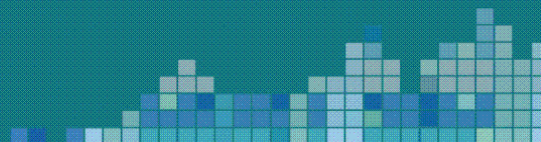




Australian Government  
Department of Health and Ageing



Medicare Financing & Analysis Branch

**ELIGIBLE MIDWIVES  
QUESTIONS AND ANSWERS  
1 November 2013**

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## 1. General

From 1 November 2010, Medicare benefits have been payable for antenatal, intra-partum and postnatal services (up to 6 weeks post delivery), provided by eligible privately practising midwives working in collaboration with a specified medical practitioner. Eligible midwives can request certain pathology and diagnostic imaging services for their patients and refer patients to obstetricians and paediatricians, as the clinical need arises.

To provide services under Medicare, midwives must meet the eligibility requirements for the Medicare Benefits Schedule (MBS) items, and be registered with Medicare Australia.

Descriptions, explanatory notes, schedule fees and benefits for MBS items provided by eligible midwives and medical practitioners (e.g. obstetricians), and specialists (paediatricians and obstetricians) and pathology and diagnostic imaging services that eligible midwives can request can be found at: [www.mbsonline.gov.au](http://www.mbsonline.gov.au).

Further information on the Medicare items in support of midwife services is available from Medicare Australia on 132 150 (for providers) or 132 011 (for patients).

## 2. Eligibility to participate under Medicare

### 2.1 What is an “eligible midwife”?

Information regarding eligibility can be found on the Nursing and Midwifery Board of Australia (NMBA) site of the Australian Health Practitioner Regulatory Agency (AHPRA) website at:

<http://www.nursingmidwiferyboard.gov.au/>.

### 2.2 What is an “eligible midwife” under the Medicare arrangements?

An eligible midwife is one who meets the requirements of the NMBA and renders a Medicare rebateable service in a collaborative arrangement or collaborative arrangements of a kind or kinds specified in the regulations, with one or more medical practitioners, of a kind or kinds specified in the regulations.

The *Health Insurance Regulations 1975* provides details of the requirements for collaborative arrangements and can be found on the Commonwealth of Australia Law website at:

<http://www.comlaw.gov.au/comlaw/comlaw.nsf/sh/homepage>.

### 2.3 I am an eligible midwife. What do I need to do to provide Medicare rebateable services?

To provide Medicare rebateable services an eligible midwife is required to:

- have a Medicare provider number;
- be working in private practice;
- have professional indemnity insurance; and
- have collaborative arrangements in place with a specified medical practitioner.

## 3. Provider numbers

### 3.1 How do I apply for a provider number?

To access the Medicare arrangements, eligible midwives must apply to Medicare Australia for a provider number. A separate provider number is required for each location at which a midwife practices. Advice for midwives about registering with Medicare Australia is available from the Medicare Australia provider inquiry line on 132150. Application forms can be downloaded from the Medicare Australia website at

[www.medicareaustralia.gov.au](http://www.medicareaustralia.gov.au)

## 4. Collaborative arrangements

### 4.1 What is a collaborative arrangement?

A collaborative arrangement is an arrangement between an eligible midwife and a specified medical practitioner that must provide for:

- consultation with an obstetric specified medical practitioner;
- referral of a patient to a specified medical practitioner; and
- transfer of the patients care to an obstetric specified medical practitioner, as clinically relevant to ensure safe, high quality maternity care.

### 4.2 Who can an eligible midwife have collaborative arrangements with?

A collaborative arrangement can be with one of the following specified medical practitioners:

- an obstetrician;
- a medical practitioner who provides obstetric services; or
- a medical practitioner employed or engaged by a hospital authority and authorised by the hospital authority to participate in a collaborative arrangement.

### 4.3 Do eligible midwives have to have a signed agreement with the collaborating practitioner/s?

Collaborative arrangements can be established in the following ways:

- (a) the midwife:
  - I. is employed or engaged by one or more obstetric specified medical practitioners, or by an entity that employs or engages one or more obstetric specified medical practitioners; or
  - II. has an agreement, in writing, with an entity, other than a hospital, that employs or engages one or more obstetric specified medical practitioners, OR
- (b) a patient is referred in writing to the midwife for midwifery treatment by a specified medical practitioner; or
- (c) a written, signed agreement between an eligible midwife and one or more specified medical practitioners, or
- (d) an arrangement recorded in the midwife's written records.
  - a. An eligible midwife must record the following for a patient in the midwife's written records:
    - i. The name of at least one specified medical practitioner who is, or will be, collaborating with the midwife in the patient's care (a **named medical practitioner**);

- ii. That the midwife has told the patient that the midwife will be providing midwifery services to the patient in collaboration with one or more specified medical practitioners;
  - iii. Acknowledgement by a named medical practitioner that the practitioner will be collaborating in the patient's care;
  - iv. Plans for the circumstances in which the midwife will do any of the following:
    - 1. consult with an obstetric specified medical practitioner;
    - 2. refer the patient to a specified medical practitioner;
    - 3. transfer the patient's care to an obstetric specified medical practitioner.
- b. The midwife must also record the following in the midwife's written records:
- i. any consultation or other communication between the midwife and an obstetric specified medical practitioner about the patient's care;
  - ii. any referral of the patient by the midwife to a specified medical practitioner;
  - iii. any transfer by the midwife of the patient's care to an obstetric specified medical practitioner;
  - iv. when the midwife gives a copy of the hospital booking letter for the patient to a named medical practitioner – acknowledgement that the named medical practitioner has received the copy;
  - v. when the midwife give a copy of the patient's maternity care plan prepared by the midwife to a named medical practitioner – acknowledgement that the named medical practitioner has received the copy;
  - vi. if the midwife requests diagnostic imaging or pathology services for the patient – when the midwife gives the results of the services to a named medical practitioner
  - vii. that the midwife has given a discharge summary at the end of the midwife's care for the patient to:
    - 1. a named medical practitioner; and
    - 2. the patient's usual general practitioner.
- (e) In relation to a hospital, the midwife is:
- I. credentialed to provide midwifery services after successfully completing a formal process to assess the midwife's competence, performance and professional suitability; and
  - II. given clinical privileges for a defined scope of clinical practice for the hospital; and

- III. permitted to provide midwifery care to his or her own patients at the hospital.

The hospital must employ or engage one or more obstetric specified medical practitioners.

Collaborative arrangements must be in place at the time the eligible midwife provides a Medicare service.

### 4.4 What is meant by an entity?

An entity may refer, for example, to a community health centre or a medical practice. For a midwife to have a collaborative arrangement in these circumstances, that midwife must be employed or engaged by, or have a written agreement with, an entity that also employs or engages one or more obstetric specified medical practitioners.

### 4.5 Does the definition of an entity include a maternity hospital or an Aboriginal Health service?

An entity may refer to a hospital or community health centre. For a midwife to have a collaborative arrangement in these circumstances, that midwife must be employed or engaged by an entity that also employs or engages one or more obstetric specified medical practitioners.

## 5. Overview of midwifery MBS items

### 5.1 Can eligible midwives care for their own patients?

Eligible midwives can treat their own patients, in collaboration with other maternity care providers including GPs, GP obstetricians and specialist obstetricians. Eligible midwives are not limited to providing care *on behalf of* medical practitioners.

### 5.2 What services can eligible midwives provide under Medicare?

Midwifery services that attract a Medicare benefit are listed in the Medicare Benefits Schedule (MBS) by an item number and description of the service. Information on all MBS items can be found at [www.mbsonline.gov.au](http://www.mbsonline.gov.au).

New midwifery MBS items effective from 1 November 2010 for antenatal, intra-partum and postnatal services, are summarised below:

ITEM	DESCRIPTORS
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82100	an initial antenatal attendance of at least 40 minutes duration
82105	a short antenatal attendance of up to 40 minutes duration
82110	a long antenatal attendance of more than 40 minutes duration
82115	a maternity care plan for a woman across a pregnancy that has progressed beyond 20 weeks
82120	management of a confinement
82125	management of a confinement in excess of 12 hours
82130	short postnatal attendance of up to 40 minutes duration
82135	long postnatal attendance of at least 40 minutes duration
82140	six week postnatal attendance
82150	telehealth professional attendance lasting less than 20 minutes
82151	telehealth professional attendance lasting at least 20 minutes
82152	telehealth professional attendance lasting at least 40 minutes

### 5.3 Can an eligible midwife provide midwifery services outside these items?

Under the Medicare arrangements, eligible midwives are limited to providing the services described in these items. Services provided outside these items or services that do not meet the item requirements will not attract Medicare benefits.

### 5.4 Can another midwife or nurse provide a Medicare service on my behalf?

For a Medicare benefit to be payable, the eligible midwife will need to personally provide the service to the woman.

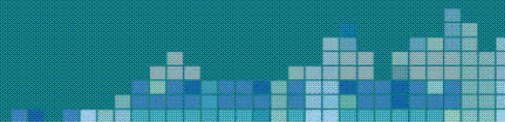
### 5.5 Can another midwife assist me in providing Medicare services?

Another midwife can provide assistance to you in rendering the service, however, you are still required to be in personal attendance on the woman.

### 5.6 If another midwife assists in providing a service, will Medicare benefits be payable for this assistance?

No. Only one Medicare benefit is payable for any individual service regardless of the number of midwives involved.





### 5.7 Can an eligible midwife see more than one woman at a time to provide midwifery services?

No. Medicare benefits are only payable where an eligible midwife attends to one patient on the one occasion.

## 6. Antenatal services

### 6.1 What antenatal services can an eligible midwife provide?

The antenatal items for eligible midwives are described below: details of schedule fees and benefits can be found at [www.mbsonline.gov.au](http://www.mbsonline.gov.au).

82100	<p><b>Initial Antenatal Attendance</b> Initial antenatal professional attendance by an eligible midwife, lasting at least 40 minutes, including all of the following:</p> <ul style="list-style-type: none"> <li>(a) taking a detailed patient history;</li> <li>(b) performing a comprehensive examination;</li> <li>(c) performing a risk assessment;</li> <li>(d) based on the risk assessment - arranging referral or transfer of the patient's care to an obstetrician;</li> <li>(e) requesting pathology and diagnostic imaging services, when necessary;</li> <li>(f) discussing with the patient the collaborative arrangements for her maternity care and recording the arrangements in the midwife's written records in accordance with section 2E of the <i>Health Insurance Regulations 1975</i>.</li> </ul> <p>Payable once only for any pregnancy.</p>
82105	<p><b>Short Antenatal Attendance</b> Short antenatal professional attendance by an eligible midwife, lasting up to 40 minutes.</p>
82110	<p><b>Long Antenatal Attendance</b> Long antenatal professional attendance by an eligible midwife, lasting at least 40 minutes.</p>

82115	<p><b>Maternity Care Plan</b> Professional attendance by an eligible midwife, lasting at least 90 minutes, for assessment and preparation of a maternity care plan for a patient whose pregnancy has progressed beyond 20 weeks, if:</p> <p>(a) the patient is not an admitted patient of a hospital; and (b) the eligible midwife undertakes a comprehensive assessment of the patient; and (c) the eligible midwife develops a written maternity care plan that contains:</p> <ul style="list-style-type: none"> <li>• outcomes of the assessment; and</li> <li>• details of agreed expectations for care during pregnancy, labour and delivery; and</li> <li>• details of any health problems or care needs; and</li> <li>• details of collaborative arrangements that apply to the patient; and</li> <li>• details of any medication taken by the patient during the pregnancy, and any additional medication that may be required by the patient; and</li> <li>• details of any referrals or requests for pathology services or diagnostic imaging services for the patient during the pregnancy, and any additional referrals or requests that may be required for the patient; and</li> </ul> <p>(d) the maternity care plan is explained and agreed with the patient; and (e) the fee does not include any amount for the management of labour and delivery.</p> <p>(Includes any antenatal attendance provided on the same occasion).</p> <p>Payable once only for any pregnancy.</p>
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The MBS includes an obstetric antenatal attendance item, where the woman is referred by an eligible midwife at 32-36 weeks of her pregnancy.

16406	<p><b>32-36 Week Obstetric Visit</b> Antenatal attendance at 32-36 weeks of the woman's pregnancy where the woman is referred by an eligible midwife</p>
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## 6.2 Is there a limit on the number of antenatal attendances an eligible midwife can provide?

Only one initial attendance (item 82100) and one midwifery care plan (item 82115) are payable in any pregnancy, regardless of the number of midwives involved in a woman's care.

There is no upper limit on the number of long and short antenatal attendances an eligible midwife can provide to a woman during her pregnancy under items 82105 and 82110. However, attendances are limited by the requirement that the service must be clinically relevant.

**Clinically relevant** in relation to midwifery care means a service generally accepted by the midwifery profession as necessary for the appropriate treatment of the patient to whom it was rendered.

As a guide, the National Institute for Health and Clinical Excellence (NICE), United Kingdom guidelines “Antenatal Care, routine care for health pregnant women, 2010” recommends that for first time mothers with uncomplicated pregnancies, 10 antenatal attendances should be adequate.

The Nursing and Midwifery Board of Australia and the Australian College of Midwives have endorsed codes and guidelines to provide guidance to midwives in their practice. These include: the *National Competency Standards for the Midwife*, the *Code of Professional Conduct for Midwives in Australia*; the *Code of Ethics for Midwives in Australia*, the *Australian College of Midwives National Midwifery Guidelines for Consultation and Referral* (“the Guidelines”) and the *NHMRC Guidance on Collaborative Maternity Care*.

These documents can be found at the following sites:

[www.midwives.org.au](http://www.midwives.org.au)

<http://www.nursingmidwiferyboard.gov.au>

### 6.3 Where can an eligible midwife provide these antenatal services?

A midwife may practise in a range of settings to provide antenatal care including the home, hospitals, clinics, health units, a medical practice or the midwife’s rooms.

### 6.4 The antenatal attendances are time based. Does this include travel time?

No. Where MBS services are time based, practitioners can only claim for the time the patient is receiving active attention. Periods such as the time taken to travel to the patient’s home or where the patient is resting between blood pressure readings cannot be included in the time of the consultation.

### 6.5 Can an eligible midwife provide antenatal Medicare rebateable services over the telephone?

No. Services provided where the patient is not in attendance, such as the issuing of repeat prescriptions, updating patient notes or telephone consultations do not attract Medicare benefits.

### 6.6 Do consultations with other midwives or medical practitioners attract a Medicare benefit?

No. A service where a patient is not in attendance does not attract a Medicare benefit.

### 6.7 Are Medicare benefits payable for group attendances such as antenatal or birth education classes?

No. Medicare benefits are only payable for midwifery services where an eligible midwife attends a single patient on the one occasion.

### 6.8 Can more than one antenatal attendance be provided on the same day?

Yes. Medicare benefits may be payable where it is clinically relevant to provide more than one antenatal attendance on the one day. However, the subsequent attendance should not be a continuation of the earlier attendance and there should be a reasonable lapse of time between attendances before they can be regarded as separate.

For example, if an eligible midwife attends a woman in the morning for a scheduled antenatal attendance and the woman returned in the afternoon with symptoms that had subsequently developed, the two services would be considered separate attendances.

If a woman was resting between blood pressure readings, this would not be considered separate attendances.

To assist Medicare in processing claims for multiple attendances on the same day, the time of each attendance on that day should be stated on the account (e.g. 10am and 3.15pm).

### 6.9 Can an eligible midwife provide an antenatal attendance for a woman who is having a miscarriage?

Medicare benefits would be payable for any clinically relevant antenatal attendance.

### 6.10 Would Medicare benefits be payable for an eligible midwife to provide antenatal attendances on a patient in hospital while they are in labour?

No. The MBS items 82120 and 82125, covering management of confinement include all associated attendances (refer to section 7 of this document).

### 6.11 If the woman is having a homebirth, which is not covered by the intra-partum MBS items, can an eligible midwife claim antenatal attendances during her labour?

No. Medicare benefits are not payable for antenatal attendances for attending a woman in labour having a homebirth.

## 7. Intra-partum services

### 7.1 What intra-partum services can an eligible midwife provide?

The intra-partum items for midwifery services are described below:

82120	<p><b>Management of confinement for up to 12 hours, including delivery where performed</b>                  Management of confinement for up to 12 hours, including delivery (if undertaken), if:</p> <ul style="list-style-type: none"> <li>(a) the patient is an admitted patient of a hospital; and</li> <li>(b) the attendance is by an eligible midwife who:                         <ul style="list-style-type: none"> <li>(i) provided the patient's antenatal care; or</li> <li>(ii) is a member of a practice that provided the patient's antenatal care.</li> </ul> </li> </ul> <p>(Includes all attendances related to the confinement by the eligible midwife)</p> <p>Payable once only for any pregnancy</p>
82125	<p><b>Management of confinement for in excess of 12 hours, including delivery where performed.</b>                  Management of confinement, including delivery (if undertaken) when care is transferred from 1 eligible midwife to another eligible midwife (the <b>second eligible midwife</b>), if:</p> <ul style="list-style-type: none"> <li>(a) the patient is an admitted patient of a hospital; and</li> <li>(b) the patient's confinement is for longer than 12 hours; and</li> <li>(c) the second eligible midwife:                         <ul style="list-style-type: none"> <li>(i) has provided the patient's antenatal care; or</li> <li>(ii) is a member of a practice that has provided the patient's antenatal care.</li> </ul> </li> </ul> <p>(Includes all attendances related to the confinement by the second eligible midwife)</p> <p>Payable one only for any pregnancy.</p>

### 7.2 Where can an eligible midwife provide intra-partum services?

Medicare benefits are only payable for intra-partum services when the service is provided to an admitted patient of a hospital, including a hospital birthing centre.

### 7.3 Can an eligible midwife claim an intra-partum service if the woman they are caring for delivers before she is admitted to hospital and the eligible midwife is in attendance?

No. Medicare benefits would not be payable in this situation.

### 7.3 Can these items be claimed where an eligible midwife does not undertake the delivery?

MBS items 82120 and 82125 provide for a Medicare benefit to be payable for the management of confinement by an eligible midwife, whether or not the eligible midwife undertakes the delivery. This is in recognition that a midwife may spend considerable time with a woman in labour after which circumstances may arise that require the woman's intra-partum care to be handed over to a second eligible midwife or care is escalated to a medical practitioner.

It is not intended that the MBS items be claimed routinely by eligible midwives who do not intend to undertake the delivery i.e. where the eligible midwife has arranged beforehand for a medical practitioner to undertake the delivery.

A Medicare benefit is payable where the eligible midwife does not undertake the delivery because:

- care was transferred to a second midwife for management of labour which had exceeded 12 hours; or
- there was a clinical need to escalate care to an obstetrician or medical practitioner who provides obstetric services.

### 7.5 The items are time based. What does the time component cover?

The MBS items cover the period of exclusive and continuous care by an eligible midwife of an in-hospital patient in labour, including delivery where performed.

### 7.6 Following delivery, if an eligible midwife needs to repair an episiotomy or tear, what Medicare item would apply?

No additional benefit would be payable. The delivery includes repair of an episiotomy and repair of tears.

### 7.7 What Medicare benefit would be payable if the woman is referred to a second midwife because labour exceeded 12 hours and continues for another 12 hours necessitating a third midwife to attend?

There is no additional Medicare benefit for the third midwife.

## 7.8 Would Medicare benefits be payable under both items if the first eligible midwife chose to remain with the woman beyond 12 hours?

No. Medicare benefits are only payable under item 82125 where the woman's care is transferred to a second midwife.

## 7.9 If the patient's care required transfer to a medical practitioner before labour commences, can the eligible midwife attend the woman in labour and assist the obstetrician with the delivery and claim an intra-partum item?

No. Medicare benefits are not payable for the eligible midwife's attendance where the woman's care is transferred to a medical practitioner prior to labour commencing, as the medical practitioner will be managing the confinement.

## 7.10 If an eligible midwife needs to escalate care to an obstetrician during labour, what item would apply for the obstetrician's delivery?

The following items would apply, depending on the service provided:

16527	<p><b>MANAGEMENT OF VAGINAL DELIVERY,</b></p> <p>- if the patient's care has been transferred by an eligible midwife for management of the delivery, including all attendances related to the delivery (Anaes)</p> <p>Payable only once for a pregnancy</p>
16528	<p><b>CAESAREAN SECTION</b> and post-operative care for 7 days,</p> <p>- if the patient's care has been transferred by an eligible midwife for management of the birth (Anaes)</p> <p>Payable once only for a pregnancy</p>

If care is escalated to an obstetrician prior to the commencement of labour, the following item would apply for the obstetrician's delivery:

16519	<p><b>MANAGEMENT OF LABOUR AND DELIVERY,</b></p> <p>- by any means (including caesarean section) including post-partum care for 5 days - Payable only once for a pregnancy</p>
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### 7.11 MBS items 16528 and 16519 include postoperative and post-partum care for 7 and 5 days respectively. Does this mean an eligible midwife cannot provide postnatal services to the woman during this period?

If an obstetrician transfers the woman back to the eligible midwife for routine postnatal care, Medicare benefits would be payable during this period as long as it were an arms length arrangement i.e. the midwife and the medical practitioner were not in the same group practice.

If both were in the same group practice, Medicare benefits would not be payable for midwifery postnatal care during this period and the midwife and the medical practitioner would need to come to a financial arrangement between themselves.

## 8. Postnatal services

### 8.1 What postnatal Medicare rebateable services can an eligible midwife provide?

The midwifery postnatal MBS items are described below:

82130	<p><b>Short Postnatal Attendance</b> Short postnatal professional attendance by an eligible midwife, lasting up to 40 minutes, within 6 weeks after delivery.</p>
82135	<p><b>Long Postnatal Attendance</b> Long postnatal professional attendance by an eligible midwife, lasting at least 40 minutes, within 6 weeks after delivery.</p>
82140	<p><b>Six Week Postnatal Attendance</b> Postnatal professional attendance by an eligible midwife on a patient, not less than 6 weeks but not more than 7 weeks after delivery of a baby, including: (a) a comprehensive examination of patient and baby to ensure normal postnatal recovery; and (b) referral of the patient to a general practitioner for the ongoing care of the patient and baby  Payable once only for any pregnancy.</p>

### 8.2 Is there a limit on the number of postnatal attendances an eligible midwife can provide?

There is no upper limit on the number of postnatal attendances an eligible midwife can provide to a woman under items 82130 and 82135, other that they can only be provided in the first 6 weeks post delivery.

However, attendances are limited by the requirement that the service must be clinically relevant. **Clinically relevant** in relation to midwifery care means a service generally accepted by the midwifery profession as necessary for the appropriate treatment of the patient's clinical condition.

### 8.3 Are there any other limitations associated with postnatal services?

As with antenatal attendances, Medicare benefits are not available:

- (a) where the service rendered does *not* meet the item description and associated requirements;
- (b) where the service is *not* personally performed by the eligible midwife;

- (c) for the inclusion of time in the consultation periods when the patient is *not* receiving active attention e.g. the time the provider may take to travel to the patient's home;
- (d) services provided where the patient is not in attendance, such as the issuing of repeat prescriptions;
- (e) telephone attendances; and
- (f) group sessions.

## 9. Telehealth services

### 9.1 What telehealth Medicare rebateable services can an eligible midwife provide?

New time-tiered MBS items were introduced on 1 July 2011 for eligible midwives providing clinical support during a specialist or consultant physician consultation, undertaken via videoconference with a patient located in a regional, remote or outer metropolitan area. These services are listed below.

Item	Group M13– Eligible Midwives
	Subgroup 2 - Telehealth attendance
82150	<p>A professional attendance lasting less than 20 minutes (whether or not continuous) by a participating midwife that requires the provision of clinical support to a patient who:</p> <ul style="list-style-type: none"> <li>a) is participating in a video consultation with a specialist practising in his or her speciality of obstetrics or a specialist or consultant physician practising in his or her speciality of paediatrics; and</li> <li>b) is not an admitted patient; and</li> <li>c) is located:               <ul style="list-style-type: none"> <li>(i) both:                   <ul style="list-style-type: none"> <li>(A) outside an Inner metropolitan area; and</li> <li>(B) at the time of the attendance—at least 15 kms by road from the specialist or consultant physician mentioned in paragraph (a); or</li> </ul> </li> <li>(ii) in Australia if the patient is a patient of:                   <ul style="list-style-type: none"> <li>(A) an Aboriginal Medical Service; or</li> <li>(B) an Aboriginal Community Controlled Health Service for which a direction made under subsection 19(2) of the Act applies.</li> </ul> </li> </ul> </li> </ul>

82151	<p>A professional attendance lasting at least 20 minutes (whether or not continuous) by a participating midwife that requires the provision of clinical support to a patient who:</p> <ul style="list-style-type: none"> <li>a) is participating in a video consultation with a specialist practising in his or her speciality of obstetrics or a specialist or consultant physician practising in his or her speciality of paediatrics; and</li> <li>b) is not an admitted patient; and</li> <li>c) is located:             <ul style="list-style-type: none"> <li>(i) both:                 <ul style="list-style-type: none"> <li>(A) outside an Inner metropolitan area; and</li> <li>(B) at the time of the attendance—at least 15 kms by road from the specialist or consultant physician mentioned in paragraph (a); or</li> </ul> </li> <li>(ii) in Australia if the patient is a patient of:                 <ul style="list-style-type: none"> <li>(A) an Aboriginal Medical Service; or</li> <li>(B) an Aboriginal Community Controlled Health Service for which a direction made under subsection 19(2) of the Act applies.</li> </ul> </li> </ul> </li> </ul>
82152	<p>A professional attendance lasting at least 40 minutes (whether or not continuous) by a participating midwife that requires the provision of clinical support to a patient who:</p> <ul style="list-style-type: none"> <li>a) is participating in a video consultation with a specialist practising in his or her speciality of obstetrics or a specialist or consultant physician practising in his or her speciality of paediatrics; and</li> <li>b) is not an admitted patient; and</li> <li>c) is located:             <ul style="list-style-type: none"> <li>(i) both:                 <ul style="list-style-type: none"> <li>(A) outside an Inner metropolitan area; and</li> <li>(B) at the time of the attendance—at least 15 kms by road from the specialist or consultant physician mentioned in paragraph (a); or</li> </ul> </li> <li>(ii) in Australia if the patient is a patient of:                 <ul style="list-style-type: none"> <li>(A) an Aboriginal Medical Service; or</li> <li>(B) an Aboriginal Community Controlled Health Service for which a direction made under subsection 19(2) of the Act applies.</li> </ul> </li> </ul> </li> </ul>

From 1 November 2012, there is a requirement for the patient and specialist to be located a minimum of 15km apart at the time of the consultation. Minimum distance between specialist and patient video consultations are measured by the most direct (ie least distance) route by road. The patient or the specialist is not permitted to travel to an area outside the minimum 15 km distance in order to claim a video conference.

This rule will not apply to specialist video consultation with patients who are at an Aboriginal Medical Service or an Aboriginal Community Controlled Health Service for which a direction made under subsection 19(2) of the *Health Insurance Act 1973* as these patients are able to receive telehealth services anywhere in Australia.

More information can be found at [www.medicareaustralia.gov.au](http://www.medicareaustralia.gov.au) and [www.mbsonline.gov.au](http://www.mbsonline.gov.au).

## 10. Schedule fees and Medicare rebates

### 10.1 How are Medicare benefits calculated?

The fee set for any item in the MBS is known as the “Schedule fee”. There are two levels of benefit payable for midwifery services:

- (a) **75% of the Schedule fee** for services rendered to privately admitted patients receiving hospital treatment (i.e. other than for public patients); or
- (b) **85% of the Schedule fee** for services rendered to non-admitted patients.

### 10.2 Is an eligible midwife required to bulk bill patients?

This is a matter for each individual practitioner. Eligible midwives can bulk bill patients i.e. accept the relevant Medicare benefit, assigned to them, as payment in full for the service. Where eligible midwives charge in excess of the Medicare benefit, the resultant out-of-pocket costs are the responsibility of the patient.

### 10.3 What is the Medicare safety net?

Assistance is provided to patients for high out-of-pocket costs for out-of-hospital services through the “original” and “extended” Medicare safety nets:

- the original safety net provides that once the threshold is met, the Medicare benefit increases to 100% of the Schedule fee; and
- under the extended Medicare safety net (EMSN), once certain thresholds are met, Medicare rebates 80% of the out-of-pocket costs. However, from 1 January 2010, a benefit limit under the EMSN (the EMSN benefit cap) has been applied to certain services, including midwifery and obstetric services.

### 10.4 What is the Extended Medicare Safety Net (EMSN) Cap for midwifery services?

In line with obstetric services, certain midwifery services are subject to an ESMN benefit cap. The caps that apply to midwifery services at 1 January 2011 are outlined below:

Item	Maximum increase (\$)
82100	20.65
82105	15.50
82110	20.65
82115	51.55
82130	15.50
82135	20.65
82140	15.50

### 10.5 What Rural and Remote services are there for midwives

#### Midwives in the public health system at rural and remote sites.

In January 2011, Directions were issued under section 19(2) of the *Health Insurance Act 1973*, to enable Medicare benefits to be payable for bulk billed services provided by eligible midwives employed by the Aboriginal and Torres Strait Islander Community Controlled Health Services (ACCHS), including those located in regional and remote areas.

As well, under the COAG *Improving Access to Primary Care in Rural and Remote Areas* exemption, eligible nurse practitioners and midwives can provide bulk billed services under Medicare from designated public hospital and community clinics in rural and remote communities.

#### *Where to get further information*

For information on The Directions issued under section 19(2) of the *Health Insurance Act 1973*:

Contacts:

The Office for Aboriginal and Torres Strait Islander Health at [oatsih19.2enquiries@health.gov.au](mailto:oatsih19.2enquiries@health.gov.au).

The Department of Health in your State or Territory

## 11. Referral requirements

### 11.1 Can eligible midwives refer to specialists?

Under the Regulation 2 of the *Health Insurance Regulations 1975*, a midwife can make a referral to a paediatrician or to an obstetrician if the referral arises out of a midwifery service provided by the midwife.

### 11.2 Is it mandatory for me to refer my client to an obstetrician at 34 weeks?

No. The changes to the Medical Benefits Schedule (MBS) allow eligible midwives to refer a woman to an obstetrician at 32-36 weeks for a check up if clinically indicated and/or requested. The terminology used in some general fact sheets on the Department's website are targeted at 'health consumers' and is not meant to be read as a mandatory referral.

### 11.3 Can a midwife refer to a paediatrician?

Yes. Under the *Health Insurance Regulations 1975*, a midwife can make a referral to a paediatrician or an obstetrician if the referral arises out of a midwifery service provided by the midwife. The legislation giving the midwife the right to refer to a paediatrician includes referral of the newly born baby if clinically necessary.

A midwife will generally provide a post-natal service for the woman and child in her care within 6 weeks following the birth of the child (MBS item 82130).

### 11.4 How long does a referral from a midwife last?

A referral given by an eligible midwife is valid until 12 months after the first service given in accordance with the referral and applies to 1 pregnancy only. If the woman undergoes a second pregnancy in that 12 month period, a new referral will be required.

### 11.5 Why is a new referral required for a new pregnancy?

A new pregnancy represents a new episode of care.

#### 11.6 What details need to be included on a referral?

A referral must be in writing in the form of a letter or a note to the specialist and must be signed and dated by the referring midwife. The referral must contain any information relevant to the patient and the specialist must have received the referral on or prior to providing a specialist consultation.

### 11.7 What happens if a specialist provides a consultation without referral?

The specialist's consultation would not attract Medicare benefits at the specialist rate.

### 11.8 Are there any exemptions in regard to a specialist providing a service without referrals, such as an emergency?

An emergency is exempt from this requirement if the specialist considers the patient's condition requires immediate attention without a referral. In that situation, the specialist is taken to be the referring practitioner.

If a referral is lost, stolen or destroyed, the midwife would need to provide a replacement referral as soon as is practicable after the service is provided.

If the woman is a privately admitted patient of a hospital, a letter or note is not required to refer the patient to a specialist. The referring midwife would make a notation in the woman's hospital records, which the eligible midwife would sign approving the referral.

### 11.9 Does the woman need a referral if an eligible midwife transfers her care during the intra-partum period under items 16527 and 16528?

The midwife would make a signed notation in the woman's clinical record approving the transfer of care.

### 11.10 Does the woman need a referral back to her GP after the 6 week postnatal period?

The midwife would provide a discharge summary to the GP outlining her maternity history and any relevant clinical issues, which would also be recorded in the patient's notes.

### 11.11 Can eligible midwives refer to allied health professionals?

If an eligible midwife referred patients to an allied health practitioner, Medicare benefits would not be payable for any allied health services.

### 11.11 Can a lactation consultant provide Medicare rebateable services in the postnatal period?

Medicare benefits are not payable for services provided by a lactation consultant. Medicare benefits would of course be payable for breast feeding support provided as part of the postnatal care by the eligible midwife

### 11.12 If the patient's care is transferred to a medical practitioner practising in a public hospital, is the midwife covered by insurance to attend the woman in labour and assist the obstetrician with the delivery if the woman is a public patient?

It has always been the case that the Commonwealth-supported MIGA policy does not cover the midwife once a patient becomes a public patient.

The Nursing and Midwifery Board of Australia (NMBA) has always required midwives to have professional indemnity cover when midwifery care/services are being provided (except with respect to the homebirth exemption).

The NMBA's definition of 'midwifery practice' is clear, and a midwife is not to practice unless covered by Professional Indemnity Insurance (PII). To do so risks action by the Board with respect to the midwife's registration.

On 2 September 2011, the NMBA released a Position Statement advising that the midwife can adopt the role of support person to the woman in this situation as long as the midwife's changed role is clearly articulated to both the woman and the health service. This position statement can be accessed at the following site:  
[www.nursingmidwiferyboard.gov.au](http://www.nursingmidwiferyboard.gov.au).



## 12. Prescribing medicines and Requesting pathology tests and diagnostic imaging services

### 12.1 What medicines can a midwife prescribe under the Pharmaceutical Benefits Scheme?

Eligible midwives who have completed the approved midwifery prescribing course can prescribe selected Pharmaceutical Benefits Scheme (PBS) listed medicines. These are the Department of Health and Ageing agreed PBS subsidised items.

Item Code	Name, manner of administration and form & strength	Max Quantity	No. of repeats	Pack size
<a href="#">1884E</a>	<a href="#">AMOXYCILLIN</a> Capsule 250 mg	20	1	20
<a href="#">1889K</a>	<a href="#">AMOXYCILLIN</a> Capsule 500 mg	20	1	20
<a href="#">1891M</a>	<a href="#">AMOXYCILLIN with CLAVULANIC ACID</a> Tablet 500 mg-125 mg	10	1	10
<a href="#">1775K</a>	<a href="#">BENZYL PENICILLIN</a> Powder for injection 600 mg	10	1	1
<a href="#">3058Y</a>	<a href="#">CEPHALEXIN</a> Capsule 250 mg	20	1	20
<a href="#">3119E</a>	<a href="#">CEPHALEXIN</a> Capsule 500 mg	20	1	20
<a href="#">2360F</a>	<a href="#">CHLORAMPHENICOL</a> Eye drops 5 mg per mL (0.5%), 10 mL	1	2	1
<a href="#">1171P</a>	<a href="#">CHLORAMPHENICOL</a> Eye ointment 10 mg per g (1%), 4 g	1	0	1
<a href="#">3138E</a>	<a href="#">CLINDAMYCIN</a> Capsule 150 mg	24	0	24
<a href="#">1302M</a>	<a href="#">DICLOFENAC SODIUM</a> Suppository 100 mg	40	3	20
<a href="#">8121K</a>	<a href="#">DICLOXACILLIN</a> Capsule 250 mg	24	0	24
<a href="#">8122L</a>	<a href="#">DICLOXACILLIN</a> Capsule 500 mg	24	0	24
<a href="#">1526H</a>	<a href="#">FLUCLOXACILLIN</a> Capsule 250 mg (as sodium)	24	0	24

<a href="#">1527J</a>	<a href="#">FLUCLOXACILLIN</a> Capsule 500 mg (as sodium)	24	0	24
<a href="#">1440T</a>	<a href="#">FRAMYCETIN SULFATE</a> Eye and ear drops 5 mg per mL (0.5%), 8 mL	1	2	1
<a href="#">3192B</a>	<a href="#">IBUPROFEN</a> Tablet 400 mg	30	0	30
<a href="#">2913H</a>	<a href="#">LEVONORGESTREL</a> Tablets 30 micrograms, 28	4	2	4
<a href="#">2530E</a>	<a href="#">LINCAMYCIN</a> Injection 600 mg in 2 mL	5	0	5
<a href="#">1207M</a>	<a href="#">METOCLOPRAMIDE HYDROCHLORIDE</a> Tablet 10 mg	25	0	25
<a href="#">1206L</a>	<a href="#">METOCLOPRAMIDE HYDROCHLORIDE</a> Injection 10 mg in 2 mL	10	0	10
<a href="#">1644M</a>	<a href="#">MORPHINE SULFATE</a> Injection 10 mg in 1 mL	5	0	5
<a href="#">1645N</a>	<a href="#">MORPHINE SULFATE</a> Injection 15 mg in 1 mL	5	0	5
<a href="#">1692C</a>	<a href="#">NITROFURANTOIN</a> Capsule 50 mg	30	1	30
<a href="#">1693D</a>	<a href="#">NITROFURANTOIN</a> Capsule 100 mg	30	1	30
<a href="#">1978D</a>	<a href="#">RANITIDINE HYDROCHLORIDE</a> Tablet 150 mg (base)	60	5	60

For more information, please go to: <http://www.pbs.gov.au/browse/midwife>  
<http://www.pbs.gov.au/browse/midwife>

## 12.2 What pathology tests can a midwife request?

Midwives can request the pathology services outlined below.

MBS Pathology Services that a Midwife can Request
<b>65060</b> - Haemoglobin, erythrocyte sedimentation rate, blood viscosity - 1 or more tests
<b>65070</b> - Erythrocyte count, haematocrit, haemoglobin, calculation or measurement of red cell index or indices, platelet count, leucocyte count and manual or instrument generated differential count - not being a service where haemoglobin only is requested - one or more instrument generated set of results from a single sample; and (if performed) (a) a morphological assessment of a blood film; (b) any service in item 65060 or 65072
<b>65090</b> - Blood grouping (including back-grouping if performed) - ABO and Rh (D antigen)
<b>65093</b> - Blood grouping - Rh phenotypes, Kell system, Duffy system, M and N factors or any other blood group system - 1 or more systems, including item 65090 (if performed)
<b>65096</b> - Blood grouping (including back-grouping if performed), and examination of serum for Rh and other blood group antibodies, including: (a) identification and quantitation of any antibodies detected; and (b) (if performed) any test described in item 65060 or 65070
<b>65099</b> - Compatibility tests by crossmatch - all tests performed on any one day for up to 6 units, including: (a) all grouping checks of the patient and donor; and (b) examination for antibodies, and if necessary identification of any antibodies detected; and (c) (if performed) any tests described in item 65060, 65070, 65090 or 65096
<b>65114</b> - 1 or more of the following tests: (a) direct Coombs (antiglobulin) test; (b) qualitative or quantitative test for cold agglutinins or heterophil antibodies
<b>66500</b> - Quantitation in serum, plasma, urine or other body fluid (except amniotic fluid), by any method except reagent tablet or reagent strip (with or without reflectance meter) of: acid phosphatase, alanine aminotransferase, albumin, alkaline phosphatase, ammonia, amylase, aspartate aminotransferase, bicarbonate, bilirubin (total), bilirubin (any fractions), C-reactive protein, calcium (total or corrected for albumin), chloride, creatine kinase, creatinine, gamma glutamyl transferase, globulin, glucose, lactate dehydrogenase, lipase, magnesium, phosphate, potassium, sodium, total protein, total cholesterol, triglycerides, urate or urea - 1 test
<b>66503</b> - 2 tests described in item 66500
<b>66506</b> - 3 tests described in item 66500
<b>66509</b> - 4 tests described in item 66500
<b>66512</b> - 5 or more tests described in item 66500
<b>66545</b> - Oral glucose challenge test in pregnancy for the detection of gestational diabetes that includes: (a) administration of glucose; and (b) 1 or 2 measurements of blood glucose; and (c) (if performed) any test in item 66695
<b>66548</b> - Oral glucose tolerance test in pregnancy for the diagnosis of gestational diabetes that includes: (a) administration of glucose; and (b) at least 3 measurements of blood glucose; and (c) any test in item 66695 (if performed)
<b>66566</b> - Quantitation of: (a) blood gases (including pO <sub>2</sub> , oxygen saturation and pCO <sub>2</sub> ); and (b) bicarbonate and pH; including any other measurement (eg. haemoglobin, lactate, potassium or ionised calcium) or calculation performed on the same specimen - 1 or more tests on 1 specimen

<b>66743</b> - Quantitation of alpha-fetoprotein in serum or other body fluids during pregnancy except if requested as part of items 66750 or 66751
<b>66750</b> - Quantitation, in pregnancy, of any two of the following - total human chorionic gonadotrophin (total HCG), free alpha human chorionic gonadotrophin (free alpha HCG), free beta human chorionic gonadotrophin (free beta HCG), pregnancy associated plasma protein A (PAPP-A), unconjugated oestriol (uE <sub>3</sub> ), alpha-fetoprotein (AFP) - to detect foetal abnormality, including a service described in 1 or more of items 73527 and 73529 (if performed) -
<b>66751</b> - Quantitation, in pregnancy, of any three or more tests described in 66750
<b>69303</b> - Culture and (if performed) microscopy to detect pathogenic micro-organisms from nasal swabs, throat swabs, eye swabs and ear swabs (excluding swabs taken for epidemiological surveillance), including (if performed): (a) pathogen identification and antibiotic susceptibility testing; or (b) a service described in item 69300; specimens from 1 or more sites
<b>69306</b> - Microscopy and culture to detect pathogenic micro-organisms from skin or other superficial sites, including (if performed): (a) pathogen identification and antibiotic susceptibility testing; or (b) a service described in items 69300, 69303, 69312, 69318; 1 or more tests on 1 or more specimens
<b>69309</b> - Microscopy and culture to detect dermatophytes and other fungi causing cutaneous disease from skin scrapings, skin biopsies, hair and nails (excluding swab specimens) and including (if performed): (a) the detection of antigens not elsewhere specified in this Table; or (b) a service described in items 69300, 69303, 69306, 69312, 69318; 1 or more tests on 1 or more specimens
<b>69312</b> - Microscopy and culture to detect pathogenic micro-organisms from urethra, vagina, cervix or rectum (except for faecal pathogens), including (if performed): (a) pathogen identification and antibiotic susceptibility testing; or (b) a service described in items 69300, 69303, 69306 and 69318; 1 or more tests on 1 or more specimens
<b>69316</b> - Detection of Chlamydia trachomatis by any method - 1 test (Item is subject to rule 26)
<b>69317</b> - 1 test described in item 69494 and a test described in 69316. (Item is subject to rule 26)
<b>69324</b> - Microscopy (with appropriate stains) and culture for mycobacteria - 1 specimen of sputum, urine, or other body fluid or 1 operative or biopsy specimen, including (if performed): (a) microscopy and culture of other bacterial pathogens isolated as a result of this procedure; or (b) pathogen identification and antibiotic susceptibility testing; including a service mentioned in item 69300
<b>69384</b> - Quantitation of 1 antibody to microbial antigens not elsewhere described in the Schedule - 1 test (This fee applies where a laboratory performs the only antibody test specified on the request form or performs 1 test and refers the rest to the laboratory of a separate APA)
<b>69387</b> - 2 tests described in item 69384
<b>69390</b> - 3 tests described in item 69384
<b>69393</b> - 4 tests described in item 69384
<b>69396</b> - 5 or more tests described in item 69384
<b>69400</b> - A test described in 69384, if rendered by a receiving APP where no tests have been rendered by the referring APP - 1 test
<b>69401</b> - A test described in 69384, other than that described in 69400, if rendered by a receiving APP - each test to a maximum of 4 tests.

<p><b>69405</b> - Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness or close contact with a patient suffering from parvovirus infection or varicella during that pregnancy) including:</p> <p>(a) the determination of 1 of the following - rubella immune status, specific syphilis serology, carriage of Hepatitis B, Hepatitis C antibody, HIV antibody and</p> <p>(b) (if performed) a service described in 1 or more of items 69384, 69475, 69478 and 69481</p>
<p><b>69408</b> - Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness or close contact with a patient suffering from parvovirus infection or varicella during that pregnancy) including:</p> <p>(a) the determination of 2 of the following - rubella immune status, specific syphilis serology, carriage of Hepatitis B, Hepatitis C antibody, HIV antibody and</p> <p>(b) (if performed) a service described in 1 or more of items 69384, 69475, 69478 and 69481</p>
<p><b>69411</b> - Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness or close contact with a patient suffering from parvovirus infection or varicella during that pregnancy) including:</p> <p>(a) the determination of 3 of the following - rubella immune status, specific syphilis serology, carriage of Hepatitis B, Hepatitis C antibody, HIV antibody and</p> <p>(b) (if performed) a service described in 1 or more of items 69384, 69475, 69478 and 69481</p>
<p><b>69413</b> - Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness or close contact with a patient suffering from parvovirus infection or varicella during that pregnancy) including:</p> <p>(a) the determination of 4 of the following - rubella immune status, specific syphilis serology, carriage of Hepatitis B, Hepatitis C antibody, HIV antibody and</p> <p>(b) (if performed) a service described in 1 or more of items 69384, 69475, 69478 and 69481</p>
<p><b>69415</b> - Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness or close contact with a patient suffering from parvovirus infection or varicella during that pregnancy) including:</p> <p>(a) the determination of all 5 of the following - rubella immune status, specific syphilis serology, carriage of Hepatitis B, Hepatitis C antibody, HIV antibody and</p> <p>(b) (if performed) a service described in 1 or more of items 69384, 69475, 69478 and 69481</p>
<p><b>73053</b> - Cytology of a smear from cervix where the smear is prepared by direct application of the specimen to a slide, excluding the use of liquid based slide preparation techniques, and the stained smear is microscopically examined by or on behalf of a pathologist - each examination</p> <p>(a) for the detection of precancerous or cancerous changes in women with no symptoms, signs or recent history suggestive of cervical neoplasia, or</p> <p>(b) if a further specimen is taken due to an unsatisfactory smear taken for the purposes of paragraph (a); or</p> <p>(c) if there is inadequate information provided to use item 73055;</p>
<p><b>73529</b> - Human chorionic gonadotrophin (HCG), quantitation in serum by 1 or more methods (except by latex, membrane, strip or other pregnancy test kit) for diagnosis of threatened abortion, or follow-up of abortion or diagnosis of ectopic pregnancy, including any services performed in item <a href="#">73527</a> - 1 test</p>

## 12.3 How do these arrangements affect episode coning?

Episode coning applies in the same way it is applied for general practitioners. That is, the Medicare benefits payable in a patient episode for a set of pathology services, containing more than three items, ordered by a nurse practitioner or midwife for a non-hospitalised patient, will be equivalent to the sum of the benefits for the three items with the highest Schedule fees.

## 12.4 How do these arrangements affect bulk billing incentives?

The current bulk billing incentives for pathologists will apply to services requested by eligible nurse practitioners and midwives, who have a Medicare provider number.

## 12.5 How do these arrangements affect patient episode initiation fees (PEIs)?

PEIs apply to all episodes where a nurse practitioner or midwife requests pathology tests. Under section 16A(1)(aa)(i) and (1)(ab)(i) of the *Health Insurance Act 1973*, midwives and nurse practitioners are respectively defined as the “treating practitioner”.

## 12.5 Which diagnostic imaging services can a midwife request?

Eligible midwives can order the diagnostic imaging services outlined below.

Diagnostic Imaging MBS Items a Midwife Can Request	
55700	Pregnancy-related or pregnancy complication ultrasound scan , where the dating of the pregnancy (as confirmed by ultrasound) is less than 12 weeks of gestation and where one or more conditions are present such as hypertension or diabetes mellitus.
55704	Pregnancy-related or pregnancy complication, foetal development and anatomy, ultrasound scan of, by any or all approaches, if the dating of the pregnancy (as confirmed by ultrasound) is 12 to 16 weeks of gestation and where one or more conditions are present such as hypertension or diabetes mellitus.
55706	Pregnancy-related or pregnancy complication, foetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, if the dating for the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation.
55707	Pregnancy-related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, if the pregnancy (as confirmed by ultrasound) is dated by a fetal crown rump length of 45 to 84 mm and nuchal translucency measurement is performed to assess the risk of foetal abnormality.
55718	Pregnancy-related or pregnancy complication, foetal development and anatomy, ultrasound scan of, by any or all approaches, if the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation and certain where one or more conditions are present such as known or suspected foetal abnormality or malpresentation.

### 12.6 Can an eligible midwife request other diagnostic imaging or pathology services?

If other diagnostic services are required outside those listed, the woman would need to attend her GP or be referred to an obstetrician or the baby to a specialist practising in the speciality of paediatrics depending on the clinical circumstances.

## 13. Auditing by Medicare

### 13.1 Is an eligible midwife subject to Medicare Australia audits?

Medicare Australia conducts random and targeted audits.

Random compliance audits quantify and document incorrect payments from the Medicare and PBS programs administered by Medicare Australia. These audits select claims on a random basis and verify all aspects of the selected services.

Targeted compliance audits are specific, in-depth reviews aimed at confirming compliance with the appropriate legislation or benefit schedules. Audits are conducted by Medicare Australia program review staff in consultation with professional advisers.

### 13.2 What is a Professional Services Review (PSR)?

The PSR is a statutory body that has the objective of protecting the integrity of the Commonwealth Medicare benefits and pharmaceutical benefits programs. Under the *Health Insurance Act 1973*, Medicare Australia has the power to refer practitioners to the PSR. The PSR provides a peer review mechanism to deal quickly and fairly with concerns about inappropriate practice. On receiving a referral from Medicare Australia, the PSR may either:

- Take no action against a practitioner;
- Enter into an agreement involving signing a document that acknowledges the practitioner has engaged in inappropriate practice. This may also involve an agreement to repay Medicare benefits, or partial or full disqualification from Medicare; or
- Establish and make a referral to a peer review Committee. Practitioners who have had two or more previous agreements regarding inappropriate practice must be referred to such as committee.

The PSR may also refer a practitioner directly to the relevant State or Territory regulatory body if the conduct of the practitioner is such that the life or safety of patients is at risk.