IMAGINE BETTER

CHHN

FREQUENTLY USED

# DESKTOP GUIDE TO ITEM NUMBERS

## FOR GENERAL PRACTICE SERVICES

NOVEMBER 2019

phn ACT
An Australian Government Initiative

Capital Health Network
Partnering for better health

# TABLE OF CONTENTS

## ITEM NUMBERS



## FLOW CHARTS



## PRACTICE INCENTIVE PROGRAM

# FREQUENTLY USED DESKTOP GUIDE TO ITEM NUMBERS

For a comprehensive explanation of each MBS Item number please refer to the Medicare Benefits Schedule online at www.health.gov.au/mbsonline

## Commonly Used Item Numbers

| Item | Name | $ | Description / Recommended Frequency |
|---|---|---|---|
| **3** | Level A | $17.50 | Brief - see MBS for complexity of care requirements |
| **23** | Level B | $38.20 | < 20 min - see MBS for complexity of care requirements |
| **36** | Level C | $73.95 | ≥ 20 min - see MBS for complexity of care requirements |
| **44** | Level D | $108.85 | ≥ 40 min - see MBS for complexity of care requirements |
| **10990** | Bulk Billing item | $7.50 | DVA, under 16's and Commonwealth Concession Card holders. Can be claimed concurrently for eligible patients. |
| **10991** | Bulk Billing item | $11.35 | DVA, under 16's and Commonwealth Concession Card holders. Can be claimed concurrently for eligible patients. |
| **11506** | Spirometry | $20.90 | Measurement of respiratory function before and after inhalation of bronchodilator |

## Chronic Disease Management

| Item | Name | $ | Description / Recommended Frequency |
|---|---|---|---|
| **721** | GP Management Plan (GPMP) | $146.55 | Management plan for patients with a chronic or terminal condition. Not more than once yearly |
| **723** | Team Care Arrangement (TCA) | $116.15 | Management plan for patients with a chronic or terminal condition and complex needs requiring ongoing care from a team including the GP and at least 2 other health or care providers. Enables referral for 5 rebated allied health services. Not more than once yearly |
| **732** | Review of GP Management Plan and/or Team Care Arrangement | $73.20 | The recommended frequency is every 6 months. If a GPMP and TCA are both reviewed on the same date item 732 can be claimed twice on the same day |
| **729** | GP Contribution to, or Review of, Multidisciplinary Care Plan | $71.55 | Contribution by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), to a multidisciplinary care plan prepared by another provider or a review of a multidisciplinary care plan prepared by another provider (other than a service associated with a service to which any of items 735 to 758 apply). Not more than once every 3 months |

## Health Assessments

| Item | Name | $ | Description / Recommended Frequency |
|---|---|---|---|
| **701** | Brief Health Assessment | $60.30 | Lasting not more than 30 minutes |
| **703** | Standard Health Assessment | $140.10 | >30 - 44 minutes - see MBS for complexity of care requirements |
| **705** | Long Health Assessment | $193.35 | >45 - <60 minutes - see MBS for complexity of care requirements |
| **707** | Prolonged Health Assessment | $273.10 | > 60 minutes - see MBS for complexity of care requirements |
| **715** | Aboriginal and Torres Strait Islander Health Assessment | $215.65 | Not timed |
| **699*** | Heart Health Assessment | $86.95 | Professional attendance for a heart assessment by a VR GP lasting at least 20 minutes |
| **177*** | Heart Health Assessment | $69.55 | Professional attendance for a heart assessment by a non-VR GP lasting at least 20 minutes |

*The heart health assessment items can be claimed only once per patient in a 12 month period. They cannot be claimed if a patient has had a health assessment service in the previous 12 months (items 699, 177, 701, 703, 705, 707, and 715)

## Medication Management

| Item | Name | $ | Description / Recommended Frequency |
|---|---|---|---|
| **900** | Home Medicines Review (HMR) | $157.30 | Review of medications in collaboration with a pharmacist for patients at risk of medication related misadventure. Once every 12 months |
| **903** | Residential Medication Management Review (RMMR) | $107.70 | For permanent residents of Residential Aged Care Facilities who are at risk of medication related misadventure. Performed in collaboration with the resident's pharmacist. Once every 12 months |

## Practice Nurse Item (PNIP) Numbers

| Item | Name | $ | Description / Recommended Frequency |
|---|---|---|---|
| **10987** | Follow Up Health Services for Indigenous people | $24.40 | Follow up services for an Indigenous person who has received a Health Assessment, not an admitted patient of a hospital. Maximum of 10 services per patient, per calendar year |
| **10997** | Chronic Disease Management | $12.20 | Monitoring and support for patients being managed under a GPMP or TCA. Not more than 5, per patient, per year |

| Mental Health Item Numbers | | | |
|---|---|---|---|
| **Item** | **Name** | **$** | **Description / Recommended Frequency** |
| **2700** | GP Mental Health Treatment Plan | $72.85 | Min 20 mins – Prepared by GP who has not undertaken Mental Health Skills Training. Assessment of patient and preparation of a care plan with option to refer for rebated psychological services. Not more than once yearly. |
| **2701** | GP Mental Health Treatment Plan | $107.25 | Min 40 mins – Prepared by GP who has not undertaken Mental Health Skills Training. Assessment of patient and preparation of a care plan with option to refer for rebated psychological services. Not more than once yearly. |
| **2715** | GP Mental Health Treatment Plan | $92.50 | Min 20 mins - Prepared by GP who has undertaken Mental Health Skills Training. Assessment of patient and preparation of a care plan with option to refer for rebated psychological services. Not more than once yearly. |
| **2717** | GP Mental Health Treatment Plan | $136.25 | Min 40 mins - Prepared by GP who has undertaken Mental Health Skills Training. Assessment of patient and preparation of a care plan with option to refer for rebated psychological services. Not more than once yearly. |
| **2712** | Review of GP Mental Health Treatment Plan | $72.85 | Plan should be reviewed between 1 - 6 months and no more than 2 per year |
| **2713** | Mental Health Consultation | $72.85 | Consult ≥ 20 min, for the ongoing management of a patient with mental disorder. No restriction on the number of these consultations per year. |
| **2721** | GP Focused Psychological Strategies | $94.25 | 30 - 40 minutes. Provision of focused psychological strategies by a GP registered with the Chief Executive Medicare. |
| **2723** | GP Focused Psychological Strategies | Derived fee | Out of surgery consultation. 30 - 40 minutes.<br><br>Provision of focused psychological strategies by an appropriately trained and registered GP with the Chief Executive Medicare. |
| **2725** | GP Focused Psychological Strategies | $134.85 | > 40 minutes. Provision of focused psychological strategies by an appropriately trained and registered GP with the Chief Executive Medicare. |
| **2727** | GP Focused Psychological Strategies | Derived fee | Out of surgery consultation. > 40 minutes.<br><br>Provision of focused psychological strategies by an appropriately trained and registered GP with the Chief Executive Medicare. |

# ALLIED HEALTH SERVICES FOR CHRONIC CONDITIONS REQUIRING TEAM CARE

GP must have completed a GP Management Plan (721) and Team Care Arrangement (723) or contributed to a Multidisciplinary Care Plan in a Residential Aged Care Facility (731).

**Patient must have a chronic or terminal medical condition and complex care needs requiring care from a multidisciplinary team consisting of their GP and at least two other health or care providers.**

| Allied Health Services for Chronic Conditions Requiring Team Care | | |
|---|---|---|
| **Item** | **Name** | **Description / Recommended Frequency** |
| **10950** | Aboriginal Health Worker Services | Allied Health Provider must be Medicare registered.<br><br>Maximum of 5 allied health services per patient each calendar year.<br><br>Can be 5 sessions with one provider or a combination e.g. 3 dietitian and 2 diabetes education sessions.<br><br>GP refers to allied health professional using 'Referral Form for Chronic Disease Allied Health (Individual) Services under Medicare' or a referral form containing all components. One for each provider.<br><br>Services must be of at least 20min duration and provided to an individual not a group.<br><br>Allied health professionals must report back to the referring GP after first and last visit. |
| **10951** | Diabetes Educator Services | |
| **10952** | Audiologist Services | |
| **10953** | Dietitian Services | |
| **10958** | Occupational Therapist Services | |
| **10960** | Physiotherapist Services | |
| **10962** | Podiatrist Services | |
| **10964** | Chiropractor Services | |
| **10966** | Osteopath Services | |
| **10970** | Speech Pathologist Services | |
| **10956** | Mental Health Worker Services | For mental health conditions use Better Access Mental Health Care items - 10 sessions.<br><br>For chronic physical conditions use GPMP and TCA - 5 sessions.<br><br>Better access and GPMP can be used for the same patient where eligible. |
| **10968** | Psychologist Services | |

| Eating Disorders Item Numbers | | | | |
|---|---|---|---|---|
| **Item** | **Name** | **Duration** | **$** | **Description / Recommended Frequency** |
| **90250** | GP Eating Disorders Treatment Plan prepared by GP who has not undertaken Mental Health Skills Training | 20-39 mins | $72.85 | Written Eating Disorders (ED) Treatment and Management plan which includes:<br><br>a. Diagnosis<br><br>b. Treatment options and recommendations for the 12 months<br><br>c. Outline referral options to allied health professionals for mental health and dietetic services, and specialists, etc (referred clinicians must be eligible to provide MBS services under Better Access for psychological treatment or Chronic Disease Management for dietetic services)<br><br>d. Offer the patient & carer (if any, and deemed appropriate with patient consent) a copy of plan and ED education |
| **90251** | GP Eating Disorders Treatment Plan prepared by GP who has not undertaken Mental Health Skills Training | 40 mins and above | $107.25 | |
| **90252** | GP Eating Disorders Treatment Plan prepared by GP who has undertaken Mental Health Skills Training | 20-39 mins | $92.50 | |
| **90253** | GP Eating Disorders Treatment Plan prepared by GP who has undertaken Mental Health Skills Training | 40 mins and above | $136.25 | |
| **90264** | Review of GP Eating Disorders Treatment Plan performed by GP who has/has not undertaken Mental Health Skills Training | Not specified | $72.85 | Review ED Treatment and Management plan<br><br>a. Treatment efficacy and evaluate with patient if it meets their needs<br><br>b. Modifications to continue with Treatment options in the plan OR alter treatment options in the plan with new arrangements<br><br>c. Initiate referrals to psychiatrist or paediatrician as appropriate<br><br>d. Offer the patient & carer (if any, and deemed appropriate with patient consent) a copy of plan and ED education |

| Item | Name | Duration | $ | Description / Recommended Frequency |
|---|---|---|---|---|
| **90271** | GP Focused Psychological Strategies (in consulting room) provided by GP registered with Chief Executive Medicare as meeting the credentialing requirements for provision of this service | 30-39 mins | $94.25 | GP providing psychological services indicated in ED Treatment and Management plan<br><br>Specified evidence-based modalities:<br>• Family Base Treatment for Eating Disorders (EDs)<br>• Adolescent Focused Therapy for EDs<br>• Cognitive Behavioural Therapy (CBT) for EDs (CBT-ED)<br>• CBT-Anorexia Nervosa (CBT-AN)<br>• CBT for Bulimia Nervosa and Binge Eating Disorder (CBT-BN, CBT-BED)<br>• Specialist Supportive Clinical Management (SSCM) for EDs<br>• Maudsley Model of Anorexia Treatment in Adults (MANTRA)<br>• Interpersonal Therapy (IPT) for BN, BED<br>• Dialectical Behavioural Therapy (DBT) for BN, BED<br>• Focal psychodynamic therapy for EDs<br><br>**Refer to MBS for detailed patient eligibility and assessment criteria** |
| **90272** | GP Focused Psychological Strategies (out of consulting room, i.e. group session) provided by GP registered with Chief Executive Medicare as meeting the credentialing requirements for provision of this service | 30-39 mins | 90271 Plus $26.35/Pt number seen up to 6 patients. For 7 or more patients - the fee for 90271 plus $2.05 per patient | |
| **90273** | GP Focused Psychological Strategies (in consulting room) provided by GP registered with Chief Executive Medicare as meeting the credentialing requirements for provision of this service | 40 mins and above | $134.85 | |
| **90274** | GP Focused Psychological Strategies (out of consulting room, i.e. group session) provided by GP registered with Chief Executive Medicare as meeting the credentialing requirements for provision of this service | 40 mins and above | 90273 Plus $26.35/Pt number seen up to 6 patients. For 7 or more patients - the fee for 90273 plus $2.05 per patient | |
| **90279** | GP Focused Psychological Strategies via video conference provided by GP registered with Chief Executive Medicare as meeting the credentialing requirements for provision of this service | 30-39 mins | $94.25 | |
| **90280** | GP Focused Psychological Strategies via video conference provided by GP registered with Chief Executive Medicare as meeting the credentialing requirements for provision of this service | 40 mins and above | $134.85 | |

# FOLLOW-UP ALLIED HEALTH SERVICES FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES WHO HAVE HAD A HEALTH ASSESSMENT

For a comprehensive explanation of each MBS Item number please refer to the Medicare Benefits Schedule online at www.health.gov.au/mbsonline

A person who is of Aboriginal or Torres Strait Islander descent may be referred by their GP for follow-up allied health services under items 81300 to 81360 **when the GP has undertaken a health assessment and identified a need for follow-up allied health services.**

These items provide an alternative pathway for Aboriginal and Torres Strait Islander peoples to access allied health services. If a patient meets the eligibility criteria for individual allied health services under the Chronic Disease Management items (10950 to 10970) and for follow-up allied health services, they can access both sets of services and are eligible for up to ten allied health services under Medicare per calendar year.

| Assessment and Provision of services | | |
|---|---|---|
| **Item** | **Name** | **Description / Recommended Frequency** |
| **81300** | Aboriginal and Torres Strait Islander Health Services | Allied Health Provider must be Medicare registered.<br><br>Maximum of 5 allied health services per patient each calendar year (in addition to the 5 services eligible from TCA 10950-10970).<br><br>Services must be of at least 20min duration.<br><br>GP refers to allied health professional using a referral form that has been issued by the Department or a referral form that substanially compliaes with the form issued by the Department of Health.<br><br>Allied health professionals must report back to the referring GP after the first and last services. |
| **81305** | Diabetes Education | |
| **81310** | Audiology | |
| **81315** | Exercise Physiology | |
| **81320** | Dietetics | |
| **81325** | Mental Health | |
| **81330** | Occupational Therapy | |
| **81335** | Physiotherapy | |
| **81340** | Podiatry | |
| **81345** | Chiropractic | |
| **81350** | Osteopathy | |
| **81355** | Psychology | |
| **81360** | Speech Pathology | |

# ALLIED HEALTH GROUP SERVICES FOR PATIENTS WITH TYPE 2 DIABETES

For a comprehensive explanation of each MBS Item number please refer to the Medicare Benefits Schedule online at www.health.gov.au/mbsonline

**GP must have completed a GP Management Plan (721), or reviewed an existing GPMP (732), or contributed to, or reviewed, a Multidisciplinary Care Plan in a Residential Aged Care Facility (731)**

| Assessment and Provision of Group Services | | |
|---|---|---|
| **Item** | **Name** | **Description / Recommended Frequency** |
| **81100** | Assessment for Group Services by Diabetes Educator | One assessment session only by either Diabetes Educator, Exercise Physiologist or Dietitian, per calendar year.<br><br>Referral form for group allied health service under Medicare for patients with Type 2 diabetes. |
| **81110** | Assessment for Group Services by Exercise Physiologist | |
| **81120** | Assessment for Group Services by Dietitian | |
| **81105** | Diabetes Education Group Services | 8 group services per calendar year, can be 8 sessions with one provider or a combination e.g. 3 diabetes education, 3 dietitian and 2 exercise physiology sessions.<br><br>Referral form for group allied health service under Medicare for patients with Type 2 diabetes. |

# AFTER-HOURS SERVICES

## Assessment and Provision of Group Services

<table>
<tr><th colspan="3">Attendance Period</th><th>Item No</th><th>MBS Payment</th><th>Brief Guide</th></tr>
<tr><td colspan="3">Urgent attendance – after hours</td><td rowspan="2">585</td><td rowspan="2">$131.90</td><td rowspan="4">• These items can only be used for the first patient, if more than one patient is seen on the one occasion, standard (non-urgent) after hours items apply<br>• The urgent after-hours items can only be used where the patient has a medical condition that requires urgent treatment, which could not be delayed until the next in-hours period<br>• For consultations at the health centre, it is necessary for the practitioner to return to, and specially open the consulting rooms for the attendance</td></tr>
<tr><td>Mon-Fri<br>7am-8am or 6pm-11pm</td><td>Sat<br>7am-8am or 12noon-11pm</td><td>Sun & Pub Holidays<br>7am-11pm</td></tr>
<tr><td colspan="3">Urgent attendance – unsociable hours</td><td rowspan="2">599</td><td rowspan="2">$155.45</td></tr>
<tr><td>Mon-Fri<br>11pm-7am</td><td>Sat<br>11pm-7am</td><td>Sun & Pub Holidays<br>11pm-7am</td></tr>
<tr><td colspan="3">Non-urgent after hours at a place other than consulting rooms</td><td rowspan="2">5023 (1 patient)<br>5043 (1 patient)<br>5028 (1 patient)<br>5028 (2 patients)<br>5028 (3 patients)<br>5049 (1 patients)<br>5049 (2 patients)<br>5049 (3 patients)</td><td rowspan="2">Derived fee</td><td rowspan="2"></td></tr>
<tr><td>Mon-Fri<br>Before 8am or after 6pm</td><td>Sat<br>Before 8am or After 12pm</td><td>Sun & Pub Holidays<br>All day</td></tr>
<tr><td colspan="3">Non-urgent after hours at consulting rooms</td><td rowspan="2">5000 (Level A)<br>5020 (Level B <20min)<br>5040 (Level C >20min)<br>5060 (Level D >40min)</td><td rowspan="2">$29.45<br>$49.80<br>$85.30<br>$119.65</td><td rowspan="2"></td></tr>
<tr><td>Mon-Fri<br>Before 8am or After 8pm</td><td>Sat<br>Before 8am or After 1pm</td><td>Sun & Pub Holidays<br>All day</td></tr>
</table>

# GP MULTIDISCIPLINARY CASE CONFERENCE

| Item | Name | Description / Recommended Frequency |
|---|---|---|
| **735** | Organise and coordinate a case conference | 15 - 20 minutes. GP organises and coordinates case conference in RACF or community or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs |
| **739** | Organise and coordinate a case conference | 20 - 40 minutes. GP organises and coordinates case conference in RACF or community or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs |
| **743** | Organise and coordinate a case conference | > 40 minutes. GP organises and coordinates case conference in RACF or community or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs |
| **747** | Participate in a case conference | 15 - 20 minutes. GP participates in a case conference in RACF or community or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs |
| **750** | Participate in a case conference | 30 - 40 minutes. GP participates in a case conference in RACF or community or on discharge. For patients with a chronic or terminal condition complex, and multidisciplinary care needs |
| **758** | Participate in a case conference | > 40 minutes. GP participates in a case conference in RACF or community or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs |

# HEALTH ASSESSMENTS

For a comprehensive explanation of each MBS Item number please refer to the Medicare Benefits Schedule online at www.health.gov.au/mbsonline

## There are 8 Health Assessment target groups:

### Health Assessment - 40 – 49 years Type 2 Diabetes Risk Evaluation

Provision of lifestyle modification advice and interventions for patients aged 40-49 years who score ≥12 on AUSDRISK. Once every 3 years

### Health Assessment - 45 - 49 Year Old

Once only health assessment for patients 45-49 years who are at risk of developing a chronic disease

### Health Assessment - 75 Years and Older

Health assessment for patients aged 75 years and older. Once every 12 months

### Health Assessment - Comprehensive Medical Assessment

Comprehensive Medical Assessment for permanent residents of Residential Aged Care Facilities. Available for new and existing residents. Not more than once yearly

### Health Assessment for patient with an Intellectual Disability

Health assessment for patient with an Intellectual Disability. Not more than once yearly

### Health Assessment for Refugees and other Humanitarian Entrants

Once only health assessment for new refugees and other humanitarian entrants, as soon as possible after their arrival (within 12 months of arrival).

Australian Refugee Health Practice Guide: refugeehealthguide.org.au

### Health Assessment for former serving members of the Australian Defence Force.

Once only health assessment for former serving members of the ADF, including former members of permanent and reserve forces.

### Heart Health Assessment

Heart health assessment items 699 and 177 were introduced with the intent of supporting patients with cardiovascular disease, or patients at risk of developing cardiovascular disease. In particular, the items are intended to support (a) Aboriginal or Torres Strait Islander persons aged 30 years and above; and (b) adults aged 45 years and above.

There are **four time based Health Assessment item numbers** which may be used for any of the target groups:

| Item | Name | Description / Recommended Frequency |
|---|---|---|
| **701** | Brief Health Assessment<br><br>**<30mins** | a. Collection of relevant information, including taking a patient history;<br>b. A basic physical examination;<br>c. Initiating interventions and referrals as indicated; and<br>d. Providing the patient with preventive health care advice and information. |
| **703** | Standard Health Assessment<br><br>**30 - 44 minutes** | a. Detailed information collection, including taking a patient history;<br>b. An extensive physical examination;<br>c. Initiating interventions and referrals as indicated; and<br>d. Providing a preventive health care strategy for the patient. |
| **705** | Long Health Assessment<br><br>**45 - 59 minutes** | a. Comprehensive information collection, including taking a patient history;<br>b. An extensive examination of the patient's medical condition and physical function;<br>c. Initiating interventions and referrals as indicated; and<br>d. Providing a basic preventive health care management plan for the patient. |
| **707** | Prolonged Health Assessment<br><br>**> 60 minutes** | a. Comprehensive information collection, including taking a patient history;<br>b. An extensive examination of the patient's medical condition, and physical, psychological and social function.<br>c. Initiating interventions and referrals as indicated; and<br>d. Providing a comprehensive preventive health care management plan for the patient. |
| **715** | Aboriginal and Torres Strait Islander Health Assessment<br><br>No designated time / complexity requirements | **Aboriginal and Torres Strait Islander Child Health Assessment**<br>Health Assessment for Aboriginal and Torres Strait Islander patients 0 - 14 years old. Not available to in-patients of a hospital or RACF. Not more than once every 9 months<br>**Aboriginal and Torres Strait Islander Adult Health Assessment**<br>Health Assessment for Aboriginal and Torres Strait Islander patients aged 15 – 54 years old. Not available to in-patients of a hospital or RACF. Not more than once every 9 months<br>**Aboriginal and Torres Strait Islander Health Assessment for an Older Person**<br>Health Assessment for Aboriginal and Torres Strait Islander patients aged 55 years and over. Not available to in-patients of a hospital or RACF. Not more than once every 9 months |
| **177** | Heart Health Assessment | **Heart Assessment by a non-VR GP lasting at least 20 minutes**<br>The heart health assessment can be claimed only once per patient in a 12 month period. They cannot be claimed if a patient has had a health assessment service in the previous 12 months (all the above item numbers) |
| **699** | Heart Health Assessment | **Heart Assessment by a non-VR GP lasting at least 20 minutes**<br>The heart health assessment can be claimed only once per patient in a 12 month period. They cannot be claimed if a patient has had a health assessment service in the previous 12 months (all the above item numbers) |

# RESIDENTIAL AGED CARE FACILITY ITEM NUMBERS

For a comprehensive explanation of each MBS Item number please refer to the Medicare Benefits Schedule online at www.health.gov.au/mbsonline

| Item | Name | Description / Recommended Frequency |
|---|---|---|
| **701** | Brief Health Assessment | < 30 minutes - see MBS for complexity of care requirements<br>Incorporating:<br>**Health Assessment - Comprehensive Medical Assessment**<br>Comprehensive Medical Assessment (CMA) for permanent residents of Residential Aged Care Facilities. Available for new and existing residents. Not more than once yearly |
| **703** | Standard Health Assessment | 30 - 44 minutes - see MBS for complexity of care requirements.<br>**Incorporating: Health Assessment - CMA** |
| **705** | Long Health Assessment | 45 - 60 minutes - see MBS for complexity of care requirements.<br>**Incorporating: Health Assessment - CMA** |
| **707** | Prolonged Health Assessment | > 60 minutes - see MBS for complexity of care requirements. Incorporating:<br>**Health Assessment - CMA** |

**CMA Activities:**

Time based, see MBS for complexity of care requirements for each item.

CMA requires assessment of the resident's health and physical and psychological function, and must include:

- Obtain and record resident's consent
- Information collection, including taking patient history and undertaking or arranging 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 - CMA, and offering the patient a written report about the health assessment, with recommendations about matters covered by the Health Assessment - CMA

Providing a written summary of the outcomes of the Health Assessment - CMA for the resident's records and to inform the provision of care for the resident by the RACF, and assist in the provision of Medication Management Review services for the resident

| | | |
|---|---|---|
| **731** | GP Contribution to, or Review of, Multidisciplinary Care Plan prepared by RACF | GP contribution to, or review of, a multidisciplinary care plan prepared by RACF, at the request of the facility, for patients with a chronic or terminal condition and complex needs requiring ongoing care from a team including the GP and at least 2 other health or care providers. Not more than once every 3 months |

**Activities:**

- Obtain and record resident's consent
- Prepare part of the plan or amendments to the plan and add a copy to the patient's medical records; or
- Give advice to a person (e.g. Nursing staff in RACF) who prepares or reviews the plan and record in writing, on the patient's medical records, any advice provided.

# RESIDENTIAL AGED CARE FACILITY ITEM NUMBERS CONT'D

| Item | Name | Description / Recommended Frequency |
|---|---|---|
| **735** | Organise and coordinate a case conference | 15 – 19 minutes. GP organises and coordinates case conference in RACF or community or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs |
| **739** | Organise and coordinate a case conference | 20 - 39 minutes. GP organises and coordinates case conference in RACF or community or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs |
| **743** | Organise and coordinate a case conference | > 40 minutes. GP organises and coordinates case conference in RACF or community or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs |
| **747** | Participate in a case conference | 15 - 20 minutes. GP participates in a case conference in RACF or community or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs |
| **750** | Participate in a case conference | 30 - 40 minutes. GP participates in a case conference in RACF or community or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs |
| **758** | Participate in a case conference | > 40 minutes. GP participates in a case conference in RACF or community or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs |

**Activities:**

Time based items 735 - 743 Organise and Coordinate requires:

- Obtain and record resident's consent
- Record meeting details including date, start and end time, location, participants names, all matters discussed and identified by team
- Discuss outcomes with patient and carer and offer a summary of the conference to them and team members
- Keep record in the patient's medical file

**Telehealth - Residential MBS Items**

Professional attendance by a general practitioner at a residential aged care facility that requires the provision of clinical support to a patient who is:

a. a care recipient receiving care in a residential aged care service (other than a professional attendance at a self-contained unit); or

b. at consulting rooms situated within such a complex where the patient is a resident of the aged care service (excluding accommodation in a self-contained unit)

Time based items 2125, 2138, 2179 and 2220

**Residential Medication Management Review (RMMR) - Item 903**

For permanent residents (new or existing) of RACFs. A RMMR is a review of medications, in collaboration with pharmacist, for patients at risk of medication related misadventure or for whom quality use of medicines may be an issue.

**Activities:**

Obtain and record resident's consent

- Collaborate with reviewing pharmacist
- Provide input from the resident's CMA or relevant clinical information for RMMR and resident's records
- Participate in post–review discussion with pharmacist (unless exceptions apply) regarding the findings, medication management strategies, issues, implementation, follow up and outcomes
- Develop and/or revise Medication Management Plan and finalise plan after discussion with resident

# TYPE 2 DIABETES RISK EVALUATION – HEALTH ASSESSMENT

## ITEMS 701 / 703 / 705 / 707

**Perform records search to identify 'at risk' patients**

**Identify Risk Factors**

**Perform Health Check**

**Nurse may collect information**

**GP must see patient**

**Claim MBS Item**

### Eligibility Criteria

- Patients with newly diagnosed or existing diabetes are not eligible
- Patients aged 40 to 49 years inclusive
- Patients must score ≥12 points (high risk) on Australian Type 2 Diabetes Risk Assessment Tool (AUSDRISK)
- Not for patients in hospital

### Clinical Content

- Explain Health Assessment process and gain consent
- Evaluate the patient's high risk score determined by the AUSDRISK, which has been completed within a period of 3 months prior to undertaking Type 2 Diabetes Risk Evaluation
- Update patient history and undertaking physical examinations and clinical investigations in accordance with relevant guidelines
- Make an overall assessment of the patient's risk factors, and results of relevant examinations and investigations
- Initiate interventions where appropriate, and follow-up relating to management of any risk factors identified
- Provide advice and information, such as Lifescripts resources, including strategies to achieve lifestyle and behaviour changes

### Essential Documentation Requirements

- Record patient's consent to Health Assessment
- Completion of AUSDRISK is mandatory, with a score of ≥12 points required to claim; Update patient history
- Record the Health Assessment and offer the patient a copy

### Claiming

- All elements of the service must be completed to claim
- Requires personal attendance by GP with patient

| MBS Item | Name | Age Range | Recommended Frequency |
|---|---|---|---|
| **701 / 703 / 705 / 707** | Health Assessment – Type 2 Diabetes Risk Evaluation | 40 - 49 years | Once every 3 years |

# 45 - 49 YEAR OLD – HEALTH ASSESSMENT

## ITEMS 701 / 703 / 705 / 707

**Perform records search to identify 'at risk' patients**

↓

**Identify Risk Factors**

↓

**Perform Health Check**

**Nurse may collect information**

**GP must see patient**

↓

**Claim MBS Item**

### Eligibility Criteria

- Patients aged 45 to 49 years inclusive
- Must have an identified risk factor for chronic disease
- Not for patients in a hospital

### Risk factors

- Include, but are not limited to:
- Lifestyle: Smoking; Physical inactivity; Poor nutrition; Alcohol use
- Biomedical: High cholesterol; High BP; Impaired glucose metabolism; Excess weight
- Family history of chronic disease

### Clinical Content

**Mandatory**

- Explain Health Assessment process and gain consent
- Information collection – takes patient history; undertake examinations and investigations as clinically required
- Overall assessment of the patient's health, including their readiness to make lifestyle changes
- Initiate interventions and referrals as clinically indicated
- Advice and information about lifestyle modification programs and strategies to achieve lifestyle and behaviour changes

**Non-Mandatory:**

- Written patient information such as the Lifescripts resources, are recommended

### Essential Documentation Requirements

- Record patient's consent to Health Assessment
- Record the Health Assessment and offer the patient a copy

### Claiming

- All elements of the service must be completed to claim

| MBS Item | Name | Age Range | Recommended Frequency |
|---|---|---|---|
| **701 / 703 / 705 / 707** | Health Assessment – 45 - 49 Year Old | 45 - 49 years | Once only |

# 75 YEARS AND OLDER – HEALTH ASSESSMENT

## ITEMS 701 / 703 / 705 / 707

**701 / 703 / 705 / 707** - Time based, see MBS for complexity of care requirements of each item

**Establish a patient register and recall when due for assessment**

↓

**Perform Health Assessment**

**Allow 45-90 minutes**

**Nurse may collect information**

**GP must see patient**

↓

**Complete Documentation**

↓

**Claim MBS Item**

### Eligibility Criteria

- Patients aged 75 years and older
- Patient seen in consulting rooms and/or at home
- Not for patients in hospital

### Clinical Content

**Mandatory**

- Explain Health Assessment process and gain patient's/carer's consent
- Information collection– takes patient history; undertake examinations and investigations as clinically required
- Measurement of: BP, Pulse rate and Rhythm
- Assessment of: Medication; Continence; Immunisation status for influenza, tetanus and pneumococcus; Physical function including activities of daily living and falls in the last 3 months; Psychological function including cognition and mood; and Social function including availability and adequacy of paid and unpaid help and the patient's carer responsibilities
- Overall assessment of patient
- Recommend appropriate interventions
- Provide advice and information
- Discuss outcomes of the assessment and any recommendations with patient

**Non-Mandatory:**

- Consider: Need for community services; Social isolation; Oral health and dentition; and Nutrition status
- Additional matters as relevant to the patient

### Essential Documentation Requirements

- Record patient's/carer's consent to Health Assessment
- Record the Health Assessment and offer the patient a copy (with consent, offer to carer)

### Claiming

- All elements of the service must be completed to claim

| MBS Item | Name | Age Range | Recommended Frequency |
|---|---|---|---|
| **701 / 703 / 705 / 707** | Health Assessment – 75 Years and Older | 75 years and older | Once every 12 months |

# ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH ASSESSMENT ITEM 715

**Item 715** – Patients that have identified as Aboriginal and Torres Strait Islander and have undertaken the Item 715 Health Assessment can be referred for Allied Health follow-up if required [Referral to Care coordination team to assist with access to allied health]. The assessment covers all age groups; however, it may vary depending on the age of the person. Refer to MBS primary care items

**Items 81300 to 81360 – Allied Health Service**

**GP performs Health Assessment 715**

↓

**Claim MBS Item 715**

↓

**If Allied Health Service is required**

↓

**Allied Health Service**

**Must be of at least 20 minutes duration**

**Service must be performed by Allied Health Professional**

↓

**Allied Health must provide written report to GP**

## Eligibility Criteria

- Items 81300 to 81360 with the exception of 81305 (which does not require a health assessment) are in addition to items 10950 to 10970 and provide an alternative to the referral pathway to access Allied Health Services
- Items available to individual patients only, not a group service
- The person is not an admitted patient of a hospital
- Eligible patients may access Medicare rebates for up to 5 allied health services in a calendar year. Allied health professionals may set their own fees. Charges in excess of the Medicare benefit for these items are the responsibility of the patient

## Essential documentation requirements

Allied Health Professional must provide a written report to the GP after the first and last service (more often if clinically required)

### Mandatory

Health Assessment includes physical, psychological and social wellbeing. It also assesses what preventative health care, education and other assistance that should be offered to improve the patient's health and wellbeing. It must include:

- Information collection of patient history and undertaking examinations and investigations as required;
- Overall assessment of the patient;
- Recommending appropriate interventions
- Providing advice and information to the patient
- Recording the health assessment; and
- Offering the patient a written report with recommendations about matters covered by the health assessment

### Optional

- Offering the patient's carer (if any, and the patient agrees) a copy of the report or extracts of the report relevant to the carer

| MBS Item | Name | Age Range | Recommended Frequency |
|---|---|---|---|
| **715** | Aboriginal and Torres Strait Islander Health Assessment | All Ages | Once in a 9 month period |
| **81300 to 81360** | *Allied Health Services | All Ages | Max 5 services per year |
| **10987** | Service provided by practice nurse or registered Aboriginal health worker | All Ages | Max 10 services per year |

# HEART HEALTH ASSESSMENT

## ITEM 699

**Perform records search to identify 'at risk' patients**

↓

**Identify Risk Factors**

↓

**Perform Health Check**

**Nurse may collect information**

**GP must see patient**

↓

**Claim MBS Item**

**177 non-VR**

**699 VR-GP**

### Eligibility Criteria

Patients at risk of developing cardiovascular disease. The items are intended to support:

a. Aboriginal or Torres Strait Islander persons aged 30 years and above; and

b. Adults aged 45 years and above

### Risk Factors

Identifying cardiovascular risk factors including, but are not limited to:

- Diabetes status
- Alcohol intake
- Smoking status
- Cholesterol status (if not performed within the last 12 months)
- Blood glucose

### Clinical Content

**Mandatory**

- Explain Health Assessment process and gain consent
- Information collection – takes patient history; undertake examinations and investigations as clinically required
- A physical examination which must include recording blood pressure
- Initiating interventions and referrals to address the identified risks factors
- Implementing a management plan for appropriate treatment of identified risk factors
- Providing the patient with preventative health care advise and information, including modifiable lifestyle factors

### Essential Documentation Requirements

- Record patient's consent to Health Assessment
- Record the Health Assessment and offer the patient a copy

### Claiming

- All elements of the service must be completed to claim

# HOME MEDICINES REVIEW (HMR)

## ITEM 900

## Also known as Domiciliary Medication Management Review (DMMR)

**Ensure Patient Eligibility**

↓

**First GP Visit**

**Discussion and referral to pharmacist**

↓

**HMR Interview**

**Conducted by accredited pharmacist**

↓

**Second GP Visit**

**Discuss and develop medication management plan**

↓

**Claim MBS Item**

### Eligibility Criteria

- Patients at risk of medication related problems or for whom quality use of medicines may be an issue
- Not for patients in a hospital or a Residential Aged Care Facility

### Initial Visit with GP

- Explain purpose, possible outcomes, process, information sharing with pharmacist and possible out of pocket costs
- Gain and record patient's consent to HMR
- Inform patient of need to return for second visit
- Complete HMR referral and send to patient's preferred pharmacy or accredited pharmacist

### HMR Interview

- Pharmacist holds review in patient's home unless patient prefers another location
- Pharmacist prepares a report and sends to the GP covering review findings and suggested medication management strategies
- Pharmacist and GP discuss findings and suggestions

### Second GP Visit

- Develop summary of findings as part of draft medication management plan
- Discuss draft plan with patient and offer copy of completed plan
- Send copy of plan to pharmacist

### Claiming

- All elements of the service must be completed to claim
- Requires personal attendance by GP with patient

| MBS Item | Name | Recommended Frequency |
|---|---|---|
| **900** | Home Medicines Review | Once every 12 months |

# RESIDENTIAL MEDICATION MANAGEMENT REVIEW (RMMR)

## ITEM 903

**Ensure Patient Eligibility**

**Patients likely to benefit from a review**

↓

**Refer to Pharmacist**

**Obtain patient/ carer**

↓

**Medication Review**

**By pharmacist**

↓

**Post Review Discussion**

**Face to face or by phone**

↓

**Complete Documentation**

↓

**Claim MBS Item**

### Eligibility Criteria

- For permanent residents (new or existing) of a Commonwealth funded Residential Aged Care Facility (includes veterans)
- Patients at risk of medication related misadventure because of significant change in their condition or medication regimen, or for whom quality use of medicines may be an issue
- Not for patients in a hospital or respite patients in RACF

### GP Initiates Service

- Explain RMMR process and gain resident's consent
- Send referral to accredited pharmacist to request collaboration in medication review
- Provide input from Comprehensive Medical Assessment or relevant clinical information for RMMR and the resident's records

### Accredited Pharmacist Component

- Review resident's clinical notes and interview resident
- Prepare Medication Review report and send to GP

### GP and Pharmacist Post Review Discussion

Discuss: Findings and recommendations of the Pharmacist;

- Medication management strategies; issues; implementation; follow up; outcomes
- If no (or only minor) changes recommended a post review discussion is not mandatory

### Essential Documentation Requirements

- Record resident's consent to RMMR
- Develop and/or revise Medication Management Plan which should identify medication management goals and medication regimen
- Finalise Plan after discussion with resident
- Offer copy of Plan to resident/carer, provide copy for resident's records and for nursing staff at RACF, discuss plan with nursing staff if necessary

### Claiming

- All elements of the service must be completed to claim
- Derived fee arrangements do not apply to RMMR

| MBS Item | Name | Recommended Frequency |
|---|---|---|
| **903** | Residential Medication Management Review | As required (Minimum 12 monthly) |

# DIABETES ANNUAL CYCLE OF CARE

**Ensure Patient Eligibility**

**Clinical care requirements**

**Claim MBS Item**

## Eligibility Criteria

- No age restrictions for patients
- Patients with established Diabetes Mellitus
- For patients in the community and in Residential Aged Care Facilities

## Essential Clinical and Documentation Requirements

- Explain Annual Cycle of Care process, gain and record patient's consent

## 6 Monthly

- Measure height, weight and calculate BMI
- Measure BP
- Examine fee

## Yearly

- Measure HbA1c, eGFR, total cholesterol, triglycerides and HDL cholesterol
- Test for microalbuminuria
- Provide patient education regarding diabetes management including self-care education
- Review diet and levels of physical activity - reinforce information about appropriate dietary choices and levels of physical activity
- Check smoking status - encourage smoking cessation
- Review medication

## 2 Yearly

- Comprehensive eye examination by ophthalmologist or optometrist to detect and prevent complications - requires dilation of pupils

## Claiming

- All elements of the service must be completed to claim
- Paid once every 11 – 13 month period

| Name | Frequency | In surgery | Out of surgery |
|---|---|---|---|
| **Diabetes Cycle of Care Completion - Standard Consult. (Level B)** | 11-13 monthly | 2517 | 2518 |
| **Diabetes Cycle of Care- Long Consult. (Level C)** | 11-13 monthly | 2521 | 2522 |
| **Diabetes Cycle of Care - Prolonged Consult. (Level D)** | 11-13 monthly | 2525 | 2526 |

# ASTHMA CYCLE OF CARE

**Ensure Patient Eligibility**

**Requirements**

**Clinical content**

**Documentation requirements**

**Claim MBS Item**

## Eligibility Criteria

- No age restrictions for patients
- Patients with moderate to severe asthma
- For patients in the community and in Residential Aged Care Facilities

## Essential Clinical Requirements

- At least 2 asthma consultations within 12 months
- One of the consultations must be for a Review
- Review must be planned during previous consultation

## Clinical Content

- Explain Cycle of Care process and gain patient's consent
- Diagnosis and assessment of level of asthma control and severity
- Review use of and access to asthma-related medication and devices
- Give patient written Asthma Action Plan (if the patient is unable to use a written Asthma Action Plan, discussion with the patient about an alternative method of providing an Asthma Action Plan)
- Provide asthma self-management education
- Review of written or documented Asthma Action Plan

## Essential Documentation Requirements

- Record patient's consent to Cycle of Care
- Document diagnosis and assessment of level of asthma control and severity
- Include documentation of the above requirements and clinical content in the patient file, including clinical content of the patient-held written Asthma Action Plan

## Claiming

- All elements of the service must be completed to claim
- Paid once every 12 months

| Name | Frequency | In surgery | Out of surgery |
|---|---|---|---|
| **Asthma Cycle of Care - Standard Consult. (Level B)** | 2 consults in 12 months | 2546 | 2547 |
| **Asthma Cycle of Care- Long Consult. (Level C)** | 2 consults in 12 months | 2552 | 2553 |
| **Asthma SIP - Prolonged Consult. (Level D)** | 2 consults in 12 months | 2558 | 2559 |

# GP MANAGEMENT PLAN (GPMP)

## ITEM 721

**Ensure Patient Eligibility**

**Develop Plan**

**Nurse may collect information**

**GP must see patient**

**Complete Documentation**

**Claim MBS Item**

### Eligibility Criteria

- No age restrictions for patients
- Patients with a chronic or terminal condition
- Patients who will benefit from a structured approach to their care
- Not for public patients in a hospital or patients in a Residential Aged Care Facility

### Clinical Content

- Explain steps involved in GPMP, possible out of pocket costs, gain consent
- Assess health care needs, health problems and relevant conditions
- Agree on management goals with the patient
- Confirm actions to be taken by the patient
- Identify treatments and services required
- Arrangements for providing the treatments and services
- Review using item 732 at least once over the life of the plan

### Essential Documentation Requirements

- Record patient's consent to GPMP
- Patient needs and goals, patient actions, and treatments/services required
- Set review date
- Offer copy to patient (with consent, offer to carer), keep copy in patient file

### Claiming

- All elements of the service must be completed to claim
- Requires personal attendance by GP with patient
- Review using item 732 at least once during the life of the plan

| MBS Item | Name | Recommended Frequency |
|---|---|---|
| **721** | GP Management Plan | 2 yearly (Minimum 12 monthly) |

# TEAM CARE ARRANGEMENT (TCA)

## ITEM 723

**Ensure Patient Eligibility**

**Develop TCA**

**Nurse may collect information**

**GP must see patient**

**Complete Documentation**

**Claim MBS Item**

### Eligibility Criteria

- No age restrictions for patients
- Patients with a chronic or terminal condition and complex care needs
- Patients who need ongoing care from a team including the GP and at least 2 other health or care providers
- Not for patients in a hospital or Residential Aged Care Facility

### Clinical Content

- Explain steps involved in TCA, possible out of pocket costs, gain consent
- Treatment and service goals for the patient
- Discuss with patient which 2 providers the GP will collaborate with and the treatment and services the 2 providers will deliver
- Actions to be taken by the patient
- Gain patient's agreement on what information will be shared with other providers
- Ideally list all health and care services required by the patient
- Obtain potential collaborating providers' agreement to participate
- **Consult with 2 collaborating providers and obtain feedback on treatments/services they will provide to achieve patient goals**

### Essential Documentation Requirements

- Record patient's consent to TCA
- Goals, collaborating providers, treatments/services, actions to be taken by patient
- Set review date
- Send copy of relevant parts to collaborating providers
- Offer copy to patient (with consent, offer to carer), keep copy in patient file

### Claiming

- Requires personal attendance by GP with patient
- Review using item 732 at least once during the life of the plan
- Claiming a GPMP and TCA enables patients to receive 5 rebated services from allied health.

| MBS Item | Name | Recommended Frequency |
|---|---|---|
| **723** | Team Care Arrangement | 2 yearly (Minimum 12 monthly) |

# REVIEWING A GP MANAGEMENT PLAN (GPMP) AND/OR TEAM CARE ARRANGEMENT (TCA) ITEM 723

## Reviewing a GP Management Plan (GPMP)

**GPMP Review**

**Nurse can assist**

**GP must see patient**

**Claim MBS Item**

### Clinical Content

- Explain steps involved in the review and gain consent
- Review all matters in relevant plan

### Essential Documentation Requirements

- Record patient's agreement to review
- Make any required amendments to plan
- Set new review date
- Offer copy to patient (with consent, offer to carer), keep copy in patient file

### Claiming

- All elements of the service must be completed to claim
- Item 732 should be claimed at least once over the life of the GPMP
- Cannot be claimed within 3 months of a GPMP (item 721)
- Item 732 can be claimed twice on same day if review of both GPMP and TCA, in this case the Medicare claim should be annotated

## Reviewing a Team Care Arrangement (TCA)

**TCA Review**

**Nurse can assist**

**GP must see patient**

**Claim MBS Item**

### Clinical Content

- Explain steps involved in the review and gain consent
- Consult with 2 collaborating providers to review all matters in plan

### Essential Documentation Requirements

- Record patient's consent to review
- Make any required amendments to plan
- Set new review date
- Send copy of relevant parts of amended TCA to collaborating providers
- Offer copy to patient (with consent, offer to carer), keep copy in patient file

### Claiming

- All elements of the service must be completed to claim
- Requires personal attendance by GP with patient
- Item 732 should be claimed at least once over the life of the TCA
- Cannot be claimed within 3 months of a TCA (item 723)
- Item 732 can be claimed twice on same day if review of both GPMP and TCA are completed, in this case the Medicare claim should be annotated

| MBS Item | Name | Recommended Frequency |
|---|---|---|
| **732** | Review of GP Management Plan and/or Team Care Arrangement | 6 monthly (Minimum 3 monthly) |

# MENTAL HEALTH TREATMENT PLAN
## ITEMS 2700/2701/2715/2717

**2700/2701 -** prepared by a GP who has not undertaken mental health skills training
**2715/2717 -** prepared by a GP who has undertaken mental health skills training

**Ensure Patient Eligibility**

**Develop Plan**

**Complete Documentation**

**Claim MBS Item**

### Eligibility Criteria

- No age restrictions for patients
- Patients with a mental disorder, excluding dementia, delirium, tobacco use disorder and mental retardation (without mental health disorder)
- Patients who will benefit from a structured approach to their treatment
- Not for patients in a hospital or an Residential Aged Care Facility

### Clinical Content

- Explain steps involved, possible out of pocket costs and gain patient's consent
- Relevant history - biological, psychological, social and presenting complaint
- Mental state examination, assessment of risk and co-morbidity, diagnosis of mental disorder and/or formulation
- Outcome measurement tool score (e.g. K10), unless clinically inappropriate
- Provide psycho-education
- Plan for crisis intervention/relapse prevention, if appropriate
- Discuss diagnosis/formulation, referral and treatment options with the patient
- Agree on management goals with the patient and confirm actions to be taken by the patient
- Identify treatments/services required and make arrangements for these

### Essential Documentation Requirements

- Record patient's consent to GP Mental Health Treatment Plan
- Document diagnosis of mental disorder
- Results of outcome measurement tool
- Patient needs and goals, patient actions, and treatments/services required
- Set review date
- Offer copy to patient (with consent, offer to carer), keep copy in patient file

### Claiming

- All elements of the service must be completed to claim
- Requires personal attendance by GP with patient
- Review using item 2712 at least once during the life of the plan

| MBS Item | Name | Recommended Frequency |
|---|---|---|
| **2700, 2701, 2715, 2717** | GP Mental Health Treatment Plan | Not more than once yearly |

# REVIEW OF THE MENTAL HEALTH TREATMENT PLAN ITEM 2712

**Reviewing the Plan**

**Complete Documentation**

**Claim MBS Item**

## Clinical Content

- Explain steps involved, possible out of pocket costs and gain patient's consent
- Review patient's progress against goals outlined in the GP Mental Health Treatment Plan
- Check, reinforce and expand psycho-education
- Plan for crisis intervention and/or relapse prevention, if appropriate and if not previously provided
- Re-administer the outcome measurement tool used when developing the GP Mental Health Treatment Plan (item 2700/2701/2715/2717), except where considered clinically inappropriate.

## Essential Documentation Requirements

- Record patient's consent to Review
- Results of re-administered outcome measurement tool
- Document relevant changes to GP Mental Health Treatment Plan
- Offer copy to patient (with consent, offer to carer), keep copy in patient file

## Claiming

- All elements of the service must be completed to claim
- Requires personal attendance by GP with patient
- Item 2712 should be claimed at least once over the life of the GP Mental Health Treatment Plan
- According to the FAQ's on The Australian Government Department of Health Website (2012) it is not mandatory for the GP to see the patient to do a referral for the further 4 allied mental health sessions.
- A review can be claimed 1–6 months after completion of the GP Mental Health Treatment Plan
- If required, an additional review can be performed 3 months after the first Review

| MBS Item | Name | Recommended Frequency |
|---|---|---|
| **2712** | Review of GP Mental Health Treatment Plan | 1–6 months after GP Mental Health Treatment Plan |

# *NEXT STEP (HIGH INTENSITY)* REFERRALS

**Ensure Patient Eligibility**

**Complete *Next Step* referral form, attach completed MHTP and fax to 6100 9961**

**Patient sees provider for up to 12 sessions**

**Review and if further sessions are required complete Review Form**

**Fax to 6100 9961**

## Eligibility Criteria

- Patient has a Mental Health Treatment Plan in place and experiencing moderate to severe symptoms of a mental health condition. Patient needs to see a Mental Health Professional for Focused Psychological Strategies and cannot otherwise access treatment through Better Access.

**Patients cannot receive sessions under Medicare (Better Access) and *Next Step.***

## Referral

- Complete the *Next Step* referral form, attach completed MHTP and fax to 6100 9961. The *Next Step* Intake Team will process this referral, send an acknowledgment of receipt to the referrer, and contact the patient within 48 hours to facilitate their first appointment.
- The *Next Step* Referral Form and Post Psychological Review Form can be found here:- https://www.chnact.org.au/referral-templates

## Treatment

- The patient can then receive up to 12 sessions of focused psychological strategies.

## Review Mental Health Treatment Plan

- The mental health professional will provide feedback regarding the patient's treatment after their final session.
- If the patient requires further sessions, complete the Review Form and fax to (02) 6100 9961.

# EATING DISORDERS TREATMENT PLAN
## ITEMS 90250/90251/90252/90253

**90250/90251 -** prepared by a GP who **has not** undertaken mental health skills training
**90252/90253 -** prepared by a GP who **has** undertaken mental health skills training

**Ensure Patient Eligibility**

**Develop Plan**

**Complete Documentation**

**Claim MBS Item**

### Eligibility Criteria

- No age restrictions for patients
- Not for patients in a hospital

There are two cohorts of eligible patients:

a. Patients with a clinical diagnosis of anorexia nervosa; or

b. Patients who meet the eligibility criteria (below) and have a clinical diagnosis of any of:

- bulimia nervosa;
- binge-eating disorder;
- other specified feeding or eating disorder

Cohort b. eligibility criteria:

- a person who has been assessed as having an Eating Disorder Examination Questionnaire (EDE-Q) score of 3 or more; and
- the condition is characterised by rapid weight loss, or frequent binge eating or inappropriate compensatory behaviour as manifested by 3 or more occurrence per week; and

- A person has at least two of the following indicators:
  - clinically underweight with a body weight <85% of expected weight where weight loss is directly attributable to the eating disorder;
  - current or high risk of medical complications due to eating disorder behaviours and symptoms;
  - serious comorbid medical or psychological conditions significantly impacting on medical or psychological health status with impacts on function;
  - the person has been admitted to a hospital for an eating disorder in the previous 12 months;
  - inadequate treatment response to evidence-based eating disorder treatment over the past six months despite active and consistent participation.

## Clinical Content

- Explain steps involved, possible out of pocket costs and gain patient's consent
- Relevant history - biological, psychological, behavioural, nutritional, social
- Mental state examination, assessment of risk and co-morbidity, diagnosis of mental disorder and/or formulation
- Outcome measurement tool score, unless clinically inappropriate
- Plan for crisis intervention/relapse prevention/education for patient/family/carer
- Assess associated risk and any co-morbidity (see MBS explanatory note AN.36.1)
- Discuss diagnosis/formulation, referral and treatment options, plan review date with the patient
- Agree on management goals with the patient and confirm actions to be taken by the patient
- Identify treatments/services required and make arrangements for these
- Agree on management goals with the patient and confirm actions to be taken by the patient
- Identify treatments/services required and make arrangements for these

## Essential Documentation Requirements

- Record patient's consent to GP Eating Disorders Treatment Plan
- Document diagnosis of mental disorder and results of outcome measurement tool
- Document patient needs, goals and actions, and referrals and treatments/services required
- Document review date
- Offer copy to patient (with consent, offer to carer), keep copy in patient file

## Claiming

- Requires personal attendance by GP with patient
- All elements of the service must be completed to claim
- Review using item 90264 at least once during the 12 month life of the plan.
- Cannot be claimed with items 2713, 279, 735, 758, 235, or 244

| MBS Item | Name | Recommended Frequency |
|---|---|---|
| **90250,90251, 90252, 90253** | GP Eating Disorders Treatment Plan | Not more than once yearly |

# REVIEW OF EATING DISORDERS TREATMENT PLAN ITEM 90264

**Reviewing the Plan**

**Clinical Content**

**Complete Documentation**

**Claim MBS Item**

## Eligibility Criteria

- Patient must have had an Eating Disorders Plan (EDP) in the previous 12 months.
- The 12 month period commences from the date of the EDP
- Item 90264 cannot be claimed with item 2713 and 279

## Clinical Content

- Explain steps involved, possible out of pocket costs and gain patient's consent
- Referral to a psychiatrist or paediatrician for review under items 90266-90269 if this has not already been initiated
- Review patient's progress against goals outlined in the GP Eating Disorders Treatment Plan and modify documented EDP if required
- Check, reinforce and expand education
- Plan for crisis intervention and/or relapse prevention, if appropriate and if not previously provided
- Review reports back from allied mental health professional on the patient's response to treatment and document whether patient should continue another course of services
- Re-administer the outcome measurement tool and mental state examination used when developing the GP Eating Disorders Treatment Plan (item 90250/90251/90252/90253), except where considered clinically inappropriate. (see specifics in MBS AN.36.3)

## Essential Documentation Requirements

- Record patient's consent to Review
- Results of re-administered outcome measurement tool and mental state examination
- Document relevant changes to GP Eating Disorders Treatment Plan
- Document referral to psychiatrist or paediatrician
- Document recommendation on whether patient should continue with another course of EDPT services with allied mental health professional originally referred to, or change to another
- Offer copy to patient (with consent, offer to carer), keep copy in patient file

## Claiming

- All elements of the service must be completed to claim
- Requires personal attendance by GP with patient
- Item 90264 should be claimed at least once over the life of the GP Eating Disorders Treatment Plan
- A review should be claimed on a regular, ongoing and as required basis. Review must occur at the end of each course of treatment as per stepped model
- **See stepped model in MBS explanatory note AN.36.1**

| MBS Item | Name | Recommended Frequency |
|---|---|---|
| **90654** | Review of GP Eating Disorders Treatment Plan | At least at the end of each course of treatment as per stepped model |

# PRACTICE INCENTIVE PAYMENTS SUMMARY

**PIP Enquiry Line: 1800 222 032**

| Item | Activity | PIP ($ per SWPE) | Notes |
|---|---|---|---|
| **eHealth** | **Requirement 1:** Integrating Healthcare Identifiers into Electronic Practice Records | $6.50 per SWPE, per annum<br><br>Capped at $12,500 per quarter | To qualify practices must meet each of the requirements:<br>**Requirement 1:**<br>1. Apply for a Healthcare Provider Identifier-Organisation (HPI-O)<br>2. Ensure each GP within the practice has a Healthcare Provider Identifier-Individual (HPI-I)<br>3. Use a compliant clinical software system to access, retrieve and store verified Individual Healthcare Identifiers (IHI) for patients |
| | **Requirement 2:** Secure messaging capability | | **Requirement 2:**<br>1. Apply for a NASH PKI Certificate<br>2. Have a standards-compliant secure messaging capability and use it where feasible<br>3. Work with your secure messaging vendor to ensure it is installed and configured correctly<br>4. Have a written policy to encourage its use |
| | **Requirement 3:** Data records and clinical coding | | **Requirement 3:**<br>1. Be working towards recording the majority of diagnoses electronically using a medical vocabulary that can be mapped against a nationally recognised disease classification or terminology system<br>2. Provide a written policy to this effect to all GPs |
| | **Requirement 4:** Electronic transfer of prescriptions | | **Requirement 4:**<br>Use a software system that is able to send an electronic prescription to a Prescription Exchange Service (PES) |
| | **Requirement 5:** My Health Record (eHealth) record system | | **Requirement 5.**<br>1. Use compliant software to access the personally controlled electronic health (eHealth) record system and create and post Shared Health Summaries and Event Summaries when available<br>2. Apply to participate in the eHealth record system upon obtaining a HPI-O |
| **Practice Nurse** | Practice employs or retains the services of a Registered Nurse, Enrolled Nurse or Aboriginal Health Worker | Capped at $125,000 per annum | This incentive aims to broaden the range of services a nurse can provide. Payments are based on practice SWPE and nurse hours. Refer to ACTML website for complete PNIP guidelines. |

# PRACTICE INCENTIVE PAYMENTS SUMMARY

**PIP Enquiry Line: 1800 222 032**

| Item | Activity | PIP ($ per SWPE) | Notes |
|---|---|---|---|
| **Quality Improvement (QI PIP)** | **Requirement 1:** Participate in continuous Quality Improvement | Capped at $12,500 per quarter, based on $5.00 per SWPE, per year | General Practices commit to:<br>• Implementing continuous quality improvement activities that support their role of managing their patients' health.<br>• Submit nationally consistent, de-identified general practice data, against ten key improvement measures that contribute to local, regional and national health outcomes |
| | **Requirement 2:** Provide the PIP eligible data set to your local PHN | | |
| **Aged Care Access** | Provision of primary care services for patients in Residential Aged Care Facilities (RACFs).<br><br>**Tier 1:** GP completes the Qualifying Service Level (QSL) 1 - 60 MBS services in RACF claimed in a financial year | $1500 | MBS items that count towards QSLs include attendances in RACF, contributions to multidisciplinary care plans and Residential Medication Management Reviews.<br>GPs need to provide the service using their PIP linked Medicare provider number.<br>GPs do not need to apply to participate in the Incentive. Medicare will request bank details from GPs eligible to receive payments once they have reached the QSL. |
| | **Tier 2:** GP completes the QSL 2 - 140 MBS services in RACF claimed in a financial year | $3500 | |

# PRACTICE INCENTIVE PAYMENTS SUMMARY

**PIP Enquiry Line: 1800 222 032**

| Item | Activity | PIP ($ per SWPE) | Notes |
|---|---|---|---|
| **Indigenous Health** | Provision of better health care for Indigenous patients, including best practice management of chronic disease.<br><br>Sign-on payment | $1000 | One-off payment only. Practice must be registered for PIP.<br>Practice:<br>• Seeks consent to register their Aboriginal and Torres Strait Islander patients (regardless of age) who have, or are at risk of, chronic disease, with Medicare and the practice for chronic disease management in a calendar year.<br>• Establishes a mechanism to ensure their Aboriginal and Torres Strait Islander patients aged 15 years and over with a chronic disease, are followed up e.g. recall/reminder system, to ensure they return for ongoing care<br>• Undertakes cultural awareness training within 12 months of joining incentive<br>• Annotates PBS prescriptions for eligible Aboriginal and Torres Strait Islander patients for the PBS Co-payment |
| | Annual patient registration payments | $250 per registered Aboriginal and Torres Strait Islander patient, per calendar year | • Practice registers their eligible Aboriginal and Torres Strait Islander patients with Medicare for the PIP Indigenous Health Incentive or PBS Co-payment Measure.<br>• Practice must actively plan and manage care of their Aboriginal and Torres Strait Islander patients with chronic disease for a calendar year.<br>• Payment made to practice for each Aboriginal and Torres Strait Islander patient who:<br>- Is aged 15 years or over<br>- Has a chronic disease<br>- Has had (or has been offered) the 715 Aboriginal and Torres Strait Islander Health Assessment<br>- Has provided informed consent to be registered for the PIP Indigenous Health Incentive<br>• The patient's registration period commences from the date they provide consent to participate in the incentive and will end on 31 December that year. Practices are required to obtain consent to re-register patients each year. |
| | **Tier 1**<br>Outcomes payment: Chronic Disease Management | $100 per registered patient, per calendar year | Payment made to practices that (in a calendar year):<br>1. Develop a 721 GP Management Plan or 723 Team Care Arrangement for the patient and undertake at least one 732 Review of the GPMP or TCA; or<br>2. Undertake two 732 Reviews of GPMP or TCA; or<br>3. Complete 731 contribute to, or review, a care plan for a patient in a RACF, on two occasions. |
| | **Tier 2**<br>Outcomes payment: Total Patient Care | $150 per registered patient, per calendar year | Payment made to practices that provide the majority (i.e. the highest number) of MBS services for the patient (with a minimum of 5 MBS services) in a calendar year. This may include the MBS services provided to qualify for Tier 1. |

# PRACTICE INCENTIVE PAYMENTS SUMMARY

**PIP Enquiry Line: 1800 222 032**

| Item | Activity | PIP ($ per SWPE) | Notes |
|---|---|---|---|
| **Teaching** | Aims to encourage general practices to provide teaching sessions to undergraduate and graduate medical students preparing for entry into the Australian Medical profession. | $200.00 for each 3-hour teaching session. You can claim a maximum of 2 sessions per GP daily | Practices can access a maximum of $100 for each three hour teaching session provided to medical students. Each practice can claim a maximum of two sessions per GP, per calendar day. |