medicare matters

AUGUST 2026

QAIHC
Queensland Aboriginal and Islander Health Council

Certificate III Business — Medical Administration

Our QAIHC Members are supporting their staff to attend professionals development to complete the Certificate III in Business (Medical Administration) qualification, delivered by UNE Partnerships and hosted by QAIHC. There are 15 students from 12 of the QAIHC Members from urban, regional, and very remote locations attended the workshop during 3-7 August 2026. A further workshop will be held in March 2027.

New resource: Referrals for specialist services

This factsheet and quick reference guide provide general information on the rules and requirements of referrals for specialist services under the Medicare Benefits Schedule.

MBS Online — Referrals for specialist services

Please share this information with the relevant health professionals.

See over page for Medicare Q&A.

Medicare Q&As

These Medicare Q&As provide practical Medicare guidance on common claiming, referral, and care-planning questions for primary health care teams. It is designed as a quick reference to support consistent decision-making and documentation in day-to-day practice.

Q1: Can the Heart Health Check item 699 be claimed in the same 12-month period as the Aboriginal and Torres Strait Islander Health Assessment item 715?

A1: Yes. The Heart Health Check item 699 and Aboriginal and Torres Strait Islander Health Assessment item 715 can both be claimed within the same 12-month period, but they cannot be claimed on the same day. This claiming rule was amended in 2023.

The Heart Health Check is age specific. Review the explanatory note to confirm patient eligibility:
Item 699 | Medicare Benefits Schedule

Word FS — 1 July 2023 Amendment MBS heart health assessment items.docx

The Heart Health Check item can be claimed once per patient in a 12-month period. It cannot be claimed if the patient has received another health assessment service in the previous 12 months, except for an Aboriginal and Torres Strait Islander Health Assessment item 715, 228, 92004 or 92011.

Q2: Where can I find patient resources for the Aboriginal and Torres Strait Islander Health Assessment item 715?

A2: Patient resources for the Aboriginal and Torres Strait Islander Health Assessment item 715 are available from the Australian Government Department of Health, Disability and Ageing:
Annual health check for Aboriginal and Torres Strait Islander people — Resource collection | Australian Government Department of Health, Disability and Ageing

Medicare eLearning resources include:

- IHSM05 — Indigenous health assessments
- IHSM05INFO1 — Completing an Aboriginal and Torres Strait Islander health assessment

Q3: What are the Medicare bulk billing incentive items when claiming?

A3: The following document outlines the Medicare bulk billing incentive items:
Bulk billing incentive items GP tables

Medicare Q&As

Q4: How do I register a patient for the Closing the Gap (CTG) PBS Co-payment Measure?

A4: Register eligible patients for the Closing the Gap (CTG) PBS Co-payment Measure through PRODA. Registration must be completed by a PBS prescriber, an Aboriginal and Torres Strait Islander Health Practitioner, or an authorised delegate with appropriate PRODA access.

The infographic and simulation below outline the registration process:

- Infographic: PBSM08INFO1 — Register a patient for Closing the Gap (CTG) PBS Co-payment
- Simulation: PBSM08_1 — How to register a patient for Closing the Gap (CTG) Pharmaceutical Benefits Scheme (PBS) Co-payment.

Q5: How often do I need to register the patient for Closing the Gap (CTG) PBS Co-payment Measure?

A5: Registration for the Closing the Gap (CTG) PBS Co-payment Measure is once per lifetime for a patient.

Q6: When completing the Medicare Enduring Agreement to assign the Medicare benefits to the organisation, what needs to be included relating to the professional services that will be covered under the agreement?

A6: The Medicare Enduring Agreement must specify the professional services covered for the individual patient, including the relevant category or group or subgroup or item numbers where applicable. Do not use a blanket agreement for all patients; the categories should include the services that the patient's may require under the agreement e.g. health needs, chronic conditions, mental health etc. Establish a clear internal process before asking patients to complete an enduring agreement. If a service category or item is not covered by the existing agreement, a new agreement must be signed before claiming. Upload the signed agreement to the patient's medical record and retain it in line with Medicare record-keeping requirements.

- Enduring Agreement — Patient in ACCHO or AMS
- Assignment of Medicare Benefits for Bulk Billing — Frequently Asked Questions | Australian Government Department of Health, Disability and Ageing.

Medicare Q&As

Q7: If Medicare enduring agreements for assignment of benefits have not yet been implemented, what other options can support compliant assignment of Medicare benefits?

A7: Until Medicare enduring agreements are implemented, the organisation must ensure there is a valid assignment of benefit for each bulk bill claim. Available options include:

- Print the fully completed Medicare assignment of benefits form, obtain the patient's signature, and retain the signed form for two years.
- If supported by your medical software and agreed to by the patient, send the assignment of benefits request electronically and retain evidence of the patient's agreement in the medical software for two years.
- Where verbal assignment of benefit is used, provide the patient with a copy of the Medicare assignment of benefits form in person, by encrypted email, or by text, and store the record in the medical software for two years.

Further requirements are available here:
Assignment of benefit for bulk bill claims — Health professionals — Services Australia.

Q8: What is the new criteria when providing the Aboriginal & Torres Strait Islander Health Assessment item 715?

A8: From 1 March 2026, age-based clinical activities will be removed from the item requirements for Aboriginal and Torres Strait Islander health assessment items. The change supports holistic care that is tailored to the patient's individual health needs and clinical circumstances across the life course. Medical practitioners and practice staff who support health assessments should review the updated criteria here: Note AN.0.43 | Medicare Benefits Schedule.

Further information is available in this factsheet:
Health assessment items for persons of Aboriginal and Torres Strait Islander descent.

Medicare Q&As

Q9: Can Allied Health Professionals be involved in GP Case Conferences for chronic condition management, and can they claim a Medicare item?

A9: Eligible allied health professionals may participate in multidisciplinary case conferences for chronic condition management with medical practitioners, and the eligible allied health professional, depending on the timeframe can claim either item 10955, 10957 or 10959 where all the item requirements are met.

For chronic disease management case conferences:

- Aboriginal and Torres Strait Islander health practitioners;
- Aboriginal health workers;
- audiologists;
- chiropractors;
- diabetes educators;
- dietitians;
- exercise physiologists;
- mental health workers;
- occupational therapists;
- osteopaths; physiotherapists;
- podiatrists;
- psychologists; or
- speech pathologists.

For chronic disease management case conferences, eligible allied health multidisciplinary case conference items include MBS items 10955, 10957 and 10959. Refer to the explanatory note for item requirements prior to claiming: Note MN.3.2 | Medicare Benefits Schedule

See the factsheet for Autism, pervasive developmental disorder and disability case conference services and eligible disability case conference services, and the additional requirements to claim: Factsheet-Allied-Health-Case-Conferencing.14.12.21.pdf

Medicare Q&As

Q10: What referral requirements apply after a Mental Health Treatment Plan item has been completed for a patient?

A10: Following completion of an eligible Mental Health Treatment Plan item, the patient may be referred for mental health treatment services using a signed and dated referral letter. An electronic signature from the referring practitioner is acceptable. Refer to: Allied health referrals for mental health treatment services — Health professionals — Services Australia and Note AN.0.56 Medicare Benefits Schedule

The referral should include:

- the patient's name
- date of birth
- address
- their symptoms or diagnosis
- any current medications
- the number of treatment services the patient is being referred for
- a statement about whether the patient has a MHTP prepared.

Allied health professional eligibility

Under Better Access, these allied health professionals can provide mental health treatment services:

- clinical psychologists
- registered psychologists
- occupational therapists
- social workers.

If they have met the qualification requirements, they must register with Services Australia to ensure eligibility requirements are met.

Referral validity

Referrals are valid for the number of services shown on the referral letter, even if the patient changes their treating allied health professional.

If your patient has unused services on their referral at the end of the calendar year, they can use them the next year, but they will count towards the new year's claiming limit.

Referral course of treatment

The number of services stated in the referral letter is a 'course of treatment'.

The maximum limit for each course of individual treatment is:

- a maximum of 6 services for the initial course of treatment
- the remaining services for subsequent courses of treatment, up to the maximum of 10 services per calendar year

Note: The GP cannot refer for 10 services after the Mental Health Treatment Plan has been completed.

Medicare Q&As

A10: Continued...

Referring practitioners may also refer a patient for up to 10 group therapy mental health treatment services in any one referral.

Patients need a new referral for each course of individual and group therapy mental health treatment.

Better Access services for family and carer participation

Better Access services allow eligible health professionals to deliver up to a maximum of 2 services per calendar year to a family member or carer of the patient — though the 2 services are part of the 10 that the patient is eligible to receive.

Additional resources

Services Australia

- Medicare eLearning: Health Professional Education Resources | Services Australia
- Telehealth MBS items — Health professionals - Services Australia

AHPRA & Medical Board of Australia — Telehealth Resources

- Medical Board of Australia — Telehealth consultations with patients

Avant & DoHDA

- https://avant.org.au/resources/medicare-faqs
- https://avant.org.au/resources/video-referrals-and-medicare-billing
- https://avant.org.au/resources/understanding-the-80-20-rul and DoHDA Prescribed pattern of services (the 80/20 and 30/20 rules) — How breaches are detected and what happens next?
- https://avant.org.au/resources/does-your-healthcare-practice-meet-these-important-legal-obligations
- https://avant.org.au/resources/provider-numbers