

How much will it cost?

Allied health professionals may set their own fees. The Medicare rebate is \$50.05 (May 2010). When the fee charged is greater than the Medicare rebate the patient is responsible for paying the difference. However, such out of pocket costs will count towards the Medicare safety net.

Patients with private health insurance need to decide if they will use Medicare or their health insurance to pay for these services. Patients cannot use private health insurance cover to 'top up' the Medicare rebate for these services.

Out of pocket expenses may vary with different Allied Health Providers. Patients should find out if there are any out of pocket expenses prior to attending.

What type of service?

Services provided under the allied health Medicare items must be of at least 20 minutes duration and provided to an individual, not as part of a group.

The allied health provider must send a written report on the service to the GP.

Practice details:

If you have any questions...
Please speak with your GP
or

Refer to the Department of Health &
Ageing website
<http://www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-chronicdisease-pdf-brochure>


or
Phone Medicare Australia
Patient Enquiry Line 132 011.

DCGPA would like to acknowledge Monash Division of General Practice for developing this brochure and we would like to thank the DCGPA Consumer Reference Group for their input into the 2010 revision of this brochure.



Are You Eligible for Allied Health Medicare Rebates?

Patient Information Sheet



You may have heard that some people can now obtain Medicare rebates for services such as physiotherapy and podiatry.

It is important to note that **Medicare has strict criteria** as to who can use these services and sets limits on how often the services can be used.

Who is eligible?

Allied health service rebates under Medicare are only available for people with a chronic medical condition and complex care needs.

A chronic condition is one that has been, or is likely to be, present for at least six months for example heart disease, diabetes, cancer, arthritis.

A person is considered to have complex care needs if they require ongoing care from a team consisting of their doctor and at least two other health or care providers.

Other requirements

A person can only be referred for the allied health rebates if they are being managed by their usual doctor and have:

- GP Management Plan (GPMP)
Written plan developed by the Doctor outlining a person's needs and health care required

AND A

- Team Care Arrangement (TCA)
Written plan developed by the doctor and including at least two other care providers involved in ongoing care of the patient.

The doctor must see the patient to complete both a GPMP and a TCA **before** the patient can claim the Medicare rebate for the allied health services.

Preparing a GPMP and a TCA takes time and involves the GP working with the patient and other providers.

It should be noted that doctors manage chronic illness in a variety of ways; not all doctors choose to use GP Management Plans and Team Care Arrangements.

Which allied health services are eligible?

GPs can only refer eligible patients to certain Medicare-registered private allied health services. Eligible services include those provided by:

- Aboriginal health workers
- Audiologists
- Chiropractors
- Chiropodists
- Dental prosthetists
- Diabetes educators
- Dietitians
- Exercise physiologists
- Occupational therapists
- Osteopaths
- Physiotherapists
- Podiatrists
- Speech pathologists.

*Allied health services funded by other Commonwealth or State programs are **not eligible** for Medicare rebates, for example community health centre services, state government hospital outpatient clinics or Department of Veterans' Affairs services.*

How many services?

People who meet the eligibility requirements can have a maximum of five allied health service rebates per calendar year (ie January – December).

More than one allied health service may be used but the total number of services from **all** providers cannot exceed five per calendar year (eg three podiatry visits plus two physiotherapy).

