

MBS Item Numbers

Chronic Disease Management and Health Assessments



First Floor 120 Hutt Street, Adelaide SA 5000

PO Box 7293, Hutt Street SA 5000

P. 08 8112 1100 F. 08 8227 2220

www.gppadelaide.org.au

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The MBS Item Number flip chart is produced for you by

GP partners Adelaide

If you have any queries or concerns please do not hesitate to contact us.

This MBS Item Number flip chart is designed as a quick reference guide to MBS items for Chronic Disease Management and Health Assessments. For a comprehensive guide refer to the Chronic Disease Management Resource Manual produced by GP partners Adelaide (GPPA), available online at **www.gppadelaide.org.au**.

The information included in this flip chart has been taken from:

- MBS Online at **www.health.gov.au/mbsonline**,
- Department of Health and Ageing website at **www.health.gov.au**,
- Practice Incentive Payments (PIP) on the Medicare Australia website at **www.medicareaustralia.gov.au/pip**.

Further information is available from these websites.

This flip chart has been adapted with permission from the MBS Item Number flip chart produced by the Yorke Peninsula Division of General Practice.

Website References

Taking a Cervical Smear from a Woman who is Unscreened or Significantly Under-screened

GPs working in a PIP practice that have signed on for the cervical screening incentive will receive a Service Incentive Payment (SIP-Cervical) for screening under-screened women aged between 20 and 69 years who have not had a cervical smear within the last 4 years. Upon completion of a cervical smear for women meeting the above criteria, GPs can claim the appropriate item number below to receive payment for consult plus SIP payment of \$35.00. These items apply only to women between the ages of 20 and 69 years inclusive who have a cervix, have had intercourse and have not had a cervical smear in the last four years.

Women from the following groups are more likely than the general population to be unscreened or significantly under-screened - low socioeconomic status, culturally and linguistically diverse backgrounds, Indigenous communities, rural and remote areas and older women.

Item No.	Level B 2501	Level C 2504	Level D 2507
Fee	\$35.60	\$69.00	\$101.55

The item numbers above relate to Group A18 surgery consultations. For the relevant out-of-surgery consultation item numbers and Group A19 item numbers refer to the MBS.

SIP Payment = \$35
for each cervical smear taken on an under-screened woman.

Outcomes Payment—
Payment to practices where a specified proportion of women aged between 20 and 69 years have been screened in the last 30 months.

For further information visit www.medicareaustralia.gov.au/pip or call the PIP enquiry line on 1800 222 032.

PIP—Cervix Screening

Annual cycle of care for patients with Diabetes Mellitus

The item numbers listed below should be used in place of the usual attendance item when a consultation **completes** the minimum annual requirements of care for a patient with **established diabetes mellitus**. The GP receives payment for Level B, C or D consult plus the SIP (Service Incentive Payment). The SIP item can only be claimed once in a 12 month period for each patient with diabetes. For further information visit www.medicareaustralia.gov.au/PIP or call the PIP enquiry line on 1800 222 032.

Minimum requirements of care

6 Monthly	Annually	Bi-Annually	Other Requirements
Weight, Height, BMI*	HbA1c	Eye Examination	Self Care Education
Blood Pressure	Total Cholesterol, Triglycerides & HDL Cholesterol		Review Physical Activity Levels
Foot Examination	Microalbuminuria		Review Diet
* At initial Consult then weight only required			Medication Review
			Smoking Status

SIP payment = \$40 for each annual cycle of care completed.

Item No.	Level B 2517	Level C 2521	Level D 2525
Fee	\$35.60	\$69.00	\$101.55

Diabetes Outcomes Payment—

A Diabetes Outcomes Payment is made to practices that complete an annual program of care for a target proportion of their patients with diabetes.

PIP—Diabetes Annual Cycle of Care

Completion of the Asthma Cycle of Care

For patients with moderate to severe asthma.

Patients must receive the following treatment:

- At least 2 asthma related consultations within 12 months
- At least one of these consultations must be planned recalls
- Documented diagnosis and assessment of severity and level of asthma control
- Review of the patients use of and access to asthma related medication and devices
- Provision of written asthma action plan (if patient is unable to use a written action plan, discuss alternative and record the discussion in the patients medical records)
- Provision of asthma self management education to the patient, and
- Review of the written or documented asthma action plan
- The patient's medication record should include documentation of each of these requirements and the clinical content of the patient-held written action plan.

Medicare Item Numbers

The first time the patient is seen they are billed as normal, the second time the GP can bill using the appropriate item number to initiate a SIP payment in addition to a Medicare rebate, providing that the minimum requirements of care have been met.

Item No.	Level B 2546	Level C 2552	Level D 2558
Fee	\$35.60	\$69.00	\$101.55

SIP payment: \$100 per Asthma Cycle of Care completed for patients with moderate to severe asthma, payable once per year per patient.

PIP—Asthma Cycle of Care

The minimum requirements of the Asthma Cycle of Care may be carried out in two (2) visits or if necessary as many visits as clinically required. An example visit schedule is shown below.

Visit 1 (claim normal consult)

- Patient came to GP for another reason, however asthma was also raised.
- Introduce the concept of a contract for care (Asthma Cycle of Care) and the reasons for review.
- Give Asthma Cycle of Care handout to patient.
- Ascertain status (history, medication and management).
- Schedule next appointment for patient to see the Asthma Nurse Educator (ANE) and yourself.

Visit 2 (GP only or GP/ANE combined) Claim normal consult

Asthma Nurse Educator (ANE) or GP

- Find out what they know and what they need to know.
- Find out how they feel about their asthma.
- Review device technique.
- Perform physical examination (including spirometry).
- Grade asthma severity and level of control.
- Provide education on the above.
- Begin writing out cycle of care visit plan.

GP to see patient at end of ANE visit

- Review medication.
- Is a change in medication required?
- Further identify trigger factors.
- Complete written Asthma Action Plan.

Visit 3 (Claim Asthma Item)

- Assess progress.
- Review Asthma Action Plan.
- Check on, reinforce and expand education.
- Answer any questions.

**Completing the Asthma Cycle of Care—
A guide for General Practitioners**
is available from the GP partners Adelaide website at
www.gppadelaide.org.au under Resources.

Health Assessment Items

There are four time-based health assessment items, consisting of brief, standard, long and prolonged consultations that may be used to provide a health assessment service to a member of any of the target groups listed on the following page. The health assessment item that is selected will depend on the time taken to complete the health assessment service. This is determined by the complexity of the patient's presentation and the specific requirements that have been established for each target group eligible for health assessments. The time period includes the time taken by the doctor and the practice nurse to undertake a health assessment.

Brief Health Assessment (MBS Item 701)

A brief health assessment is used to undertake simple health assessments. The health assessment should take not more than 30 minutes to complete.

Item No.	701	703	705	707
Fee	\$57.10	\$132.70	\$183.05	\$258.65

Standard Health Assessment (MBS Item 703)

A standard health assessment is used for straightforward assessments where the patient does not present with complex health issues but may require more attention than can be provided in a brief assessment. The assessment lasts more than 30 minutes but takes less than 45 minutes.

Long Health Assessment (MBS Item 705)

A long health assessment is used for an extensive assessment, where the patient has a range of health issues that require more in-depth consideration, and longer-term strategies for managing the patient's health may be necessary. The assessment lasts at least 45 minutes but less than 60 minutes.

Prolonged Health Assessment (MBS Item 707)

A prolonged health assessment is used for a complex assessment of a patient with significant, long-term health needs that need to be managed through a comprehensive preventive health care plan. The assessment takes 60 minutes or more to complete.

Health Assessment Items

Health Assessment Items

MBS Items 701, 703, 705 and 707 may be used to undertake a health assessment for the following target groups:

Target Group	Frequency of Service
Healthy Kids Check for children aged at least 3 years and less than 5 years of age, who have received or who are receiving their 4 year old immunisation	Once only to an eligible patient
Type 2 diabetes risk evaluation for people aged 40-49 years (inclusive) with a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool (AUSDRISK)	Once every three years to an eligible patient
Health assessment for people aged 45-49 years (inclusive) who are at risk of developing chronic disease	Once only to an eligible patient
Health assessment for people aged 75 years and older	Provided annually to an eligible patient
Comprehensive medical assessment for permanent residents of residential aged care facilities	Provided annually to an eligible patient
Health assessment for people with an intellectual disability	Provided annually to an eligible patient
Health assessment for refugees and other humanitarian entrants	Once only to an eligible patient

The health assessment items above are not available to people who are in-patients of a hospital or care recipients in a residential aged care facility (with the exception of a comprehensive medical assessment provided to a permanent resident of a residential aged care facility).

For further information on each of these health assessments refer to the relevant page of the flip chart or the Department of Health and Ageing website at www.health.gov.au/mbsprimarycareitems.

Health Assessment Items (page 2)

Healthy Kids Check

The aim of the Healthy Kids Check is to ensure every four year old child in Australia has a basic health check to see if they are healthy, fit and ready to learn when they start school. It promotes early detection of lifestyle risk factors, delayed development and illness, and introduce guidance for healthy lifestyles and early intervention strategies. The Healthy Kids Check can be provided by a GP or practice nurse and is to be delivered in conjunction with the four year old immunisation.

Eligibility

- All four year old children who are permanently resident in Australia or covered by a Reciprocal Health Care Agreement
- Available once only for any eligible patient.

Components

The Healthy Kids Check is an assessment of a child's physical health, general well-being and development, with the purpose of initiating medical interventions as appropriate. It must include:

- information collection, including taking a patient history and undertaking or arranging examinations and investigations as required;
- making an overall assessment of the child;
- recommending appropriate interventions;
- providing advice and information to the child's parent(s) or carer;
- keeping a record of the health assessment, and offering the child's parent(s) or carer a written report about the health assessment, with recommendations about matters covered by the health assessment; and
- updating any relevant records, such as a parent-held child health record.

Examinations and assessments **must include:**

- height and weight (plot and interpret growth curve and calculate BMI); eyesight; hearing; oral health (teeth and gums); toileting; and allergies.

The *Get Set 4 Life – habits for healthy kids* guide is to be provided to parents/carers as part of the Healthy Kids Check. The medical practitioner, practice nurse or registered Aboriginal health worker must note if a copy of the guide has been provided to the child's parent(s) or carer.

Healthy Kids Check (4 year old)

Healthy Kids Check

Immunisation

It is intended that the Healthy Kids Check be delivered in conjunction with the four year old immunisation. The medical practitioner or nurse providing the Check is required to document in the patient's records that the four year old immunisation has already been given; or the four year old immunisation will be given, following the Healthy Kids Check. The four year old immunisation must have been provided prior to an itemised account being issued for Medicare purposes for the Healthy Kids Check.

Medicare Item Numbers

The Healthy Kids Check may be completed by a GP under MBS Items 701 (brief), 703 (standard), 705 (long) or 707 (prolonged), depending on the length of the consultation as determined by the complexity of the patient's presentation. If a practice nurse or registered Aboriginal health worker undertakes the Healthy Kids Check on behalf of a medical practitioner, MBS item 10986 may be claimed. If the practice nurse or registered Aboriginal health worker identifies any problems arising from the Healthy Kids Check, the child must be reviewed by his or her usual medical practitioner, who must arrange referrals and follow-up as required.

Health Assessment Item—				
Item No.	701	703	705	707
Fee	\$57.10	\$132.70	\$183.05	\$258.65
OR				
Healthy Kids Check provided by a Practice Nurse or Aboriginal Health Worker—Item 10986				
Fee: \$57.10 Benefit: 100% = \$57.10				

Further information, including a fact sheet and checklist, is available from www.health.gov.au/mbsprimarycareitems.

Healthy Kids Check (4 year old)

Type 2 Diabetes Risk Evaluation

Attendance by a GP **at a place other than a hospital** to undertake a type 2 diabetes risk evaluation for a patient who is 40 to 49 years of age (inclusive) with a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment (AUSDRISK) tool. This item enables GPs to review patients' risk factors and instigate early interventions such as lifestyle modification programs to assist with the prevention of type 2 diabetes.

Eligible Patients

- Must be aged 40 to 49 years (inclusive)
- Have a 'high risk' of developing type 2 diabetes as determined by a score of 12 or higher on the AUSDRISK tool
- Must not have newly diagnosed or existing diabetes (type 2 diabetes must be excluded)
- Available once every 3 years for an eligible patient

Item No.	701	703	705	707
Fee	\$57.10	\$132.70	\$183.05	\$258.65

*For further information see **Health Assessment Items** page*

Components of the Risk Evaluation

- Evaluation of a 'high risk' score determined by the Australian type 2 diabetes risk assessment (AUSDRISK) tool;
- Updating a patient history and undertaking examinations and investigations
- Making an overall assessment of the patient's risk factors, relevant examinations and the results of any investigations;
- Initiating interventions where appropriate, including referrals e.g. to a Lifestyle Modification Program (see below) and follow-up relating to the management of any risk factors identified; and
- Providing advice and information (such as *Lifescrpts* resources) to the patient including strategies to achieve lifestyle and behaviour changes where appropriate.

Lifestyle Modification Programs

Patients who have attended a Type 2 Diabetes Risk Evaluation with their GP may be referred to a subsidised Lifestyle Modification Program (LMP). The intention of a LMP is to help people modify their risk factors to delay or prevent the onset of type 2 diabetes. The referring GP needs to complete a '**GP Referral Form to a Lifestyle Modification Program under the prevention of type 2 diabetes program**'. Patients with a high AUSDRISK score may also be referred through the 45-49 year old health check or an Aboriginal and Torres Strait Islander health check.

GP partners Adelaide offer a Lifestyle Modification Program called ***Reset your Life***

For further information contact GPPA by phone on 8112 1100. Referrals can be faxed to 8227 2220.

The AUSDRISK tool, GP referral form and further information is available from www.gppadelaide.org.au/Programs/Resetyourlife

Type 2 Diabetes Risk Evaluation (40 to 49 year old)

45 to 49 Year Old Health Check

Attendance by a GP **at a place other than a hospital** to undertake a health check for a patient between the age of 45 - 49 (inclusive) who is risk of developing a chronic disease. The purpose of the 45 to 49 year old health check is to assist with detection and prevention of chronic disease and enable early intervention strategies to be put in place where appropriate. Benefits are **payable on one occasion only** for each eligible patient. This health check item cannot be claimed in conjunction with another GP attendance item on the same day, unless clinically required.

A patient must be at risk of developing a chronic disease or condition which has been or is likely to be present for at least 6 months, including but not limited to: asthma, cancer, cardiovascular illness, diabetes, mellitus, mental health conditions, arthritis and musculoskeletal conditions. Whether an individual is at risk of developing a chronic disease rests with the clinical judgement of the GP, but **a specific risk factor must be identified**. Factors GP's may consider, but are not limited include:

- Lifestyle risk factors such as smoking, physical inactivity, poor nutrition or alcohol misuse
- Biomedical risk factors, such as high cholesterol, high blood pressure, impaired glucose metabolism or excess weight
- A family history of a chronic disease

Components of the health check:

- Information collection, including taking a patient history (if one does not already exist) or updating an existing history and undertaking examinations and investigations as required
- Making an overall assessment of the patient
- Interventions as indicated. Where appropriate, arrangements need to be put in place for referrals and follow up of any problems identified.
- Providing advice and information to the patient. Where appropriate, advice should be provided to the patient on strategies to achieve lifestyle and behaviour changes, using in particular the *Lifescrpts* resources.

Patients at 'high risk' of developing type 2 diabetes as determined by the AUSDRISK tool can be referred to a subsidised Lifestyle Modification Program through the 45 to 49 year old health check including the **Reset your Life** program at GPpA.

Practice Nurses, Aboriginal Health Workers and other health professionals may assist GP's in performing the health check, in accordance with accepted medical practice and under the supervision of the GP.

Item No.	701	703	705	707
Fee	\$57.10	\$132.70	\$183.05	\$258.65

*For further information see **Health Assessment Items** page*

Further information is available from www.health.gov.au/mbsprimarycareitems.

45 to 49 Year Old Health Check

Health Assessment for People with an Intellectual Disability

This health assessment provides a structured clinical framework for general practitioners (GPs) to comprehensively assess the physical, psychological and social function of patients with an intellectual disability and to identify any medical intervention and preventative health care required.

Eligibility

The health assessment is available to people who have an intellectual disability. For the purpose of the health assessment, a person has an intellectual disability if they have significantly sub-average general intellectual functioning (two standard deviations below the average intelligence quotient (IQ)) and would benefit from assistance with daily living activities. It is an annual health assessment, claimable 12 monthly. It does not apply to in-patients of a hospital or a RACF.

Components

The assessment should also include consideration of the patient's physical, psychological and social function domains as outlined in the explanatory notes of the MBS. Refer to the MBS for further information, available online at www.health.gov.au/mbsonline, or phone the Medicare Australia provider enquiry line on 132 150.

The balance between the patient's health and physical, psychological and social function domains is a matter for professional judgement in relation to each patient. If any health problems are identified during the health assessment, the GP should arrange for a follow up consultation to determine further management. The GP should also consider the health impact of the patient's general skill levels and whether a referral for a formal review of daily living activities is required.

A record of the health assessment must be kept and a written report about the health assessment offered to the patient. The report must include recommendations identified during the health assessment. Where appropriate, a copy of the report (or relevant extracts) should also be offered to the patient's carer and relevant disability professionals, with the agreement of the patient. Where the patient has a carer, the medical practitioner may find it useful to consider having the carer present for the assessment or components of the assessment (subject to the patient's agreement).

It may be relevant to consult or refer with disability professionals such as case managers who have responsibility for assessing and facilitating appropriate accommodation and disability support services and psychologists who have responsibility for developing strategies to address challenging behaviours. If a patient needs but does not have such a professional involved, the practitioner should make appropriate referrals.

Further information including a fact sheet and consumer/carers brochure is available from www.health.gov.au/mbsprimarycareitems.

Item No.	701	703	705	707
Fee	\$57.10	\$132.70	\$183.05	\$258.65

For further information see Health Assessment Items page

Health Assessment for People with an Intellectual Disability

Refugee and Other Humanitarian Entrants Health Assessment

This health assessment is for refugees and other humanitarian entrants who often arrive in Australia with complex and unusual medical conditions resulting from their area of origin or previous living conditions. The purpose of this health assessment is to introduce new refugees and other humanitarian entrants to the Australian primary health care system, as soon as possible after their arrival in Australia (within twelve months of arrival).

Some refugees or other humanitarian entrants will have little experience of western health care systems and this health assessment provides an opportunity to introduce these patients to preventive health care in Australia, in particular immunisation, maternal and child health care, and breast and cervical screening. Many will have been exposed to war, famine, repression, torture and/or extreme poverty. The health assessment should be undertaken in a manner that is sensitive to the needs of the patient.

Eligibility

The health assessment applies to humanitarian entrants who are resident in Australia with access to Medicare services. It is a voluntary one-off service and must be provided within twelve months of the person's arrival in Australia or grant of visa.

Medical practitioners may telephone Medicare Australia on 132011, with the patient present, to check eligibility.

Components of the Health Assessment

The health assessment must include the components listed in the explanatory notes in the MBS. The Department of Health and Ageing's Medicare Health Assessment Resource Kit also provides details of the components of the health assessment for refugees and other humanitarian entrants and a proforma for the assessment, available from www.health.gov.au/internet/main/publishing.nsf/Content/mha_resource_kit.

A desktop guide - *Caring for Refugee Patients in General Practice* is available on the RACGP website www.racgp.org.au.

The medical practitioner and patient can use the services of a translator by accessing the Commonwealth Government's Translating and Interpreting Services (TIS) and the Doctors Priority Line. To be eligible for fee-free TIS and Doctors Priority Line, the medical practitioner must be in a private practice and provide a Medicare service to patients who do not speak English and are permanent residents. Further information can be obtained by phoning 1300 131 450.

Item No.	701	703	705	707
Fee	\$57.10	\$132.70	\$183.05	\$258.65

For further information see Health Assessment Items page

Further information is available from www.health.gov.au/mbsprimarycareitems.

Refugee and Other Humanitarian Entrants Health Assessment

Health Assessments for Older Persons

An **Older Person's Health Assessment** is an **annual** in-depth **assessment of an older patient 75 years and over**. The health assessment provides a structured way of identifying health issues and conditions that are potentially preventable or amenable to interventions in order to improve health and/or quality of life.

The purpose of this health assessment is to help identify any risk factors exhibited by an elderly patient that may require further health management. In addition to assessing a person's health status, a health assessment is used to identify a broad range of factors that influence a person's physical, psychological and social functioning.

Specific components of the health assessment for older people include:

- measurement of the patient's blood pressure, pulse rate and rhythm;
- an assessment of the patient's medication;
- an assessment of the patient's continence;
- an assessment of the patient's immunisation status for influenza, tetanus and pneumococcus;
- an assessment of the patient's physical function, including the patient's activities of daily living, and whether or not the patient has had a fall in the last 3 months;
- an assessment of the patient's psychological function, including the patient's cognition and mood; and
- an assessment of the patient's social function, including the availability and adequacy of paid and unpaid help, and whether the patient is responsible for caring for another person.

The health professional undertaking the health assessment may also consider

- any need the patient may have for community services;
- whether the patient is socially isolated;
- the patient's oral health and dentition; and
- the patient's nutrition status.

The health assessment can be conducted at the GP's surgery or in the patient's home. The GP may suggest a home assessment if he or she thinks that this will give a better picture of a patient's health condition and needs. The **information collection component** of the assessment may be rendered **by a nurse or other assistant** in accordance with accepted medical practice, acting under the supervision of the medical practitioner. The other components must include a personal attendance by the medical practitioner.

A health assessment for people aged 75 years and older may be claimed once every twelve months by an eligible patient.

Item No.	701	703	705	707
Fee	\$57.10	\$132.70	\$183.05	\$258.65

*For further information see **Health Assessment Items** page*

Further information on the Older Persons Health Assessment is available from www.health.gov.au/mbsprimarycareitems.

Health Assessment for Older Persons

Aboriginal and Torres Strait Islander Health Check

The purpose of the health check is to ensure that Aboriginal and Torres Strait Islander people receive the optimum level of health care by encouraging prevention, early detection, diagnosis and intervention for common and treatable conditions that cause considerable morbidity and early mortality. They are not applicable to in-patients of hospital/day hospital or RACF.

The health assessment includes an assessment of the patient's health, including their physical, psychological and social wellbeing. It also assesses what preventive health care, education and other assistance should be offered to the patient to improve their health and wellbeing. It complements existing services already undertaken by a range of health care providers. This health assessment is an annual service. The minimum time allowed between services is 9 months.

The health assessment must include:

- information collection, including taking a patient history and undertaking examinations and investigations as required;
- making an overall assessment of the patient;
- recommending appropriate interventions;
- providing advice and information to the patient;
- keeping a record of the health assessment, and offering the patient a written report about the health assessment, with recommendations about matters covered by the health assessment; and
- offering the patient's carer (if any, and if the medical practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report relevant to the carer.

Further details of the requirements for the Aboriginal and Torres Strait Islander Peoples Health Assessment are at A.32-A.35 of the MBS Explanatory Notes including:

- Children between ages of 0 and 14 years – A.33
- Adults between the ages of 15 and 54 years – A.34
- Older people over the age of 55 years – A.35

Aboriginal and Torres Strait Islander people aged 15 to 54 years that are identified as being at high risk of developing type 2 diabetes according to the Australian Type 2 Diabetes Risk Assessment Tool (AUSDRISK) can be referred through this health assessment item to a lifestyle modification program including the *Reset your Life* program offered by GP partners Adelaide.

Aboriginal and Torres Strait Islander *Lifescrpts* resources are available through GPpA to assist in the assessment of patient's lifestyle risk factors and the provision of advice in the form of a written lifestyle script.

Southern General Practice Network (in NSW) has developed Aboriginal and Torres Strait Islander Health Check templates that are broken into smaller age ranges, are sex specific and in line with best practice guidelines and developmental milestones. The templates can be downloaded and imported in to Medical Director from the Southern General Practice Network website: www.sgpn.com.au.

Item 715—Aboriginal and Torres Strait Islander Health Check

Fee: \$204.20 Benefit: 100% = \$204.20

Further information including a resource kit is available from www.health.gov.au/mbsprimarycareitems

Aboriginal and Torres Strait Islander Health Check

Follow-up service provided by a Practice Nurse or Aboriginal health worker, on behalf of a GP, for an Indigenous person who has received a health check

A person of Aboriginal or Torres Strait Islander descent who has had a health assessment may be eligible for up to 10 follow-up services, provided by a practice nurse or registered Aboriginal health worker, on behalf of a GP (**MBS item 10987**). For further information refer to the 'Services Provided by Practice Nurses and Aboriginal Health Workers' section of this flip chart or visit www.health.gov.au/mbsprimarycareitems.

Follow-up Allied Health Services for people of Aboriginal and Torres Strait Islander Descent

Aboriginal or Torres Strait Islander Australians who have had a health check may be referred by a GP for allied health services under items 81300 to 81360. It is expected that the GP will undertake a health check consistent with the Aboriginal and Torres Strait Islander Medicare health checks (item 704, 706, 708 or 710) and, if a need for follow-up allied health services is identified, will refer the patient to an eligible allied health professional.

The following allied health professionals are eligible to provide services under these items:

- Aboriginal Health Workers
- Diabetes Educators
- Mental Health Workers
- Physiotherapists
- Speech Pathologists
- Audiologists
- Dietitians
- Occupational Therapists
- Podiatrists
- Chiropractors
- Exercise Physiologists
- Osteopaths
- Psychologists

Allied health professionals need to meet specific eligibility requirements, be in private practice and register with Medicare Australia. Those who are already registered with Medicare, e.g. for items 10950 to 10970, do not need to register again to claim these items.

A Medicare rebate of \$51.95 is available for up to five (5) allied health services per eligible patient, per calendar year, with out-of-pocket costs counting towards the extended Medicare safety net. The five allied health services can be made up of one type of service or a combination of different types of services.

Allied health items 81300 – 81360 are available **in addition** to:

- Individual allied health services for patients who have an Enhanced Primary Care plan;
- Group allied health services for people with type 2 diabetes;
- Allied mental health services.

A written report for the referring GP is required after the first and last service, or more often if clinically necessary. The report should include any investigations, tests, and/or assessments carried out on the patient, any treatment provided and future management of the patient's condition or problem.

For Medicare benefits to be payable, the patient must be referred to an eligible allied health professional by their GP using a '**Referral form for follow-up allied health services under Medicare for Indigenous Australians who have had a health check**'. The referral form may be downloaded from the Department of Health and Ageing website at www.health.gov.au/mbsprimarycareitems.

A referral is valid for the stated number of services. If all services are not used during the calendar year in which the patient was referred, the unused services can be used in the next calendar year. However, those services will be counted as part of the five (5) rebates for allied health services available to the patient during that calendar year.

Follow-up Services for Aboriginal and Torres Strait Islanders

Services Provided by Practice Nurses and Aboriginal Health Workers

A practice nurse must be either a registered or an enrolled nurse and employed by, or their services retained by, a general practice. **The medical practitioner does not need to be present at the administration of these item numbers, but retains responsibility for the health, safety and clinical outcomes of the patient.**

Where the GP has a consultation with the patient on the same day, the GP can claim for both their own professional service and the service provided by the practice nurse or Aboriginal health worker (*e.g. Item 23 plus Item 10996*).

These items can be used where the patient is treated under the DVA arrangements. The supplementary veterans payment is available in addition to 100% of the schedule fee for these items.

Immunisation performed by a Practice Nurse: Item 10993: Benefit \$11.80 or an Aboriginal Health Worker: Item 10988: Benefit \$11.80

- These items can be claimed by the medical practitioner where an immunisation is provided by a practice nurse or Aboriginal health worker on behalf of a medical practitioner and the person is not an admitted patient of a hospital.
- Immunisation means the administration of a registered vaccine to a patient for any purpose other than as a part of a mass immunisation of persons.
- Item 10993 or 10988 can only be claimed **once per patient visit** even if more than one vaccine is administered during the same patient visit.

Wound Management provided by a Practice Nurse: Item 10996: Benefit \$11.80 or an Aboriginal Health Worker: Item 10989: Benefit \$11.80

- Can be claimed by the medical practitioner where wound management is provided by a practice nurse or Aboriginal health worker on behalf of a medical practitioner.
- These services can be provided in any location, except where the patient has been admitted to a hospital or day-hospital facility.
- Item 10996 or 10989 can be claimed for the treatment of any wound, except for normal post-operative aftercare and can only be claimed **once per patient visit**.

Monitoring and support for a patients with a chronic disease provided by a practice nurse or Aboriginal health worker: Item 10997: Benefit \$11.80

This item can be claimed by the medical practitioner where a practice nurse or registered Aboriginal health worker provides monitoring and support for patients with a chronic disease if:

- the service is provided on behalf of and under the supervision of a medical practitioner; and
- the person is not an admitted patient of a hospital; and
- the person has a GP Management Plan, Team Care Arrangements or Multidisciplinary Care Plan in place; and
- the service is consistent with the GP Management Plan, Team Care Arrangements or Multidisciplinary Care Plan

Item 10997 will assist patients who require access to ongoing care, routine treatment and ongoing monitoring and support between the more structured reviews of the care plan by the patient's usual GP. It may be used to provide checks on clinical progress; monitoring medication compliance; self management advice, and; collection of information to support GP reviews of Care Plans. Item 10997 may be claimed up to a maximum of 5 times per patient per calendar year.

Continued over page.

Services Provided by Practice Nurses and Aboriginal Health Workers

Services Provided by Practice Nurses and Aboriginal Health Workers

Follow up service provided by a practice nurse or registered Aboriginal health worker for an Indigenous person who has received a health check: Item 10987: Benefit \$23.55

This item can be claimed by a medical practitioner where a follow up service is provided by a practice nurse or registered Aboriginal health worker for an Indigenous person who has received a health check if:

- the service is provided on behalf of and under the supervision of a medical practitioner; and
- the person is not an admitted patient of a hospital; and
- the service is consistent with the needs identified through the health check

Item 10987 may be used to provide:

- Examinations/interventions as indicated by the Health Check;
- Education regarding medication compliance and associated monitoring;
- Checks on clinical progress and service access;
- Education, monitoring and counselling activities and lifestyle advice;
- Taking a medical history; and
- Prevention advice for chronic conditions, and associated follow up.

Item 10987 may be claimed up to a maximum of 10 times per patient per calendar year.

Pap smear services and preventative checks provided by a practice nurse - Items 10994, 10995, 10998 and 10999

The practice nurse must be appropriately qualified and trained to take cervical smears and other preventive checks. All nurses taking pap smears and providing preventive checks should have undertaken an accredited training course.

The following items numbers can be claimed by the medical practitioner where a cervical smear is provided by a practice nurse on behalf of a medical practitioner. In all cases, the medical practitioner under whose supervision the Pap smear and preventive checks are provided retains responsibility for the health, safety and clinical outcomes of the patient. The medical practitioner must be satisfied that the practice nurse is appropriately qualified and trained to perform Pap smears and other preventive checks.

Item number	10998	10999	10994	10995
	Pap smear only	Pap smear taken from a woman between the ages of 20 - 69 inclusive, who has NOT had a pap smear in the last 4 years.	Pap smear and at least one preventative check	Pap smear and at least one preventative check taken from a woman between the ages of 20 - 69 inclusive, who has NOT had a pap smear in the last 4 years.
Benefit	\$11.80	\$11.80	\$23.55	\$23.55

Preventative checks include: Checks for sexually transmitted infections (including Chlamydia), taking of a sexual reproductive history, advice on contraception, breast awareness education, advice on post natal issues or continence advice and education. They may also include Smoking, Nutrition and Physical Activity (SNAP) behavioral risk factor assessment or blood pressure measurement.

Where the medical practitioner claims item 10995 or 10999 instead of a Practice Incentives Program (PIP) item (2497 - 2509 and 2598 - 2616) for an under-screened woman, a PIP cervical screen incentive will be available. More detailed information on PIP is available from the Medicare PIP enquiry line on 1800 222 032 or www.medicareaustralia.gov.au/pip.

Services Provided by Practice Nurses and Aboriginal Health Workers (page 2)

Chronic Disease Management

The Chronic Disease Management (CDM) items are for:

- **preparation** by a GP of a **GP Management Plan (GPMP)**;
- **coordination** by a GP of **Team Care Arrangements (TCA)**;
- **review** by a GP of a **GP Management Plan**;
- **coordination** by a GP of a **review of Team Care Arrangements**;
- **contribution** to a multidisciplinary care plan or contribution to a review of a multidisciplinary care plan (for patients who are not residents of aged care facilities);
- **contribution** to a multidisciplinary care plan or contribution to a review of a multidisciplinary care plan (for residents of aged care facilities).

GPMPs and TCAs should be comprehensive documents that set out and enable evidence-based management of the patient's health and care needs. Patients with a chronic or terminal medical condition are eligible for a GP Management Plan item. Patients who also have complex needs requiring care from a multidisciplinary team are eligible for a Team Care Arrangements item.

While a GP Management Plan and a Team Care Arrangements are able to be provided independently, it is expected that in most cases a patient with complex needs would have both services. It is not mandatory, however, to follow the preparation of a GP Management Plan with the coordination of Team Care Arrangements or to prepare a GP Management Plan before coordinating Team Care Arrangements.

For patients to be eligible to access rebates under the allied health and dental care items (item numbers 10950 to 10977 inclusive) they must have **both a GP Management Plan and a Team Care Arrangements in place and claimed on Medicare**. However, residents of aged care facilities are eligible to access rebates under the allied health and dental care items where their **GP has contributed to a care plan** prepared for them (Item 731) and the contribution item has been claimed on Medicare. Eligible patients can claim a **maximum of five** allied health services **per 12 month period** and **up to \$4,250** over **two consecutive years** for dental services.

Preparation of a GP Management Plan (Item 721)

- Provides a rebate for a GP to prepare a management plan for a patient with a chronic or terminal condition (including patients who have multiple chronic conditions and multidisciplinary care needs).
- Recommended frequency is **once every two years**, supported by regular review services every 6 months. (Minimum claim period is 12 months)
- The GP (who may be assisted by their practice nurse or other) assesses the patient, agrees management goals, identifies actions to be taken by the patient, identifies treatment and ongoing services to be provided, and documents these in the GP Management Plan.

Item 721— Preparation of a GP Management Plan

Medicare Fee	\$138.75
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Coordination of Team Care Arrangements (Item 723)

- Provides a rebate for a GP to coordinate the preparation of Team Care Arrangements for a patient with a chronic or terminal medical condition who also requires ongoing care from a multidisciplinary team of at least three health or care providers (including the GP)
- In most cases the patient will already have a GP Management Plan in place but this is not mandatory.
- Recommended frequency is **once every two years**, supported by regular review services. (Minimum claiming period is 12 months)

Item 723— Coordination of Team Care Arrangements

Medicare Fee	\$109.95
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Chronic Disease Management

Review of a GP Management Plan (Item 732)

- Provides a rebate for a GP to review a GP Management Plan
- Practice nurse or other can assist.
- Recommended frequency is **once every six months**; can be earlier if clinically required. (Minimum claiming period 3 months)
- Involves reviewing the patient's GP Management Plan, documenting any changes and setting the next review date.

Coordination of a Review of Team Care Arrangements (Item 732)

- For patients who have a current TCA and require a review of their TCA.
- Recommended frequency is **once every six months**; can be earlier if clinically required. (Minimum claiming period 3 months)
- Involves the GP (who may be assisted by their practice nurse or other) collaborating with the participating providers on progress against treatment/services and documenting any changes to the patient's TCA.

Item 732 can be claimed twice on the same day providing an item 732 for reviewing a GP Management Plan and another 732 for reviewing Team Care Arrangements (TCAs) are both delivered on the same day as per the MBS item descriptors and explanatory notes.

Contribution to a multidisciplinary care plan being prepared by another health or care provider (Item 729)

- For patients who are having a multidisciplinary care plan prepared or reviewed by another health or care provider (other than their usual GP).
- Recommended frequency is **once every six months**; can be earlier if clinically required. (Minimum claim period 3 months)
- Involves the GP (who may be assisted by their practice nurse or other) collaborating with the providers preparing or reviewing the plan and including their contribution with the patient's records.

Contribution to a multidisciplinary care plan being prepared by another health or care provider for a resident of an aged care facility (Item 731)

- This is for patients in residential aged care facilities and is otherwise similar to Item 729 (immediately above).

**Item 732—
Review of a GP Management Plan
OR
Coordination of a Review of Team Care
Arrangements**

Medicare Fee \$69.35

**Item 729—
Contribution to a multidisciplinary care plan
being prepared by another health or care
provider**

Medicare Fee \$67.70

**Item 731—
Contribution to a multidisciplinary care plan
being prepared by another health or care
provider for a resident of an aged care facility**

Medicare Fee \$67.70

Detailed information to support the provision on the CDM items is available at available from www.health.gov.au/mbsprimarycareitems and follow the links.

Chronic Disease Allied Health (Individual) Services under Medicare

Medicare benefits (under item 10950 to 10970) are available for services provided by eligible allied health professionals to people with chronic conditions and complex care needs who are being managed by a GP using certain Chronic Disease Management (CDM) Medicare items.

Eligible patients

Patients must have received the following CDM services:

- **GP Management Plan MBS item 721** (or review item 732 for a review of a GPMP).; **AND**
- **Team Care Arrangements - MBS item 723** (or review item 732 for a review of TCAs)

Alternatively, for patients who are permanent residents of an aged care facility, their GP must have contributed to, or contributed to a review of, a multidisciplinary care plan prepared for them by the aged care facility (MBS item 731).

The allied health services must be recommended in the patient's plan as part of the management of their chronic condition. The allied health professional providing the service may be part of the planning team convened by the GP to manage a patient's chronic condition and complex care needs as part of Team Care Arrangements. However, the service may also be provided by an allied health professional who is not part of the planning team, provided that the service has been identified as necessary by the patient's GP and recommended in their care plan/s.

Eligible allied health professionals

The eligible allied health professionals include:

Aboriginal health workers	Audiologists
Chiropractors	Diabetes educators
Dietitians	Exercise physiologists
Mental health workers	Occupational therapists
Osteopaths	Physiotherapists
Podiatrists	Psychologists
Speech pathologists	

Allied health services must be registered with Medicare Australia for the purpose of this initiative. Items 10950 to 10970 do not apply for services that are provided to an admitted patient of a hospital or for services provided by any Commonwealth or State funded services (except where a subsection 19(2) exemption has been granted).

Referral

GPs must use the '**Referral Form for Chronic Disease Allied Health (Individual) Services under Medicare**' to refer patients to an eligible allied health professional. The referral form is downloadable from www.health.gov.au/mbsprimarycareitems or from the GP partners Adelaide website at www.gppadelaide.org.au/templates.

Medicare Benefits Payable

A maximum of 5 allied health services per 12 month calendar year, services can be made up of one type of service, or a combination of different types. When referring a patient to more than one allied health professional, a separate referral form for each referral is required. The allied health services must be of at least 20 minutes in duration and be provided to an individual patient. A Medicare rebate of \$51.95 per allied health service will apply, with out-of-pocket costs counting towards the extended Medicare safety net.

In addition to individual services, patients who have type 2 diabetes may also access MBS items 81100 to 81125 which provide allied health group services.

Reporting

Allied health professionals are to provide a written report on the service to the referring practitioner after the first and last service, or more often if clinically necessary.

Further information is available from www.health.gov.au/mbsprimarycareitems.

Chronic Disease Allied Health (Individual) Services under Medicare

Dental Services under Medicare

The Medicare Dental Items (85011 to 87777) cover services by dentists, dental specialists and dental prosthetists.

Eligible patients

- Patients with a chronic medical condition and complex care needs for whom a **GP Management Plan** (item 721 or a review of a GPMP item) **AND** a **Team Care Arrangements** (item 723 or a review of TCA item), has been claimed in the last two years. For patients who are permanent residents of an aged care facility, their GP must have contributed to or reviewed a multidisciplinary care plan prepared for them by the aged care facility (item 731) in the last two years.
- The patients oral health must be impacting on, or likely to impact on, their general health.

Types of dental services covered

A comprehensive range of services are covered including, dental assessments, preventative services, restorative services such as fillings, crowns, bridges and implants, extractions and other oral surgery (other than hospital services), orthodontic services and denture.

Eligible dental practitioners

Dentists, dental specialists and dental prosthetists who are registered with Medicare Australia

Medicare Benefits Payable

Eligible patients can receive up to \$4,250 in Medicare benefits (including Extended Medicare Safety Net benefits where applicable) for dental services over two consecutive calendar years. The two-year period is counted from the calendar year of the patient's first eligible dental service. For example, if the patient's first dental service is on 15 November 2007, the applicable two-year period will be the 2007 and 2008 calendar years. The next two-year period commences in the calendar year that the patient receives their next dental service.

Patients, GPs and dental practitioners will be able to call Medicare to check how much the patient has already received in Medicare benefits for dental services over the relevant period. GPs may call the Provider Enquiry Line on 132 150. Patients may call the Patient Enquiry Line on 132 011

Referral

GPs must use the 'Referral Form for Dental Services under Medicare.' The form can be downloaded from www.health.gov.au/mbsprimarycareitems or from the GP partners Adelaide website at www.gppadelaide.org.au/templates.

The GP referral remains valid for two consecutive years from the date of the patients first dental service.

When referring patients for dental services, GPs should inform patients that dental services may not be bulk billed. In some instances, patients may incur out-of-pocket expenses. Dental practitioners are free to bulk bill or set their own fees for service.

Reporting by the dental practitioner to the GP

Dental practitioners must provide a copy or summary of the patients treatment plan to the referring GP at the commencement of the course of treatment.

Refer to the Department of Health and Ageing website www.health.gov.au/mbsprimarycareitems, or the MBS for further information.

Dental Services under Medicare

Allied Health Group Services for patients with Type 2 Diabetes

The Allied Health Items (81100 to 81125) allow people with type 2 diabetes to receive Medicare rebates for group services provided by eligible diabetes educators, exercise physiologists and dietitians, on referral from a GP. These services are **in addition to** the five individual allied health services available to eligible patients each calendar year.

Eligible patients

- Have type 2 diabetes;
- Are being managed under a GP Management Plan (ie item 721 or 732), or if the person is a resident of an aged care facility, their medical practitioner has contributed to a multidisciplinary care plan (item 731);
- Must be referred by their GP to an eligible allied health professional

(Patients being referred by a GP for allied health group services **DO NOT need to have a Team Care Arrangement**)

Eligible allied health professionals

Only **private** diabetes educators, exercise physiologists and dietitians who are registered with Medicare Australia are eligible.

Referrals

The '**Referral form for allied health group services under Medicare for patients with type 2 diabetes**' must be used by GPs to refer patients. The form can be downloaded from the Department's website at www.health.gov.au/mbsprimarycareitems or from the GP partners Adelaide website at www.gppadelaide.org.au/templates.

GPs are also encouraged to attach a copy of the relevant part of the patient's care plan.

Once the patient has been referred by their GP, a diabetes educator, exercise physiologist or dietitian will conduct an individual assessment (under items 81100, 81110 or 81120) and determine the patient's suitability for a group services program. This involves taking a comprehensive patient history and identification of individual goals. It may also provide an opportunity to identify any patient who is likely to be unsuitable for group services. A maximum of one (1) assessment service is available per calendar year. This service must be of at least 45 minutes duration and provided to an individual patient. The allied health professional undertaking the assessment service will need to complete Part B of the Referral Form, and the patient will then need to present this form to the provider/s of group services.

After assessment, the patient may receive up to eight (8) group services per calendar year from an eligible diabetes educator, exercise physiologist and/or dietitian (under items 81105, 81115 and 81125). The service must be provided to a person who is part of a group of between 2 and 12 persons and each group service must be of at least 60 minutes duration.

Reporting

On completion of the assessment service, the allied health professional must provide a written report back to the referring GP outlining the assessment undertaken, whether the patient is suitable for group services and, if so, the nature of the group services to be delivered.

On completion of group services program, the allied health professional must provide, or contribute to, a written report back to the referring GP in respect of each patient. The report should describe the group services provided for the patient and indicate the outcomes achieved.

Further information is available from www.health.gov.au/mbsprimarycareitems.

Allied Health Group Services for patients with Type 2 Diabetes

Home Medicines Review (HMR)

also known as a **Domiciliary Medication Management Review (DMMR)**

The goal of a HMR is to maximise an individual patient's benefit from their medication regimen, and prevent medication-related problems through a team approach, involving the patient's GP and preferred community pharmacy.

In collaboration with the GP, a pharmacist comprehensively reviews the patient's medication regimen in a home visit. After discussion of the visit findings and report with the pharmacist, the GP and patient agree on a medication management plan.

Process:

1. **Identify** suitable patients.
2. Obtain informed **consent** from patient, explaining charging procedure and document in medical record.
3. Complete **referral form** (available on MD or from GPPA). Include medication and medical history and recent blood test (eg. blood electrolytes and other bio-chemical test results).
4. Patient can be charged for **initial consult** only if attending for matter unrelated to HMR.
5. Ensure delivery of referral form to **patient's chosen community pharmacist**. Patient can deliver referral form if appropriate.
6. The community pharmacist, if not accredited, will arrange for an **accredited pharmacist** to conduct the home review and provide the referring GP with a written report.
7. GP and accredited pharmacist **MUST DISCUSS** the report either face to face or over the phone.
8. Using information from the report, the GP drafts a patient **medication plan** (available on MD and in HMR kit).
9. Patient recalled to discuss and **agree** to the medication plan.
10. Patient, community pharmacist and GP records all provided with **copies** of the medication plan.
11. **Implementation** of agreed actions with appropriate follow-up and monitoring.
12. Patient **charged MBS item number 900**.

Other Points to Consider:

- Allied health workers, carers and consumers may identify patients considered suitable for a HMR, but **only the GP can initiate a referral** to a community pharmacist.
- Not available to patients in hospital or nursing homes.
- The HMR should be conducted in the patient's home.
- Do not conduct a separate consultation in conjunction with completing the HMR unless it is clinically indicated that a problem must be treated immediately.

Available once per patient per year, except where significant changes in patient's condition or medication regimen (eg diagnosis of new condition or recent discharge from hospital involving significant changes in medication).

Some possible indications suggesting that a patient may benefit from a HMR referral:

- Significant changes made to medication regimen in the last 3 months
- Medication with a narrow therapeutic index or medications requiring therapeutic monitoring
- Symptoms suggestive of an adverse drug reaction
- Sub-therapeutic response to treatment with medicines
- Suspected non-compliance or inability to manage medication related therapeutic devices
- Patients having difficulty managing their own medicines because of literacy or language difficulties, dexterity problems or impaired sight, confusion/dementia or other cognitive difficulties
- Currently taking 5 or more regular medications

Item 900

Medicare Fee \$148.90

For further information refer to the MBS available online at www.health.gov.au/mbsonline.

Home Medicines Review

Multidisciplinary Case Conferencing

Items 735 to 758 provide rebates for medical practitioners to organise and coordinate, or participate, in multidisciplinary case conferences for patients in the community or patients being discharged into the community from hospital or people living in residential aged care facilities. Eligible patients have a medical condition that has been or is likely to be present for at least 6 months or that is terminal and require ongoing care from a multidisciplinary case conference team which includes:

- a medical practitioner and
- at least two other members, each of whom provides a different kind of care or service to the patient and is not a family carer of the patient, and one of whom may be another medical practitioner.

A case conference is a discussion process by which a **multidisciplinary team** carries out the following activities:

- Discuss patient's history
- Identify patients multi-disciplinary care needs
- Identify outcomes to be achieved by members of the case conference team giving care to the patient;
- Identify tasks that need to be undertaken in order to achieve outcomes and allocate tasks to team members;
- Assess whether previously identified outcomes have been achieved.

A case conferencing team includes a medical practitioner and at least 2 other contributing members, each of whom provides a different kind of care (one who may be a medical practitioner providing a different kind of care). **The minimum 3 care providers must be communicating at the one time for the whole of the conference**, either face to face, via video-conferencing, by telephone, or a combination. Examples of persons who may be included in a multidisciplinary care team are:

- allied health professionals
- home and community service providers
- care organisers such as education providers, "meals on wheels" providers, personal care workers and probation officers.

The patient's informal or family carer can be included as a formal member of the team, but does not count towards the minimum of three service providers.

To **organise and coordinate** the case conference involves explaining to the patient the nature of the conference, obtaining and recording consent, recording day, times, names of participants, recording all matters mentioned and providing a summary to patient and team members.

When **participating** in a case conference organised by another, the medical practitioner should inform the patient that his/her medical history, diagnosis and care preferences will be discussed with other providers, and provide an opportunity for them to specify what may be conveyed or withheld from others.

Patients should be informed that they will incur a charge for this service, for which a Medicare rebate will be payable. It is expected that a patient would **not require more than five case conferences in a 12 month period**.

Item number	Fee	Service time
Organise and coordinate a GP Case Conference		
735	\$67.95	At least 15 minutes and less than 20 minutes
739	\$116.40	At least 20 minutes and less than 40 minutes
743	\$194.00	At least 40 minutes
Participate in a GP Case Conference		
747	\$49.95	At least 15 minutes and less than 20 minutes
750	\$85.60	At least 20 minutes and less than 40 minutes
758	\$142.60	At least 40 minutes

Multidisciplinary Cancer Care Case Conference

Item numbers 871 and 872 are for use when leading and coordinating or participating in a case conference for a patient that has cancer, where the case conference is of at least 10 minutes in duration, there are at least four medical practitioners from different areas of practice and, in addition, allied health providers.

871—Lead and coordinate a Case Conference for a patient with cancer to develop a multidisciplinary treatment plan.

872—Participation in a Case Conference for a patient with cancer to develop a multidisciplinary treatment plan.

Detailed information to support the use of Multidisciplinary Case Conferencing items is available at www.health.gov.au/mbsprimarycareitems.

Multidisciplinary Case Conferencing

Services provided to Residents of Aged Care Facilities

The following MBS items relate to eligible services provided by a GP to Residents of Aged Care Facilities:

- **Comprehensive Medical Assessment**
- **Contribution to a Multidisciplinary Care Plan** being prepared by another health or care provider
- **Residential Medication Management Review** (see next page)
- **Multidisciplinary Case Conferencing Items** (see next page)

Comprehensive Medical Assessment in Residential Aged Care Facilities

A Comprehensive Medical Assessment (CMA) are available for new and existing Residents of Aged Care Facilities (RACF). The CMA is a full system review, including an assessment of the resident's health physical and psychological function.

A CMA is an opportunity for a periodic assessment, not a substitute for normal medical care. It focuses on medical assessment of the resident and does not require an assessment of the resident's social function.

CMAs are available to permanent RACF, receiving either high or low care. There is no age limit for the resident to be eligible. CMAs are available to new residents on admission to an aged care home. Existing residents can have a CMA where it is required in the opinion of the resident's medical practitioner, because of a significant change in the resident's medical condition and/or physical and/or psychological function requiring a CMA. Only one CMA per resident is payable by Medicare in any twelve month period.

What is involved in undertaking a CMA:

- Personal attendance by the resident's usual GP
- An assessment of the resident's relevant medical history
- Completion of a comprehensive medical examination of the resident to determine their current health and well being
- Development of a list of diagnoses and/or problems
- Provision of information based on the outcome of the CMA for the resident's records to inform the provision of care for the resident by the aged care home and the provision of medication management review services for the resident

Item No.	701	703	705	707
Fee	\$57.10	\$132.70	\$183.05	\$258.65

Practice nurses can assist GPs with the provision of CMAs in the same way that they assist with other GP consultation items. They can assist the GP in obtaining information relevant to the CMA for the GPs consideration, in taking the resident's history and in the examination, but **cannot replace the GPs involvement** in these components of the CMA.

Information to support the provision of CMAs including a checklist and sample form are available from www.health.gov.au/mbsprimarycareitems.

Contribution to a multidisciplinary care plan being prepared by another health or care provider for a resident of an aged care facility

MBS Item 731 can be claimed by a GP for **contribution** to:

- (a) a multidisciplinary care plan for a patient in a **residential aged care facility**, prepared by that facility, or to a **review** of such a plan prepared by such a facility; or
- (b) a multidisciplinary care plan prepared for a resident by another provider before the resident is discharged from a hospital or an approved day-hospital facility, or to a review of such a plan prepared by another provider; (not being a service associated with a service to which items 735 to 758 apply).

It involves the GP (who may be assisted by their practice nurse or other) collaborating with the providers preparing or reviewing the plan and including their contribution in the patient's records. The GP's contribution should be documented in the care plan maintained by the aged care facility or discharging hospital and a record included in the resident's medical record.

A rebate will not be paid within three months of a previous claim for the same item or other CDM items, except where there has been a significant change in the patient's clinical condition or care circumstances that requires a new contribution to the multidisciplinary care plan.

Residents of RACF whose GP has contributed to a care plan prepared by the aged care home (item 731) will have access to the allied health and dental care items on the MBS.

Item 731— Contribution to a multidisciplinary care plan being prepared by another health or care provider for a resident of an aged care facility	
Medicare Fee	\$67.70

Services provided to Residents of Aged Care Facilities

Services provided to Residents of Aged Care Facilities

Residential Medication Management Review

Residential Medication Management Reviews (RMMR) are collaborative services available to residents of a Residential Aged Care Facility (RACF) who are likely to benefit from such a review. This includes residents for whom quality use of medicines may be an issue or who are at risk of medication misadventure because of a significant change in their condition or medication regimen.

An RMMR is available to existing residents of a RACF where it is required in the opinion of the resident's medical practitioner because of a significant change in the resident's medical condition or medication regimen, for example (but not limit to):

- (a) discharge from an acute care facility in the previous 4 weeks;
- (b) significant changes to medication regimen in the last 3 months;
- (c) change in medical conditions or abilities (including falls, cognition, physical function);
- (d) prescription of medication with a narrow therapeutic index or requiring therapeutic monitoring;
- (e) presentation of symptoms suggestive of an adverse drug reaction;
- (f) sub-therapeutic response to treatment;
- (g) suspected non-compliance or problems with managing drug related therapeutic devices; or
- (h) at risk of inability to continue managing own medications (eg due to changes with dexterity, confusion or impaired sight).

Process:

1. **Identify** suitable patients (this may be done through a Comprehensive Medical Assessment)
2. Patient can be charged for **initial consult** only if attending for matter unrelated to RMMR.
3. Obtain informed **consent** from patient, explaining charging procedure and document in medical record.
4. Complete **referral form** (available from GPpA). Include a copy of the CMA, if recently completed.
5. Ensure delivery of referral form to **visiting Accredited Pharmacist**.
6. **Accredited pharmacist** to conduct the review and provide the referring GP with a written report.
7. GP and accredited pharmacist **MUST DISCUSS** the report either face to face or over the phone.
8. Using information from the report, the GP drafts a patient **medication plan**
9. Patient recalled to discuss and **agree** to the medication plan.
10. RACF, Accredited Pharmacist and GP records all provided with **copies** of the medication plan. A copy of the plan is also offered to the resident. **Implementation** of agreed actions with appropriate follow-up and monitoring.
11. Patient **charged MBS item number 903**.

Item 903—Residential Medication Management Review

Medicare Fee	\$101.95
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Multidisciplinary Case Conferencing Items for Residents of Aged Care Facilities

Multidisciplinary Care Conferencing Items are available for medical practitioners to organise and coordinate, or participate, in multidisciplinary case conferences for patients living in residential aged care facilities that

- have a medical condition that has been or is likely to be present for at least 6 months or that is terminal and
- require ongoing care from a multidisciplinary case conference team.

A case conference team includes a medical practitioner and at least two other members, who participate in the case conference, each of whom provides a different kind of care or service to the patient, and one of whom may be another medical practitioner (normally a specialist or consultant physician).

For these items the medical practitioner must give a record of the conference, or a record of the medical practitioner's participation in the conference, to the residential aged care facility, place a copy in the patient's medical records, and offer a copy to the patient and to the patient's carer, if appropriate and with the patient's agreement.

For Medicare rebate see the Multidisciplinary Case Conferencing section of this flip chart.

Further information is available from www.health.gov.au/mbsprimarycareitems or refer to the MBS available online at www.health.gov.au/mbsonline.

GP Mental Health Treatment Items

The GP Mental Health Treatment items define services for which Medicare rebates are payable where GPs undertake early intervention, assessment and management of patients with mental disorders.

Preparing a GP Mental Health Treatment Plan: MBS Item 2700, 2701, 2715 or 2717

These items cover both the assessment and preparation of the GP Mental Health Treatment Plan. Claimable once in a twelve month period, with provision for exceptional circumstances.

An assessment of a patient must include:

- recording the patient's agreement for the GP Mental Health Treatment Plan service;
- taking relevant history (biological, psychological, social) including the presenting complaint;
- conducting a mental state examination;
- assessing associated risk and any co-morbidity;
- making a diagnosis and/or formulation; and
- administering an outcome measurement tool, except where it is considered clinically inappropriate.

In addition to the assessment of a patient, preparation of a GP Mental Health Treatment Plan must include:

- discussing the assessment with the patient, including the mental health formulation and diagnosis or provisional diagnosis;
- identifying and discussing referral and treatment options with the patient, including appropriate support services;
- agreeing goals with the patient - what should be achieved by the treatment - and any actions the patient will take;
- provision of psycho-education;
- a plan for crisis intervention and/or for relapse prevention, if appropriate at this stage;
- making arrangements for required referrals, treatment, appropriate support services, review and follow-up; and
- documenting this (results of assessment, patient needs, goals and actions, referrals and required treatment/services, and review date) in the patient's GP Mental Health Treatment Plan.

Once the plan has been completed and claimed a patient is eligible to be referred for up to ten Medicare rebateable allied mental health services per calendar year for psychological therapy or focused psychological strategy services, or be referred the Mental Health Shared Care and ATAPS programs at GP partners Adelaide (see details on following page). In addition, patients will be eligible to claim up to 10 separate services for the provision of group therapy (either as part of psychological therapy or focused psychological strategies).

Training Requirements (Item 2715 and 2717)

GPs providing Mental Health Treatment Plans, and who have undertaken mental health skills training recognised through the General Practice Mental Health Standards Collaboration, have access to items 2715 and 2717. For GPs who have not undertaken training, items 2700 and 2701 are available. It is strongly recommended that GPs providing mental health treatment have appropriate mental health training. GP organisations support the value of appropriate mental health training for GPs using these items.

Item number	2700	2701	2715	2717
Service time	At least 20 minutes	At least 40 minutes	At least 20 minutes	At least 40 minutes
Fee	\$69.00	\$101.55	\$87.60	\$129.00

Review a GP Mental Health Treatment Plan: MBS Item 2712—Benefit \$69.00

The recommended frequency for the review service, allowing for variation in patients' needs, is: an initial review, which should occur between four weeks to six months after the completion of a GP Mental Health Treatment Plan; and if required, a further review can occur three months after the first review. In general, most patients should not require more than two reviews in a 12 month period with ongoing management through the GP Mental Health Treatment Consultation and standard consultation items, as required.

A review must include:

- recording the patient's agreement for this service
- a review of the patient's progress against the goals outlined in the GP Mental Health Treatment Plan
- modification of the documented GP Mental Health Treatment Plan if required
- checking, reinforcing and expanding education
- a plan for crisis intervention and/or for relapse prevention, if appropriate and if not previously provided; and
- re-administration of the outcome measurement tool used in the assessment stage, except where considered clinically inappropriate

GP Mental Health Treatment Consultation: MBS Item 2713—Benefit \$69.00

Consultations associated with this item must be at least 20 minutes duration, where the primary treating problem is related to a mental disorder, including for a patient being managed under a GP Mental Health Treatment Plan. This item may be used for ongoing management of a patient with a mental disorder. It should not be used for the development of a GP Mental Health Treatment Plan.

A consultation must include:

- taking relevant history and identifying the patient's presenting problem(s) (if not previously documented)
- providing treatment, advice and/or referral for other services or treatment
- documenting the outcomes of the consultation

A patient may be referred from a GP Mental Health Treatment Consultation for other treatment and services as per normal GP referral arrangements. (This does not include referral for Medicare rebateable services by focussed psychological strategy services, clinical psychology or other allied mental health services, unless the patient is being managed by the GP under a GP Mental Health Treatment Plan or under a referred psychiatrist assessment and management plan).

For further information refer to the MBS available online at www.health.gov.au/mbsonline.

MENTAL HEALTH SHARED CARE and ATAPS

Referral options available through GP partners Adelaide (GPpA)

- All GPs should use the MBS item numbers listed below to prepare new mental health treatment plans for patients who require them.
- These numbers are applicable to Better Access and Better Outcomes programs. Access to Allied Psychological Services (ATAPS) and Mental Health Shared Care (MHSC) are available through GPpA.
- To refer a patient to either ATAPS or MHSC services the referring GP needs to fax a copy of the GP Mental Health Treatment Plan to the GPpA on 8227 2220. GPpA will ascertain which of these services the patient is most suited to and make arrangements accordingly.
- **Patient eligibility for ATAPS** are patients with a high prevalence mental health disorder (e.g. anxiety and depression), including those with co-morbidity, who present in general practice – excluding dementia, delirium, tobacco use disorder and intellectual disability. Patients need to be young, a pensioner, single parent unemployed, healthcare card holder or chronically ill.
- **Patient eligibility for Mental Health Shared Care 2** are patients with Tier 3 mental health disorders e.g. severe depression/anxiety, bipolar disorder, schizophrenia and personality disorder, including those with co-morbidity. who present in general practice.

Preparation of a GP Mental Health Treatment Plan	
Provides a structured approach for the management of patients with mental disorders	
MBS item No:	MBS fee
2700	\$69.00
2701	\$101.95
2715	\$87.60
2717	\$139.00



GP Mental Health Treatment Review	
Enables a review of the patient's progress against the goals outlined in the GP Mental Health Care Plan	
MBS item No:	MBS fee
2712	\$69.00



GP Mental Health Consultation	
An extended consult with a patient where the primary treating problem is related to a mental disorder	
MBS item No:	MBS fee
2713	\$69.00

MENTAL HEALTH SHARED CARE
<ul style="list-style-type: none"> • Severe mental health disorders and co-morbidity • GP to complete Mental Health Treatment Plan • Tier 3 clients (e.g. Clients presenting with severe depression/anxiety, bipolar disorder, schizophrenia, personality disorder) • No cost to patient • Mental Health Clinician provides a service at the patient's general practice or at GPpA rooms • Patient can access unlimited sessions of individual therapy with a mental health clinician • Referral to other services as needed • Collaborative management - Clinician provides full assessment report, management plan and regular updates to the referring GP

ATAPS
<p style="text-align: center;">ACCESS TO ALLIED PSYCHOLOGICAL SERVICES</p> <ul style="list-style-type: none"> • High Prevalence disorders (e.g. anxiety and depression) • GP to complete Mental Health Treatment Plan • Referral is made to GPpA. Patients need to be young, a pensioner, single parent, unemployed, healthcare card holder or chronically ill • Patient is seen at GPpA by a GPpA employed Clinical Psychologist or by a private Clinical Psychologist from a Preferred Provider Panel list held by GPpA • Regular feedback in regards to patients will be given to GPs • Service is free to patients • Patients can access 6 sessions up to 50 minutes each with an optional further 6 sessions following GP review