Responses from Medicare to questions raised at the APS Sydney Branch Forum
Practising ethically, compliantly and avoiding complaints held on 17 July 2015

1. For how long is a GP referral valid? Information that attendees had received previously varied with some being told 3 months and others being told 12 months. In addition, one of the attendees has since forwarded the following link which suggests there is no expiry to the referral https://www.medicareaustralia.gov.au/provider/business/education/files/medicare-requirements-for-better-access-to-mental-health-care-better-access-initiative-qrg-for-ahp.pdf. This fact sheet indicates that services can be used '**in later years'** which suggests the referrals are open and can remain open for years which is contrary to the notion that we discussed last night that when the client stops coming the course of treatment is considered to have ended and you have to report to the GP. I think this is problematic and may be that it is just worded badly in the fact sheet. This essentially suggests that if the client does not have all six sessions the psychologist is not required to write a termination letter to the GP as the client may decide to return to finish any outstanding sessions 'in later years'! to complicate things further the fact sheet, under the title "What if my patient doesn't attend to complete the course of treatment?", states, "You should write your report after the last service you provided. If the patient turns up at a later date and completes the course of treatment, you'll have to write another report to the medical practitioner". This implies that a report must be written but also clearly implies that writing a report after the patient has a 'pause' in treatment does not signal the end of the course of treatment or invalidate the original referral and one can continue treatment as per that referral. This is terribly confusing and we need guidance around this. This fact sheet is very unclear.

   Under Better Access to Mental Health Care a referral to a psychologist is valid for the stated number of services to a maximum of six, not for a specific period of time or for a calendar year.

   A report must be written to the referring medical practitioner after completing a course of treatment and as often as clinically necessary. If the patient stops their treatment before the completion of the course of treatment a report must be provided and if they return at a later date and complete the course of treatment, the psychologist must write another report to the referring medical practitioner.

2. A psychologist has today come forward to advise that he has in writing that a psychiatrist's referral to a psychologist is valid for a three month period only.

   Under Better Access to Mental Health Care a psychiatrist's referral to a psychologist is for the stated number of services to a maximum of six. Whereas, a psychiatrist referral to another psychiatrist, or to a Medical Specialist, is valid for three months.

3. A client has six sessions, then a review with the GP and a second referral which does not specify the number of sessions (so can assume up to six sessions). The client has another 4 sessions and hence, has used up their 10 for the calendar year. The client then becomes a fee paying client for a further five sessions to get them through the rest of the year. In the new calendar year they use up the final two sessions that were on the last referral and then a report is written to the GP. Is this appropriate or should the report have been provided after the 4th session?

   Reports to the referring medical practitioner should be as often as clinically necessary, the minimum reporting period is on the completion of each course of treatment.

4. Does the referral have to be in the actual practitioner's name or can it be addressed to another psychologist in same practice?

The referral does not have to be in the actual practitioner's name however, once a service has been provided under the referral the referral cannot be used for services provided by another psychologist.

5. After 6 sessions, does the report to the GP need to specifically ask for a further four sessions?

After completing a course of treatment the report back to the referring medial practitioner must include information that allows them to assess the patient's need for more services and include; Assessments carried out on the patient, where relevant the progress made, all treatments provided and recommendations on future management of the patient's disorder.

6. Are you able to charge a one off booking fee when client makes initial contact? And then all sessions are bulk billed with no extra charge?
This information was provided by claims policy and these are the main points they provided.

- Under section 20A of the *Health Insurance Act 1973*, the practitioner accepts an assignment of benefit in full payment of the medical expenses incurred in respect of the professional service by the first-mentioned eligible person;

- The broad meaning of the term 'in respect of' in the phrase 'medical expenses incurred *in respect of* the professional service' means that for the purpose of section 20A all expenses directly linked or 'directly incidental to' the provision of a bulk-billed service are included in the assignment of the "full payment" for that service and cannot be separately charged for;

- A patient must not be required to make any payment to any person in respect of the bulk-billed professional service to which the assignment relates; and

- Any fee or charge which is a pre-condition of the patient being able to undergo a bulk-billed procedure cannot be separately charged for unless the matter involves similar circumstances to Akuity No 2 (i.e. the practitioner who signs the assignment must belong to a separate legal entity to the body imposing the fee, the practitioner can't be aware that the fee is imposed, and the fee cannot be compulsory i.e. a pre-condition of receiving the service).

- So a 'booking fee' would not be allowed, but if they choose to privately bill the patient for the first visit and then bulk bill all other visits, that would be up to them.

7. Are you able to see a bulk bill client twice in one day, once on morning and then again in afternoon?

Medicare benefits are payable for more than one attendance for the same patient on the same day provided the second attendance is not a continuation on the previous attendance. This applies to all services whether the service is bulk billed or an account is issued to the patient.

8. I have been advised that under the MBS psychiatrists can run groups as long as there is a minimum of four participants. Could you please check that this is correct and let me know the relevant item number?

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