australia will cancel the cheque. The benefit will then be paid by EFT into the doctor’s bank account. To take advantage of the scheme register by calling Medicare Australia on 1800 032 259.

Intention to bulk bill

If a claimant is billed privately when the intention was to bulk bill, this can be corrected by:

- the practitioner informing the claimant in writing that the debt has been cancelled and asking the claimant to sign an assignment of benefit form
- sending the signed assignment of benefit form with a completed bulk bill claim form (DB1N or DB1H) to Medicare with a copy of the letter sent to the claimant.

These actions should take place as soon as possible after the service was rendered as the bulk billing system is not to be used to recover bad debts. All bulk bill claims should be lodged within six months of the service.

How the claimant receives the benefit

Claimants who pay for the service in full can elect to receive the rebate by cash, EFT to their bank or financial institution account, or by cheque. Claimants must give consent for a practitioner to lodge claims on their behalf. EFT payment should be made within three to six working days of lodgement.

If the consultation is not paid for, or the claimant pays only the gap, a cheque in favour of the practitioner will be sent to the claimant, who will need to forward it to the practitioner. The claimant must give consent for the practitioner to lodge the claim on their behalf. The cheque is issued within a minimum of 16 days from the date of lodgement. Cheques are not sent directly to the practitioner or practice.

Bulk billing

If a practitioner agrees to the bulk billing method, patients assign their right to a benefit to the practitioner as full payment for the medical service. The practitioner (or any other person or company) cannot make any additional charge for the service. This means that if the practitioner bulk bills, the patient cannot be charged a booking fee, an administration fee, a charge for bandages or record keeping, or a charge by the practitioner’s service company. It is a legal requirement that the assignment of benefit form be signed by the patient only after the service has been provided and the form completed. A copy of the completed assignment form must be given to the patient.
Additional bulk billing incentives are available for General Practitioners who bulk bill Commonwealth concession patients and children under 16 years. To receive the payment, medical practitioners need to claim a Medicare Benefits Schedule item in addition to the relevant item for the professional service provided to the patient.

For more information visit the Medicare Australia website or call 132 150*.

**Submitting bulk bill claims electronically**

**Electronic claiming via the Internet (online claiming)**

Online claiming enables practices to lodge bulk bill claims via the Internet.

General Practitioners, specialists, radiologists and diagnostic imaging houses can lodge bulk bill claims using the new system.

The advantages of sending bulk bill claims using online claiming are:

- more efficient payment via electronic funds transfer to the practitioner’s financial institution account
- claims can be transmitted 24 hours a day, seven days a week
- fewer claim rejections and minimal operator intervention
- problems are resolved quickly with the help of prompt electronic exception statements
- faster payments because processing staff are no longer waiting on paper documentation to process claims
- online eligibility checking for bulk bill claims, leading to a lower rate of rejected claims and improved reconciliation for practices
- certainty the claim has been lodged
- the highest levels of confidentiality, privacy and authentication available for transmitting medical data through Public Key Infrastructure
- immediate confirmation of receipt of bulk bill claims—the data is transmitted directly to Medicare Australia rather than through a third party communication carrier
- paperless business with Medicare Australia—it reduces the need to send documentation to Medicare Australia.

There should also be a minimal need for practice staff to re-key information. The Medicare claiming function is integrated into the practice management system (PMS) and builds a claim from information already stored.

Online claiming software has been released to software vendors for integration into their practice management systems. Some suppliers already offer practices the new claiming facility. If you use a PMS please contact your software supplier to determine when they will be making online claiming available.

**How online claiming impacts on Medclaims**

The bulk bill component of online claiming is the replacement for the current Medclaims system, although Medclaims will continue to be available for the submission of bulk bill claims for some time. Practitioners who continue with Medclaims rather than adopt online claiming will receive the same level of support and assistance that is currently available.

* Local call rates. Normal mobile and public phone charges apply.
For more information, please contact the Medicare Australia eBusiness Service Centre on 1800 700 199.

**Medicare Easyclaim**

From the second half of 2007, a new electronic claiming channel, Medicare Easyclaim, will be available. Medicare Easyclaim allows practices to lodge bulk bill claims using the existing EFTPOS terminals already in most practices.

The advantages of the new electronic claiming channel include:

- no batching or storing of claims—bulk bill claims lodged using Medicare Easyclaim will be entirely paperless
- your rebate is paid into your nominated bank account, usually on the next working day
- instant confirmation of a patient’s concessional entitlement status.

For more information about Medicare Easyclaim visit the Medicare Australia web site.

**Submitting bulk bill claims manually**

A non-electronic bulk bill claim consists of:

- a claim form (DB1N, DB1N-AH or DB1H)
- a “batch” of assignment forms (DB2-GP, DB2-AH, DB2-OT, DB3, DB4 or DB5) which detail the services to patients.

Claims for in-hospital services must be batched separately from services provided outside hospital. Medicare Australia has scanning technology to process non-electronic bulk bill claims.

The scanning equipment uses image and optical character recognition techniques and DB2 forms have been designed to enable the equipment to read and interpret details of the claim. The forms can be used for all services except for pathology. Separate assignment vouchers are available for GPs (DB2-GP) and others (DB2-OT). Claims for scanning must be batched separately from other claims. The DB4 form (all practices except pathology) and DB5 form (pathology only) are continuous computer stationery versions of the claim form.

**Submitting hard copy bulk bill claims for pathology**

A bulk bill claim on Medicare for requested pathology consists of:

- a claim form (DB1N or DB1H) and a combined assignment of benefits/pathology request form (DB3 or DB5)
- a claim form (DB1N or DB1H), an assignment of benefits form (DB2-GP, DB2-OT, or DB4) and the pathology request.

Usually a patient can only assign benefits after a service has been provided. However, this is not possible in many instances of requested pathology services. For this reason, forms have been designed to enable patients to offer to assign benefits to the pathologist. If the pathologist accepts the offer to assign, the service details must be entered on the assignment form and the offer attached.

* Local call rates. Normal mobile and public phone charges apply.
Completing patient details on a bulk bill claim

Information on completing forms is included with each supply of forms.

Patient details on the assignment form need to be completed for bulk bill forms to be scanned. Either:

- imprint the patient’s card using a Medicare imprinter to show the Medicare number.
  Complete the box marked “Card Ref. No.” by writing the number appearing at the left of the patient’s name on the Medicare card (if this is not completed, delays may be experienced in claiming benefits)

- where the card is not presented, complete the form by writing details of the Medicare number and card reference number (if known), first name, initial and surname of the patient treated.

The preferred method is to use the patient’s current Medicare card as it ensures the details are complete and accurate, and this assists in efficient claims processing. It also confirms the patient’s eligibility (the card should be checked for the date to which it is valid and to see if the person has restricted eligibility—for example, “Visitor RHCA”).

Where a patient presenting without a Medicare card has agreed to be bulk billed and indicates that they have been issued with a card but do not know their Medicare card number, the practitioner may call the Medicare enquiry line on 132 150* to obtain the patient’s Medicare card number.

If a patient’s Medicare number is not available, Medicare can still be bulk billed if the patient’s name, date of birth and current address are included on the voucher. The claim may be delayed while additional checking is done. If eligibility cannot be confirmed, the service for the patient will be rejected.

Completing assignment of benefit

The person assigning benefit should complete the following sections on the bulk bill form:

- one of the assignment boxes
- patient’s signature and date.

Where a patient is unable to sign, the patient’s parent/guardian or other responsible person may complete the form. The responsible person must be somebody other than the practitioner, practitioner’s staff, hospital proprietor, hospital staff, nursing home proprietor or nursing home staff. The reason the patient is unable to sign should also be stated.

In the absence of a responsible person, the patient’s signature section should be left blank, and in the section headed “Practitioner’s use” an explanation should be given as to why the patient was unable to sign (for example, “unconscious” or “injured hand”). This note should be signed or initialled by the practitioner. If, in the opinion of the practitioner, the reason is of such a sensitive nature that revealing it would constitute an unacceptable breach of patient confidentiality or cause embarrassment, the practitioner can give the reason as “due to medical condition”. This reason should not be used routinely and in most cases it is expected that a more specific explanation will be given.

* Local call rates. Normal mobile and public phone charges apply.
Lodgement

All assignment of bulk bill benefit claims must be lodged within six months of the date of service, although an application can be made to the Minister for Health and Ageing or his delegate, on a special Medicare form, for an extension of the period if special circumstances exist. Special circumstances do not include collection of bad debts. All bulk bill claims should be mailed to Medicare (GPO Box 9822 in each capital city). Bulk bill claims may also be left at Medicare offices. Claims that have been electronically transmitted should be marked appropriately. A stamp is available for use with paperwork for electronically lodged claims, and is available by calling the provider enquiry line on 132 150*.

Payment of bulk bill claims

Payment is generally made via electronic funds transfer (EFT). Practitioners must provide their relevant bank account details. Where bank account details are incorrect or have not been supplied, a cheque will be sent to the practitioner together with a statement of benefit listing all services that have been paid. The statement will also show:

- a reason code for any rejected services
- where the benefit paid differs from the benefit claimed
- where a Medicare number has changed or was not present on the assignment form
- where a Medicare card is about to expire.

Payments for general and pathology bulk bill claims are dispatched in accordance with the Australian Government’s minimum payment times. Minimum payment times are not guaranteed payment times, however most claims are paid in this period. Additional time should be added for mail handling. There is no maximum payment time set.

Medicare reason codes associated with the rejection of the claim are available via Medicare Australia’s web site.

* Local call rates. Normal mobile and public phone charges apply.
Retaining bulk billing vouchers

The original bulk bill voucher for claims that have been sent electronically must be kept for two years. They can either be stored in hard copy at the practice or scanned and kept electronically. Medicare Australia can store them for doctors but the vouchers must be sent in at the time of claiming.

Assignment forms sent to Medicare Australia can be sent to GPO Box 9822 in each capital city. Medicare Australia will retain the Medicare copy of bulk bill claims that have been sent manually.

Rejection of claims

To process bulk bill claims quickly, all forms need to be completed properly. If there are discrepancies or omissions in the details appearing on the form, or there is some doubt regarding eligibility, claims may be delayed.

Claims will be rejected if:

- the assignment form has any major omissions such as date or description of service
- the claim form (DB1N, DB1N-AH or DB1H) has not been witnessed
- the claim form has not been signed by the practitioner

(For the above three rejections, the claim will be returned with an explanatory letter and a corrected claim can be resubmitted.)

- the patient is ineligible for benefit, for example, the service was provided after the benefit period had expired
- the benefit is not payable due to various rules and interpretations.

(For the above two rejections, the voucher will be retained by Medicare and an explanation will appear on the cheque statement. If the reason quoted is not understood please call the state provider liaison officer on 132 150.)

Medicare reason codes associated with the rejection of claims can be found at Medicare Australia’s web site at.

Stationery

Bulk bill stationery consists of the following forms:

- claim forms DB1N, DB1N-AH or DB1H
- assignment of benefit forms DB2-GP, DB2-AH, DB2-OT, DB3, DB4 and DB5
- DB6B to reorder stationery.

Approved forms

It is a legislative requirement that all claims made for a Medicare benefit must be submitted on an approved form. Approval to produce forms generated by practice software can be obtained from the Minister’s delegate at Medicare Australia. Call (02) 6124 6324 or email your request to medicare.claims.policy@medicareaustralia.gov.au

* Local call rates. Normal mobile and public phone charges apply.
Assignment of benefit forms

Assignment of benefit forms DB2-GP, DB2-AH, DB2-OT, DB3 and DB4 are printed in triplicate for use where the claim is not transmitted electronically. The original is sent to Medicare Australia in batches accompanied by a practitioner claim form (DB1N, DB1N-AH or DB1H).

A two-part assignment of benefit form DB4E is available for electronically transmitted claims. The patient must receive a copy of the assignment form after the service, and a copy is held for the practitioner’s records.

The DB5 is printed in duplicate. The original is sent to Medicare Australia in batches together with the offers to assign and a claim form DB1N or DB1H.

Enquiries about bulk bill claims

Claiming practitioners can call Medicare Australia on 132 150* for information about their bulk bill claims.

Obtaining stationery, imprinters, plastic cards, brochures and posters

Stationery

Medicare stationery is available from Leigh-Mardon, the Medicare Australia printing contractor. Stationery can be obtained by completing a stationery reorder form (DB6B) and sending it to:

Leigh-Mardon
Fax: (02) 6230 0477

or by mail to:
Medicare Australia
Locked Bag 4444
Tuggeranong ACT 2901

Orders are usually dispatched within 48 hours. Please allow time for delivery.

Stationery reorder forms (DB6B) are available to download from Medicare Australia’s web site.

Imprinters

Imprinters are available from Leigh-Mardon by calling 1800 067 307.

Plastic cards

Plastic cards containing practice details for imprinting on stationery are available from Medicare Australia on request from the address above.

* Local call rates. Normal mobile and public phone charges apply.
Brochures and posters

Brochures and posters that inform patients about Medicare, the Pharmaceutical Benefits Scheme, the Australian Childhood Immunisation Register, the 30 per cent Private Health Insurance Rebate, the Australian Organ Donor Register, and various enrolment and claiming forms are available for practitioners’ surgeries. If you would like to assist your patients by displaying all or some of these, please call 132 150.*

Forms

Form DB1N

The DB1N form is used for submitting bulk bill claims for out of hospital services.

Form DB1N-AH

The DB1N-AH form is used by allied health professionals for out of hospital services.
**Form DB1H**

The DB1H form is used for submitting bulk bill claims for in-hospital services.

*Note:* The only difference between the DB1N, DB1N-AH and DB1H forms is that DB1H is used when submitting bulk bill claims for in-hospital patients and the DB1N and DB1N-AH is for non-hospital patients. Vouchers for in-hospital and non-hospital services cannot be mixed in one claim.

**Form DB2-AH**

The DB2-AH form is used by allied health professionals. This form can only be used in conjunction with the DB1N-AH.

**Form DB2-GP**

The DB2-GP form has been specifically designed for GPs.
**Form DB2-OT**

The DB2-OT form is used by practitioners other than GPs.

**Form DB3**

The DB3 form is designed to be used by pathologists to claim pathology services. The form can also be used as an offer to assign form. It must contain all patient and service details. Unlike the DB2-OT and DB2-GP forms, multiple dates of service can be shown.

**Form DB4**

The DB4 form is a continuous stationery version of DB2s designed for office accounting machines. Its use is the same as for DB2 forms.
Form DB5

The DB5 form differs slightly from forms DB3 and DB4. It is continuous stationery for pathology services. The patient cannot complete an assignment using this form so it must always be accompanied by the offer to assign form, which the patient has signed (either a DB2-OT, DB2-GP, DB4 or a specially approved form). It is not necessary to complete a DB2 form if the pathologist uses an approved combined pathology request/offer to assign form.

Separate forms should be used for different patients or for the same patients who attend on different days. Where there is insufficient room on the form, use a separate form or a DB4. Patients indicate on the form whether they are assigning the benefit for the service or offering to assign to the pathologist who will provide the requested pathology services.

If the practitioner decides the patient should have some pathology tests, it is necessary to complete two DB2-OT, DB2-GP or DB4 forms: one for the medical service and the other for an offer to assign to the pathologist. The offer to assign forms should be sent with the request. It is not necessary to complete a DB2 form if the pathologist uses an approved combined pathology request/offer to assign form.
Section 6
Compensation payments and Medicare

Background
Insurer liability
Accepting a settlement
Repaying Medicare Australia
Compensation and Medicare entitlements
Further information
Compensation payments and Medicare

Background
A compensation payment is a sum of money paid to a person for an injury/illness caused by negligence or lack of care by another person. The payment is usually made by an insurance company but can be made to the claimant by an individual or company.

Claiming Medicare benefits and receiving compensation
If a claimant has been injured, for example at work, in a car accident or as a result of the negligence of another person, they can claim Medicare benefits and/or nursing home or residential care subsidies for the treatment of their injury/illness. The treating doctor can bulk bill Medicare or request payment and give the claimant an account to take to a Medicare office.

If a claimant then receives compensation of more than $5000 (including costs) for the injury/illness, they must repay to Medicare Australia the amount of Medicare benefits and/or nursing home/residential care subsidies which have been paid for the treatment of their injury/illness. This is to prevent “double-dipping” (being paid by Medicare and also by an insurer). If the settlement is $5000 or less, the claimant is not required to repay Medicare benefits or nursing home/residential care subsidies and therefore not required to notify Medicare Australia of the compensation payment.

Insurer liability
If an insurer accepts immediate liability for the injury/illness and agrees to pay for the medical expenses, the claimant cannot claim Medicare benefits for those expenses. The insurer will pay these medical accounts and any nursing home or residential care costs.

Accepting a settlement
If a claimant has received medical treatment involving payment of Medicare benefits and/or nursing home/residential care subsidies, it is important to find out how much they need to repay to Medicare Australia before they accept a settlement. The amount due to Medicare Australia must be repaid from any compensation payment where the total amount fixed is more than $5000 (including all medical and legal damages etc).

The claimant, their solicitor (if authorised by the claimant) or the insurer can request that a Medicare history statement be sent to a claimant. This lists the services for which a Medicare benefit has been paid since the date of the injury. The claimant is required to identify services relating to the injury/illness and return to Medicare Australia. This list is used to determine the amount, if any, that needs to be repaid to Medicare Australia. For more information on how to receive a Medicare history statement call 132 127*.

Any amount owing to Medicare Australia is provided in a Notice of Past Benefits, sent to both the claimant and the compensation payer (insurer). If the claimant does not return the history within the required time, all benefits on their Medicare history, from the date of the injury, will be deemed to relate to the injury. Medicare Australia will then issue a notice setting out the amount to be repaid (if compensation of more than $5000 is awarded).

* Local call rates. Normal mobile and public phone charges apply.
Repaying Medicare Australia

By law, an insurer must inform Medicare Australia when a claim for compensation has reached judgment/settlement for more than $5000. Repayment to Medicare Australia can be made in one of three ways:

1. If the case has been finalised, but the amount that must be repaid to Medicare Australia is not known, the insurer can choose to use the advance payment option. This means that the insurer will forward 10 per cent of the total compensation to Medicare Australia, and the claimant will receive the remaining 90 per cent. When any amount refundable to Medicare Australia is determined, it will be deducted from the 10 per cent and the claimant will receive a refund of the balance. If the amount owed to Medicare Australia is greater than the 10 per cent, the claimant is required to pay the difference.

2. If the claim has been finalised and the amount refundable to Medicare Australia is known, the insurer must refund this amount to Medicare Australia before the balance of the compensation can be paid to the claimant.

3. If the claimant believes that no Medicare, nursing home benefits or residential care subsidies have been paid in relation to the injury, they can submit a statement supported by a statutory declaration to Medicare Australia at the same time as the compensation payer notifies Medicare Australia that the case has been finalised. The claimant’s statement should confirm that no Medicare, nursing home benefits or residential care subsidies have been paid in relation to the injury. If Medicare Australia accepts the declaration it will issue the claimant with a notice indicating that no amount is repayable.

Compensation and Medicare entitlements

Compensation payments do not affect a claimant’s Medicare entitlements. After a claim has been finalised the claimant will have the same entitlement to claim Medicare benefits as they had before their injury.
Further information

Phone: **132 127**
TTY: 1800 552 152 (hearing impaired)
TIS : 131 450* (Translating and Interpreting Service)
E-mail: info@medicareaustralia.gov.au
Internet: www.medicareaustralia.gov.au

Post:

Compensation Manager
Medicare Australia
GPO BOX 4104
Sydney NSW 1007
(If the insurer is in ACT or NSW)

or

Compensation Manager
Medicare Australia
GPO BOX 2436
Brisbane QLD 4001
(If the insurer is in QLD, VIC, SA, WA, TAS or the NT)

* Local call rates. Normal mobile and public phone charges apply.
Section 7
Pharmaceutical Benefits Scheme

Background
Who can access PBS medicine
Schedule of Pharmaceutical Benefits
Accessing the PBS Schedule
Costs to the patient
PBS Safety Net
PBS eligibility
One subsidy level for similar medicine types (therapeutic group premiums)
Different brands of the same medicine (brand premiums)
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Pharmacy claiming
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Taking and sending PBS medicine overseas
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Confidentiality
Keeping up-to-date
**Pharmaceutical Benefits Scheme**

**Background**

The Pharmaceutical Benefits Scheme (PBS) gives all Australian residents and eligible overseas visitors access to prescription medicine that is affordable, reliable and timely. The Australian Government does this by subsidising the cost of many prescription medicines through the PBS.

Medicare Australia administers the PBS on behalf of the Australian Government, and makes payments to approved suppliers (pharmacists, doctors and hospital authorities) for the supply of PBS and Repatriation Pharmaceutical Benefits Scheme (RPBS) medicine. The Department of Health and Ageing (DoHA) is responsible for PBS legislation, health policy development and the overall management of the PBS, including the *Schedule of Pharmaceutical Benefits*. The Department of Veterans’ Affairs (DVA) is responsible for the legislation and policy under which the RPBS is administered.

A majority of the listed PBS items are restricted to use for a particular condition or purpose. Some of these items also carry criteria set by the Pharmaceutical Benefits Advisory Committee (PBAC) that limits supply of PBS authority prescription. PBS authority prescriptions are also used in circumstances where an increased supply may be required to meet the individual patient’s treatment needs.

In 2005–06, the PBS and RPBS subsidised more than 183 million prescriptions at a cost to the Australian Government of around $6 billion.

**Who can access PBS medicine**

The PBS entitles all Australian residents and eligible overseas visitors from countries with reciprocal health care agreements (RHCA) with Australia to obtain subsidised medicine. These countries are Italy, New Zealand, the Republic of Ireland, Finland, Norway, Malta, the Netherlands, Sweden and the United Kingdom.

To prove eligibility, a person must show their current Medicare card to the pharmacist each time they have PBS medicine supplied. People from an RHCA country will have an RHCA Medicare card, with the exception of New Zealand and the Republic of Ireland. People from these two countries will need to show their current passport.

A pharmacist must be satisfied that the person is eligible for the PBS subsidy prior to supplying a PBS subsidised medicine.

**Schedule of Pharmaceutical Benefits**

The list of medicine and the conditions for which they can be prescribed on the PBS is called the *Schedule of Pharmaceutical Benefits* (the Schedule).

The Pharmaceutical Benefits Advisory Committee (PBAC) provides recommendations to the Minister for Health and Ageing based on the clinical and cost effectiveness of the medicine. Following a positive recommendation for listing a medicine on the PBS by the PBAC, the Minister for Health and Ageing—and in some cases Cabinet—decides whether to list a medicine on the PBS.
Medicine listed in the Schedule falls into three broad categories:

1. Unrestricted benefits—medicine which has no restrictions on its therapeutic uses.
2. Restricted benefits—medicine which can only be prescribed on the PBS for specific therapeutic uses (they are noted as restricted benefit).
3. Authority required benefits—medicine which is restricted and requires prior approval from Medicare Australia or Department of Veteran Affairs (they are noted as authority required).

Only patients who satisfy the restriction criteria applicable to a particular medicine can have access to it as PBS subsidised medicine. Prescribing outside these requirements would lead to inequitable access to subsidised medicine. When patients do not meet the relevant criteria, the medicine can be prescribed as a non-PBS (private) prescription.

Certain medicine in the Schedule may be prescribed for a specific purpose, and in some instances this is required to be written on an authority prescription form. The explanatory notes in the Schedule provide information on maximum quantities, number of repeats, authority prescriptions, restrictions and other procedural details.

**Accessing the PBS Schedule**

The Government is committed to reducing the time taken to list approved drugs on the PBS so that drugs can more rapidly be made available to the Australian community. The Schedule is now published monthly, rather than three times a year as previously produced. Providing a printed version of the Schedule each month is impractical and expensive. In December 2006 the Department of Health and Ageing introduced an online monthly schedule and stopped the production and distribution of the printed version.

The Department recognises that while electronic publishing has many advantages, this is a significant change for many prescribers and pharmacists. Users of the Schedule are able to view, download to CD and/or print out their own copies of the PBS Schedule and Dental Book free of charge every month from the Department’s web site. Users have the option of purchasing a printed version or a CD with either the whole PBS Schedule, the Dental Book only, or the relevant Summary of Changes. These are available by subscribing to a “print on demand” service. Users can access this service at a time and frequency that suits their needs by visiting [www.pbs.gov.au](http://www.pbs.gov.au)
**Costs to the patient**

Patients who hold one of the following concession cards should pay the concessional** patient contribution for each pharmaceutical benefit:

- Pensioner Concession Card
- Health Care Card
- Australian Seniors Health Card
- Repatriation Pharmaceutical Benefits Card (orange)
- Repatriation Health Card for All Conditions (gold)
- Repatriation Health Card for Specific Conditions (white)
- Safety Net Concession Card.

Patients who do not hold a current concession card and who can show their current Medicare card, pay the general patient contribution towards their PBS medicine. Pharmacists charge the appropriate rate depending on the patient’s eligibility.

**PBS Safety Net**

The PBS Safety Net assists individuals and families with high prescription medicine costs. Each year the Government sets a Safety Net threshold for general and concessional patients. Once this threshold is reached the PBS medicine is either cheaper, or without cost, for the remainder of the calendar year.

**Reaching the PBS Safety Net threshold**

To qualify for the PBS Safety Net, individuals and families need to keep a prescription record form listing all PBS medicine supplied to them or their eligible family. They can ask their pharmacist for a prescription record form and hand this form in each time they have a prescription filled, or they can ask their regular pharmacist to keep a record.

Once a patient reaches the relevant threshold, they can apply for a Safety Net card to receive PBS medicine cheaper, or without cost, for the rest of the calendar year. Arrangements have been made with public hospitals so that outpatient medicine can count towards the PBS Safety Net.

**PBS Safety Net 20 day rule**

When a PBS medicine is supplied to a patient within 20 days of a previous supply of the same medicine, in some cases, the cost of this medicine will not count towards their PBS Safety Net threshold. Where a patient has already been issued with a PBS Safety Net card, they will be charged their pre-Safety Net contribution amount, and not their current PBS Safety Net amount.

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** Eligible overseas visitors are considered “general” patients regardless of their status in their home country.
PBS eligibility

To prove eligibility, each time a patient gets a prescription filled, they must show the pharmacist their current:

• Medicare card
• concession card (if they have one) from Centrelink and/or their Department of Veterans’ Affairs health card
• PBS Safety Net entitlement or concession card (if they have one)
• a current passport for people residing in countries that are covered by a Reciprocal Health Care Agreement who have not been issued with Medicare cards.

If the patient cannot show their card(s), they may have to pay the full price for the medicine. If this happens they should ask the pharmacist for an official PBS refund receipt (not just a regular docket) as they may be able to claim some of the cost back.

One subsidy level for similar medicine types (therapeutic group premiums)

The Schedule of Pharmaceutical Benefits shows differences in price in some therapeutic groups where alternative drugs may have a therapeutic group premium.

The Therapeutic Group Premium policy applies within narrowly defined therapeutic sub-groups where the drugs concerned are of similar safety and health outcomes.

The Australian Government, through the PBS, subsidises up to the price of the lowest priced drug in the group. This means that consumers may have to pay for more expensive drugs (those with a therapeutic group premium). This extra amount does not count towards their PBS Safety Net threshold.

Therapeutic group premiums apply where a prescriber has prescribed a drug within a therapeutic group that attracts a therapeutic group premium and has not sought an exemption from Medicare Australia on clinical grounds.

The exemption provisions are:

• adverse effects occurring with all of the base-priced drugs
• drug interactions occurring with all of the base-priced drugs
• drug interactions expected to occur with all of the base-priced drugs or
• transfer to a base-priced drug would cause patient confusion resulting in problems with compliance.

The premiums are not a Government charge but reflect the fact that the supplier(s) of the drug charge a price higher than the Government is willing to subsidise.

Under the Therapeutic Group Premium policy drug substitution by pharmacists is not permitted.

The Government provides one subsidy level in the four groups of drugs that have similar clinical effects. These groups are:

• HMG COA Reductase inhibitors (statins)
• ACE inhibitors, plain
• Dihydropyridine-derivative calcium channel blockers
• \(H_2\)-receptor antagonists.
Different brands of the same medicine (brand premiums)

The Schedule of Pharmaceutical Benefits (the Schedule) shows differences in price between some alternative brands of the same drug product.

Manufacturers can develop generic equivalents and apply to have them listed on the PBS. In doing this, manufacturers need to ensure that they comply with the relevant legislation applicable to patents. These brands are clinically equivalent and must undergo the same strict quality controls. Although these brands are designed to act on the body in exactly the same way, they are usually cheaper than the originator brands.

The Australian Government, through the PBS, subsidises up to the price of the lowest priced brand (except in those instances where the lowest priced brand has, as part of its price, a therapeutic group premium). This means that consumers may have to pay extra for more expensive brands (those with a brand premium). This extra amount does not count towards their PBS Safety Net threshold.

Brand substitution by pharmacists without reference to the prescriber is permitted for PBS prescriptions where:

- the patient agrees to the substitution
- the brands are identified in the Schedule as being interchangeable
- the prescriber has not indicated on the prescription form that substitution is not to occur
- substitution is permitted under the relevant state or territory legislation.

Prescription forms supplied by Medicare Australia contain a box to be ticked when brand substitution is not to take place.

Prescribers not using these prescription forms should endorse the prescription if brand substitution is not permitted. Where a stamp is used for this purpose, the prescriber is required to initial the stamped statement.

Special patient contributions

A special patient contribution is payable for a pharmaceutical benefit when there is a disagreement between the manufacturer and the government over the dispensed price for that benefit item. This extra charge is paid by all patients, together with their usual patient contribution. Other than for bleomycin sulfate, exemptions on medical grounds are available through authority applications.

Highly Specialised Drug Program

Background

A Highly Specialised Drug (HSD) is medicine for the treatment of chronic conditions that, due to its clinical use or other special features, is restricted to supply through public and private hospitals with access to appropriate specialist facilities. Australian Government funding for the specialised medicine is provided under the HSD Program.
Prescribing HSDs

Initiation of treatment with a HSD is restricted to doctors affiliated with specialist hospital units. A doctor may only prescribe maintenance HSD therapy under the guidance of the treating specialist. Doctors accredited by state programs with HIV/AIDS prescribing status may under the rules of the HSD Program initiate therapy for HIV/AIDS patients.

Who can be treated with an HSD?

To be eligible to receive treatment under the HSD Program, a patient must attend a participating hospital and be a day-admitted patient, a non-admitted patient or a patient on discharge. The patient must be under appropriate specialist medical care, meet the specific medical criteria and be an Australian resident in Australia (or other eligible person) as defined in section 3 of the Health Insurance Act 1973.

Dispensing and supply arrangements

HSDs are listed on the PBS as “authority required” items. All approved community pharmacies and approved private hospital dispensaries may dispense HSDs to private hospital non-admitted patients. Public hospital arrangements for the supply of HSDs remain unchanged.

HSD prescriptions must have prior authority approval before they can be dispensed. Please ensure the prescription has been approved and telephone authorities endorsed with the telephone approval number. The telephone authority approval number for an HSD starts with “HSD”.

The dispensing pharmacist will not be paid for prescriptions supplied without prior authority approval.

Dual listings

A number of items (for example, Interferon) are listed as non-HSD items in the white pages of the Schedule and as HSD items in the apricot pages. There is a differential pricing structure between the different listings. It is important that before dispensing, pharmacists ascertain under which category the drug has been approved, by referring to the approval endorsed on the prescription denoting a HSD approval. The telephone authority approval number for a HSD starts with “HSD”.

If the authority approval does not denote an HSD approval then the drug prescribed should be dispensed as a non-HSD authority item.

Special pricing arrangements have been agreed between the Australian Government and some pharmaceutical manufacturers. The drugs affected are abacavir sulfate (Ziagen), bosentan monohydrate (Tracleer), fosamprenavir calcium (Telzir), iloprost trometamol (Ventavis), zoledronic acid (Zometa), somatropin (multiple brands), progesterone (Crinone 8%), and efavirenz (Stocrin). For information on Pharmaceutical Benefits Pricing Authority therapeutic relativity sheets, visit www.health.gov.au and search for “relativity sheets”.
Overseas visitors

Where a patient is entitled to be treated as an eligible person, under section 7 of the Health Insurance Act 1973 (a visitor from a country with which Australia has entered into a Reciprocal Health Care Agreement), the supply of an HSD will be limited to the original prescription only. Repeat prescriptions are not permitted.

If you would like further information about the HSD Program, please contact Medicare Australia on 132 290* or the Department of Health and Ageing on (02) 6289 7238.

How to write a PBS prescription

For items supplied under the PBS, practitioners should use their own personalised PBS prescription pads and authority forms. Medicare Australia recommends that doctors wishing to issue a computer-generated prescription use Medicare Australia computer stationery which incorporates security features.

Please use a ballpoint pen to write the prescription as fountain pens, felt-tip pens and others do not produce good quality carbon copies. Please ensure the following details are included:

- the prescriber’s name, address and telephone number of hospital or surgery (rather than a mobile number)
- prescriber number
- patient’s name and residential address (do not use post office box numbers)
- date prescription is written
- name of the medicine (either generic or brand name) the patient is to receive including strength, form, quantity—expressed as a number—and number of repeats
- instructions about the dose and frequency to be printed on the label by the pharmacist
- prescriber’s signature.

This information needs to be included for the prescription to be valid under PBS legislation. It is also required under most state and territory legislation. Without this information pharmacists may not be able to supply PBS subsidised medicine which may cause inconvenience/disadvantage to a patient.

Please include the patient’s Medicare number (including the individual reference number) or Veterans’ Repatriation entitlement number in the appropriate spaces on the prescription form. The inclusion of this number will help ensure pharmaceutical benefits are provided only to those people eligible to receive them.

Please ensure the instructions for the patient are as specific as possible. For example, “Take as directed”, can be confusing and dangerous to the patient and is illegal in some states.

Some items under the PBS may only be prescribed for a specific purpose or indication. The prescriber must ensure items are appropriately prescribed. In some circumstances the supply must be sought on a PBS authority prescription. Procedures to be followed in these circumstances are in the explanatory notes to the Schedule of Pharmaceutical Benefits.

* Local call rates. Normal mobile and public phone charges apply.
The following information is a guide when writing prescriptions:

- you cannot prescribe the same item for the same patient more than once on the same day
- there should be no more than three items on a PBS prescription. (There may be up to 10 items on a PBS reform public hospital prescription. This may include multiple authority required items.)
- if the doctor wants a patient to receive a specific brand of medicine, tick the “brand substitution not permitted” box
- many items are restricted to specific conditions when they are prescribed as pharmaceutical benefits. Practitioners are responsible for ensuring they have prescribed in accordance with the restrictions. For example, pethidine injections may only be prescribed as a PBS item for “short term treatment of acute pain”.
- be aware of state or territory legislation if prescribing a narcotic.

**PBS prescriptions in public hospitals**

Under the Australian Health Care Agreements the public hospital pharmaceutical reforms provide eligible patients in participating public hospitals with access to subsidised medicine under the PBS. A range of chemotherapy pharmaceuticals are also available via the Chemotherapy Pharmaceuticals Access Program (CPAP). Participating hospitals are required to adopt the Australian Pharmaceutical Advisory Council guidelines on the continuum of pharmaceutical care between the hospital and the community.

Currently prescribers at approved participating public hospitals in Victoria, Queensland and Western Australia may write PBS prescriptions for:

- eligible outpatients
- day admitted or non-admitted patients receiving chemotherapy
- patients on discharge from hospital.

The medicine can be supplied from the participating public hospital pharmacy or from an approved community pharmacy.

CPAP medicine may only be supplied by an approved public hospital pharmacy.

When writing a PBS public hospital prescription:

- all medicine on the one prescription must be written by the same practitioner and if it is authority required medicine, approval sought by the prescribing practitioner
- there can be up to 10 items on one prescription and may include multiple authorities, PBS and non-PBS items
- it is acceptable to include authority required and non-PBS medicine together with PBS medicine on the one PBS public hospital prescription. However each authority required medicine must have its own unique authority approval number.
10 steps—how medicine is subsidised and listed through the PBS

1. Research and development

Research and development is the first stage of a new medicine reaching the market. Australian companies participate in most phases of the development of new and improved medicine, from research concept, pre-clinical and clinical testing through to registration and distribution.

Research and development for a medicine takes, on average, more than 12 years and can cost around $930 million for each medicine that reaches the market (some estimates are higher).

2. Therapeutic Goods Administration (TGA)

When a manufacturer wants to put a new medicine on the Australian market, the TGA carries out a range of assessment and monitoring activities to ensure the quality, safety and efficacy of the medicine is acceptable.

3. Pharmaceutical Benefits Advisory Committee (PBAC)

Following approval from the TGA for the marketing of a medicine in Australia, a manufacturer may apply to the PBAC for a medicine to be listed on the PBS. The PBAC is an expert group of health professionals and a consumer representative, which makes recommendations to the Minister for Health and Ageing about the listing of medicines on the PBS. The PBAC meets three times a year and is required to consider both the clinical and cost effectiveness of a medicine when making recommendations.

4. Pharmaceutical Benefits Pricing Authority (PBPA)

Once the PBAC has recommended listing a medicine on the PBS, the PBPA recommends a price range for the medicine to the Minister for Health and Ageing. Once a price has been approved by the Minister, the Department of Health and Ageing negotiates a final price with the manufacturer.

The PBPA also reviews the prices for medicine already listed on the PBS.

5. Minister’s approval

The Minister for Health and Ageing receives recommendations from the PBAC on medicine to be listed on the PBS. If the PBAC recommends listing of a medicine the Minister decides whether to approve the listing of the medicine on the PBS and, if necessary, seeks Cabinet approval.

6. Medicine listed in the Schedule of Pharmaceutical Benefits

Once a medicine has been approved for subsidy through the PBS, the medicine is listed in the Schedule of Pharmaceutical Benefits, which is published monthly and available at www.pbs.gov.au
7. Practitioners prescribe PBS medicine

The Australian Government subsidises medicine listed on the PBS. Any medicine that falls below the general patient contribution rate does not attract a subsidy for general patients. Some medicine costs hundreds of dollars, but patients who are prescribed medicine under the PBS will generally only pay a small part of this amount. There are two levels of subsidy, one for general patients and a greater subsidy for concession cardholders such as pensioners.

The PBS Safety Net is in place to protect individuals and families who use a lot of PBS medicine.

8. Pharmacists supply PBS medicine

An approved pharmacist (in some cases, an approved medical practitioner or an approved hospital authority that supplies PBS medicine) supplies prescription medicine on the PBS at the general**, concessional, or applicable PBS Safety Net rate.

9. Pharmacist makes a claim

After a pharmacist supplies a PBS medicine, they submit a claim along with the relevant physical prescriptions to Medicare Australia for remuneration.

10. Medicare Australia processes claim

Medicare Australia processes all claims submitted by pharmacists and reimburses them for the cost of the medicine less the patient contribution and premiums where applicable.

Pharmacy claiming

Pharmacies are able to send their PBS claims to Medicare Australia in a number of ways. These are:

- paper-based
- diskette
- online.

Paper-based and diskette claiming has been available to pharmacies for a number of years. Only a small percentage of pharmacies use the paper-based claiming with the remainder of pharmacies using diskette or online claiming.

Online claiming for PBS was introduced to pharmacies in late 2004 and allows a pharmacist to receive a real-time, online assessment of a prescription at the time the medicine is being dispensed. Any errors that are present on the prescription will also be returned to the pharmacist in real-time, including entitlement checking of the patient and confirmation of the authority details for authority prescriptions.

It is important that information supplied by practitioners on the script is accurate and complete, to reduce the number of errors experienced by pharmacists. Errors may result in increased phone calls to practitioners confirming the prescription details and the customer may also be inconvenienced/disadvantaged.

** Eligible overseas visitors are considered “general” patients regardless of their status in their home country.
Ordering prescription pads and authority forms

Supplies of personalised PBS prescription pads and forms (standard and authority), which are used in prescribing medicine listed in the PBS, may be obtained by completing an order form and returning the order form to:

- Prescription Pad Order Clerk
- Pharmaceutical Branch
- Medicare Australia
- GPO Box 9826
- Sydney NSW 2001
- Telephone: (02) 9895 3295

Medicare Australia also provides prescription forms in single sheet format suitable for use in medical computer systems. These forms meet both state and commonwealth laws and are available in units of 2000 up to a maximum of 6000 per order for each provider, free of charge.

Order forms may be obtained and enquiries made by calling 132 290*.

Authority prescription applications

Authority prescriptions are required for certain PBS medicines, and where the doctor feels the patient requires an increased number of repeats or a quantity greater than the maximum listed in the Schedule of Pharmaceutical Benefits.

Authority medicine must be written on the correct stationery (only one item per prescription). Hospital authorities can have more than one item per prescription.

Currently a doctor must contact Medicare Australia to obtain an authority approval each time they prescribe an authority required medicine, or when prescribing increased quantities and/or repeats.

Approvals for PBS subsidies on “authority required” items can be obtained by calling 1800 888 333 or by mailing the PBS prescription to:

- REPLY PAID 9857
- PBS Authority Section
- Medicare Australia
- GPO Box 9857 in each state capital city

On 1 July 2007 a streamlined process will apply under certain conditions. Under the new process a doctor will no longer need to contact Medicare Australia to receive approval. The medicines affected by the new process will be related to chronic conditions such as diabetes and osteoporosis. The process will not change, however, for all other authority required medicines or for increased quantities and/or repeats greater than listed in the Schedule of Pharmaceutical Benefits.

Some tips to save time:
- include the patient’s Medicare number (including the individual’s reference number) to allow identification of the patient more efficiently
- where an authority approval is obtained by telephone, the third (Medicare Australia) copy

* Local call rates. Normal mobile and public phone charges apply.
should not be mailed to Medicare Australia. Retain it for 12 months.

- each authority prescription requires separate approval and the approval number cannot be reused
- only apply for approval for medicine listed in the *Schedule of Pharmaceutical Benefits*, and
- estimate daily usage for items such as creams and ointments for increased quantity and/or repeat approvals. Daily usage is used to determine the maximum quantity allowed.

Telephone approvals for narcotic preparations only allow for a maximum of one month’s supply. Three months’ supply may be granted upon approval of written application.

Authority applications for PBS, and Repatriation PBS medicine for veterans and war widows or widowers, are approved by the Department of Veterans’ Affairs.

Written applications can be sent to:

REPLY PAID 372
VAPAC (Veterans’ Affairs Pharmaceutical Approvals Centre)
GPO Box 9998
Brisbane QLD 4001
Freecall 1800 552 580

**Fourth Community Pharmacy Agreement**

The Fourth Community Pharmacy Agreement is the fourth cooperative agreement between the Australian Government and the Pharmacy Guild of Australia. It represents a five-year collaborative relationship between the parties from 1 December 2005 to 30 June 2010.

The Agreement offers certain incentive payments for community pharmacy to provide services to consumers that are designed to improve the use of medicine.

Medicare Australia administers the incentive payments for the following services:

- Home Medicine Review
- Medicine Information to Consumers
- Rural Pharmacy Maintenance Allowance
- Start up Allowance
- Succession Allowance
- Aboriginal Health Services
- Pharmacy Availability/Remoteness Index of Australia.

**Home Medicine Review**

The Home Medicine Review is designed to assist people living at home to maximise the benefits of their medicine regimen and prevent medicine-related problems. It is not available for in-patients of a hospital, day hospital facility or care recipients in residential aged care facilities.

A Home Medicine Review rural loading payment is also available to assist pharmacies in rural and remote areas with their travel costs when visiting people’s homes to perform a Home Medicine Review service.
Medicine Information to Consumers

The Medicine Information to Consumers program provides an incentive payment to encourage pharmacists to promote the quality use of medicine and assist consumers to make informed decisions.

Eligible pharmacists receive incentive payments for providing consumer medicine information at the rate of 10 cents per subsidised paid prescription. From 1 December 2005 the PBS and Repatriation PBS dispensing fees include these payments.

Rural Pharmacy Maintenance Allowance

The Rural Pharmacy Maintenance Allowance recognises the additional financial burden of maintaining a pharmacy in rural and remote areas of Australia.

This monthly allowance may be paid to eligible proprietors of approved pharmacies, approved under section 90 of the National Health Act 1953, providing support to a significantly increased number of community pharmacies.

Start-up Allowance

The Pharmacy Start-up Allowance was introduced to encourage the establishment of new pharmacies in remote locations. Under this initiative a maximum payment of $100 000—three payments over a two-year period—may be paid to eligible pharmacists.

Succession Allowance

The Pharmacy Succession Allowance was introduced to encourage the establishment and retention of pharmacies in remote locations and provides eligible pharmacists with a maximum payment of $60 000—three payments over a two-year period.

Aboriginal Health Services (AHS)

Where a community pharmacist supplies medicine to a remote area, through AHS arrangements made under section 100 of the National Health Act 1953, an allowance of between $2000 and $3500 per annum, plus a component for GST, may be paid to the pharmacist for providing a range of services to support the AHS in its implementation of the section 100 supply arrangements. An additional travel loading of $1000 may also be paid where the round trip distance between the community pharmacy and the outstation is more than 150 km by road.

Services to be provided by the pharmacies include: medicine management, training of Aboriginal Health Workers in the handling of drugs, and supervision of medication held by these communities such as out-of-date stock, etc.

Pharmacy Availability/Remoteness Index of Australia

The Pharmacy Availability/Remoteness Index of Australia is an index developed by the University of Adelaide to measure the remoteness of pharmacies. There are six categories which are used as eligibility criteria for the Start-up Allowance and other rural allowances. Further information can be found by visiting the University of Adelaide internet site—www.gisca.adelaide.edu.au or by calling Medicare Australia on (08) 8274 9641.
**Taking and sending PBS medicine overseas**

Under the *National Health Act 1953* it is illegal to take or send PBS medicine overseas unless that medicine is for the personal use of the carrier or sender, or the personal use of someone travelling from Australia with them. Illegally exporting PBS medicine is an offence and can attract a penalty of up to two years imprisonment and/or a $5000 fine.

When someone is planning to take or send PBS medicine overseas for their personal use or the personal use of someone travelling with them, they should:

- contact the embassy of the country they are visiting to ensure the medicine is legal there
- carry or enclose a letter from their doctor detailing what the medicine is, how much they will be taking or sending, and stating that the medicine is for their personal use
- leave the medicine in its original packaging.

If the medicine is being sent, so that it is at the destination before the patient arrives, the sender should also attach to their parcel a completed Customs declaration form. The form is available from any post office and must disclose that the package contains PBS medicine which is for personal use of the sender or someone who will be travelling with them.

If a person does not have appropriate documentation with them when they travel they may be suspected of illegally exporting PBS medicine and their medicine may be detained by the Australian Customs Service.

To help doctors in assisting their patients, Medicare Australia has developed a template letter which is available at the Health Care Providers section of Medicare Australia’s web site.

It is also an offence for a person to take or send overseas more than the designated quantity of a PBS medicine, unless that quantity was supplied by an approved supplier for their medical or dental treatment, or they have some other reasonable excuse for carrying or sending that amount.

The designated quantity can be calculated using this formula, as set out in section 103(4AC) of the Act:

\[ MQ \times (RA + 1) \times 2 \]

Where:

- MQ (found in the *Schedule of Pharmaceutical Benefits* under the Maximum Quantity column) is the quantity or number of units of that pharmaceutical benefit that is determined by the Minister for Health and Ageing, under paragraph 85A(2)(a) of the Act, to be the maximum quantity or the maximum number of units of that pharmaceutical benefit that may, in one prescription, be directed to be supplied on any one occasion, and
- RA (found in the *Schedule of Pharmaceutical Benefits*, under the Number of Repeats column) is the number (if any) that is determined by the Minister for Health and Ageing, under paragraph 85(2)(b) of the Act, to be the maximum number of occasions on which the supply of the pharmaceutical benefit may, in one prescription, be directed to be repeated.

For more information about taking or sending PBS medicine overseas, or to order information resources, call Medicare Australia on **1800 500 147** or visit the Health Care Providers section of Medicare Australia’s web site.
PBS medicine in excess of therapeutic need

Medicare Australia is working to identify and reduce the number of patients obtaining PBS medicine in excess of therapeutic need.

If a prescriber suspects their patient is seeking to obtain PBS medicine in excess of medical need, they can call the Medicare Australia Prescription Shopping Information Service. To use the service, they must complete a registration form which is available at the Health Care Providers section of Medicare Australia’s web site. Once registered, prescribers can call the Information Service 24 hours a day, seven days a week on 1800 631 181 to find out if one of their patients has been identified under the Prescription Shopping Program and, if so, to obtain information on the amount and type of PBS medicine recently supplied to that patient.

If a patient is obtaining PBS medicine in excess of therapeutic need, Medicare Australia may:
- contact the prescriber to request a meeting
- in the case where there are many different prescribers, write to those prescribers advising of the patient’s PBS medicine usage.

If Medicare Australia contacts a prescriber, or a prescriber contacts Medicare Australia about a patient, and they are provided with the patient’s PBS information, Medicare Australia suggests that they advise their patient at their next visit.

For more information visit the Health Care Providers section of Medicare Australia’s web site www.medicareaustralia.gov.au or call Medicare Australia on 1800 631 181.

Confidentiality

All authority prescribing information is confidential and all Medicare Australia staff are legally bound by strict privacy and confidentiality requirements.

If you have any queries or concerns please call 132 290* and ask to speak to a pharmaceutical adviser.

Keeping up-to-date

As new medicine is being marketed all the time, it is important to be aware of changes in therapeutics. Prescribers are entitled to receive Australian Prescriber, the independent review of therapeutics, as well as National Prescribing News and Adverse Drug Reactions Advisory Committee Bulletin, all free of charge. To enquire about joining the mailing list, write to:

Australian Prescriber
PO Box 100
Woden ACT 2606
Telephone: (02) 6282 6775
Fax: (02) 6282 6855
Email: info@australianprescriber.com
www.australianprescriber.com.au

* Local call rates. Normal mobile and public phone charges apply.
Section 8
Veterans’ Affairs processing

Background
Repatriation health and pharmaceutical cards
Procedural checklist for consultations
DVA paperless claiming
Contacts
Veterans’ Affairs processing

Background

Medicare Australia processes claims for services to veterans (and other entitled persons) on behalf of the Department of Veterans’ Affairs (DVA). These accounts include medical, hospital and allied health services.

Repatriation health and pharmaceutical cards

Repatriation health cards are issued by the DVA to veterans and dependants who are eligible under either the Veterans’ Entitlements Act 1986 or the Military Rehabilitation and Compensation Act 2004 for treatment at the Department’s expense.

Three types of repatriation health and pharmaceutical cards are issued by Medicare Australia on behalf of DVA:

Gold Card Repatriation Health Card - for all conditions

The Gold Card enables the holder to access health care and related services for all health care needs, for all conditions, whether they are related to war service or not.

White Card Repatriation Health Card - for specific conditions

Orange Card - Repatriation Pharmaceutical Benefits Card
A comprehensive range of medical, hospital, pharmaceutical, dental and allied health services is available to Gold Card holders, in addition to travel assistance to and from the nearest health care facilities where treatment is being provided.

The White Card enables the holder to access health care and associated services for war or service-related conditions. On application, veterans of Australian forces may be issued this card to receive treatment for malignant cancer, pulmonary tuberculosis and post traumatic stress disorder, irrespective of whether these conditions are related to war service or not.

White Card holders are eligible to receive, for specific conditions, treatment from medical, hospital, pharmaceutical, dental and allied health care providers with whom DVA has arrangements. Travel assistance may also be available to and from the nearest health care facilities where treatment is being provided.

A White Card is also issued to ex-service personnel who are eligible, under arrangements between the Australian Government and New Zealand, Canada, South Africa and the United Kingdom, for treatment of conditions accepted as war-caused by their country of origin.

The Orange Card enables the holder to access the range of pharmaceutical items available under the Repatriation Pharmaceutical Benefits Scheme (RPBS). The Orange Card entitles the holder to purchase pharmaceutical items at a concessional rate. When the annual safety net level is reached there are no further co-payment charges for RPBS-listed items for that calendar year. The Orange Card also entitles the holder to receive a fortnightly pharmaceutical allowance to help offset the cost of prescriptions.

**Procedural checklist for consultations**

**When a veteran attends a practice for a consultation**

1. Check the veteran’s eligibility for treatment. If the veteran is a White Card holder, or an allied veteran, some restrictions may apply.
2. Treat the veteran.
3. Certify a Form D800, if presented by the veteran, to allow him/her to claim reimbursement for travelling expenses from Department of Veterans’ Affairs (DVA) for their consultation.
4. Ensure that the veteran signs the Treatment Services Voucher before leaving the surgery.

**When referring a veteran on to another health care provider**

1. Check the veteran’s eligibility for the treatment. If the veteran is a White Card holder, or an allied veteran, some restrictions may apply.
2. Check that the other health care provider treats DVA patients, whether DVA contracted providers are available, and, if that provider is a specialist, that he or she accepts DVA fees as full payment for services.
3. Advise the other health care provider of the veteran’s eligibility.
4. Arrange transport, if clinically necessary, for the veteran to attend the treatment.
5. Certify a Form D800, if presented by the veteran, to allow him/her to claim reimbursement for travelling expenses from DVA for their consultation.
6. Ensure that the veteran signs the Treatment Services Voucher before leaving the surgery.
When arranging an admission to hospital

1. Check the veteran’s eligibility for the treatment. If the veteran is a White Card holder, or an allied veteran, a prior eligibility assessment and financial authorisation may be necessary.

2. Arrange the admission with the nearest suitable Tier 1 hospital.

3. If a Tier 1 hospital is not available, seek approval from DVA for admission to a Tier 2 or 3 hospital.

4. Advise the hospital of the veteran’s eligibility.

5. Arrange transport, if clinically necessary, for the veteran to attend the hospital.

6. Certify a Form D800, if presented by the veteran, to allow him/her to claim reimbursement for travelling expenses from DVA for their consultation.

7. Ensure that the veteran signs the Treatment Services Voucher before leaving the surgery.

When providing a prescription for a veteran

1. Check the veteran’s eligibility for the medication. If the veteran is a White Card holder, or an allied veteran, some restrictions may apply.

2. Ensure that the prescription form is clearly marked as RPBS.

3. Ensure that the patient is aware that he/she needs to present his/her Repatriation Health Card when filling the prescription.

4. Certify a Form D800, if presented by the veteran, to allow him/her to claim reimbursement for travelling expenses from DVA for their consultation.

5. Ensure that the veteran signs the Treatment Services Voucher before leaving the surgery.

Distinguishing between LMO and other General Practitioners

- Local Medical Officer (LMO)—A medical practitioner registered with DVA and participating in the Repatriation Comprehensive Care Scheme to provide and arrange medical services for veterans; and

- Other General Practitioner—a medical practitioner who is not registered with DVA but is able to provide and arrange medical services for veterans, attracting lower fees.

For detailed information and to register to become a LMO visit http://www.dva.gov.au

DVA paperless claiming

DVA paperless claiming enables claims from medical and pathology providers to be processed without supporting paperwork—Medicare Claims Review Panel items excluded. To take advantage of paperless claiming you will need to upgrade your practice management software.

This facility also includes Online Veteran Verification (OVV). OVV enables a practice location to check if a veteran, or other eligible person, is known to Department of Veterans’ Affairs (DVA) before a claim is lodged.
For further information relating to DVA paperless claiming:

Technical enquiries from practitioners and practice managers should be directed to the e-Business Service Centre in their state on 1800 700 199.

Contacts

For enquiries relating to a veteran’s entitlement, please contact your Department of Veterans’ Affairs (DVA) state office on 133 254*.

Enquiries related to veterans’ treatment claims submitted for payment should be directed to one of the following numbers and claims can be submitted to the following addresses:

**Allied health claims Australia-wide**

PO Box 964 Adelaide SA 5001
Phone: 1300 550 051*

**Medical and hospital claims for Victoria, Queensland and Tasmania**

Medical:

PO Box 9869 Melbourne VIC 3001
Phone: 1300 550 017*

Hospital:

PO Box 9917 Melbourne VIC 3001
Phone: 1300 551 002*

**Medical and hospital claims for ACT, NSW, NT, SA and WA**

Medical:

PO Box 9869 Perth WA 6848
Phone 1300 550 017*

Hospital:

PO Box 9917 Perth WA 6848
Phone: 1300 551 002*

For queries related to electronic data interchange issues please contact Medicare Australia on 1300 550 115*.

* Local call rates. Normal mobile and public phone charges apply.
Section 9
Practice Incentives Program

Practice Incentives Program (PIP)
How to apply for the Practice Incentives Program
Notification of changes to practice arrangements
Practice Incentives Program

The Practice Incentives Program (PIP) aims to recognise general practices that provide comprehensive quality care and which are either accredited or working towards accreditation against the Royal Australian College of General Practitioner’s Entry Standards for General Practices.

The PIP is part of a blended payment approach for general practice. Payments made through the program are in addition to other income earned by General Practitioners and the practice, such as patient payments and Medicare benefits.

The PIP aims to compensate for the limitations of fee-for-service arrangements where practices that provide numerous quick consultations receive higher rewards than those who take the time to look after the ongoing healthcare needs of their patients. High throughput of patients is also associated with unnecessary prescribing, tests and referrals.

PIP payments are mainly dependent on practice size, in terms of the nature of the patients seen, rather than on the number of consultations performed.

Payments focus on aspects of general practice that contribute to quality care. These include the use of information management/information technology, provision of after-hours care, student teaching and better prescribing.

PIP incentives have been introduced to encourage practices in rural areas and areas of workforce shortage to address the difficulties of providing care. Incentives are paid to employ a practice nurse, encourage cervical screenings, improve the management of diabetes, asthma and mental health conditions, and in rural areas to encourage General Practitioners to provide procedural services. To assist in small country towns or isolated communities the PIP payments have a rural loading.

How to apply for the Practice Incentives Program

Practices wishing to participate in the Practice Incentives Program (PIP) can obtain an information package by calling 1800 222 032 or by downloading the application form from Medicare Australia’s web site.

The information package includes an application form, which should be completed and forwarded to:

Practice Incentives Program
GPO Box 2572
Adelaide SA 5001
Fax: (08) 8274 9352
Notification of changes to practice arrangements

The Practice Incentives Program should be advised in writing, by the authorised person nominated by the practice, of any changes in practice arrangements as soon as possible. If this is not done, payment may be reduced or the practice’s continuing eligibility for the program may be affected. In particular, Medicare Australia should be notified immediately of any changes regarding practitioners, location or if a practice ceases to operate.

Notifications should be sent or faxed to the address above. Changes notified by fax must be signed by the authorised contact person and witnessed by another member of the practice. This must be done in addition to contacting any other relevant part of Medicare Australia (for example, the Medicare Provider Liaison section).
Section 10
Immunisation

Australian Childhood Immunisation Register
General Practice Immunisation Incentives Scheme
**Immunisation**

**Australian Childhood Immunisation Register**

The Australian Childhood Immunisation Register (ACIR) began operation on 1 January 1996. The ACIR records details of vaccinations given to children under the age of seven who live in Australia.

In 1997, the Immunise Australia Seven Point Plan was developed to lift immunisation rates in Australia. The Immunise Australia Seven Point Plan also links a child’s immunisation status to the payment of family assistance benefits to families, such as the Maternity Immunisation Allowance and Child Care Benefit.

**How the ACIR works**

When an immunisation provider, including General Practitioners, some hospitals and local councils vaccinate a child, they should record the details and send them to the ACIR as soon as possible. Since 1 May 2000, providers have received a notification payment of up to $6.00 for sending information to the ACIR about a vaccination that completes one of the six individual immunisation schedules. All payments are made monthly via electronic funds transfer into the financial institution account nominated by the practitioner.

**Sending data to the ACIR**

Information can be sent to the ACIR by:

- completing a manual encounter form
- electronic data interchange
- by accessing the ACIR’s secure area on Medicare Australia’s web site
- by the Internet using Medicare Australia’s online claiming.

For more information about sending data by the Internet, call the ACIR help desk on 1300 650 039*. Practitioners using Medclaims to submit claims data to Medicare Australia may wish to contact their software vendor to discuss using a similar system for the electronic transmission of immunisation data. Practitioners can also obtain a list of software vendors who have developed software which complies with the formats required for the ACIR by calling the software vendor help desk on 1300 550 115*.

Most practitioners in Queensland and the Northern Territory report immunisation services to their state/territory immunisation register, which in turn forwards immunisation notifications to the ACIR.

**Medicare Australia’s online claiming**

If you have a practice management system and your software vendor offers online claiming functions, you may be able to use the Internet to submit immunisation data to the ACIR. For more information, call the eBusiness Service Centre on 1800 700 199.

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* Local call rates. Normal mobile and public phone charges apply.
Hints for submitting data

When sending information to the ACIR, children should be identified by their Medicare number whenever possible. If the Medicare number is not available, it will be necessary to record the child’s full name, address, date of birth and gender to enable the child to be properly identified.

Sending encounter information promptly to the ACIR

Delays in reporting immunisation encounters to the ACIR impact not only the ACIR reporting and coverage rates, but may also affect parents claiming some Australian Government family assistance payments. It can also delay payments to providers and cause immunisation history forms to be completed unnecessarily.

Checking a child’s immunisation record

Information on the ACIR is available to practitioners to help determine the immunisation status of a particular child. Practitioners can call 1800 653 809 for this information; however, they must have the consent of the parent or guardian of the child to receive information over the telephone. It is recommended practitioners note on the patient record that consent was obtained.

Immunisation history statements

Information held on the ACIR is used to inform parents and guardians of the immunisation status of their children at certain age milestones. These immunisation history statements are optional and parents or guardians may choose not to participate. The purpose of immunisation history statements is to increase awareness about the importance of childhood immunisation and to assist in improving immunisation levels in Australia. The statements provide useful, up-to-date information in a certificate format, and may be used by parents to help meet the eligibility criteria for the Child Care Benefit and Maternity Immunisation Allowance. The statement can also be used to meet immunisation requirements for school enrolment in NSW, ACT and Victoria if the child has received all vaccinations required by five years of age.

Recently bereaved parents

To avoid further distress to recently bereaved parents, practitioners can notify the ACIR if they know of the death of a child under seven years of age. This will help ensure parents do not receive an immunisation history statement from the ACIR.

Ordering stationery

Stationery and information material for patients can be ordered on the approved stationery order form available for download from Medicare Australia’s web site www.medicareaustralia.gov.au or by calling 1800 067 307.

More information about the ACIR

For further information about the ACIR, please call 1800 653 809. You can also find information on the ACIR from Medicare Australia’s web site.
**General Practice Immunisation Incentives Scheme**

The General Practice Immunisation Incentives (GPII) Scheme provides financial incentives to General Practitioners who monitor, promote and provide immunisation services to children under the age of seven years.

The GPII scheme is made up of three components:

- **service incentive payment**—an $18.50 payment to General Practitioners and other medical practitioners who notify the Australian Childhood Immunisation Register of a vaccination that completes one of the six individual immunisation schedules
- **outcomes payment**—a payment made to practices that achieve 90 per cent or more proportion of full immunisation
- **immunisation infrastructure funding**—provides funds to Divisions of General Practice, state-based organisations and a national General Practitioner immunisation coordinator to improve the proportion of children who are immunised at local, state and national levels.

The overall aim of the GPII scheme is to encourage at least 90 per cent of practices to achieve 90 per cent proportions of full immunisation.

**GPII scheme contacts**

For more information about the GPII scheme, please call **1800 246 101**. Further information on the GPII scheme is also available on Medicare Australia’s web site.
Section 11
Australian Organ Donor Register

Background

Donating organs and/or tissue for transplantation
Who can donate organs and tissue for transplantation
Who can register on the Donor Register
How the Donor Register works
Changing details recorded on the Donor Register
Discussing organ and/or tissue donation with family
Registering as a donor elsewhere
General Practitioner and practice staff involvement
Further information about the Donor Register
Australian Organ Donor Register

Background

The Australian Organ Donor Register (the Donor Register) provides a national and coordinated way for Australians to record their legal decision regarding organ and tissue donation for transplantation. The purpose of the Donor Register is to assist in raising awareness of organ and tissue donation, potentially leading to an increase in the number of individual donors in Australia. Through the Donor Register, Australians are being given the opportunity to help reverse Australia’s declining rate of organ and tissue donation.

Donating organs and tissue for transplantation

For many people with life-threatening or serious illnesses, organ or tissue transplantation may mean a second chance at life, or an improved quality of life. More than 30,000 Australians have received transplants in the last 60 years. Improved survival rates now mean that most recipients of organs or tissue can look forward to a better quality of life.

Who can donate organs and tissue for transplantation

Anyone can choose to donate organs and tissue—there is no age limit on the donation of some organs and tissue for transplantation. Assumptions on being too old or not healthy enough should not be made, as age and medical history will be considered at the time.

Who can register on the Donor Register

Only persons who are aged 18 years or more can register their legal consent (or objection) on the Donor Register. A registration of intent (or objection) will be received from 16 and 17-year-olds. For people under 18, consent will be discussed with a family member at the time of death.

How the Donor Register works

Entry onto the Donor Register is voluntary, and individuals can limit their donation to specific organs or tissue. Donation can involve:

- organs—including kidneys, heart, lungs, liver and pancreas
- tissue—which includes heart valves, bone tissue, skin and eye tissue.

Organ and tissue donation can only occur if a person has died under certain circumstances, and if consent to donation has been given.

Medicare Australia operates the Donor Register 24 hours a day, and information is available to authorised personnel anywhere in Australia, making it more likely that potential donors’ decisions will be available to medical staff and families when needed.

Changing the details recorded on the Donor Register

If at any time a person changes their mind about donation, they can change their details recorded on the Donor Register by calling 1800 777 203 during business hours, visiting www.medicareaustralia.gov.au/organ to download a change of details form, or visiting any Medicare office and asking for a change of details form.
Discussing organ and/or tissue donation for transplantation with family

It is important that donors discuss their decision with family, a partner or close friend. They will be an important part of the donation process and therefore should be made aware of the decision. This informs them and increases the likelihood that the donor’s decision will be carried out.

Registering as a donor elsewhere

It is important that people register their decision regarding organ and tissue donation on the Donor Register. This is the only national register for organ and tissue donation for transplantation.

Even if an expressed intention to donate organs and tissue has been made by some other means in the past, such as on your drivers licence registration on the Donor Register should be encouraged.

General Practitioner and practice staff involvement

General Practitioners and practice staff play a vital role in improving patients’ awareness of organ and tissue donation by encouraging patients to:

- think about organ and tissue donation and what it means to be a donor
- talk to their family so their family knows what their decisions are
- tell the Donor Register by completing a registration form or registering online.

General Practitioners and practice staff can request copies of brochures to distribute to their patients and posters to display in their surgeries by calling the Donor Register enquiry line 1800 777 203 during business hours.

Further information about the Donor Register

Visit your local Medicare office.

Phone: 1800 777 203
Email: aodr@medicareaustralia.gov.au
Mail: GPO Box 711 Hobart TAS 7001
Internet: www.medicareaustralia.gov.au/organ (online registration available)
Section 12
Rural and Remote Incentive Schemes

- HECS Reimbursement Scheme
- General Practice Registrars’ Rural Incentive Payment Scheme
- Rural Retention Program
- Training for Rural and Remote Procedural General Practitioners Program
Rural and Remote Incentive Schemes

**HECS Reimbursement Scheme**

The Higher Education Contribution Scheme (HECS) Reimbursement Scheme (the HECS Scheme) was announced in the 2000–01 Federal Budget as part of the *Regional Health Strategy: More Doctors, Better Services*. The HECS Scheme aims to promote careers in rural medicine and, in the longer term, increase the number of doctors in rural and regional Australia.

To be eligible for the HECS Scheme, applicants must:

- be an Australian or New Zealand citizen or a permanent resident of Australia
- have completed an Australian accredited medical course for which a HECS fee was payable
- have completed their medical degree in the year 2000 or later
- undertake training or provide services in Rural, Remote and Metropolitan Area (RRMA) categories 3–7 locations.

Under the HECS Scheme, eligible medical graduates have one-fifth of their HECS debt reimbursed for each year of training undertaken or service provided in rural and remote areas of Australia. For the purposes of the HECS Scheme, a designated rural area is defined as RRMA categories 3–7 locations. These locations include large rural centres, remote centres and smaller rural and remote centres.

Reimbursements under the HECS Scheme are made to eligible graduates following an initial 12 months service in a designated rural area. Subsequent payments are made after each six-month period of service.

**How to apply**

Guidelines and application forms are available by:

- contacting Medicare Australia’s HECS Helpline on **1800 010 550**.

Completed Application Forms should be forwarded to:

HECS Reimbursement Scheme
Medicare Australia
GPO Box 2572
Adelaide SA 5000
Fax: (08) 8274 9373

**Notification of changes**

Medicare Australia should be advised in writing, as soon as possible, of any changes to personal details. Notification of changes must be completed and forwarded to the above address.
**General Practice Registrars’ Rural Incentive Payments Scheme**

The General Practice Rural Incentives Payments Scheme (GPRRIPS) was announced as part of the 2000–01 Federal Budget’s *Regional Health Strategy: More Doctors, Better Services* and aims to encourage doctors to pursue a career in rural and remote general practice. Under this initiative, an additional 50 rural training places in the general practice vocational training program, and the General Practice Registrars Rural Incentives Payments Scheme were established.

GPRRIPS provides incentives to medical practitioners who undertake the majority of their general practice training in practices in Rural, Remote and Metropolitan Area category 4–7 locations. Up to $60 000 is available per registrar over three years of general practice training.

**How to apply**

Guidelines and application forms are available by contacting Medicare Australia’s GPRRIPS Helpline on 1800 700 050.

Further information is available on the Department of Health and Ageing web site at www.health.gov.au/rrips

Completed Application Forms should be forwarded to:

General Practice Registrars’ Rural Incentive Payments Scheme  
Medicare Australia  
GPO Box 2572  
Adelaide SA 5000  
Fax: (08) 8274 9373

**Notification of changes**

Medicare Australia should be advised in writing, as soon as possible, of any changes to personal details. Notification of changes must be completed and forwarded to the above address.

**Rural Retention Program**

The Rural Retention Program (RRP) is an Australian Government initiative that aims to recognise and retain long-serving General Practitioners in communities. Encouraging such General Practitioners to continue practising in these communities will contribute to better access, continuity of medical care and better health outcomes in rural and remote Australia.

The RRP determines eligible rural and remote locations using a geographic classification index known as the General Practitioner Accessibility and Remoteness Index of Australia. This index, developed specifically for the RRP, classifies localities through the application of consistent criteria that reflect issues identified as important to rural doctors (general remoteness, access to services and professional isolation measures).
The program has two payment systems:

1. Central Payments System (CPS)—administered by Medicare Australia. The CPS assesses eligibility, and the amount of payment a doctor is entitled to receive, based on Medicare and Department of Veterans’ Affairs (DVA) data relating to length of service and recent workload in eligible locations. Medicare Australia determines doctors’ payment eligibility, calculates the payment amounts, and makes payments to individual doctors.

2. Flexible Payments System (FPS)—jointly administered by state-based Rural Workforce Agencies (RWAs) and Medicare Australia. RWAs assess doctors’ payment eligibility and Medicare Australia makes payments to individual doctors. Payments to long-serving doctors whose services are not adequately reflected through the CPS are made through the FPS. For example, where particular services are provided outside Medicare or a period of acceptable leave has caused accrued eligibility to be lost.

How to apply

There is no application process under the CPS. General Practitioners are assessed automatically based on Medicare and DVA data and informed when they become eligible. General Practitioners can obtain information regarding their eligibility for payment under the CPS by phoning 1800 010 550.

General Practitioners applying for payment under the FPS component of the RRP should contact the Rural Workforce Agency in their state or territory and request an application form.

Notification of changes

Medicare Australia should be advised in writing, as soon as possible, of any changes in banking arrangements. Notification of changes must be completed by General Practitioners and forwarded to:

Rural Retention Program
Medicare Australia
GPO Box 2844
Adelaide SA 5001
Fax: (08) 8274 9373

Training for Rural and Remote Procedural General Practitioners Program

The Training for Rural and Remote Procedural General Practitioners Program (TRRPGP) was introduced as part of the Strengthening Medicare package and commenced in July 2004.

The Program has two components:

1. Support for Procedural General Practitioners (RRMA 3–7), through the provision of a grant for up to 10 days of training, up-skilling or skills maintenance activities per financial year. The grant is for a maximum of $15 000 per procedural General Practitioner per financial year. Grants are paid on a pro rata basis, dependent on the length of the training activity.
2. The Program was expanded from 1 February 2006 to also support General Practitioners providing emergency medicine services in RRMA 4–7 locations with grants backdated to include approved training completed since 1 January 2006. Eligible General Practitioners can receive up to $3000 for the cost of two days of training each financial year.

Eligibility for the emergency medicine stream is open to General Practitioners in RRMA 4–7 locations who currently provide emergency medicine services in an accident and emergency facility which is available for 24 hour triaging, rapid diagnosis and management of the acute and urgent aspects of illness and injury.

These funds are provided to assist General Practitioners with the cost of attending training, including course costs, locum relief and travel expenses.

The Australian College of Rural and Remote Medicine (ACRRM) and the Royal Australian College of General Practitioners (RACGP) jointly administer both components of the program together with Medicare Australia. Under this arrangement ACRRM and the RACGP assess the eligibility of General Practitioners and training activities and Medicare Australia makes grant payments to eligible General Practitioners.

How to apply

General Practitioners wishing to apply can obtain guidelines and application forms from Medicare Australia’s web site. On completion of the application please return to either:

- Australian College of Rural and Remote Medicine
  GPO Box 2507
  BRISBANE QLD 4001
  Fax: (07) 3105 8299

or

- Royal Australian College of General Practitioners
  Floor 1
  15 Glover Street
  NORTH ADELAIDE SA 5006
  Fax (08) 8267 8359

Notification of changes

Medicare Australia should be advised in writing, as soon as possible, of any changes to personal details. Notification of changes must be completed by the General Practitioner and forwarded to:

- Training for Rural and Remote Procedural General Practitioners
  Medicare Australia
  GPO Box 2572
  Adelaide SA 5000
  Fax: (08) 8274 9373
Section 13
Medical indemnity

*The Premium Support Scheme*

*The High Cost Claim Scheme*

*The Run-off Cover Indemnity Scheme*

*Incurred But Not Reported Scheme*

*United Medical Protection Support Payment Scheme*

*Further information about medical indemnity*
Medical Indemnity

The Premium Support Scheme

The Premium Support Scheme (PSS) is designed to assist doctors with the costs of their medical indemnity insurance. Doctors participating in the Scheme may be eligible for a reduction in the level of premiums charged to them by their medical indemnity insurer where their gross medical indemnity costs exceed 7.5 per cent of their gross private medical income. Once this threshold is reached, the PSS will cover 80 cents in the dollar for additional medical indemnity costs, including the base premium, membership fees and the United Medical Protection (UMP) Support Payment.

The High Cost Claim Scheme

The High Cost Claim Scheme (HCCS) is designed to minimise the impact that large claims may have on the ability of medical indemnity insurers to continue to provide affordable indemnity cover. All incidents that occur in the course of or in connection with a doctor’s practice as a medical practitioner should be reported to the doctor’s medical indemnity insurer.

The Run-off Cover Indemnity Scheme

The Run-off Cover Indemnity Scheme (ROCS) is designed to provide free run-off cover for eligible doctors who retire or leave the private medical workforce. Instead of doctors needing to fund their own run-off cover when they stop working, a proportion of each doctor’s insurance premium is paid into the Scheme. Indemnity cover for eligible doctors will mirror the last claims arrangement they had with their medical indemnity insurer. All incidents that occur in the course of, or connection with, a doctor’s practice as a medical practitioner should be reported to the doctor’s medical indemnity insurer.

Incurred But Not Reported Scheme

Under the Incurred But Not Reported (IBNR) Scheme, Medicare Australia will make payments on behalf of the Australian Government to medical defence organisations that have not made adequate provision for their IBNR liabilities. The Scheme subsidises the cost of claims relating to certain incidents that occurred before 30 June 2002. IBNR claims relate to periods of time when United Medical Protection Ltd offered “claims incurred” cover and end when the organisation moved to policies offering “claims made” cover.

United Medical Protection Support Payment Scheme

The United Medical Protection Support Payment Scheme (UMP SP) is the mechanism through which people who were members of United Medical Protection Ltd (UMP) on 30 June 2000 contribute to the cost of UMP’s incurred but not reported liabilities, unless exempt. The Scheme runs for four financial years (2003–04 to 2006–07) and all payments are GST exempt and tax deductible.
**Further information about medical indemnity**

To find out if you are eligible for Premium Support Scheme, please contact your medical indemnity insurer. For more information about the Scheme visit the Department of Health and Ageing web site at [www.health.gov.au/medicalindemnity](http://www.health.gov.au/medicalindemnity) or phone 1800 007 757.

To find out if you are eligible for exemption under the UMP SP scheme visit the Medicare Australia web site at [medical.indemnity@medicareaustralia.gov.au](mailto:medical.indemnity@medicareaustralia.gov.au) or phone 1800 813 167.

Abbreviations
## Abbreviations

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<td>ACIR</td>
<td>Australian Childhood Immunisation Register</td>
</tr>
<tr>
<td>ACRRM</td>
<td>Australian College of Rural and Remote Medicine</td>
</tr>
<tr>
<td>AHS</td>
<td>Aboriginal Health Services</td>
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<tr>
<td>AMA</td>
<td>Australian Medical Association</td>
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<tr>
<td>AODR</td>
<td>Australian Organ Donor Register</td>
</tr>
<tr>
<td>APA</td>
<td>Approved Pathology Authority</td>
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<tr>
<td>APAC</td>
<td>Australian Pharmaceutical Advisory Council</td>
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<tr>
<td>APP</td>
<td>Approved Pathology Practitioner</td>
</tr>
<tr>
<td>ATO</td>
<td>Australian Taxation Office</td>
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<tr>
<td>CPAP</td>
<td>Chemotherapy Pharmaceuticals Access Program</td>
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<tr>
<td>CPS</td>
<td>Central Payments System</td>
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<tr>
<td>CT</td>
<td>computed tomography</td>
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<tr>
<td>DoHA</td>
<td>Australian Department of Health and Ageing</td>
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<tr>
<td>DVA</td>
<td>Department of Veterans’ Affairs</td>
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<tr>
<td>ECG</td>
<td>Electrocardiogram</td>
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<tr>
<td>EDI</td>
<td>Electronic data interchange</td>
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<tr>
<td>EFT</td>
<td>electronic funds transfer</td>
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<tr>
<td>EPC</td>
<td>Enhanced Primary Care</td>
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<tr>
<td>FaCSIA</td>
<td>Department of Families, Community Services and Indigenous Affairs</td>
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<tr>
<td>FAO</td>
<td>Family Assistance Office</td>
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<tr>
<td>FPS</td>
<td>Flexible payments system</td>
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<tr>
<td>FTB</td>
<td>Family Tax Benefit</td>
</tr>
<tr>
<td>GP</td>
<td>General practice, General Practitioner</td>
</tr>
<tr>
<td>GPARIA</td>
<td>General Practitioner Accessibility and Remoteness Index of Australia</td>
</tr>
<tr>
<td>GPET</td>
<td>General Practice Education and Training Limited</td>
</tr>
<tr>
<td>GPII</td>
<td>General Practice Immunisation Incentives</td>
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<tr>
<td>GPREC</td>
<td>General Practice Recognition Eligibility Committee</td>
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<tr>
<td>GPRRIPS</td>
<td>General Practice Registrars Rural Incentive Payment Scheme</td>
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<tr>
<td>HCCS</td>
<td>High Cost Claim Scheme</td>
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<tr>
<td>HECS</td>
<td>Higher Education Contribution Scheme</td>
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<tr>
<td>HSD</td>
<td>Highly specialised drug</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<td>IBNR</td>
<td>Incurred But Not Reported</td>
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<tr>
<td>JNMCAC</td>
<td>Joint Nuclear Medicine Credentialling and Accreditation Committee</td>
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<tr>
<td>MBCC</td>
<td>Medicare Benefits Consultative Committee</td>
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<tr>
<td>MBS</td>
<td>Medicare Benefits Schedule</td>
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<tr>
<td>MCRP</td>
<td>Medicare Claims Review Panel</td>
</tr>
<tr>
<td>MRI</td>
<td>Magnetic Resonance Imaging</td>
</tr>
<tr>
<td>MSAC</td>
<td>Medical Services Advisory Committee</td>
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<tr>
<td>PBAC</td>
<td>Pharmaceutical Benefits Advisory Committee</td>
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<tr>
<td>PBPA</td>
<td>Pharmaceutical Benefits Pricing Authority</td>
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<tr>
<td>PBS</td>
<td>Pharmaceutical Benefits Scheme</td>
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<tr>
<td>PEI</td>
<td>Patient Episode Initiation</td>
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<tr>
<td>PIP</td>
<td>Practice Incentives Program</td>
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<tr>
<td>PKI</td>
<td>Public Key Infrastructure</td>
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<tr>
<td>PMS</td>
<td>practice management system</td>
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<td>PSS</td>
<td>Premium Support Scheme</td>
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<td>PSTC</td>
<td>Pathology Services Table Committee</td>
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<td>RACGP</td>
<td>Royal Australian College of General Practitioners</td>
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<td>RAE</td>
<td>Remote Area Exemption</td>
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<tr>
<td>RHCA</td>
<td>Reciprocal Health Care Agreements</td>
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<tr>
<td>ROCS</td>
<td>Run-off Cover Scheme</td>
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<tr>
<td>RPBS</td>
<td>Repatriation Pharmaceutical Benefits Scheme</td>
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<tr>
<td>RRMA</td>
<td>Rural, Remote and Metropolitan Area</td>
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<tr>
<td>RRP</td>
<td>Rural Retention Program</td>
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<tr>
<td>RVG</td>
<td>Relative Value Guide</td>
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<tr>
<td>RWA</td>
<td>Rural Workforce Agency</td>
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<tr>
<td>SRAC</td>
<td>Specialist Recognition Advisory Committee</td>
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<tr>
<td>TGA</td>
<td>Therapeutic Goods Administration</td>
</tr>
<tr>
<td>TRRPGP</td>
<td>Training for Rural and Remote Procedural GPs Program</td>
</tr>
<tr>
<td>UMP</td>
<td>United Medical Protection Ltd</td>
</tr>
<tr>
<td>UMP SP</td>
<td>UMP Support Payment</td>
</tr>
<tr>
<td>VAPAC</td>
<td>Veterans’ Affairs Pharmaceutical Approvals Centre</td>
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Contact details
Medicare Australia

Medicare Australia offices

www.medicareaustralia.gov.au

National Office
Phone: (02) 6124 6333
Email: info@medicareaustralia.gov.au
Address: 134 Reed Street North
Greenway ACT 2900
GPO Box 9822 in each capital city

New South Wales/Australian Capital Territory
Address: Colonial State Bank Tower
150 George Street
Parramatta NSW 2150
Fax: (02) 9895 4339

Queensland
Address: 444 Queen Street
Brisbane QLD 4000
Provider liaison
Fax: (07) 3004 5408

South Australia/Northern Territory
Address: 209 Greenhill Road
Eastwood SA 5063
Provider liaison
SA Fax: (08) 8274 9307
NT Fax: (08) 8922 6322

* Local call rates. Normal mobile and public phone charges apply.
**Tasmania**
Address: 242 Liverpool Street
Hobart TAS 7000
Provider liaison
Fax: (03) 6215 5700

**Victoria**
Address: Medibank House
460 Bourke Street
Melbourne VIC 3000
Provider liaison
Fax: (03) 9605 7984

**Western Australia**
Address: Bankwest Tower
108 St Georges Terrace
Perth WA 6843
Provider liaison
Fax: (08) 9214 8201

* Local call rates. Normal mobile and public phone charges apply.
Practitioners and staff
(including schedule interpretation, Medicare numbers, claims and Medicare advisers)
Phone: 132 150*

Indigenous access line
Phone: 1800 556 955
Email: medicare.prov@medicareaustralia.gov.au

General public
Phone: 132 011*
Email: medicare@medicareaustralia.gov.au

Completing Medicare/DVA forms
Phone: 1800 067 307

Medclaims (electronically transmitted claims and EFT payments)
Phone: 1300 788 008

Online claiming and ECLIPSE
Phone: 1800 700 199

Ordering Medicare/DVA forms and other stationery (including imprinters, plastic cards, brochures and posters)
Leigh-Mardon
Phone: 1800 067 307
Fax: (02) 6230 0477
Address: Medicare Australia
Locked bag 4444
Tuggeranong ACT 2901

General PBS and stationery enquiries
Phone: 132 290*
Email: pbs.enq@medicareaustralia.gov.au
Address: GPO Box 9826 in each capital city

* Local call rates. Normal mobile and public phone charges apply.
Authority prescription approvals
Phone: 1800 888 333 (24 hour service, 7 days a week)
Address: REPLY PAID 9857
PBS Authorities Section
Medicare Australia
GPO Box 9857
In your capital city

DVA authority prescription approvals
Phone: 1800 552 580

PBS and Specialised Drugs
Phone: 1800 700 270

Australian Childhood Immunisation Register
Phone: 1800 653 809
Email: acir@medicareaustralia.gov.au
Address: GPO Box M933
Perth WA 6843

ACIR Internet help desk
Phone: 1800 650 039

Australian Organ Donor Register
Phone: 1800 777 203
Fax: 03 6281 0556
Email: aodr@medicareaustralia.gov.au
Online: www.medicareaustralia.gov.au/organ
(online registration available)
Address: REPLY PAID
GPO Box 711
Hobart TAS 7001
Other Medicare Australia programs, schemes and services

Compensation
Phone: 132 127*
TTY: 1800 552 152 (hearing or speech impaired)
TIS: 131 450* (translating and interpreting service)
Email: medicareaustralia.info@medicareaustralia.gov.au
Online: www.medicareaustralia.gov.au

Addresses:
If the insurer is in the ACT or NSW
Compensation Manager
Medicare Australia
GPO Box 4104
Sydney NSW 1007

If the insurer is in QLD, VIC, SA, TAS or NT
Compensation Manager
Medicare Australia
GPO Box 2436
Brisbane QLD 4001

eBusiness Service Centre
Phone: 1800 700 199
Email: medicareaustralia.online@medicareaustralia.gov.au

General Practice Immunisation Incentives (GPII)
Phone: 1800 246 101
Address: GPO Box 295
Hobart TAS 7001

General Practice Registrars’ Rural Incentive Payment Scheme (GPRRIPS)
Phone: 1800 010 550
Fax: (08) 8274 9373
Address: Medicare Australia
GPO Box 2572
Adelaide SA 5000

Improved Monitoring of Entitlements (IME) Medicare number hotline
Phone: 132 290*

* Local call rates. Normal mobile and public phone charges apply.
Medical Advisers
Phone: 132 150*

National Office
Dr Jo-Anne Benson, Medical Director
Dr Peter Charlton, Senior Medical Adviser
Dr David Jeacocke, Senior Medical Adviser

New South Wales/Australian Capital Territory
Dr David Rankin, Senior Medical Adviser
Dr Lynda Bates, Medical Adviser
Dr Mary Kearney, Medical Adviser
Dr Vadim Leonov, Medical Adviser
Dr Peter Lorenz, Medical Adviser
Dr Charanjit Anand, Medical Adviser

Victoria/Tasmania
Dr Tim Hegarty, Senior Medical Adviser
Dr Peter Karlik, Medical Adviser
Dr Raymond Mak, Medical Adviser
Dr Kate Strasser, Medical Adviser
Dr Andrew Leaver, Medical Adviser
Dr Barry Schmidt, Medical Adviser
Dr Ranjit Rasalam, Medical Adviser

Queensland
Dr Dilip Dhupelia, Senior Medical Adviser
Dr David Field, Medical Adviser
Dr Annabelle Alcock, Medical Adviser
Dr Michael Harding, Medical Adviser

South Australia/Northern Territory
Dr Robert Menz, Senior Medical Adviser
Dr Penelope Dargaville, Medical Adviser

Western Australia
Dr Peter Laundy, Senior Medical Adviser
Dr Christopher Thompson, Medical Adviser

* Local call rates. Normal mobile and public phone charges apply.
Medical Indemnity
Premium Support Scheme (PSS)
Phone: 1800 007 757
Online: www.health.gov.au/medicalindemnity
(To find out if you are eligible for PSS contact your medical indemnity insurer)

United Medical Protection Support Payment Scheme
Phone: 1800 813 167
Online: www.medicareaustralia.gov.au

Medical Indemnity Claims (Incurred But Not Reported Scheme, High Cost Claim Scheme or Run-off Cover Scheme)
Phone: 1800 007 757
Online: www.health.gov.au/medicalindemnity

Optometric Advisers
Phone: 13 21 50*
Steve Zantos
Marcus Kaye

Optometrists’ date of service check
Phone: 1300 652 752*

Practice Incentives Program
Phone: 1800 222 032
Email: pip@medicareaustralia.gov.au
Address: GPO Box 2572
Adelaide SA 5001

Remote Area Exemption
Phone: (08) 8274 9784

Teleclaims
Phone: 1300 360 460*

Travelling with PBS medications
Phone: 1800 500 147

90-day cheque scheme
Phone: 1800 032 259

* Local call rates. Normal mobile and public phone charges apply.
**Registration**

Provider numbers, provider cards, prescriber numbers, closing a practice
Provider Liaison Section
Phone: 132 150*
Address: GPO Box 9822 in each capital city

**Recognition and accreditation**

Australasian Sonographer Accreditation Register
Phone: (02) 8850 1144

General Practice Recognition Eligibility Committee
Medicare Australia
Address: PO Box 1001
Tuggeranong DC ACT 2901

Joint Nuclear Medicine Credentialling and Accreditation Committee
Phone: (02) 9818 4824

National Membership/GP Recognition Coordinator
Royal Australian College of General Practitioners (RACGP)
Address: 1 Palmerston Crescent
South Melbourne VIC 3205

Specialist Recognition Advisory Committee
Address: PO Box 1001
Tuggeranong DC ACT 2901

* Local call rates. Normal mobile and public phone charges apply.
Other government contacts

Department of Health and Ageing

Central Office
Phone: (02) 6289 1555
1800 020 103
Address: Scarborough House, Atlantic Street
Woden ACT 2606
PO Box 9848 in each capital city

Australian Capital Territory
Ground Floor,
Borrowdale House
Woden ACT 2606
Phone: (02) 6289 1555
Freecall: 1800 020 103

New South Wales
1 Oxford Street, Level 7
Sydney NSW 2000
Phone: (02) 9263 3555
Freecall: 1800 048 998

Northern Territory
Cascom Centre, 1st Floor
13 Scaturchio Street
Casuarina NT 0810
Phone: (08) 8946 3444

Queensland
Samuel Griffith Building, 5th Floor
340 Adelaide Street
Brisbane QLD 4000
Phone: (07) 3360 2555
Freecall: 1800 177 099

South Australia
Commonwealth Centre
55 Currie Street
Adelaide SA 5000
Phone: (08) 8237 8111
Freecall: 1800 188 098
**Tasmania**
Montpelier Building, 3rd Floor
21 Kirksway Place
Hobart TAS 7004
Phone: (03) 6221 1411
Freecall: 1800 005 119

**Victoria**
Casselden Place,
2 Lonsdale Street
Melbourne VIC 3000
Phone: (03) 9665 8888
Freecall: 1800 020 103

**Western Australia**
Central Park, 14th Floor
152–158 St Georges Terrace
Perth WA 6000
Phone: (08) 9346 5111
Freecall: 1800 198 008

---

**Department of Veterans’ Affairs (DVA)**

**Claims and enquiries**

**Allied Health Australia-wide**
Phone: 1300 550 051*
Address: PO Box 964
Adelaide SA 5001

**VIC, QLD and TAS**

Medical Claims
Phone: 1300 550 017*
Address: PO Box 9869
Melbourne Vic 3001

Hospital claims
Phone: 1300 551 002*
Address: PO Box 9917
Melbourne Vic 3001
ACT, NSW, NT, SA and WA
Medical claims
Phone: 1300 550 017*
Address: PO Box 9869
Perth WA 6848

Hospital claims
Phone: 1300 551 002*
Address: PO Box 9917
Perth WA 6848

DVA forms enquiries/orders
Phone: 1800 155 355
Fax: 1800 671 670
Address: DVA Distribution
PO Box 251
Woden ACT 2606
Online: www.dva.gov.au/health/provider/order_forms.htm

Other
Medical Services Advisory Committee (MSAC) Secretariat
GPO Box 9848 (MDP 107)
Canberra City ACT 2601
Phone: (02) 6289 6811
Fax: (02) 6289 8799
Email: msac.secretariat@health.gov.au
www.msac.gov.au

PBS Information Line
Phone: 1800 020 613

Business information
Online: www.business.gov.au
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