Medicare Policy and Compliance Webinar Follow-up Q&A

Australasian Sleep Association (ASA) 27 February 2025

Question	Answer
PART A: Home-based sleep studies	
Question One: Can we bill item number 12250 (a home based sleep study) referred by a sleep physician who wants to test the efficacy of a therapeutic device on his patient who has been diagnosed with sleep apnoea. e.g. a patient who will be undertaking a home sleep study with a MAS in situ or will be doing a study with a positional device in situ?	No, MBS item 12250 cannot be billed to test the efficacy of a therapeutic device. The item descriptor specifies that it is to *confirm the diagnosis* of obstructive sleep apnoea. Once the patient has been diagnosed, they are no longer eligible for a further diagnostic study. In addition, a patient can only access this item once in a 12-month period. There are two types of laboratory study ***that in some circumstances*** can be used to assess the efficacy of a therapeutic intervention: • MBS item 12205 provides for a follow up sleep study in a number of circumstances that include: (iii) the patient has undergone a therapeutic intervention (including, but not limited to, positive airway pressure, upper airway surgery, positional therapy, appropriate oral appliance, weight loss of more than 10% in the previous 6 months or oxygen therapy), and there is either clinical **evidence of sub-optimal response or uncertainty** about control of sleep-disordered breathing; In other words, this item is not for routine evaluation of treatment success but can be used for a follow-up sleep study where an intervention is not working as expected. • MBS item 12204 allows for overnight assessment of positive airway pressure therapy where such therapy has not been used in the previous six months.
Question Two: What are acceptable indications/reasons/justification for patient self-set up at home versus in lab set up for 12250 ambulatory sleep studies?	Any patient where an unattended sleep study is deemed to be clinically appropriate and clinically necessary by the claiming practitioner may claim item 12250 if all other item descriptor requirements are met. Medicare benefits are only payable for services which are clinically relevant. A clinically relevant service is defined as a medical service that is generally accepted in the medical profession as being necessary for the appropriate treatment of the patient to whom it is rendered. The Department relies on practitioners to use their best clinical judgement when interpreting item descriptors and associated notes. It is expected that when a practitioner makes and documents a decision regarding the clinical care of a patient, this information would generally be accepted in the medical profession as being clinically necessary and appropriate treatment for that patient. The Department notes that matters such as distance from a physical sleep laboratory, and patient request for home set up may be considered. It is up to the claiming practitioner to determine whether such requests are clinically

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	appropriate or clinically necessary, and to ensure that the study is performed in line with accepted clinical practice guidelines.
Question Three: What qualifications are necessary for a scientist to set up ambulatory sleep studies for the purpose of billing 12250?	There are no mandatory qualifications required for a sleep technician to set up ambulatory sleep studies for the purposes of billing item 12250. However, the *Australasian Sleep Association 2024 guidelines for sleep studies in adults* specifies that "All staff members must be appropriately qualified for their tasks by education, training, and/or experience." When billing item 12250, the billing sleep medicine practitioner is responsible for ensuring that staff meet these requirements to their satisfaction and to a standard that would be acceptable to their peers, and consistent with professional practice and community expectations.
Question Four: Are there proposed changes to Level 1 & 2 codes? Any new MBS for Level 3/4? The statement about 'interpretation...documentation...' is unclear; can it be clarified?	No changes to MBS items for Level 1 and Level 2 sleep studies are currently proposed. It is intended that the existing items will be considered as part of the Post-Implementation Review to inform whether changes following the MBS Taskforce review met their stated intent. Currently the MBS does not provide patient rebates for level 3 or 4 sleep studies. Before either level 3 or 4 sleep studies can be funded under the MBS, they would need to be considered by the Medical Services Advisory Committee (MSAC). MSAC is an independent, expert committee responsible for advising Government on the clinical and economic merits of publicly funding proposed and existing medical services. Further information regarding the MSAC process can be found at www.msac.gov.au and searching for 'public funding'. MSAC considered Level 3 and 4 unattended sleep studies in adult and paediatric patient populations as part of applications MSAC 1130 in 2010, MSAC 1631 in July 2021 and MSAC 1712 in 2024, and on all occasions did not support their public funding. Documents associated with these applications are available on the Department of Health and Aged Care website at: • MSAC 1130 • MSAC 1631 • MSAC 1712 All items are subject to MBS compliance processes and activities, including random and targeted audits which may require a provider to submit evidence about the services claimed. For sleep studies this would include a full copy of the PSG record that includes the raw data. The written report issued at the completion of the sleep study should include all of the requirements listed in the relevant clinical guidelines for types 1 and 2 sleep studies.
PART B: Bulk billing	
Question One: Is it acceptable for a sleep study component to be bulk billed (which includes the set-up fee, consumables, cost of the attended sleep technician, recording, report, scorer) and the accommodation component is provided for a private fee (which includes bed, linen, ensuite, food)?	No. If an MBS service is bulkbilled, then no additional charges to the patient can be made. A private facility providing an MBS supervised service on behalf of the claiming medical practitioner is not permitted to raise a separate charge for a component of the MBS service provided, regardless of the billing method. As outlined in MBS Explanatory Note GN.12.31, Medicare benefits Categories 2 and 3 of the MBS are not payable for supervised services when a medical practitioner refers patients to self-employed medical or paramedical personnel (such as sleep technicians) who either bill the patient or the

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Currently private hospitals often charge a bed fee.	practitioner requesting the service. MBS sleep services are listed in Category 2 – Diagnostic procedures and investigations. In relation to an attended sleep study, the MBS schedule fee takes into account a range of costs including the cost for the overnight stay. The facility providing the service on behalf of the claiming practitioner cannot charge the patient separately for this component of the service. Only the practitioner who is responsible for the service and for providing the report can bill for the service. It is up to the claiming practitioner to decide if the attended sleep study will be bulk billed or privately billed. Where a practitioner privately bills, they can charge an amount higher than the Medicare benefit or Schedule fee for the service and the patient will be liable for the difference between the amount charged and the Medicare benefit for that service. Under the *Private Health Insurance Act 2007* (the Act) 'hospital treatment' may include accommodation in addition to the payment of Medicare benefits for services provided, either bulk billed or privately billed. In general, a 75% rebate is payable for professional services rendered to a patient as part of an episode of 'hospital treatment' (other than services provided to public patients), including services provided in hospital outpatient settings. You can view the Act online at Federal Register of Legislation by searching by title. Benefits paid by the private health insurer to the hospital for the accommodation element of hospital treatment is determined by the amount in the contract between the insurer and the hospital, or if there is no contract, the minimum benefit in the Private Health Insurance (Benefit Requirement Rules) 2011. Where a service is provided out of hospital (such as a private sleep laboratory), the higher benefit of 85% benefit applies and the rebate payable covers all costs for the provision of the service. Where the overnight sleep study is bulk billed, no additional charges can be raised for the service. Importantly, a private sleep laboratory cannot raise a separate patient charge i.e. for accommodation or any other component of the service. The complete study can only be billed by the responsible sleep physician. However, where a sleep physician chooses not to bulk bill a service, a fee may be privately charged for the service which is equal to or greater than the Medicare benefit or Schedule fee. Billing in this manner permits a sleep physician to set a charge for the service which includes an amount to compensate for the use of consumables or to cover other costs, provided that this additional fee component is only in relation to the service being claimed.
Question Two: Can any additional fee be charged for home-based sleep studies (12250) that are bulk billed?	No. If an MBS service is bulkbilled, then no additional charges to the patient can be made The Schedule fee for a listed MBS item is that which is regarded by the Australian Government as being reasonable on average for that service having regard to usual and reasonable variation in the time involved in performing the service on different occasions and to reasonable ranges of complexity and technical difficulty encountered. The Medicare benefit is calculated as a proportion of the Schedule fee and is the amount paid to a patient when they make a Medicare claim for a service for which they have incurred an expense. Alternatively, under bulk billing arrangements, the benefit is the amount paid to the health professional who

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	provided the service, through the patient's assignment of their benefit to the health professional. If the practitioner bulk bills the service additional charges cannot be raised in relation to the Medicare service being bulk billed, whether for consumables or some other reason. The restriction on additional charges applies even if, for example, a separate invoice is used. No matter how the arrangement is described, if the practical effect is that the patient is required to pay additional charges, the service cannot be bulk billed. Where a practitioner privately bills, they can charge an amount higher than the Medicare benefit or Schedule fee for the service and the patient will be liable for the difference between the amount charged and the Medicare benefit for that service.
Question Three: Once the diagnostic pathway for 12250 is completed, can the clinic technician raise an out of pocket fee from the patient to explain the result of their study, provided they are adequately equipped to do so?	Under Medicare, there is no role envisaged for the clinic technician in explaining the sleep study report to the patient. The item descriptor requires that interpretation and preparation of a permanent report is provided by a qualified adult sleep medicine practitioner as part of a service billed to item 12250. Further guidance provided in Explanatory Note DN.1.17 is that the results and treatment options following a diagnostic sleep study should be discussed during a professional attendance with a medical practitioner before the initiation of any therapy. If there is uncertainty about the significance of diagnostic sleep study results or the appropriate management for that individual, then referral to a sleep or respiratory medicine specialist is recommended. This consultation with a medical practitioner, who could be the referring practitioner or a sleep or respiratory medicine specialist, is not part of item 12250 and may be billed as a separate attendance.
Question Four: After the bulk-billed 12250 sleep study has been completed, is it acceptable to charge a fee for an appointment with a technician regarding therapy, compliance and a management plan for the patient's sleep issues?	Once the sleep study is completed and all elements of the item descriptor have been met, including providing the report to the medical practitioner that requested the service, it is possible for the patient to book a separate appointment with the technician, noting that this would not be a Medicare-eligible service. However, the policy intent of the MBS item is that the results and treatment options following a diagnostic sleep study should be discussed during a professional attendance with a medical practitioner.
PART C: Professional guidelines	
Question One: What if I can't do exactly as specified in guidelines in an individual case because of patient-related factors, but my usual protocol fits with the guidelines?	The Department relies on practitioners to use their best clinical judgement when interpreting item descriptors and associated notes. It is expected that when a practitioner makes and documents any decision regarding the clinical care of a patient (including deviations from guidelines due to patient-specific factors) that their peers in the medical profession would accept the chosen course of action as clinically necessary for appropriate treatment for that patient.
PART D: Dentistry	
Please cover item numbers associated with the management of OSA by dental practitioners:	No. Under Medicare, respiratory and sleep physicians can only accept referrals from dental practitioners who are also licensed medical practitioners or dental practitioners who have been individually approved to perform oral

Question	Answer
Question One: (a) Can dentists refer to sleep physicians for consultation (item 110 / 132)?	and maxillofacial surgery. For Medicare purposes, Respiratory and Sleep Medicine Physicians are recognised as 'consultant physicians' (i.e., not 'specialists'), and can access consultant physician attendance items such as 110/116 and 132/133 in the MBS. They cannot also access specialist attendance items such as 104/105. The manner of patient referrals to specialists and consultant physicians is specified in sections 95 – 102 of the Health Insurance Regulations 2018, with who can make a referral addressed in section 96. This information is also outlined in Note GN.6.16 (Referral of Patients to Specialists or Consultant Physicians). All registered dental practitioners may make a referral to a specialist, however only the following categories of dental practitioners may also make a referral to a consultant physician for an MBS-funded service: 1. Dental practitioners who are *also* licensed medical practitioners; and 2. Dental practitioners who were individually approved by the Minister, prior to 1 November 2004, to perform oral and maxillofacial surgery services listed in Category 4 of the MBS. See MBS Note ON.1.12 for further information on 'approved dental practitioners'. These approvals ceased on 1 November 2004 and fewer than 100 such providers remain active. Therefore, consultant physicians, respiratory and sleep medicine physicians cannot accept referrals from dental practitioners other than those who are also licensed medical practitioners or individually approved by the Minister, as described above.
Question One: (b) Can dentists refer patients for 12250?	No. Two referral pathways lead to an unattended sleep study billed to MBS item 12250, and neither is available to the majority of dentists. For the direct pathway, based on use of screening questionnaires, the patient must be referred by a medical practitioner. Therefore, dentists who are not also licensed medical practitioners (e.g., are not oral and maxillofacial surgeons with dual dental and medical qualifications) cannot use this pathway. Pathway 2 involves a professional attendance by a qualified adult sleep medicine practitioner or a consultant respiratory physician. Both types of practitioners are recognised as consultant physicians for Medicare purposes, thus only 'approved dental practitioners' or dentists who are also licensed medical practitioners can refer patients for this assessment.
Question Two: Just hoping to clarify in what circumstance is a dental practitioner also considered a licensed medical practitioner?	A dental practitioner is also considered a licensed medical practitioner when they are registered under the National Law in the medical profession. This applies to the Oral and Maxillofacial Surgery (OMS) specialty and Fellowship in the Royal Australasian College of Dental Surgeons, which requires qualifications in both medicine and dentistry.
Question Three: How does one check if a dental practitioner is a licensed medical practitioner?	You can find the registration details of any registered practitioner on the Australian Health Practitioner Regulation Agency (AHPRA) website, using the 'Look up a practitioner' button and the practitioner's name. Individuals with dual registration will have separate medical and dental registration numbers. Note that 'approved dental practitioners' can also make referrals to consultant physicians. These approvals ceased in 2004 and only a small

Question	Answer
	number of these practitioners remain active. They are not readily identifiable by the general public.
PART E: Provider numbers	
Question One: I do sleep study reporting for a sleep unit in a public hospital and do not have a clear idea of what sleep study billings to Medicare have been put against my provider number. Please advise how I can check what sleep study billings have been claimed using my provider number so I can ensure my provider number is being used appropriately?	Any provider who has concerns on billing against their provider number should talk to their employer in the first instance, including providers who have the rights of private practice at a public hospital. The provider should ask for a summary of billings made against their provider number. As the person responsible for any Medicare Benefits Schedule (MBS) billing, the doctor should be approving and have visibility of which items are billed. Providers may also access Services Australia's Health Professional Online Services (HPOS) portal to get more detail on their provider number. Note that information on MBS billed services delivered in public hospitals may depend on the type of billing e.g. bulk billed, or system used. Refer to the Services Australia website (or contact Services Australia) for further detail. While HPOS, or similar systems, may provide MBS billing history, it is unlikely to provide detail on whether a hospital patient was a public or private patient. More general information is available at Medicare billing in public hospitals – overview | Australian Government Department of Health and Aged Care.
When the HST service multiple remote clinics, though provider is located at only one site. Question Two: Can a provider use one provider number when reporting on studies from external sites? Or should a separate provider number be used for every external site?	The provider number identifies the location of the practitioner at the time of the service – for sleep studies this is the reporting location. If a practitioner is reporting from different sites, then it is expected the practitioner will have a provider number for each location. Administration of the Medicare program, including the processing of Medicare claims and payments (benefits), provider registration and issuing of provider numbers is best discussed with Services Australia by contacting SA (phone: 132 150).
PART F: Overseas requirements	
Question One: (a) Do the overseas requirements include both reporting and billing of a sleep study, or only billing? My understanding from the answer (given in the webinar) was that billing should only take place once the procedure and all associated with the procedure (including report) has been completed. Therefore, the date for billing should be the date when the report is completed, and the expectation is that the reporting physician reports the study whilst in the country.	As required by the *Health Insurance Act 1973*, Medicare benefits are only payable for professional services rendered in Australia to an eligible person. All elements of an MBS service, including the preparation of a report, must be performed in Australia. This requirement also applies to telehealth (video and telephone) services and the legislation provides no exemptions. The date of service for the purposes of MBS overnight sleep study items is deemed to be the day of the morning the overnight investigation is completed. However, billing for the service must only occur once all of the requirements of the item have been fulfilled (i.e. interpretation and preparation of a permanent report has been completed by a qualified sleep medicine practitioner), so the date the claim is lodged may be different to the date of service. In relation to sleep study items, the reporting practitioner who claims the service must be present in Australia when preparing the report and while supervising the service (if they are the practitioner responsible for supervision). Medicare claims may be submitted while the claiming

Question	Answer
However, when physicians bill private sleep studies, they bill the date the patient is admitted/ discharged from hospital. If they bill a date that does not correspond to when the patient is in hospital (I.e. a week later when they have returned to Australia and then completed the report), this will be rejected by the health fund.	practitioner is overseas but only if the date of the MBS service is consistent with the presence of that provider in Australia.
Question One (b): Please advise sleep physicians how they can avoid this problem? This is a significant issue for private hospitals, patients and clinicians. Private hospitals and clinicians may need to monitor their movements in and out of the country and potentially cancel patients if their referring clinician has decided to take an international holiday/attend overseas conference. Medicare prescribes that a service can be billed only after it has been reported. Question One (c): So, if I report my studies after I come back from overseas, wouldn't that comply? Question One (d): If a sleep study is done while you are overseas, but you report it when in Sydney upon return and then submit billing after reporting it (at end of service), I thought that was Medicare compliant - can this be clearer please. Comments too vague on this. Question One (e): Medicare prescribes that a service can be billed only after it has been reported. So, if I report my studies after I come back from overseas, wouldn't that be in compliance? Question One (f): For item number 12250 if the sleep study report has been completed by the sleep physician on the 1.03.2025 for example and then travels overseas, can his practice staff	The Department notes the issue of sleep medicine practitioners who are not involved in supervising the sleep study being outside of Australia on the date of the overnight investigation or submission of claim, but present when they analyse the data and prepare the report on the study. Data matching laws allow the Department to match Medicare records with immigration records to determine whether a doctor and/or patient were in Australia on the dates that services were performed and billed. However, Medicare does not have a record of the date on which reports were prepared, so it is recommended that providers keep their own records in case of an audit.

Question	Answer
submit his billing on his behalf when he is overseas (pls note the service has been completed)?	
Question Two: Does the sleep medicine practitioner supervising the study need to be in Australia at the time the overnight investigation is undertaken? Please clarify what 'supervision' of the investigation means.	Yes. Explanatory Note GN.12.31 makes clear that supervision from outside Australia is not acceptable. In the context of sleep study items, the overnight investigation of sleep must be performed under the supervision of a qualified adult sleep medicine practitioner. This individual may be the same or a different individual to the practitioner who interprets the data and prepares a report (see DN.1.17 – Billing requirements for level 1 and 2 sleep studies). As per GN.12.31, a supervising medical practitioner need not be present for the entire service but must have a direct involvement in at least part of the service. Although the supervision requirements will vary according to the service in question, they will, as a general rule, be satisfied where the medical practitioner has: (a) established consistent quality assurance procedures for the data acquisition; and (b) personally analysed the data and written the report, noting again that, for sleep study items, (a) and (b) may be undertaken by a different individual. As stated in GN.12.31, the qualified adult sleep medicine practitioner(s) responsible for each component of the sleep study service must be present in Australia at the time they fulfil their role.
PART G: Compliance	
Question One: What defines (constitutes) an 'outlier', and could rising OSA billing trigger compliance?	The department uses the term 'outlier' to generally refer to an individual or group of providers who exhibit behaviour which appears to be significantly different to the majority of their peers. For example, this could be an individual with a significantly higher volume of claims, either overall or individual items, or claiming combinations of items not generally claimed together by other members of their peer group. It should be noted that being an 'outlier' does not necessarily mean that non-compliant claiming is occurring. In these circumstances, the department reviews the claiming profile of the provider to determine whether there are factors that may explain why the provider is different prior to determining whether compliance action is warranted. The requirements for claims relating to obstructive sleep apnoea are contained in Category 2 – Diagnostic Procedures and Investigations of Medicare Benefits Schedule (MBS). These items should be claimed only when clinically relevant and where all requirements of the item descriptor have been met. A rise in claiming for these items would not necessarily trigger a compliance activity provided the claims are made appropriately and meet item requirements. The Department's 2025 compliance priorities are published on our website. We continually monitor MBS claims and the broader health environment, meaning our priorities may change in response to emerging issues. Where a provider wishes to seek clarification about MBS item requirements, they can contact the department's AskMBS email advice service. AskMBS responds to email enquiries from providers of services listed on the MBS

Question	Answer
	seeking advice on interpretation of MBS items (including those for dental, pathology and diagnostic imaging), explanatory notes and associated legislation. This advice is intended primarily to assist health professionals, practice managers and others to understand and comply with MBS billing requirements. If a provider has a query relating exclusively to interpretation of the Schedule, they should email askMBS@health.gov.au.
PART H: Consultation item numbers	
Question One: If a patient is seen in a public outpatient sleep clinic with at least 2 issues addressed, just wish to confirm we cannot bill 132 if it's a 45 min appt?	Time and number of issues addressed are not the only relevant factors when considering whether it is appropriate to bill MBS item 132 rather than item 110 or 116. Firstly, MBS services provided by a public hospital must comply with the rules for the claiming of Medicare benefits under the *Health Insurance Act 1973* (the Act) and with the requirements of the 2020-25 Addendum to the National Health Reform Agreement (NHRA), which govern the provision of MBS services to private patients in public hospitals. Key provisions in the NHRA include that an eligible patient presenting at a public hospital outpatient department will be treated as a public patient, unless the patient has a referral to a named medical specialist who is exercising a right of private practice, and the patient chooses to be treated as a private patient. If the person chooses to be treated as a public patient, no MBS item should be billed. Where a person does elect to be treated as a private patient, MBS item 132 is for a service that goes beyond the routine patient management that item 110 provides for. Item 132 provides for an initial assessment of a patient with at least two morbidities, and preparation of a comprehensive treatment and management plan of significant complexity, to be given to the referring practitioner. As specified in the item descriptor and Explanatory Note AN.0.23, the plan should address the specific questions and issues raised by the referring practitioner, and include an opinion on diagnosis and risk assessment, treatment options and decisions, and medication recommendations. It should include a planned follow-up of issues and/or conditions, including an outline of the recommended intervention activities and treatment options, and alternative measures that might be taken in the future if the clinical situation changes. Consideration should also be given to recommendations for allied health professional services, where appropriate. It is anticipated that the majority of patients will be able to be managed effectively by the referring practitioner using this plan without the need for regular care by the consultant physician. Where a patient with a GP health assessment, GP management plan (GPMP) or Team Care Arrangements (TCAs) is referred to a consultant physician for further assessment, it is intended that the consultant physician treatment and management plan should augment the GPMP or TCAs for that patient. This item may only be claimed once in a 12 month period on receipt of a new referral for a new or changed condition. Further attendances that are part of a single course of treatment should be claimed under review or subsequent attendance items.

Question	Answer
Question Two: (a) Why can't 132 and 133 be used in hospital? Patients admitted in hospital often have complex and multiple issues and need a management plan. The review is needed on following day.	MBS items 132 and 133 can be used in the hospital setting where clinically relevant and all elements of the item descriptors are met. These include that the patient is referred to the consultant physician by another medical practitioner who is managing their day-to-day care, and that the initial or revised treatment and management plan is provided to that practitioner. Standard attendance items (110, 116 and 119) are appropriate where the consultant physician is directly managing the patient's care. As outlined in the previous response, item 132 provides for an initial assessment of a patient and preparation of a consultant physician treatment and management plan of significant complexity, to be provided to the referring practitioner. As per Explanatory Note AN.0.23, it is anticipated that the majority of patients will be able to be managed effectively by the referring practitioner using this plan without the need for regular care by the consultant physician. Item 133 provides for a subsequent attendance for review of the initial treatment and management plan developed under item 132; this includes reviewing the patient's response to the recommended treatment. Item 133 is intended for use in the event of a change to circumstances/condition of the patient which requires a modified treatment and management plan to be provided to the referring practitioner. Like item 132, item 133 is not intended for routine use and is not payable unless item 132 has been claimed by the same practitioner in the preceding 12 months. The review under item 133 may be instigated by the referring practitioner, or the need for a review may be noted by the consultant physician in the initial plan (as specified in MBS Explanatory Note AN.0.23). The item has a minimum time requirement of 20 minutes and is payable twice in a 12-month period.
Question Two (b): Just to clarify my question about 132 and 133, I meant admitted patients in a private hospital … or privately admitted patients in a public hospital.	MBS services in public and private hospitals are only payable for private patient services. MBS services are not payable for public patients and are a matter for state and territory Governments who are the system managers of public hospital services.
Question Two (c): For patients admitted to a private hospital, or privately admitted patients in public hospital, their health insurance pays for the item number. Is Medicare involved with this payment at all or health insurance is being paid by Medicare for part of these claims? Question Two (d): For a no gap arrangement, when PHI pays for item number 110 ... all the payment is coming from PHI and Medicare is Not contributing and is Not aware of the payment?	Yes. Where a person is treated in hospital as a private patient, Medicare covers 75% of the MBS fee. This means all services must comply with the Medicare requirements and will be recorded by Medicare against the relevant provider number. For patients who hold appropriate private health insurance, private health funds are required to pay at least (the remaining) 25% of the MBS fee. In addition, health insurers may have gap cover arrangements in place to eliminate or reduce the gap between the MBS fee and the fee charged. Where there is a no gap arrangement in place, the patient would be eligible to receive an MBS benefit (i.e., 75% of the MBS Schedule Fee) and health insurers pay the remainder.

Question	Answer
Question Three (a): There is a Department of Health factsheet which states that a GP referral (in particular) is needed asking specifically for a "comprehensive treatment and management plan." I have had discussions with many GP colleagues and not one GP was aware of this factsheet requirement. The MBS item number descriptor and/or explanatory notes seem to say that the consultant physician needs to develop a comprehensive treatment and management plan (not that the GP must directly ask for this).	The MBS item descriptor does not require the referral to specifically request a treatment and management plan. However, the reason for seeing the patient should be clear to both the referring and receiving practitioners. A Medicare referral is a legal document and must be retained for compliance reasons. To support good clinical care, the referring medical practitioner should detail the purpose of the proposed visit including presenting symptoms and current difficulties; patient's history; relevant pathology results; medications details (including interactions); and relevant care plans and assessments by other health professionals. In general, a referral should contain sufficient information for the receiving practitioner to provide a clinically relevant service. Where the intent and requirements of the referring practitioner are unclear, clarification should be sought from that practitioner.
Question Three (b): the Dept of Health factsheet says we cannot see a patient for follow up unless the GP asks us to review the patient again. Again, this is not anywhere in the MBS item number or explanatory notes. When a 132 is billed for a complex patient, it would be negligent of us to not follow up this patient (and only wait to see if the GP requests us to do this).	The review of a patient's treatment and management plan under MBS item 133 may be instigated by the referring practitioner, or where the need for further review was noted by the consultant physician in the initial consultant physician treatment and management plan (as specified in Explanatory Note AN.0.23 'Indications for Review'). As per AN.0.23, it is anticipated that the majority of patients will be able to be managed effectively by the referring practitioner using the consultant physician treatment and management plan provided under item 132. Item 133 is intended for use in the event of a change to circumstances/condition of the patient which requires a modified treatment and management plan to be provided to the referring practitioner.
Question Three (c): The inability to use 133 for follow-up when 110 was used initially is a common issue. Not uncommonly, sleep consult follow-up can take >20 minutes, as the diagnostic results require multiple issues to be addressed and management plans, which would normally qualify for 133.	Item 133 requires the review of a complex treatment and management plan prepared under item 132. It is not intended for routine use (e.g. for longer or complex consultations) and is not payable unless item 132 was claimed by the same practitioner (or a locum tenens) in the preceding 12 months.
Question Four: With a new referral, is it acceptable to use item 110 (new), even if you have been following the patient for several years? Is that correct?	If a specialist or consultant physician accepts a referral, only one initial attendance item (e.g., MBS items 104 or 110) can be billed per each single course of treatment. A single course of treatment for a patient includes: • the initial attendance on the patient by a specialist or consultant physician; • the continuing management or treatment up to and including the stage when the patient is referred back to the care of the referring practitioner; and • any subsequent review of the patient's condition by the specialist or consultant physician that may be necessary, whether the review is initiated by the referring practitioner or by the specialist or consultant physician.

Question	Answer
	Receipt of a new referral, after a previous referral for the same condition(s) has expired, does not necessarily indicate the commencement of a new course of treatment allowing the claiming of a new initial attendance. In the continuing management/treatment situation, the new referral is to allow the patient to receive benefits at the referred rate rather than the non-referred rate. An exception is where the referring practitioner considers it necessary for the patient's condition to be reviewed, the patient's previous referral for the same condition(s) has expired, and it is more than nine months since the patient was last seen by the specialist or consultant physician. This attendance initiates a new course of treatment for which Medicare benefits would be payable at the initial consultation rate. For the patient to receive MBS benefits at the referred rate, a new referral must be in place. If the patient develops a new or unrelated condition and a new referral is provided in relation to that condition, a new single course of treatment commences, and another initial attendance may be claimed. More information on referral of patients to specialists or consultant physicians, including hospital referrals, can be found at General Explanatory Note GN.6.16 and as part of the AskMBS Advisory 'Non-GP specialist and consultant physician services' which is published on the Department's website
PART I: Other	
Question One: Can registered nurses conduct sleep studies through GP referrals after getting qualified? How can registered nurses get MPN?	Registered nurses could perform sleep studies if they are 'appropriately qualified for their tasks by education training, and/or experience' as outlined in the Australasian Sleep Association 2024 guidelines for sleep studies in adults. However, nurses would be required to perform studies under the supervision of a sleep physician who would be responsible for ensuring all requirements of the MBS item number are met, including that the nurses involved were appropriately qualified for the tasks undertaken in performing sleep studies. Nurses are not able to obtain a Medicare provider number to bill Medicare for sleep studies. This is restricted to sleep physicians.
Question Two: Why don't ASA and the government make sleep service accreditation with NATA mandatory?	The Australasian Sleep Association (ASA) encourages all sleep services to become NATA accredited, however, it should be noted that currently, NATA accreditation is voluntary. An exception is sites that provide advanced training in sleep medicine, where NATA accreditation is a mandatory requirement for accreditation as a training site. There are some concerns that mandatory NATA accreditation may unintentionally affect access to sleep services by people living outside metropolitan areas.
Question Three: What is the role of Medicare in assessing new technology/ innovation and whether it is compliant as a technology to be used to conduct a MBS compliant study?	Before new technologies can be listed on the MBS, they must be considered by the Medical Services Advisory Committee (MSAC). MSAC is an independent, expert committee responsible for advising Government on the clinical and economic merits of publicly funding proposed and existing medical services. Applications to MSAC are considered as part of a formal health technology assessment process, which assesses the evidence base to

Question	Answer
	determine whether the technology is equivalent or non-inferior to a comparative service. Further information regarding the MSAC process can be found at www.msac.gov.au and searching 'public funding'.
Question Four: Has there been any consensus with regards to the gender based questions in the OSA 50 and STOPBANG screeners for patients who have transitioned?	Clinicians will need to determine the most appropriate gender on a case-by-case basis. Alternatively, they can use the Berlin questionnaire as this is gender neutral.