Chapter of Community Child Health
Chapter Chat
Issue 17, April 2014

Dr Chris Pearson

A word from the Chair ...

Another busy year is underway.

The Chapter committee met in February and had a full day's discussion on various issues. This included thoughts on the future direction and emphasis of the Chapter. An important issue was recognised by the committee and this was the recognition of the importance of the family in the work that we all do. In the Child Behaviour and Development stream involvement with the family is crucial to our work. In Child Protection stream the work done in re-enforcing and supporting the family is very much a part of primary and secondary level child protection. Finally in the area of Child Population Health all good policy initiatives are usually expressed through the family.

So once recognised how do we actually turn thought into action? The Chapter has submitted a brief to the Divisional Council and received unqualified support in the Chapter making progress with this issue. The next step is to write a paper exploring the issue of how best to describe the role of family in the work of all paediatricians. This could lead to a position statement from the College on this important issue so that others outside the College may know the value we place on family. And of course we can ask the Paediatric Policy and Advocacy Committee to examine our current policies to ensure that there is due emphasis on the importance of family in all College statements.

Obviously paediatricians in practice should not be the only focus of our thoughts and thus it will be important to ask the SAC to ensure that this topic is given due emphasis in our Community Child Health trainees. Obviously some thought should be given to basic training and the basic training Committee should be asked to ensure that this is an important part of this curriculum.

The Committee would be most interested in the thoughts of others in the Chapter. I hope to see a good number of you at the Chapter Satellite day at the beginning of the Congress in Auckland in May.

Chris Pearson, Chair of CCCH

From the Editor

Welcome to the April Edition of Chapter Chat. Many thanks for Dr Alaric Koh for writing an article to explain the intricacies of Medicare Item numbers – a topic I personally find quite confusing at times. Hopefully this will prove to be a good resource for you.

We also look forward to the Chapter Day and RACP Congress which is happening very soon in Auckland in May. We have included some photos taken at last year's Chapter Satellite Day and the International Congress of Paediatrics in Melbourne in August 2013.

Looking forward to seeing you at the Chapter activities in Auckland - for those of you who are attending. In the meanwhile, please do send us any interesting photos or articles you may have for the next edition of Chapter Chat – we are always looking for interesting ideas!

Grace Wong, Editor

Inside this issue:

Welcome to new members of the Chapter:

- Dr Renae Dayman
- Dr Leanne Browning
- Dr Sarah Townsend
- Dr Anutosh Shee
- Dr Kate Rodwell
- Dr Manina Pathak
- Dr Reeta Singh

National Families Week 2014

National Families Week will be held between 15 and 21 May 2014. The Week will commence on the United Nations International Day of Families on Thursday 15 May and will run until Wednesday 21 May.

The theme for National Families Week 2014 - the 20th Anniversary of the International Year of the Family - is *'Stronger Families, Stronger Communities'*. This theme highlights the important role families play as the central building block of our communities and that community wellbeing is enhanced by family wellbeing. Further information on National Families Week can be found on the website.

Chapter of Community Child Health Committee
Current Membership List

Chair & Child Development & Behaviour SIG Chair Dr Chris Pearson	**Child Protection SIG Chair & SAC in Community Child Health Chair** Dr Terence Donald
Child Population Health SIG Chair A/Professor John Eastwood	**Appointed Member** Dr Sharon Greenwood
Appointed Member Dr Deepa Jeyaseelan	**Appointed Member** Dr Tim Jelleyman
Appointed Member Dr Brad Jongeling	**Adolescent Health representative** Dr Bessy Lampropoulos
Appointed Member Dr Catherine Marraffa	**Advanced Trainee Representative** Dr Angela Titmuss
Casual Vacancy Dr Murray Webber	

CCCH/PSNZ Satellite Day & Dinner

Please note that registration for the 2014 Chapter of Community Child Health (CCCH)/Paediatric Society of New Zealand (PSNZ) Satellite day is now open. To register please click here.

CCCH Satellite Day:
Sunday,18 May 2014
8.30am - 5pm
Venue: 12 Grafton Road, Auckland Central, Auckland
Building Name: Owen G Glen Building (OGGB)
Room: 260-051
Cost: NZ$79

CCCH Satellite Dinner:
Dinner: 7pm arrival for a 7.30pm start until 10pm.
Venue: Marvel Grill
1 Jellicoe Street, North Wharf, Auckland
Cost: NZ$77

Registration closes on **9am Monday, 5 May 2014** and registration will NOT be accepted beyond this date.

Chapter of Community Child Health SIGs Annual Meetings on Sunday, 18 May 2014, University of Auckland (Chapter Satellite Day):

- Child Protection SIG annual meeting—from 10.15—10.30am.
- Child Development & Behaviour SIG annual meeting—from 1.15—1.30pm.
- Child Population Health SIG—from 2.30—2.45pm.

The Chapter of Community Child Health Annual Meeting will be held on Monday, 19 May 2014 from 10.30—11am as part of the RACP Congress. Room TBA.

RACP Future Directions in Health Congress 2014

It's nearly ten years since the annual RACP Congress was held in New Zealand! The Congress will be held at the Auckland Convention Centre, 18 – 21 May.

Following the College Ceremony on the Sunday (and the Chapter Satellite Day and Dinner!) the Congress starts Monday 19 May with a Powhiri (for the Australian's reading this the Powhiri is the New Zealand ceremonial equivalent to Welcome to Country).

Over the next few days there is much on offer within the streams of physicians as advocates, physicians as educators, physicians in the workplace, physicians as professionals and physicians as medical experts. The physicians as medical experts stream houses specific paediatric sessions; and within each of these sessions one or more of our New Zealand colleagues are speakers and / or Chairs. Sessions include neonates, respiratory, and neurology. This year two sessions on obesity/epigenetics and infectious diseases will be held with the Adult Medicine Division. To keep you on your feet the dermatology session is shaping up as quiz; you will be able to respond to questions via your smartphone!

The Rue Wright Memorial Award (related to the Chapter), the Wiley New Investigator Award and the RACP Trainee Research Awards for Excellence – Paediatrics will be held on the Monday with the winners being announced at the Annual Division Dinner that night (yes, there will be a DJ!). Also on the Monday is 'Paediatric Hospital Papers'; presenters will showcase their research following the high calibre abstracts received for another year.

The Best Poster Award is being held on the Tuesday with the award given at the Division Annual Meeting. Make sure you attend the Annual Meeting at which Dr Nicola Murdock is handed the Division medal by outgoing President A/Prof Susan Moloney. Dr Sarah Dalton the incoming PCHD President-Elect will be in attendance too.

Of course paediatricians are involved throughout the Congress program. Dr Nicola Murdock is speaking on an administrators view in the health and resource management session, Prof Elizabeth Elliott is presenting on FASD in the alcohol and addiction session, Dr Sarah Dalton is talking about teaching clinical practice improvement to advanced trainees in the learning professionalism session, and Dr Ross Drake is speaking about care planning for children and young people in the training and education session for end of life care.

Note there is one session dedicated to Adolescent & Young Adult Medicine co-chaired by A/Prof Susan Moloney and A/Prof Alasdair MacDonald. Dr Bridget Farrant and Dr Simon Denny are presenting. The Chapter has a representative on the AYAM Committee so it would be wonderful to see support given to this session especially as the Board has given support for progression towards AYAM being recognised as a field of specialty practice.

Last but certainly not least is the launch of the Child Protection position statement, led by Dr Terrence Donald on Tuesday 20 May; a Chapter derived initiative!

Take a look at the online Congress program for further paediatric involvement and details, or if you would like to easily view the specific paediatric component you may view this on the Division webpage. Note that programs are being updated regularly – register online now!

Medicare item numbers—what you can bill

One of the important issues we face once we finish our training or start out in private practice, but don't really learn about during our training, is the ins and outs of Medicare (and also PBS prescribing). For almost everyone in private practice, the MBS is how we get paid, and unless you start out going into an established practice dealing with consultant physician or paediatric consultations, you might not know much about this.

Lately the MBS has also become an important issue for staff specialists in public organisations, as management are now looking to see to how you may be able to fund your service. It may also be important if you are trying to find extra dollars to pay for a trainee or an allied health staff member. You may remember always being asked to complete the front sheets as complete as possible, as this is how hospitals get funded by the government - well this is a little bit similar. You need to know what Medicare item number to list for your patients in order for them to get their money back (some of it at least).

If you are experienced you will likely know about all these different item numbers, but for some others, what is written here will hopefully be helpful when starting out your practice.

There are a few standard Medicare item numbers we can charge for when seeing children as consultant physicians (which is what we are categorised as with Medicare). The first and foremost point is that you will require a *valid* written referral from another doctor, for you to see the patient for their consultation to be claimed back/ subsidised by Medicare.

Referrals will require a few things (Table 1) on them. A standard referral lasts only 12 months if from a GP or "trainee" (with a valid provider number). If the referral is from a specialist, it will only last 3 months, so a referral you write to another specialist only lasts 3 months. A GP can note for the referral to be indefinite, but this has its good and bad points, which I will explain later.

If a referral is written to you but is at a different address, that is OK. If a referral is written to someone else but at the same address as you, and they are also a 'Consultant Physician', in the same line of practice, then that is acceptable as well. If the referral is however to someone else and not at an address for which you are seeing the patient, this will not be 'acceptable' by Medicare and you would need to get a new one, or have the referral edited by the referrer. Also, the referral needs to be dated before or on the day of your consultation. This is a big problem when you bulk bill and patients do not turn up with a referral, you will then need to chase them up to see their GP to get a referral dated the day you saw them, or you will not get paid.

Indefinite referrals are good in that you can keep seeing the patient without the patient having to go back to the GP for a new referral. This however will hamstring you into only claiming the "Subsequent attendance" consultations (which have lower rebates) and cannot claim "Complex consultations" (which attract greater rebates from Medicare) after the first 12 months of that referral.

Table 1. Requirements on a referral.
Date
Your name and practice address
Referrer's name and practice address
Referrer's provider number
The problem

Now, when you do see them for a problem there are a few different 'standard' item numbers you can charge them. These are generally grouped into 'Initial attendance', 'Subsequent attendance' and 'Minor attendance'.
Generally the **Initial attendance consultations (Items 110, 122 and 132)** require a new referral for the problem. The **Subsequent attendance consultations (Items 116, 128 and 133)** follow on from an initial consultation but some with special conditions. The **Minor attendance consultations (Items 119 and 131)** are for any minor review that 'does not require the physical examination of the patient and does not involve a substantial alteration to the patient's treatment'. I would usually use the item numbers 119 and 131 if I saw them just to give them a script (you actually have to see and interact with the patient, not just leave the script at the front desk for

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Medicare item numbers—what you can bill … *cont.*

them). Some are for home visit consultations (Items 122, 128 and 131) which attract a slightly higher rebate than an in room/hospital consultation for a single problem (Items 110, 116 and 119).

These Item numbers above can all be claimed by you or any other Paediatrician, as long as the requirements are fulfilled.

Then there are Item numbers which I would class as **'once off' consultations (Items 135 and 137)** that can only be claimed once in the patient's lifetime by yourself or anyone else, including Psychiatrists or GPs.

Of the standard and once off Item numbers, only one can be claimed once on any one day. In other words, if you saw them in the morning for an item 110, and got them back in the afternoon to review their X-Ray, you cannot claim any other of the item numbers (eg 116 or 119) that day.

Here are descriptions of the different Item numbers talked about above, with special conditions noted. Note that all these item numbers require a valid (non-expired) referral.

***Item 110**. Initial consultation for a single issue. It requires a new referral for this review. There is no minimum time required for this consultation. If you see a patient on 3 different occasions and each occasion has a new referral, and they are for different problems, you can bill each of them an Item 110.*

***Item 116**. Subsequent consultation. There is no minimum time required for this consultation. It requires that you have seen them for a Medicare billed consultation in the past (Items 110, 116, 119, 122, 128, 131, 132, 133, 135 or 137).*

***Item 119**. Minor consultation for a single issue. There is no minimum time required for this consultation. It requires that you have seen them for a Medicare billed consultation in the past (Items 110, 116, 119, 122, 128, 131, 132, 133, 135 or 137).*

***Item 122**. Home visit consultation (ie attendance in a place outside of consulting rooms or hospital, so could be used for a school visit) where it is for an initial consultation for a single issue. It requires a new referral for this review. There is no minimum time required for this consultation.*

***Item 128**. Home visit consultation (ie attendance in a place outside of consulting rooms or hospital, so could be used for a school visit) where it is for a subsequent consultation. There is no minimum time required for this consultation. It requires that you have seen them for a Medicare billed consultation in the past (Items 110, 116, 119, 122, 128, 131, 132, 133, 135 or 137). So if you saw them in rooms the first time (you would have used Item 110) and the second time you saw them at home or in school, you would be using this item number rather than 116.*

***Item 131**. Home visit consultation (ie attendance in a place outside of consulting rooms or hospital, so could be used for a school visit) where it is for a minor consultation.*

***Item 132**. Initial consultation for at least 2 issue (Complex) and needs to have a treatment and management plan issued. It requires a new referral for this review, and has a minimum time requirement of 45 minutes for this consultation. This can also only be claimed once a year by yourself, so if you saw them for an item 132 on the first of January, you cannot bill them (or Medicare) another item 132 until the first of January the next year, even if they have a new referral. They would then need to be charged an Item 110 (with a new referral), or 116 or 133.*

***Item 133**. Subsequent consultation for at least 2 issue (Complex) and needs to have a treatment and management plan reviewed. It requires to have had an item 132 billed in the prior 12 months. It has a minimum time requirement of 20 minutes for this consultation. This can also only be claimed twice in the last 12 months, so if you see them on the first of January and fifth of March, you cannot charge them another 133 until the first of January the following year. If you have billed them twice item 133 in the last 12 months, you can only then bill them an Item 116 without a new referral.*

***Item 135**. Autism or other Pervasive Developmental Disorder assessment, diagnosis and treatment plan. This requires a new referral and has a minimum time requirement of 45 minutes for this consultation. This is a once off for*

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Medicare item numbers—what you can bill … *cont.*

the patient's lifetime and is linked to a few other items numbers. The patient cannot have an item 135, 137, 289 or 139 claimed against them by any doctor in the past. Item 289 is identical to Item 135, but for claiming by a Psychiatrist. Item 139 is identical to Item 137 (see below) but claim by a GP. So if they had seen another paediatrician or psychiatrist who gave them an Autism Spectrum Disorder diagnosis and claimed an Item 135 or 289, you cannot claim it again. Sometimes you need to call Medicare up (Ph: 132150) to ask them if it has been claimed already against the patients Medicare.

Item 137. *Assessment, diagnosis and treatment plan for a child with an eligible disability (Table 2). This requires a new referral and has a minimum time requirement of 45 minutes for this consultation. This is a once off for the patient's lifetime and is linked to a few other items numbers. The patient cannot have an item 135, 137, 289 or 139 claimed against them by any doctor in the past. Item 289 is identical to Item 135, but for claiming by a Psychiatrist. Item 139 is identical to Item 137 (see below) but claim by a GP. So if they had seen another paediatrician or GP who claimed an Item 135, 139 or 289, you cannot claim it again. Again, you may have to call Medicare up (Ph: 132150) to ask them if it has been claimed already against the patients Medicare.*

Table 2. Eligible conditions for item 137.

- Sight impairment with vision of less than or equal to 6/18 or equivalent field loss in the better eye, with correction.
- Hearing impairment that results in:
  - Hearing loss of 40 decibels or greater in the better ear, across 4 frequencies; or
  - Permanent conductive hearing loss and auditory neuropathy.
- Deaf - blindness
- Cerebral palsy
- Down syndrome
- Fragile X syndrome
- Prader-Willi syndrome
- Williams syndrome
- Angelman syndrome
- Kabuki syndrome
- Smith-Magenis syndrome
- CHARGE syndrome
- Cri du Chat syndrome
- Cornelia de Lange syndrome
- Microcephaly if a child has:
  - Head circumference >3rd percentile for age and sex; and
  - Functional level at or below 2 standard deviations below the mean for age on a standard developmental test, or an IQ score of less than 70 on a standardised test of intelligence.
- Rett's disorder

Next there are the **'Community Case Conference' Medicare item numbers (Items 820, 822, 823, 825, 826, 828)**. There are also **'Discharge Case Conference' Medicare items numbers (Items 830, 832, 834, 835, 837, 828)** but these are primarily to discharge a patient from a service or hospital. I will just talk about the Community Case Conference here. They are for a meeting between yourself and other multidisciplinary members. This can include nurses, speech pathologist, occupational therapist, educator/teacher, physiotherapist, social worker or psychologist. Any other doctor may attend, but only their GP can be considered another member of the team in numbers for the conference.

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Medicare item numbers—what you can bill … *cont.*

There are time based requirements involved, being 15-30 minutes (Items 820 and 825), 30-45 minutes (Items 822 and 826) or >45 minutes (Items 823 and 828). There are also team member number based requirements, where you need at least yourself and 2 other team members in the meeting (this does not include the patient or their family) (Item 820, 822 and 823) or 3 other members in the meeting (Items 825, 826 and 828).

The patient needs to have a chronic condition (been present for at least 6 months) or a terminal condition. There are also requirements as specifics that need to be recorded during the case conference and what needs to be provided to all the team members and the patient's GP. The case conference item numbers can be claimed on the same day as one of the other standard Item numbers. This can be used in a Multi-disciplinary assessment setting, where you see the patient with their family in a multi-disciplinary assessment with at least 2 other team members. You can then claim a 110 or 132 plus one of the Case conference Item numbers. Or this can be used when you go to a school to see a child with an Allied health member, and at that time you meet and discuss the case with the teacher. You could then claim one of the standard Item numbers plus a Case Conference one, if you meet their criteria.

Medicare has now also added some **Videoconference/Telehealth Item numbers (Items 112 and 114)**. They need to be at least 10 minutes in duration and need to fulfil the criteria of A, B and (C or D or E).

A. the attendance is by video conference.
B. the patient is not an admitted patient.
C. the patient is within a telehealth eligible area and at the time of the attendance, is at least 15 km by road from the physician.
D. The patient is a care recipient in a residential care service
E. The patient is a patient of an Aboriginal Medical Service or an Aboriginal Community Controlled Health Service.
F. When you see a family group for therapy and counselling regarding behaviours, you could use the 'Family Group Therapy' Item numbers (Items 170, 171 and 172). For these, the consultation needs to be more than 1 hour, and needs to have a formal intervention with a specific therapeutic outcome. These need to have at least 2, 3 or 4 patients in the group, respectively for Items 170, 171 and 172, for the consultation and they all need to be members of a family or persons with close personal relationships with that family.

For Item 112, you also need to be claiming one of the Standard item numbers that I had listed above (Items 110, 116, 119, 132 or 133).

There are a few other extras which some of us may sometimes use, including:

- 41500: removal of a foreign body (other than ventilating tube) in, removal of, other than by simple syringing
- 30278: repair of tongue tie
- 11506: measurement of respiratory function (spirometry) involving a permanently recorded tracing performed before and after inhalation of bronchodilator

We can talk about the significance of Item 135 and 137, as well as 110 for the initial work up for Autism or one of the diagnoses in item 137, and what it entitles you to refer the patient on for, but that is another article in itself. Similarly, the issues of knowing about PBS prescribing, Authority PBS, private scripts and stimulant prescribing is another whole topic in itself. I hope is of help to some of those out there. I do not work for Medicare and have not taken any specific advice from them, but this is how I have interpreted their item numbers from reading through them and talking to other Paediatricians. For more specifics on each of the item numbers listed, search on the Government website: [http://www.mbsonline.gov.au].

Alaric Koh

Interest Sought: Mental Health Professionals Network

The RACP is a partner organisation of the MHPN having supported its establishment. The Mental Health Professionals Network (MHPN) brings together clinicians from different disciplines working in community mental health for networking purposes. Regular networking contributes to effective clinical pathways informed referrals and a better service for consumers.

You are welcome to take part in the network via two means:

1. Join an active community network (meeting). In the last two years 450 active community networks were established throughout Australia with over 40% outside of metropolitan Australia.
2. Via a national online professional development program (webinar) that supports and promotes collaborative care and interdisciplinary practices. 23 have been delivered to date and attracted over 20,000 views.

Check out the initiative at www.mhpn.org.au

2014 National consultations about the National Framework

National Commission of Audit

Families Australia's submission to the National Commission of Audit discusses the importance of ongoing Federal Government leadership on the National Framework for Protecting Australia's Children 2009-2020. View the submission here.

2014 National consultations about the National Framework

Families Australia will run consultations about the National Framework in all State and Territory capitals in 2014 as follows:

17 February - Sydney
26 May - Brisbane
26 June - Darwin
21 July - Melbourne (annual Coalition meeting)
23 July - Hobart
10 November - Canberra
04 December - Perth

More information will be provided to Coalition and Families Australia members closer to the forums.

Please note that the views contained in this edition may be those of individuals and do not necessarily represent the Division or the Chapter of Community Child Health.

Chapter of Community Child Health Satellite Dinner 2013