PART 3

PSYCHOLOGICAL THERAPY SERVICES FOR PATIENTS WITH AN ASSESSED MENTAL DISORDER

PROVISION OF PSYCHOLOGICAL THERAPY SERVICES BY CLINICAL PSYCHOLOGISTS (ITEMS 80000 TO 80020)

OVERVIEW

The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative commenced on 1 November 2006. Under the Better Access initiative MBS items provide Medicare benefits for the following allied mental health services:

- psychological therapy (items 80000 to 80020) – provided by eligible clinical psychologists; and
- focussed psychological strategies – allied mental health (items 80100 to 80170) – provided by eligible psychologists, occupational therapists and social workers (refer to Part 4).

PSYCHOLOGICAL THERAPY SERVICES ATTRACTING MEDICARE REBATES

Eligible psychological therapy services

There are five MBS items for the provision of psychological therapy services to eligible patients by a clinical psychologist. The clinical psychologists must meet the provider eligibility requirements set out below and be registered with Medicare Australia.

In these notes, ‘GP’ means a medical practitioner, including a general practitioner, but not including a specialist or consultant physician.

Services provided under the Psychological Therapy items will not attract a Medicare rebate unless:

- a referral has been made by a GP who is managing the patient under a GP Mental Health Care Plan (item 2710);
- a referral has been made by a GP who is managing the patient under a referred psychiatrist assessment and management plan (item 291); or
- a referral has been made by a psychiatrist or paediatrician from an eligible psychiatric or paediatric service (see Referral Requirements for further details regarding psychiatrist and paediatrician referrals).

Number of services per year

Medicare rebates are available for up to twelve individual allied mental health services in a calendar year. These twelve services may consist of: GP focussed psychological strategies services (items 2721 to 2727); and/or psychological therapy services (items 80000 to 80015); and/or focussed psychological strategies – allied mental health services (items 80100 to 80115; 80125 to 80140; 80150 to 80165; and/or Access to Allied Psychological Services (ATAPS) consultations under the Better Outcomes in Mental Health Care Program. Referrals should be provided, as required, in one or more groups of up to six sessions.
In addition, the referring practitioner may consider that in exceptional circumstances the patient may require an additional six individual psychological therapy or focused psychological strategies services above those already provided (to a maximum total of 18 individual services per patient per calendar year). Exceptional circumstances are defined as a significant change in the patient’s clinical condition or care circumstances which make it appropriate and necessary to increase the maximum number of services. It is up to the referring practitioner to determine that the patient meets these requirements. In these cases a new referral should be provided, and exceptional circumstances noted in that referral. Invoices for services provided under exceptional circumstances must state that exceptional circumstances apply.

Patients will also be eligible to claim up to 12 separate services within a calendar year for group therapy services involving 6-10 patients to which items 80020 (psychological therapy – clinical psychologist), 80120 (focused psychological strategies – psychologist), 80145 (focused psychological strategies – occupational therapist) and 80170 (focused psychological strategies - social worker) apply. These group services are separate from the individual services and do not count towards the 12 services per calendar year maximum associated with those items.

**Service length and type**
Services provided by eligible clinical psychologists under these items must be within the specified time period within the item descriptor. The clinical psychologist must personally attend the patient.

It is expected that professional attendances at places other than consulting rooms would be provided where treatment in other environments is necessary to achieve therapeutic outcomes.

In addition to psycho-education, it is recommended that cognitive-behaviour therapy be provided. However, other evidence-based therapies — such as interpersonal therapy — may be used if considered clinically relevant.

**Course of treatment and reporting back to the referring medical practitioner**
Patients are eligible to receive up to twelve individual services (up to eighteen in exceptional circumstances) and up to twelve group sessions in a calendar year.

Within this maximum service allocation, the clinical psychologist can provide one or more courses of treatment. For the purposes of the allied mental health items, a course of treatment consists of up to six services (but may involve less than six depending on the referral). This enables the referring medical practitioner to consider a report from the clinical psychologist on the services provided to the patient, and the need for further treatment.

On completion of the initial course of treatment, the clinical psychologist must provide a written report to the referring medical practitioner, which includes information on:

- assessments carried out on the patient;
- treatment provided; and
- recommendations on future management of the patient's disorder.

A written report must also be provided to the referring medical practitioner at the completion of any subsequent course(s) of treatment provided to the patient. Following receipt of this report, the referring practitioner will consider the need for further treatment, before further allied mental health services may be provided.
Out-of-pocket expenses and Medicare safety net

Charges in excess of the Medicare benefit for these items are the responsibility of the patient. However, such out-of-pocket costs will count toward the Medicare safety net for that patient. Any psychological therapy services and/or focussed psychological strategies – allied mental health services that are in excess of the entitlement of twelve (12) individual services (apart from where exceptional circumstances apply) and twelve (12) group sessions in a calendar year will not attract a Medicare benefit and the safety net arrangements will not apply to costs incurred by the patient for such services.

Eligible patients

Items 80000 to 80020 (inclusive) apply to people with an assessed mental disorder and where the patient is referred by a GP who is managing the patient under a GP Mental Health Care Plan (item 2710), or under a referred psychiatrist assessment and management plan (item 291); or on referral by a psychiatrist or paediatrician from an eligible service.

The conditions classified as mental disorders for the purposes of these services are informed by the World Health Organisation, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care: ICD-10 Chapter V Primary Care Version. For the purposes of these items, dementia, delirium, tobacco use disorder and mental retardation are not regarded as a mental disorder.

Checking patient eligibility for psychological therapy services

Patients seeking Medicare rebates for psychological therapy services will need to have a referral from a GP, psychiatrist or paediatrician. If there is any doubt about a patient’s eligibility, Medicare Australia will be able to confirm whether a GP Mental Health Care Plan; and/or a psychiatrist assessment and management plan is in place and claimed; or an eligible psychiatric or paediatric service has been claimed, as well as the number of allied mental health services already claimed by the patient during the calendar year.

Clinical psychologists can call Medicare Australia on 132 150 to check this information, while patients can seek clarification by calling 132 011.

The patient will not be eligible if they have not been appropriately referred and a relevant Medicare service provided to them. If the referring service has not yet been claimed, Medicare Australia will not be aware of the patient’s eligibility. In this case the patient or the clinical psychologist (with the patient’s permission) should contact the referring practitioner to ensure the relevant service has been provided to the patient.

Publicly funded services

Psychological therapy items 80000 to 80020 do not apply for services that are provided by any other Commonwealth or State funded services or provided to an admitted patient of a hospital. However, where an exemption under subsection 19(2) of the Health Insurance Act 1973 has been granted to an Aboriginal Community Controlled Health Service or State/Territory clinic, the items apply for services that are provided by eligible clinical psychologists salaried by, or contracted to, the service as long as all requirements of the items are met, including registration with Medicare Australia. These services must be direct billed (that is, the Medicare rebate is accepted as full payment for services).
**Private health insurance**
Patients need to decide if they will use Medicare or their private health insurance ancillary cover to pay for these services. Patients cannot use their private health insurance ancillary cover to ‘top up’ the Medicare rebate paid for the services.

**REFERRAL REQUIREMENTS (GPs, PSYCHIATRISTS OR PAEDIATRICIANS TO CLINICAL PSYCHOLOGISTS FOR PSYCHOLOGICAL THERAPY)**

**Referrals**
Patients must be referred for psychological therapy services by a GP managing the patient under a GP Mental Health Care Plan (item 2710); or a referred psychiatrist assessment and management plan (item 291); or on referral from a psychiatrist or a paediatrician from an eligible service.

Referrals from psychiatrists and paediatricians must be made from eligible Medicare services. For specialist psychiatrists and paediatricians these services include any of the specialist attendance items 104 through 109. For consultant physician psychiatrists the relevant eligible Medicare services cover any of the consultant psychiatrist items 293 through 370; while for consultant physician paediatricians the eligible services are consultant physician attendance items 110 through 131.

Referring practitioners are **not** required to use a specific form to refer patients for these services. The referral may be a letter or note to an eligible clinical psychologist signed and dated by the referring practitioner.

The clinical psychologist must be in receipt of the referral at the first allied mental health consultation. A clinical psychologist is required to retain the referral for 24 months from the date the service was rendered for Medicare Australia auditing purposes.

**Referral validity**
Medicare benefits are available for up to twelve (12) individual (up to 18 services where exceptional circumstances apply) and/or twelve (12) group psychological therapy services and/or focussed psychological strategies services per patient per calendar year. Referrals should be made in one or more groups of up to six sessions. If a patient has not used all of their psychological therapy services and/or focussed psychological strategies services under a referral in a calendar year, it is not necessary to obtain a new referral for the “unused” services. However, any “unused” services received from 1 January in the following year under that referral will count as part of the total of twelve services for which the patient is eligible in that calendar year.

When patients have used all of their referred services they will need to obtain a new referral from the referring practitioner if they are eligible for further services. Where the patient’s care is being managed by a GP, the GP may choose to use this visit to undertake a review of the patient’s GP Mental Health Care Plan and/or psychiatrist assessment and management plan.

It is not necessary to have a new GP Mental Health Care Plan and/or psychiatrist assessment and management plan prepared each calendar year in order to access a new referral(s) for eligible psychological therapy services and/or focussed psychological strategies services. Patients continue to be eligible for rebates for psychological therapy services and/or focussed
psychological strategies services while they are being managed under a GP Mental Health Care Plan and/or a psychiatrist assessment and management plan as long as the need for eligible services continues to be recommended in their plan.

**CLINICAL PSYCHOLOGIST PROFESSIONAL ELIGIBILITY**

**Eligible clinical psychologists**
All consultations providing psychological therapy services must be rendered by a clinical psychologist who is a member of the Australian Psychological Society's College of Clinical Psychologists or meets the requirements for such membership, based on assessment by the Australian Psychological Society; and who is registered with Medicare Australia.

**Registering with Medicare Australia**
Advice about registering with Medicare Australia to provide psychological therapy services using items 80000-80020 inclusive is available from the Medicare Australia provider inquiry line on 132 150.

**Further information**

For providers, further information is also available from the Medicare Australia provider inquiry line on 132 150.
# ITEM DESCRIPTIONS

## PSYCHOLOGICAL THERAPY SERVICES

### CLINICAL PSYCHOLOGY

Professional attendance for the purpose of providing psychological assessment and therapy for a mental disorder by a clinical psychologist registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting more than 30 minutes but less than 50 minutes, where the patient is referred by a medical practitioner, as part of a GP Mental Health Care Plan or a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics.

These therapies are time limited, being deliverable, in general, in up to 12 planned sessions in a calendar year (including services to which items 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 and the Better Outcomes in Mental Health Care Program Access To Allied Psychological Services apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply.

(Professional attendance at consulting rooms)

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<td>$76.65</td>
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### CLINICAL PSYCHOLOGY

Professional attendance at a place other than consulting rooms.

As per the service requirements outlined for item 80000.

(Professional attendance at consulting rooms)

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### CLINICAL PSYCHOLOGY

Professional attendance for the purpose of providing psychological therapy for a mental disorder by a clinical psychologist registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting for at least 60 minutes duration where the patients are referred by a medical practitioner, as part of a GP Mental Health Care Plan; or a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics.

These therapies are time limited, being deliverable, in general, in up to 12 planned sessions in a calendar year (including services to which items 80120, 80145 and 80170 apply).

- GROUP THERAPY with a group of 6 to 10 patients, EACH PATIENT

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PART 6

CLAIMING FROM MEDICARE

Account/Receipt Requirements
For a Medicare payment to be made the account/receipt must include the following information:

- patient’s name;
- date of service;
- MBS item number;
- allied health professional’s name and provider number, or name and practice address;
- referring medical practitioners name and provider number, or name and practice address;
- date of referral; and
- amount charged, total amount paid, and any amount outstanding in relation to the service.

PAID ACCOUNTS

The patient can pay the account provided by the allied health professional and present the itemised receipt (see above) at a Medicare office for assessment and payment of the Medicare benefit in cash. From 1 November 2007, patients may also be able to lodge Medicare claims electronically with their provider.

If the patient chooses to mail the claim to Medicare, a Medicare Patient Claim Form (PC-1) must be completed. This also applies when the patient is arranging for an agent to collect cash on his/her behalf at a Medicare office.

UNPAID ACCOUNTS

Cheque from Medicare
If the patient has not paid the account, the itemised unpaid account can be presented to Medicare (in person or by mail) with a Medicare Patient Claim Form (PC-1). In this case Medicare will forward to the patient a benefit cheque made payable to the allied health professional. It is the patient’s responsibility to forward the cheque to the allied health professional and make arrangements for payment of the balance of the account, if any.

When issuing a receipt to a patient for an amount that is being paid wholly or in part by a Medicare ‘pay allied health professional’ cheque, the allied health professional should indicate on the receipt that a ‘Medicare cheque for $…. was included in the payment of the account’.

Assignment of benefit (bulk billing or direct payment) arrangements
Where an allied health professional chooses to bulk bill for the service, s/he undertakes to accept the Medicare benefit as full payment for the service. Additional charges for that service (irrespective of the purpose or title of the charge) cannot be raised against the patient.
When bulk billing, the allied health professional will need to submit the approved forms (DB2-AH and DBIN-AH) to Medicare. These forms are approved forms under the Health Insurance Act, and no other forms can be used to assign benefits without the approval of Medicare Australia. They can be ordered by telephoning 1800 067 307.

To bulk bill, the allied health professional will need to complete:

a) **An assignment of benefit (direct-payment) form (Medicare form DB2-AH) for each patient**

This form contains the patient’s details. Under these arrangements:

- the patient’s Medicare number must be quoted on all direct-payment assignment forms for that patient. If the number is not available, then the direct-payment facility should not be used. To do so would incur a risk that the patient may not be eligible and Medicare benefits not payable.

- the allied health professional must set out on the assignment form the details relating to the professional service before the patient signs the form. The patient must then receive a copy of the form;

- where a patient is unable to sign the assignment form, the signature of the patient’s parent, guardian or other responsible person (other than the allied health professional or their staff) is acceptable. The reason the patient is unable to sign should also be stated. In the absence of a ‘responsible person’ the patient signature section should be left blank and in the section headed ‘Allied Health Professional’s Use’ an explanation should be given as to why the patient was unable to sign (e.g. injured hand etc.). This note should be signed or initialled by the allied health professional. If in the opinion of the allied health professional, the reason is of such a ‘sensitive’ nature that revealing it would constitute an unacceptable breach of patient confidentiality a concessional reason ‘due to medical condition’ to signify that such a situation exists may be substituted for the actual reason. However, this should not be used routinely and in most cases it is expected that the reason given will be more specific.

b) **A claim for assignment of benefit form (Medicare claim form DBIN-AH)**

To claim the Medicare benefit, the allied health professional then forwards the individual assignment of benefit forms (DB2-AH) to Medicare using a claim for assignment of benefit form DBIN-AH. Up to 50 individual assignment of benefit (direct-payment) forms may be submitted with each claim form.

The claim for assignment of benefits form must relate to assigned Medicare benefits for allied health services by one provider from a single practice location.

Claims should be posted to Medicare, GPO Box 9822, in the Capital City in each State.

From 1 November 2007, Medicare Australia is also rolling out electronic claiming to enable bulk billing claims to be submitted online. For more information please contact Medicare Australia on 1800 700 199.
Time limits applicable to lodgement of claims for assigned benefits

A time limit of six months applies to the lodgement of claims with Medicare under the direct-payment (assignment of benefits) arrangements. Medicare benefits are not payable for any service where the service was provided more than six months earlier than the date the claim was lodged with Medicare. In certain circumstances (eg hardship cases, third party workers compensation cases), the Minister may waive the time limits.

Billing practices contrary to the Act

Under the *Health Insurance Act 1973* (as amended), it is not permissible to:

1. Include the cost of a non-clinically relevant service in a consultation charge. Medicare benefits can only be paid for clinically relevant services. If an allied health professional chooses to use a procedure that is not generally accepted in their profession as necessary for the treatment of the patient, the cost of this procedure cannot be included in the fee for a Medicare item. Any charge for non-clinically relevant services must be separately listed on the account and not included in the fee billed to Medicare.

2. Include an amount for goods supplied for the patient to use at home in the consultation charge (eg. wheelchairs, oxygen tanks, continence pads). Charges can be levied for these items, but they must be listed separately on the account and not billed to Medicare.

3. Charge part or all of an in-patient procedure to an out-patient consultation. If an allied health professional charges part or all of an in-patient procedure to an out-patient consultation, the account issued by the practitioner is not an accurate statement of the services provided and would constitute a false or misleading statement.

4. Re-issue modified accounts to include other charges and out of pocket expenses not previously included in the account. The account issued to a patient by an allied health professional must state the amount charged for the service provided and truly reflect what occurred between the patient and practitioner. While re-issuing an account to correct a genuine error is legitimate, if an account is re-issued to increase the fee or load additional components to the fee, the account is not a true statement of the fee charged for the service and would constitute a false or misleading statement.

Where a Medicare benefit has been inappropriately paid, Medicare Australia may request recovery of that benefit from the practitioner concerned.
Medicare Australia

Medicare Australia is responsible for the operation of Medicare and the payment of Medicare benefits. Listed below are the locations of Medicare offices:

Postal: Medicare, GPO Box 9822, in the Capital City in each State
Telephone: 132 150 - Australia wide at the cost of a local call.

AUSTRALIAN CAPITAL TERRITORY
134 Reed Street
TUGGERANONG ACT 2901

NEW SOUTH WALES
The Colonial State Bank Tower
150 George Street
PARRAMATTA NSW 2165

NORTHERN TERRITORY
As per South Australia

QUEENSLAND
State Headquarters
444 Queen Street
BRISBANE QLD 4000

SOUTH AUSTRALIA
State Headquarters
209 Greenhill Road
EASTWOOD SA 5063

TASMANIA
242 Liverpool Street
HOBART TAS 7000

VICTORIA
State Headquarters
460 Bourke Street
MELBOURNE VIC 3000

WESTERN AUSTRALIA
State Headquarters
Bank West Tower
108 St. George's Terrace
PERTH WA 6000

The day-to-day administration and payment of benefits under the Medicare arrangement is the responsibility of Medicare Australia. Inquiries concerning payment of benefits should be directed to Medicare Australia and not to the Department of Health and Ageing. The following telephone numbers have been reserved by Medicare Australia exclusively for inquiries relating to the Schedule:

ACT – 02 6124 6362
NT – use South Australian number
SA – 08 8274 9788
VIC – 03 9605 7964

NSW – 132 150
QLD – 07 3004 5450
TAS – 03 6215 5740
WA – 132 150