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SYDNEY NORTH Health Network

DESKTOP GUIDE TO CHRONIC DISEASE MANAGEMENT & MEDICARE BENEFITS SCHEDULE (MBS) ITEM NUMBERS

A Resource Manual for General Practice

November 2020

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INTRODUCTION:
This Desktop Guide is intended as a resource manual to assist General Practice staff to effectively coordinate care for their patients with chronic conditions. It provides comprehensive information regarding the MBS items relevant to the management of chronic diseases and other conditions commonly treated in general practice. For current and comprehensive information about each MBS item number, please refer to the Medicare Benefits Schedule at MBS Online http://www.mbsonline.gov.au. MBS Online is frequently updated as changes to the MBS occur.

FEEDBACK / COMMENTS:
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DISCLAIMER: whilst every effort has been made to ensure that the information included in this Desktop Guide is current and up-to-date, you should exercise your own independent skill and judgement before relying on it. Refer to MBS Online for current information.

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CHRONIC DISEASE MANAGEMENT

Chronic disease overview

Our current health system is not optimally set up to effectively manage long term conditions. Increased and poorly targeted service use is resulting in variable patient outcomes and significant financial impacts across the entire health system. While not all hospital presentations for chronic or other conditions can be prevented through primary health care interventions, it may be possible to prevent many:

- In 2013–14, 48% (285,000) of potentially avoidable hospitalisations were for chronic conditions; and
- Nearly a quarter (23%) of people who visited an emergency department felt their care could have been provided by a general practitioner.

Source: Better Outcomes for people with chronic and complex health conditions – Report of the Primary Health Care Advisory Group, December 2015.

CHRONIC DISEASE IN THE SNHN REGION

The SNHN region spans 899 square kilometres, aligns with the Northern Sydney Local Health District and encompasses 9 Local Government Areas (LGAs). It has a total population of 914,298 (2018). The population is projected to grow by 23.5% between 2016-2036 compared to 28.1% for NSW. By 2036, the region is expected to have an additional 213,300 residents living in the area.

Whilst the prevalence of chronic diseases within SNHN is lower compared to NSW as a whole, 40% of the population have one (1) or more chronic conditions with cancer and circulatory system diseases being leading causes of premature mortality between 2010-2014. An estimated 9% (65,000) of people within the region are smokers, 18% of people aged 18 years and over are obese, 18% of people aged 15 years and over consume more than two (2) standard alcoholic drinks per day and 34% of people aged 16 years and over within the region do not undertake sufficient physical activity. These risk factors can result in a compromised state of health and wellbeing in relation to chronic diseases especially among vulnerable population groups and mitigating these risk factors is critical to further support general health and wellbeing within SNHN.

Commonly used MBS item numbers

The following Item Numbers are commonly used in the treatment and management of chronic conditions in general practice.

Item	Name	Description/recommended frequency
3	Level A	Short: see MBS for complexity of care requirements.
23	Level B	< 20mins: see MBS for complexity of care requirements.
36	Level C	> 20 min: see MBS for complexity of care requirements.
44	Level D	> 40 min: see MBS for complexity of care requirements.
10991	Bulk Billing item	DVA, under 16's and Commonwealth Concession Card holders. Can be claimed concurrently for eligible patients. Confirm with Medicare as to Regional coding.

Commonly used MBS item numbers (Cont)

Health Assessments and Health Checks

Item	Name	Description/recommended frequency
701	Brief Health Assessment	<30 mins: see MBS for complexity of care requirements.
703	Standard Health Assessment	30 – 45 mins: see MBS for complexity of care requirements.
705	Long Health Assessment	45 – 60 mins: see MBS for complexity of care requirements.
707	Prolonged Health Assessment	> 60 mins: see MBS for complexity of care requirements.
715	Aboriginal & Torres Strait Islander Health Assessment	Every 9 months: see MBS for care requirements.
699	Heart Health Check	> than 20 mins: see MBS for care requirements.

Chronic Disease Management

Item	Name	Description/recommended frequency
721	GP Management Plan (GPMP)	Management plan for patients with a chronic or terminal condition – not more than once yearly.
723	Team Care Arrangement (TCA)	Management plan for patients with a chronic or terminal condition who require ongoing care from a team including the GP and at least two (2) other health or care providers. Enables referral for five (5) rebated allied health services – not more than once yearly.
732	Review of GP Management Plan and/or Team Care Arrangement	Recommended six (6) monthly, must be performed at least once over the life of the plan.
729	GP Contribution to, or review of, Multidisciplinary Care Plan	Contribution to, or review of, a multidisciplinary care plan prepared by another provider (e.g. community, home or allied health providers, specialists). For patients with a chronic or terminal condition and complex needs requiring ongoing care from a team including the GP and at least two (2) other health or care providers. Not more than once every three (3) months.
731	GP contribution to Care Plan 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 two (2) other health or care providers. Not more than once every three (3) months.

Restriction of Co-claiming of Chronic Disease and General Consultation Items
Co-claiming of GP consultation items 3, 4, 23, 24, 36, 37, 44, 47, 52, 63, 54, 57, 58, 59, 60, 65, 597, 598, 599, 600, 5000, 5003, 5020, 5023, 5040, 5043, 5060, 5063, 5200, 5203, 5207, 5208, 5220, 5223, 5227 and 5228 with chronic disease management items 721, 723, or 732 is not permitted for the same patient, on the same day.

Commonly used MBS item numbers (Cont)

Medication and management of cycles of care

Item	Name	Description/recommended frequency
900	Home Medicines Review (HMR)	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)	For permanent residents of Residential Aged Care Facilities who are at the risk of medication related misadventure. Performed in collaboration with the resident's pharmacist. Not more than once yearly.
2521	Diabetes Annual Cycle of Care Level C + SIP	For accredited practice. Used in place of usual attendance item when completing diabetes Annual Cycle of Care. Once every 11 – 13 months.
2552	Asthma Cycle of Care Level C + SIP	For accredited practices. Used in place of usual attendance item when completing the Asthma Cycle of Care for patients with moderate to severe asthma. Not more than once yearly.
11505	Spirometry	a) involves a permanently recorded tracing, performed before and after inhalation of a bronchodilator; and (b) is performed to confirm diagnosis of: (i) asthma; or (ii) chronic obstructive pulmonary disease (COPD); or (iii) another cause of airflow limitation;
11506	Spirometry	Measurement of respiratory function involving a permanently recorded tracing performed before and after inhalation of bronchodilator.

Mental Health

Item	Name	Description/recommended frequency
2700	GP Mental Health Treatment Plan	Prepared by GP who has not undertaken Mental Health Skills Training. Assessment of patient taking between 20 – 39 minutes. Not more than once yearly.
2701	GP Mental Health Treatment Plan	Prepared by GP who has not undertaken Mental Health Skills Training. Assessment of patient taking more than 40 minutes. Not more than once yearly.
2715	GP Mental Health Treatment Plan	Prepared by GP who has undertaken Mental Health Skills Training. Assessment of patient taking between 20 – 39 minutes. Not more than once yearly.
2717	GP Mental Health Treatment Plan	Prepared by GP who has undertaken Mental Health Skills Training. Assessment of patient taking more than 40 minutes. Not more than once yearly.
2712	Review of GP Mental Health Care Plan	Plan should be reviewed after 1 – 6 months.
2713	Mental Health Consultation	Consult > 20 min, for the ongoing management of a patient with mental disorder. No restriction on the number of these consultations per year.

Practice Nurse activity - Item number income estimator

The table below is a snapshot of the Practice Nurse Item Number Calculator Tool that assists with identifying activities frequently undertaken to provide care for patients with or at risk of chronic disease. It shows the potential financial contribution that can be made by practice nurses towards claiming these item numbers. Click here to download an Excel version of the Calculator.

ITEM	ACTIVITY	MBS ITEM NO.	NO. OF SERVICES	MBS FEE	INCOME GENERATED
HEALTH ASSESSMENTS	Type II Diabetes Risk Evaluation (40 - 49 year old)	701 (Brief)		$60.30	$0.00
		703 (Standard)		$140.10	$0.00
		705 (Long)		$193.35	$0.00
		707 (Prolonged)		$273.10	$0.00
	45 - 49 year old Health Check	701 (Brief)		$60.30	$0.00
		703 (Standard)		$140.10	$0.00
		705 (Long)		$193.35	$0.00
		707 (Prolonged)		$273.10	$0.00
	75 years and older	701 (Brief)		$60.30	$0.00
		703 (Standard)		$140.10	$0.00
		705 (Long)		$193.35	$0.00
		707 (Prolonged)		$273.10	$0.00
	Intellectual Disability	701 (Brief)		$60.30	$0.00
		703 (Standard)		$140.10	$0.00
		705 (Long)		$193.35	$0.00
		707 (Prolonged)		$273.10	$0.00
	Refugees/Humanitarian entrants	701 (Brief)		$60.30	$0.00
		703 (Standard)		$140.10	$0.00
		705 (Long)		$193.35	$0.00
		707 (Prolonged)		$273.10	$0.00
	Aboriginal & Torres Strait Islander	715		$215.65	$0.00
	Follow up service provided by PN or AHW	10987		$24.40	$0.00
	Heart Health Check	699		$75.05	$0.00
CHRONIC DISEASE MANAGEMENT	GP Management Plan	721		$146.55	$0.00
	Team Care Arrangement	723		$116.15	$0.00
	Review GP Management Plan	732		$73.20	$0.00
	Review Team Care Arrangement	732		$73.20	$0.00
	PN contribution to CDM	10997		$12.20	$0.00
CVC	CVC Initial Enrollment	UP01		$424.15	$0.00
	Quarterly monitoring	UP03		$442.65	$0.00
BULK BILLING ITEMS	Bulk Billing item (<16 or concession)	10990		$7.20	$0.00
OTHER SERVICES	ECG	11707		$38.75	$0.00
	Holter Monitor	11709		$167.45	$0.00
	Ear syringe with GP review (level B)	23		$37.05	$0.00
	HMR (assist referral process)	900		$154.80	$0.00
	RMMR (assist referral process)	903		$106.00	$0.00
	Spirometry	11506		$21.20	$0.00
	Spirometry	11505		$42.40	$0.00
	ABI	11610		$65.70	$0.00
				TOTAL	$0.00

Preparation of a GP Management Plan (GPMP)

The Chronic Disease Management (CDM) Medicare items are for General Practitioners (GPs) to manage the health care of people with chronic or terminal medical conditions. This includes those requiring multidisciplinary, team-based care from a GP and at least two (2) other health or care providers. Click here for more information.

Preparation of a GPMP
Item 721

Ensure patient eligibility

Develop plan

Nurse / Aboriginal Health Worker or Health Practitioner may collect information

GP must see patient

Complete relevant activities and documentation

Claim MBS Item

Eligibility criteria

- No age restrictions for patients
- Patients with a chronic (present for or likely to persist 6 months or more) 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
- A GP Mental Health Treatment Plan (item 2702 / 2710) is suggested for patients with a mental health disorder only

Clinical content

- Explain steps involved in GPMP, possible out of pocket costs and gain patient's consent
- Assess health care needs, health problems, relevant history and conditions
- Agree on management and patient goals with the patient
- Identify treatments and services required
- Arrangements for providing the treatments and services
- Arrangements for review using item 732 at least once over the life of the plan (12-24 months)

Essential documentation requirements

- Record patient's consent to GPMP
- Patients' needs and goals, patient actions and treatments/services required
- Set review date
- Offer copy to patient or carer, keep copy in patient records

Claiming

- All elements of the service must be completed to claim
- Requires personal attendance by GP
- Review using item 732 at least once during the life of the plan (8 reviews over 24 months, more if clinically indicated)
- MBS item 10991 (bulk billing incentive) may also be claimed for eligible patients

Item	Name	Recommended frequency
721	GP Management Plan	Two (2) yearly (min 12 monthly)

For further information about this item on the MBS Online website click here

Coordination of Team Care Arrangement (TCA)

Item 723

Ensure patient eligibility

Develop TCA

Nurse / Aboriginal Health Worker or Health Practitioner may collect information

GP must see patient

Complete relevant activities and 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 PN, and at least two (2) other healthcare providers
- Not for patients in a hospital or patients in a Residential Aged Care Facility

Clinical content

- Explain steps involved in TCA, possible out of pocket costs, gain and document patient's consent
- Treatment and service goals for the patient and actions to be taken by the patient
- Discuss with patient which two (2) providers the GP will collaborate with and the treatment/services the two (2) providers will deliver
- 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 collaborating providers agreement to participate
- Obtain feedback on treatments/services two (2) collaborating providers will administer to achieve patient goals

Essential documentation requirements

- 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 and/or carer, keep copy in patient record

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
- Claiming a GPMP and TCA enables patients to receive five (5) rebated services from allied health during one (1) calendar year
- NB – Indigenous patients, refer to 715 for additional TCA eligibility
- MBS item 10991 (bulk billing incentive) may also be claimed for eligible patients

Item	Name	Recommended frequency
723	Team Care Arrangement	Two (2) yearly (min 12 monthly)

Practice Nurse Monitoring and Support

Patients with either a GPMP or a TCA can also receive monitoring and support services from a practice nurse or Aboriginal and Torres Strait Islander health practitioner on behalf of the GP (MBS item 10997) to a maximum of 5 services per patient in a calendar year.

For further information about this item on the MBS Online website click here

Reviewing a GPMP and/or TCA

Item 732

GPMP review

Nurse / Aboriginal Health Worker or Health Practitioner may collect information

GP must see patient

Claim MBS Item

TCA review

Nurse / Aboriginal Health Worker or Health Practitioner may collect information

GP must see patient

Claim MBS Item

Reviewing a GP Management Plan (GPMP)

Clinical content

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

Essential documentation requirements

- Record patient's agreement to review
- Make any required amendments to plan
- Set new review date
- Offer copy to patient and/or carer
- Keep copy in patient record

Claiming of GPMP and TCA review

- 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 three (3) months of a GPMP (Item 721) except where there are exceptional circumstances arising from a significant change in the patients clinical condition, in this case the Medicare Claim should be annotated as to why the service was required earlier.
- Item 732 can be claimed twice on the same day if review of both GPMP and TCA are completed. Medicare claim should be annotated **"Review of GPMP"** for one (1) item number and **"Review of TCA"** for other item number.

Reviewing a Team Care Arrangement (TCA)

Clinical content

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

Claiming

- Record patient's agreement to review
- Make any required amendments to plan
- Set new review date
- Offer copy to patient and/or carer
- Keep copy in patient record
- Send copy of relevant amendments of TCA to collaborating providers

Item	Name	Recommended frequency
732	Review of GP Management Plan and/or Team Care Arrangement	Six (6) monthly (minimum three (3) monthly)

MBS item 10991 (bulk billing incentive) may also be claimed for eligible patients

Further detailed information about these items can be found at
Questions and Answers on the Chronic Disease Management (CDM) items

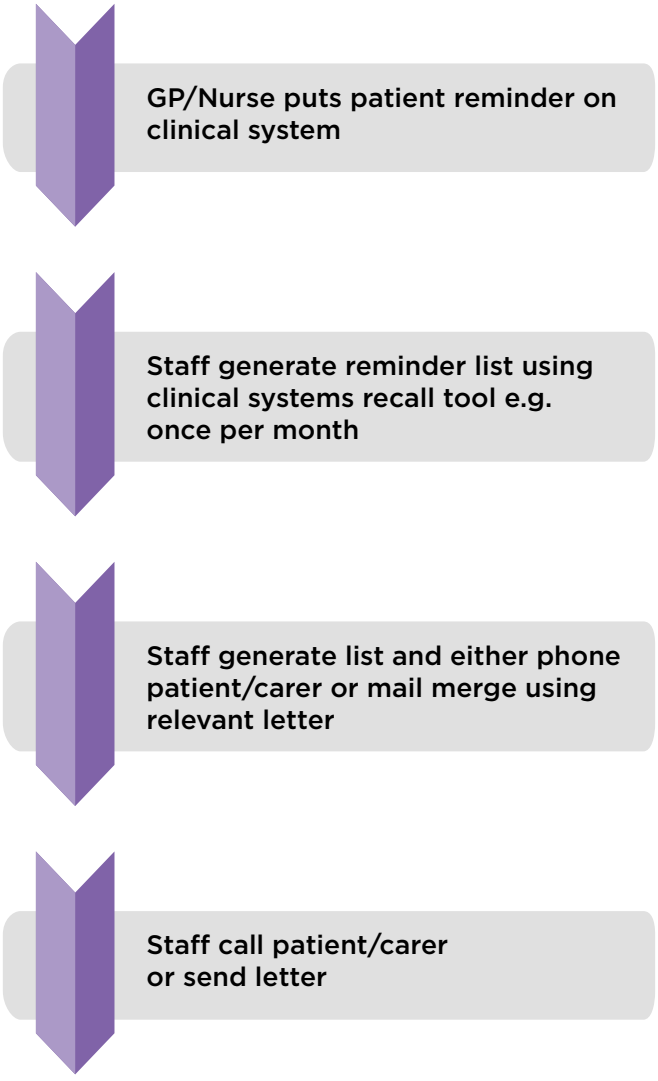
Recall and reminder systems

Reminders are used to initiate a prevention activity, before or during the patient visit. They can be either opportunistic or proactive. Recalls are a proactive follow up to a preventive or clinical activity.

Prompts are usually computer generated through clinical information systems, and designed to opportunistically draw attention during the consultation to a prevention or clinical activity needed by the patient. Using a recall system can seem complex, but there are three (3) steps you can take:

- Be clear about when and how you want to use these flags.
- Explore systems used by other practices and those endorsed by information technology specialists to ensure you get the correct system.
- Identify all the people who need to be recalled and place them in a practice register. This will help to ensure that the recall process is both systematic and complete.

Source: Putting Prevention into Practice (Green Book) http://www.racgp.org.au/your-practice/guidelines/greenbook/



PRACTICE NURSES AND CHRONIC DISEASE MANAGEMENT

Practice Nurses and Chronic Disease Management

The Workforce Incentive Program (WIP) The Workforce Incentive Program (WIP) provides targeted financial incentives to encourage doctors to deliver services in rural and remote areas. The WIP also provides financial incentives to support general practices to engage the services of nurses, Aboriginal and Torres Strait Islander Health Practitioners and Health Workers, and eligible allied health professionals.

The SNHN region is not classified as Rural so this particular stream of the WIP is not available to GPs in this region.

From early 2020, general practices participating in the Practice Nurse Incentive Program (PNIP) automatically transitioned to the WIP. An up to date rural classification system will be used to ensure metropolitan areas will no longer be able to access incentives intended for rural and remote Australia.

WIP – Practice Stream

Practices in all locations may be eligible for incentives to support the engagement of nurses, allied health professionals, and Aboriginal and Torres Strait Islander Health Practitioners or Health Workers. The WIP will expand eligibility for allied health to all areas of Australia and include pharmacists (non-dispensing role) and Nurse Practitioners to support increased team-based care arrangements. Practices will need to consider the needs of their community when determining which health professional or combination of health professionals to engage.

Guidelines: health.gov.au/internet/main/publishing.nsf/Content/work-pr-wip-workforce-incentive-program

Diabetes

It is not necessary for a doctor to perform each step for the Diabetes Annual Cycle of Care. For example, a doctor may assess a patient's condition, monitor and prescribe relevant medications. An appropriately trained and skilled Practice Nurse under GP supervision can undertake checks such as blood pressure, BMI, feet examination and review the patient's diet and exercise. The nurse will then report back to the doctor who must note that the elements of annual diabetes care have been provided. The doctor may claim only for the time in which he/she saw the patient, not the time the nurse takes to undertake checks.

Asthma

A GP is expected to provide the majority of care for the Asthma Cycle of Care. However, under doctors supervision an appropriately skilled practice nurse can provide information and reinforce key messages on asthma education, ensure the patient's record is up-to-date including medication, and undertake spirometry or peak flow testing. The doctor must be satisfied that each of the requirements has been completed and only claim for the duration of time in which they saw the patient.

Practice Nurses and Chronic Disease Management (Cont)

Cervical Screening

A practice nurse can take a cervical smear if they have undertaken appropriate training. The doctor should review the pathology results. The service can be covered by WIP funding alone, or the GP can see the patient at the conclusion of the test and claim for the length of time that the GP saw the patient. SIP item numbers still exist for completing cycles of care but will not trigger the payment to the GP. The new PIP QI incorporates the SIP payments.

Mental Health

A GP Mental Health Treatment Plan can only be provided by a GP registered with Medicare Australia; a Practice Nurse does not take part in delivery of this service.

Health Assessments

A Practice Nurse can assist the GP to conduct an annual health assessment for a patient over 75 years, a chronic disease 45-49 year check, a 40-49 year diabetes evaluation, or a Comprehensive Medical Assessment for a patient in residential aged care. The nurse can collect information for the assessment, provide lifestyle advice and education, as well as facilitate appropriate referral pathways inclusive of a multidisciplinary team. **MBS items 701- 707 apply (time based)**. *Item number 699 is not time based.*

Care Plan preparation

A nurse may assist a GP in preparing or reviewing a GP Management Plan (GPMP) or Team Care Arrangement (TCA). The 'usual' GP co-ordinates the plan for a patient with chronic disease/s and ensures that each member of the multidisciplinary team has contributed to the plan's development or review. The nurse can collect history, identify needs, goals and the actions, and make arrangements with services. The GP must review the plan with the patient before claiming the relevant item/s. **Items 721, 723 and 732 apply**.

Care Plan monitoring

Patients being managed under a GPMP-TCA may receive ongoing support and monitoring from Practice Nurses, up to five (5) times per year, on behalf of the GP who prepared the plan. **MBS nurse item 10997 applies**.

GPs and nurses should read the relevant MBS items before providing a primary care service: see www.mbsonline.gov.au and www.health.gov.au/mbsprimarycareitems.

Source: Functions of the practice nurse within general practice – North Western Melbourne PHN.

Note: The Practice Nurse item number income estimator (reproduced in this Guide) provides information regarding the financial contribution practice nurses can make when involved in providing care for patients with common chronic conditions. This calculator can be downloaded from our website.

Cycles of Care - Diabetes Annual Cycle of Care

Cycle of Care item number still exists but does not trigger a SIP for completing a cycle of care.

The aim of the Diabetes Cycle of Care is to enhance prevention, earlier diagnosis and management of people with diabetes. The GP is the coordinator of the patient care who ensures that all aspects of the Annual Cycle of Care are completed.

Patient Register and Recall and Reminder System
Recall system must include:

- A list of all known patients who have diabetes attending the practice, by name, contact number and file number,
- An active patient recall reminder system, electronic or paper based.

New MBS pathology item for diagnostic HbA1c
Medicare Benefits Schedule (MBS) pathology item **66841** was introduced on 1 November 2014: **Quantitation of HbA1c (glycated haemoglobin) performed for the diagnosis of diabetes in asymptomatic patients at high risk.**

Where a patient is unlikely to do an OGTT or is reluctant to fast, GPs now have the option of ordering HbA1c as a screening tool.

If the HbA1c is within normal limits no further testing is required.

If the HbA1c is ≥ 48mmol/mol (6.5%) diabetes is likely.

The RACGP recommends two tests on separate occasions before a diagnosis is confirmed. However, under item 66841 each patient is entitled to only one (1) Medicare-funded HbA1c diagnostic test in a 12 month period [Rule P19.1, 25.c applies]. Therefore, confirm the diagnosis either by ordering the second HbA1c test as 'management' of a patient with diabetes* or by ordering a Fasting Blood Glucose (FBG) or Oral Glucose Tolerance Test (OGTT).

- Path item 66551 (or 66554 if patient is pregnant) can be claimed up to 4 times in a 12 month period by the same patient.
- For diagnostic purposes this must be notated on the pathology request form.

Note: these MBS specific diabetes item numbers are to be used once all components of the diabetes annual cycle of care are completed (see table below).

Diabetes Annual Cycle of Care (Cont)

Ensure patient eligibility

Care requirements

This item certifies that the minimum requirements of the annual cycle of care have been completed

Eligibility criteria
- No age restrictions for patients
- Patients with established diabetes mellitus
- For patients in the community and Residential Aged Care Facilities

Essential clinical documentation requirements
- Explain Annual Cycle of Care process, gain and record patient's consent

Essential requirements: six (6) monthly
- Measure height, weight and calculate BMI
- Measure BP
- Examine feet

Essential requirements: yearly
- Measure HbA1c, total cholesterol, triglycerides and HDL cholesterol and eGFR
- Test for micro albuminuria
- 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

Essential requirements: two (2) yearly
- Comprehensive eye examination by ophthalmologist or optometrist to detect and prevent complications – requires dilation of pupils

Other requirements
- Provide self-care education – Patient education regarding diabetes management
- Review diet - reinforce information on appropriate dietary choices
- Review levels of physical activity – reinforce information on appropriate levels of activity
- Smoking status – encourage smoking cessation where relevant
- Review of medication – consider Home Medicine Review

All elements of the Cycle of Care should be completed every 12 months. Completion item numbers below.

Name	Frequency	MBS Item In Surgery	Rebate
Diabetes : Level B Standard Consult	11 – 13 monthly	2517	+Level B
Diabetes : Level C Long Consult	11 – 13 monthly	2521	+Level C
Diabetes : Level D Prolonged Consult	11 – 13 monthly	2525	+Level D

MBS item 10991 (bulk billing incentive) may also be claimed for eligible patients

Patient Education: A range of Diabetes-related information for patients is available at: ndss.com.au/my-diabetes.

Asthma Annual Cycle of Care

Cycle of Care item number still exists but does not trigger a SIP for completing a cycle of care.

Patient Eligibility

Patients must have moderate to severe asthma:

- Frequency of episodes
- Frequency of use of medication
- Bronchodilator use > three (3) times per week
- Hospital attendance following acute attack

Completion of the Asthma Cycle of Care

- The patient is required to attend two (2) asthma-related consultations; one (1) visit is opportunistic and is to be recorded, and the second visit is a planned visit for the asthma action plan to be completed.
- Consultations are attended at a minimum over a four (4) week period and not greater than 12 months for the cycle to be completed.

The visits must include:

- Diagnosis and assessment of severity
- Review of medication
- Written asthma action plan and education of the patient

Utilising a Practice Nurse for the Asthma Cycle of Care

A Practice Nurse can be used to assist the GPs with the completion of the Asthma Cycle of Care. A nurse can provide patient education, record peak-flow or spirometry results; take detailed patient and medication history and review device techniques.

Asthma Annual Cycle of Care (Cont)

TWO (2) STEP ASTHMA VISIT EXAMPLE

Visit 1:

This visit is best attended as an opportunistic visit. The clinician assesses the patient's asthma severity and knowledge of their condition. Questions that are commonly asked include:

- How do you feel your asthma is currently managed?
- How often do you take preventative or reliever medications?
- What conditions trigger your asthma symptoms?
- Do you suffer from a persistent cough?
- Do your asthma symptoms prevent you from participating in any activities?
- Do your asthma symptoms cause you to wake at night?

The patient can be encouraged to keep a symptom diary for review at next visit. This visit is recorded in the patient's file and the patient is then invited to return for a thorough assessment and development of an Asthma Action Plan

Visit 2:

The patient is booked in for a 30-40 minute visit and is advised to come to the visit having avoided any asthma- related medications on the day prior to the visit.

- A pre and post peak-flow or spirometry is attended. This is a system to both monitor lung function and also to assess medication delivery technique. The patient is educated and supported in relation to medication delivery and the best techniques to maximize effectiveness of the medications.
- Review symptom diary from visit 1.
- GP review peak-flow or spirometry results.
- Asthma Action Plan completed using the clinical software program; the action plan must be in written format and the patient must be supplied with a copy of the action plan.
- Plan is signed off by GP.

New Patient: ascertain status, including history, medication and management.

Existing Patient: assess present situation, including review of medical records and consolidation/ collection of information on history, medication and management.

Asthma may be treated in General Practice using either the **Asthma Cycle of Care** OR the **GPMP**. Both schemes **should not be claimed in the same 12 months** for the patient due to overlap in the two (2) services. If however the patient has other chronic health conditions or complex care needs requiring a **GPMP and TCA** this can be attended in addition to the **Asthma Cycle of Care**. The two (2) cannot be billed with less than a three (3) month interval between claims. Refer to Medicare Benefit Schedule for further information.

Asthma Annual Cycle of Care (Cont)

Ensure patient eligibility

Note

A specialist consultation does not constitute one (1) of the two (2) visits – both must be with the same GP or in exceptional circumstances with another GP from the same practice

Eligibility criteria

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

Essential requirements

- At least two (2) asthma consultations within 12 months
- One (1) 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 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 patient 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

Name	Frequency	MBS Item In Surgery	Rebate
Asthma: Level B Standard Consult	12 monthly	2546	+Level B
Asthma: Level C Long Consult	12 monthly	2552	+Level C
Asthma: Level D Prolonged Consult	12 monthly	2558	+Level D

MBS item 10991 (bulk billing incentive) may also be claimed for eligible patients

Multidisciplinary Case Conferences

Patients with a chronic or terminal medical condition and complex care needs requiring care or services from their usual GP and at least two (2) other health or care providers are eligible for a case conference service. There is no list of eligible conditions. However, the CDM items are designed for patients who require a structured approach and to enable GPs to plan and coordinate the care of patients with complex conditions requiring ongoing care from a multidisciplinary team.

Case conferences can be undertaken for patients in the community, for patients being discharged into the community from hospital and for people living in Residential Aged Care Facilities.

When are patients most likely to benefit from a Case Conference?

- When there is a need to develop immediate solutions in response to a recent change in the patient's condition or circumstances; e.g. death of a carer, unexpected event such as a stroke.
- To facilitate ongoing management such as sharing of information to develop or communicate goals for patient care or define relevant provider contributions to care.

How can a GP be involved in a Case Conference?

Prepare and co-ordinate a case conference
- For patients living in the community
- For private patients on discharge from hospital
- For patients in a Residential Aged Care Facility; not those receiving nursing home level care

Participate in a case conference
- For patients living in the community
- On discharge from hospital, for public or private patients
- For patients in a Residential Aged Care Facility, not those receiving nursing home level care

A case conference can occur face-to-face, by phone or by video conference, or through a combination of these. The minimum three (3) care providers (including the GP) must be in communication with each other throughout the conference. 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.

MBS item numbers for Case Conferences	GP prepares & co-ordinates			GP participates		
	15 – 20 mins	30 – 40 mins	>40 mins	15 – 20 mins	30 – 40 mins	>40 mins
Community Case Conference	735	739	743	747	750	758
Discharge Case Conference (At the invitation of the hospital)	For private patients			For public and private patients		
	735	739	743	747	750	758
RACF Case Conference	735	739	743	747	750	758

HEALTH ASSESSMENTS

HOW TO MAKE HEALTH ASSESSMENTS WORK FOR YOUR PRACTICE

Take a systematic approach to healthcare in your practice: designate the task of setting up health assessment processes in the practice:

- Obtain a list of appropriate patients (database search) that have been seen by the GP over the last 12 months
- Ensure all patients are eligible for a Health Assessment
- Set up a process for contacting patients (phone or mail)
- Ensure adequate time is allowed for each assessment; 30-90 minutes (longer for home assessments) – these provide a more thorough approach
- Identify and discuss the benefits of a Health Assessment with each patient
- Obtain patient consent
- Findings and outcomes must be discussed with the patient (and carer where appropriate)
- The GP prepares a written summary which the patient signs, including outcomes and recommendations - a copy should be offered to the patient
- Keep a copy of each assessment in patient's records
- Use a Practice Nurse to help conduct the assessments if available

If a third person is undertaking the information collection component, the GP must ensure that this person has suitable skills, experience and qualifications.

HEALTH ASSESSMENT TARGET GROUPS

Medical practitioners may select one (1) of the MBS health assessment items to provide a Health Assessment service to a member of any of the target groups listed in the following table. The Health Assessment item that is selected will depend on 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.

This excludes the Heart Health Check item number 699, which must be at least 20 minutes.

Health Assessment Item Numbers

Item	Name	Description/recommended frequency
699	Heart Health Check	**≥ 20 mins** a) collection of relevant information, including taking a patient history that is aimed at identifying cardiovascular disease risk factors, including diabetes status, alcohol intake, smoking status and blood glucose; b) a physical examination, which must include recording of blood pressure and cholesterol status; c) initiating interventions and referrals to address the identified risk factors; d) implementing a management plan for appropriate treatment of identified risk factors; e) providing the patient with preventative health care advice and information, including modifiable lifestyle factors;
701	Brief Health Assessment	**< 30 mins** a) Collection of relevant information, including taking a patient history; b) A basic physical examination; c) Initiating interventions and referral as indicated; and d) Providing the patient with preventative health care advice and information. Incorporating: **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 three (3) years. **45 – 49 year old** Once only Health Assessment for patients 45 – 49 years who are at risk of developing a chronic disease. **75 years and older** Health Assessment for patients aged 75 years and older. Once every 12 months. **Comprehensive Medical Assessment** Comprehensive Medical Assessment for permanent residents of Residential Aged Care Facilities. Available for new and existing residents. Not more than once a year. **For patient with an Intellectual Disability** Health Assessment for patients with an intellectual disability. Not more than once a year. **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). Note: Caring for Refugee Patients in General Practice is available on the RACGP website: www.racgp.org.au.

Health Assessment Item Numbers (Cont)

Item	Name	Description/recommended frequency
703	Standard Health Assessment	**30 - 45 mins** a) Detailed information collection, including taking a patient history; b) An extensive physical examination; c) Initiating interventions and referrals as indicated; and d) Providing a preventive health strategy for the patient. **Incorporating the Health Assessment categories listed in item number 701.**
705	Long Health Assessment	**45 – 60 mins** a) Comprehensive information collection, including taking a patient history; b) An extensive examination of the patient's medical condition and physical function; c) Providing a basic preventive health care strategy for the patient. **Incorporating the health assessment categories listed in item number 701.**
707	Prolonged Health Assessment	**> 60 mins** a) Comprehensive information collection, including taking a patient history; b) An extensive examination of the patient's medical condition and physical and social function; c) Initiating interventions and referrals as indicated; and d) Providing a comprehensive preventative health care management plan for the patient. **Incorporating the health assessment categories listed in item number 701.**
715	Aboriginal and Torres Strait Islander Health Assessment	**No designated time or complexity requirements** **Aboriginal and Torres Strait Islander Child** For patients 0 – 14 years old. Not available to inpatients of a hospital or RACF. Not more than once every nine (9) months. **Aboriginal and Torres Strait Islander Adult** For Aboriginal & Torres Strait Islander patients 15 – 54 years old. Not available to inpatients of a hospital or RACF. Not more than once every nine (9) months. **Aboriginal and Torres Strait Islander for an Older Person** For Aboriginal & Torres Strait Islander patients 55 years and over. Not available to inpatients of a hospital or RACF. Not more than once every nine (9) months.

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

Eligibility criteria

- Aboriginal or Torres Strait Islander persons who are aged 30 years and above
- Adults aged 45 years and above
- The absolute cardiovascular disease risk must be calculated as per the Australian Absolute Cardiovascular Disease Risk Calculator which can viewed at cvdcheck.org.au/calculator/
- Not for patients in 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, excessive weight
- Family history of chronic disease

Clinical content

Mandatory

- Explain Health Assessment process and gain consent
- Collection of relevant information including taking a patient history that is aimed at identifying cardiovascular disease risk factors, including diabetes status, alcohol intake, smoking status, cholesterol status (if not performed within the last 12 months) and blood glucose
- A physical examination, which must include recording of blood pressure
- Initiating interventions and referrals to address the identified risk factors
- Implementing a management plan for appropriate treatment of identified risk factors
- Providing the patient with preventative health care advice and information, including modifiable lifestyle factors

Non-mandatory

- Written patient information is 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

Item	Name	Age Range	Recommended frequency
699	Heart Health Assessment	• Aboriginal and Torres Strait Isander adults over 30 years • Adults over 45 years	Annually

To view / download a Health Assessment Fact Sheet click here

Health Assessment for Aboriginal & Torres Strait Islander People

Item 715

Ensure patient eligibility

Note

It may take several shorter sessions to complete the full Health Assessment with the Aboriginal or Torres Strait Islander Patient. The Practice cannot claim the 715 until all components are completed.

Complete documentation

Claim MBS Item

Eligibility criteria

- Patients 0-14years use "child" assessment
- Patients 15-54years use "adult" assessment
- Patient 55+ years use "older adult" assessment
- May be provided once every nine (9) months

Clinical content: mandatory

- Explain health assessment process and gain parent's/carer's consent
- Information collection – take patient history and undertake or arrange examinations and investigations as required
- Overall assessment of patient
- Recommend appropriate interventions
- Provide advice and information
- Keep a record of the health assessment and offer a copy of the assessment with recommendations about matters covered to the patient and/or carer

Clinical content: non mandatory

- Discuss eating habits, physical activity, speech and language development, fine and gross motor skills, behaviour and mood
- Other examinations considered necessary by GP/Practice Nurse

Essential documentation requirements

- Record parent's/carer's consent to health assessment
- Record the Health Assessment and offer the parent/carer a copy
- Update parent held child record for children under 5 years of age
- Record immunisations provided

Claiming

- All elements of the service must be completed to claim 715
- May be completed over several sessions but do not claim 715 until all components are complete

NB: Once the patient has had a 715 health assessment they are eligible for 10x follow-ups by the practice nurse
Item Number = 10 x 10987

NB: Once the patient has had a 715 health assessment they are eligible for 5 x "at risk" allied health visits
(Separate/additional to the five (5) allied health visits under TCA if the patient is diagnosed with a chronic disease)

(USE "Referral form for follow-up allied health services under Medicare for People of Aboriginal or Torres Strait Islander descent")

Item	Name	Age Range	Recommended frequency
715	Aboriginal & Torres Strait Islander Health Assessment "Child"	0 – 14 years	Every 9 months
	Aboriginal & Torres Strait Islander Health Assessment "Adult"	15 - 54 Years	Every 9 months
	Aboriginal & Torres Strait Islander Health Assessment "Older Adult"	55+ years	Every 9 months

For further information about this item on the MBS Online website click here

Health Assessment: (Type 2 Diabetes risk) 40 – 49 years

Items 701 / 703 / 705 / 707

To reduce the risk of Type 2 Diabetes

Ensure patient eligibility

Age and AUSDRISK

Attend Health Assessment

Claim MBS Item

Commence diabetes prevention or commence diabetes management

Eligibility criteria

- Non – Aboriginal & Torres Strait Islander patients aged 40 - 49 years inclusive: MBS item 701, 703, 705 or 707
- Aboriginal & Torres Strait Islander patients aged 15 to 54 years inclusive: MBS item 715
- Patients must score > 12 points on Australian Type 2 Diabetes Risk Assessment Tool (AUSDRISK)
- GP must exclude diabetes via glucose tolerance test
- Document outcomes
- Determine if diabetes prevention/lifestyle modification or diabetes management is required based on the outcomes of glucose tolerance test

Item	Name	Age Range	Recommended frequency
701 / 703 / 705 / 707	Health assessment: annotated Type 2 Diabetes risk evaluation	40 - 49 years	Once every 3 years
23	Consulting at consultation room Level B: if referral not taken up within 2 months by the patient – must be annotated with the original item number claimed when the original referral was written		

MBS item 10991 (bulk billing incentive) may also be claimed for eligible patients

Health Assessment: 45 - 49 year old

Item 701 / 703 / 705 / 707

Perform record 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 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, excess weight, impaired glucose metabolism
- Family history of chronic disease

Clinical content: mandatory

- Explain Health Assessment process and gain consent
- Information collection: take 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 Program and strategies to achieve lifestyle and behaviour changes

Clinical content: 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
- Requires personal attendance by GP with patient

Item	Name	Age Range	Recommended frequency
701 / 703 / 705 / 707	Health assessment: 45 – 49 year old	45 – 49 years	Only once

MBS item 10991 (bulk billing incentive) may also be claimed for eligible patients

To view / download a Health Assessment Fact Sheet click here

Health Assessment: 75 years and older

Item 701 / 703 / 705 / 707

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

Eligibility criteria

- Patients aged 75 years and older
- Patients seen in consulting rooms and/or at home
- Not for patients in hospital or a Residential Aged Care Facility

Clinical content: mandatory

- Explain Health Assessment process and gain patient's/carer's consent
- Information collection: take 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
- Assessment of physical function including activities of daily living and falls in the last three (3) months
- Assessment of psychological function including cognition and mood
- Assessment of 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 the patient

Clinical content: non mandatory

- Consider the need for community services, social isolation, oral health and dentition and nutrition status
- Additional matters as relevant to the patient

Claiming

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

Item	Name	Age Range	Recommended frequency
701 / 703 / 705 / 707	Health Assessment 75 years and older	75 years and older	Once every 12 months

MBS item 10991 (bulk billing incentive) may also be claimed for eligible patients

To view / download a Health Assessment Fact Sheet click here

Health Assessments for Government Humanitarian Program

Items 701, 703, 705 and 707 may be used to undertake a Health Assessment for refugees and other humanitarian entrants.

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 12 months of arrival).

In addition to general requirements for Health Assessments, the assessments must include development of a management plan addressing the patient's health care needs, health problems and relevant conditions.

The Health Assessment applies to humanitarian entrants who are residents in Australia with access to Medicare services. This includes Refugees, Special Humanitarian Program and Protection Program entrants.

Patients should be asked to provide proof of their visa status and date of arrival in Australia. Alternatively, medical practitioners may telephone Medicare Australia on 132 011, with the patient present, to check eligibility.

The medical practitioner and patient can use the service of a translator by accessing the Commonwealth Government's Translating and Interpreting Service (TIS) 131 450 and the Doctors Priority Line.

A Health Assessment for refugees and other humanitarian entrants may only be claimed once by an eligible patient.

To view / download a Health Assessment Fact Sheet click here

Health Assessments for People with an Intellectual Disability

Items 701, 703, 705 and 707 may be used to undertake a Health Assessment for people with an intellectual disability.

A person is considered to have an intellectual disability if they have significantly sub-average general intellectual functioning (two (2) standard deviations below the average intelligence quotient [IQ]) and would benefit from assistance with daily living activities. Where medical practitioners wish to confirm intellectual disability and a patient's need for assistance with activities of daily living, they may seek verification from a paediatrician registered to a practice in Australia or from a government-provided or funded disability service that has assessed the patient's intellectual function.

The health assessment provides a structured clinical framework for medical practitioners to comprehensively assess the physical, psychological and social function of a patient with intellectual disability and to identify any medical intervention and preventive health care required.

A Health Assessment for people with an intellectual disability may be claimed once every 12 months.

To view / download a Health Assessment Fact Sheet click here

Health Assessments and Chronic Disease Management Flowchart

FINDING YOUR WAY THROUGH THE MAZE.

If your patient is of **Aboriginal** and/or **Torres Strait Islander** descent...

Do an Aboriginal and Torres Strait Islander Health Assessment **item 715** → Utilise **item 10987** for follow-up by PN or Aboriginal and Torres Strait Islander Health Worker

If patient has a chronic or terminal illness, initiate a GP Management Plan **item 721** and Team Care Arrangement **item 723** as appropriate

If your patient has a **chronic condition** that has been or will be in place for six months, or has a **terminal illness**...

Do a GP Management Plan **item 721**
Review after 3–6 months using **item 732**

If your patient also has **complex care needs** necessitating the involvement of at **least two other health or care providers**

Utilise **item 10997** for follow-up by PN or Aboriginal and Torres Strait Islander Health Worker if patient has a GP Management Plan or TCA in place

Do a TCA **item 723**. Review after 3–6 months using **item 732** → **Your patient is eligible to access allied health**

If your patient has **diabetes**...

Commence a Diabetes Cycle of Care

Initiate a GP Management Plan **item 721** and Team Care Arrangement **item 723** as appropriate

If your patient has type 2 diabetes and has a GPMP in place, refer for group diabetes education

If your patient has moderate to severe **asthma**...

Commence an Asthma Cycle of Care and initiate a GP Management Plan and TCA if necessary

If patient has an additional chronic or terminal illness, initiate a GP Management Plan **item 721** and Team Care Arrangement **item 723** as appropriate

This resource must be used in conjunction with the item descriptor and explanatory notes for all items as set out in the Medicare Benefits Schedule (MBS) as claiming conditions apply.

Is your patient eligible for **any health assessments**?

If your patient is over 75 years...	Do an over 75 health assessment
If your patient was a serving member of the Australian Defence Force (ADF)...	Do an Australian Defence Force post-discharge GP health assessment
If your patient is 45–49 years with no diagnosed chronic condition...	Do a 45–49 health check
If your patient is 40–49 years and at 'high risk' of developing diabetes as defined by **ausdrisk**...	Do a type 2 diabetes risk evaluation
If your patient has an intellectual disability...	Do an intellectual disability assessment
If your patient resides in an aged care facility...	Do a comprehensive medical assessment
If your patient is a refugee or humanitarian entrant...	Do a refugee or humanitarian entrant assessment

- Brief health assessment of less than 30 minutes **item 701**
- Standard health assessment lasting more than 30 minutes but less than 45 minutes **item 703**
- Long health assessment lasting more than 45 minutes but less than 60 minutes **item 705**
- Prolonged health assessment lasting more than 60 minutes **item 707**

If your patient has a **mental health issue**...

Prepare a GP Mental Health Treatment Plan **item 2700** (if no MH skills training) or **item 2715** (if MH Skills Training) and review with **item 2712**. For ongoing management of mental health issues **item 2713**

If patient has an additional chronic illness, initiate a GP Management Plan **item 721** and Team Care Arrangement **item 723** as appropriate

Could your patient benefit from a **medication review**?

Organise a **home medication review item 900**

Case conferencing

Organise and coordinate a Case Conference **item 735, 739, or 743**
Participate in a Case Conference **item 747, 750, or 758** with two other health care providers
Consider contributing to multi-disciplinary care plan if requested by another health provider **item 729**

If your patient resides in an **aged care facility**...

Contribute to RACF Care Plan **item 731**
Review after 3–6 months using **item 731**

If your patient also has **complex care needs** necessitating the involvement of at **least 2 other health or care providers**

Your patient is eligible to access allied health

Could your patient be at 'high risk of developing type 2 diabetes? Should your patient be referred to a **lifestyle modification program**?

1. If your patient is of Aboriginal and/or Torres Strait Islander descent and aged 15–54 years, do an Aboriginal and Torres Strait Islander Health Assessment—use **ausdrisk** tool
2. If your patient is 45–49 years with no diagnosed chronic condition, do a 45 year health check—use **ausdrisk** tool
3. If your patient is 40–49 years, use **ausdrisk** tool to determine diabetes type 2 risk. If patient is at 'high risk' do a diabetes type 2 risk evaluation

If your patient is found to be at 'high risk' of developing type 2 diabetes, provide advice and information such as *My health for life* program and/or information and strategies to achieve lifestyle and behaviour changes.

Adapted from an original resource that was developed by North Queensland Primary Health Network.

Systematic care claiming rules

For the most up to date information refer to the Medicare Benefits Schedule online at www.health.gov.au/mbsonline or phone the Medicare Australia Schedule Interpretation Team on 132 150.

	Item Number	Service	Brief Guide	Claim Period
Chronic Disease Management	721	Preparation of a **General Practitioner Management Plan (GPMP)**	Patients with a chronic or terminal medical	**2 Yearly** (Minimum 12 months)
	723	Coordination of a **Team Care Arrangement (TCA)**	Patients with a chronic disease who require ongoing care from a multidisciplinary team	**2 Yearly** (Minimum 12 months)
	732	**Review** of a GPMP	Systematic review of the patient's progress against GPMP goals	**6 monthly** (Minimum 3 months)
		Coordinate a review of TCA	Systematic team based review of the patient's progress against TCA goals	
	729	**Contribution to care plan or to review the care plan** being prepared by the other provider	Not available to patients of RACF	**6 monthly** (Minimum 3 months)
	731	**Contribution to care plan or to review the care plan** for patient of RACF	Plan prepared by such a facility	**6 monthly** (Minimum 3 months)
	139	**Assessment, diagnosis and development of a treatment and management plan for a disability**	Children aged under 13 years with an eligible disability	**Once only**
Medication Reviews	900	**Domiciliary Medication Management Review (DMMR)** for patients living in the community setting.	Assessment, referral to a community pharmacy	**12 months** Except in circumstances with significant change
	903	**Residential Medication Management Review (RMMR)**	For new or existing residents of Residential Aged Care Facilities	**12 months** Except in circumstances with significant change
Practice Nurse	10987	**Monitoring and support for a person who has had a 715 Health Assessment**	715 Health Assessment on Aboriginal Torres Strait Islander people	Maximum 10per Patient per year
	10997	**Monitoring and support for a person with a chronic disease**	Patient must have GPMP, TCA or multidisciplinary care plan in place	Maximum of 5 times per patient per calendar year

Restriction of Co-claiming of Chronic Disease and General Consultation Items
Co-claiming of GP consultation items 3, 4, 23, 24, 36, 37, 44, 47, 52, 63, 54, 57, 58, 59, 60, 65, 597, 598, 599, 600, 5000, 5003, 5020, 5023, 5040, 5043, 5060, 5063, 5200, 5203, 5207, 5208, 5220, 5223, 5227 and 5228 with chronic disease management items 721, 723, or 732 is not permitted for the same patient, on the same day.

Note: CDM services can also be provided more frequently in circumstances where there has been a significant change in the patient's clinical condition or care circumstances that require a new GPMP or TCA or review service. You must mark the Medicare claim as "exceptional circumstances" or "clinically indicated".

Individual Allied Health Services under Medicare

Summary

- A Medicare rebate is available for a maximum of five (5) services per patient each calendar year. Additional services are not possible under any circumstances.
- If a provider accepts the Medicare benefit as full payment for the service, there will be no out-of-pocket cost. If not, the patient will have to pay the difference between the fee charged and the Medicare rebate.
- Patients must have a GP Management Plan and Team Care Arrangements prepared by their GP, or be residents of a Residential Aged Care Facility who are managed under a multidisciplinary care plan.
- Referrals to allied health providers must be from GPs.
- Allied health providers must report back to the referring GP.

Eligible Patients

Community-based patients may be eligible if they have a chronic (or terminal) medical condition and their GP has provided the following Chronic Disease Management (CDM) services:

- A GP Management Plan (GPMP) – (item 721) and
- Team Care Arrangements (TCAs) – (item 723).

Residents of a Residential Aged Care Facility may be eligible if their GP has contributed to a multidisciplinary care plan prepared for them by the aged care facility or to a review of the multidisciplinary care plan (item 731).

Item	Name	Recommended frequency
10950	Aboriginal Health Worker Services	Five (5) allied health services per calendar year. Can be five (5) sessions with one (1) provider or a combination (e.g. three (3) dietitian and two (2) diabetes education sessions). Referral for Allied Health Services under Medicare form for each provider. Allied Health Provider must be Medicare registered.
10951	Diabetes Educator Services	
10952	Audiologist Services	
10953	Exercise Physiologist	
10954	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	◆ Better Access to Mental Health Care items: ten sessions. ◆ GP MP and TCA for chronic medical conditions: five (5) sessions.
10968	Psychologist Services	

For more detailed information from the Australian Government Department of Health website click here

The explanatory notes and item descriptors for these items are in the Medicare Benefits Schedule (MBS) available online at www.mbsonline.gov.au/

RESIDENTIAL AGED CARE FACILITIES

Health Assessment provided as a Comprehensive Medical Assessment for residents of Residential Aged Care Facilities (RACFs)

Items 701, 703, 705 and 707 may be used to undertake a comprehensive medical assessment of a resident of a Residential Aged Care Facility.

This requires an assessment of the resident's health and physical and psychological functioning, and must include:

a) Making a written summary of the comprehensive medical assessment;
b) Developing a list of diagnoses and medical problems based on the medical history and examination;
c) Providing a copy of the summary to the residential aged care facility;
d) Offering the resident a copy of the summary.

A Residential Aged Care Facility is a facility in which residential care services, as defined in the Aged Care Act 1997, are provided. This includes facilities that were formerly known as nursing homes and hostels. A person is a resident of a Residential Aged Care Facility if they have been admitted as a permanent resident of that facility.

This Health Assessment is available to new residents on admission. It is recommended that new residents should receive the Health Assessment as soon as possible after admission, preferably within six (6) weeks following admission into a residential aged care facility.

A Health Assessment for the purpose of a comprehensive medical assessment of a resident of a residential aged care facility may be claimed by an eligible patient:

a) On admission to a residential aged care facility, provided that a comprehensive medical assessment has not already been provided in another Residential Aged Care Facility within the previous 12 months; and
b) At 12 month intervals thereafter.

Can a GP charge for a consultation as well as the CMA?
Medical practitioners should not conduct a separate consultation for any other health-related issue in conjunction with a health assessment unless it is clinically necessary (i.e. the patient has an acute problem that needs to be managed separately from the assessment).

The only exceptions are:

The comprehensive medical assessment, where, if this Health Assessment is undertaken during the course of a consultation for another purpose, the Health Assessment item and the relevant item for the other consultation may both be claimed.

Use of a specific form to record the results of the CMA is not mandatory. A Health Assessment provided as a Comprehensive Medical Assessment (CMA) may be claimed annually to an eligible patient.

Residential Aged Care Facility – Commonly used item numbers

Comprehensive Medical Assessment
Item 701 / 703 / 705 / 707

A full systems review of a permanent resident in a Residential Aged Care Facility (RACF)

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 Medical Management Review services for the resident

GP contribution or review of a Multidisciplinary Care Plan prepared by a RACF
Item 731

For patients in RACFs with a chronic or terminal condition and complex care needs requiring ongoing care from a team including the GP and at least two (2) other health or care providers. Involves GP contributing to, or reviewing, a Multidisciplinary Care Plan prepared by the RACF, at the request of the facility. The Plan must describe, at least, treatment and services to be provided to the patient by the collaborating providers. Item number 731 enables Commonwealth funded patients who are classified as low care residents to receive five (5) rebated allied health services per calendar year. The need for allied health services must be identified in the Care Plan.

Activities:

- Obtain and record the 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

GP Multidisciplinary Case Conference
Item 735 / 758

For patients in RACFs or the community or on discharge from hospital, with a chronic or terminal condition and complex care needs requiring ongoing care from a multidisciplinary case conference team including the GP and at least two (2) other health or care providers. A carer can be included as a formal member of the team, but does not count towards the minimum three (3) providers.

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, participant's 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

Time based items 747 – 758 participation required:

- Above activities excluding discussion of outcomes with patient/carer and offering summary to patient/carer and team members

Residential Medication Management Review
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
- Offer copy of Medication Management Plan to resident/carer, provide copy of resident's records and for nursing staff or RACF, discuss plan with nursing staff if necessary

Arrangements for GP Residential Aged Care Facility (RACF) services

New items for doctors' RACF services
On 1 March 2019, the Government introduced new MBS items for professional services provided by a general practitioner (GP) or medical practitioner at a RACF. The new items include a call-out fee to cover doctors' costs of travel to a RACF (MBS items 90001 and 90002), and new (standard Level A to D) attendance items.

The new items simplify claims for RACF services, and replace the derived fee payment model.

Call-out fee
The call-out items apply to a doctor's initial attendance at a RACF, and are billable only for the first patient seen on a RACF visit. Once a call-out item is billed, doctors may then bill an applicable attendance item for each of the RACF patients they see. The fees for the call-out items are $55 for GPs and $40 for other medical practitioners.

New item from 1 March 2019	Fee/Benefit	Provider
90001	$55/(100% of fee)	GP
90020	$17.20/(100% of fee)	GP
90035	$37.60/(100% of fee)	GP
90043	$72.80/(100% of fee)	GP
90051	$107.15/(100% of fee)	GP

Billing
The RACF items are only for Medicare-eligible GP and other medical practitioners providing primary care services in RACFs. Doctors employed by RACFs cannot claim the items, nor can specialists, consultant physicians, nurses and other allied health practitioners.

Item restrictions
In general, the call-out fee is intended as a one-off payment to help reimburse travel expenses, but if a doctor has to return to a RACF, on the same day and the attendances are not a continuation of an earlier episode of treatment, another call-out fee would apply per subsequent RACF visit.

Residential Medication Management Review (RMMR)

Item 903

Ensure patient eligibility

First GP visit

Discussion and referral to pharmacist

RMMR review

Conducted by accredited pharmacist

Claim MBS Item

Eligibility criteria

- New residents on admission into a RACF
- Existing residents on an 'as required' basis every 12 months or if there is a significant change in medical condition or medication regimen
- Not for respite patients in a RACF (eligible for Domiciliary Medicines Review when they are living in the community setting)

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 regime
- Finalise plan after discussion with resident
- Offer copy of plan to resident/carer
- Provide copy for resident's records, discuss plan with nursing staff if necessary

Claiming

- All elements of the service must be completed to claim
- Derived fee arrangement does not apply to RMMRs

Item	Name	Recommended frequency
903	Residential Medication Management Review	As required (payable once in a 12 month period) (Unless the medical practitioner believes there has been a significant change to a patient's condition or medicine regimen)

For further information about this item on the MBS Online website click here

PRESCRIBING / HOME MEDICINES REVIEW

Home Medicines Review - HMR

(Also known as Domiciliary Medication Management Review - DMMR)

Targeted at patients living in the community who are likely to benefit from a review and may be at risk of medication misadventure because of risk factors such as;

- Co-morbidities
- Age or social circumstances
- Characteristics of their medicines
- Complexity of their medication regime
- Lack or skills or knowledge to use medicines to their best effect

Examples of risk factors include:

- Currently taking five (5) or more medications
- Taking more than 12 doses of medication per day
- Medications with a narrow therapeutic index or medications requiring therapeutic monitoring
- Significant changes to medication treatment in the last three (3) months
- Suspected non-compliance
- Difficulty managing medication dues to literacy difficulties, cognitive difficulties, or physical difficulties
- Recent discharge from a facility/hospital (in the last four (4) weeks)

In conducting a DMMR, a medical practitioner must:

- Assess a patients medication management needs;
- Following that assessment, refer the patient to a community pharmacy or an accredited pharmacist for DMMR;
- With the patient's consent, provide relevant clinical information required for the review;
- Discuss with the reviewing pharmacist the results of that reviews, including suggested medication management strategies;
- Develop a written medication management plan following discussion with the patient.

Home Medicines Review (Cont)

Item 900

Ensure patient eligibility

First GP visit

Discussion and referral to pharmacist

HMR review

Conducted by accredited pharmacist

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 Residential Aged Care Facility

Initial visit

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

HMR Interview

- Pharmacist holds review in patient's home unless prior approval is sought by the pharmacist
- 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 Visit

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

Claiming

- All elements of the service must be completed to claim
- Patient must be seen by the GP at the time of claiming

Item	Name	Recommended frequency
900	Home Medicine Review	Once every 12 months (Unless the medical practitioner believes there has been a significant change to a patient's condition or medicine regimen)
CP42	Medication Review DVA Patient	Once every six (6) months GP is required to ring Veteran Affairs Pharmaceutical Advisory Centre (VAPAC) 1800 552 580 for Authority Prescriptions for 6months of DAA service and discuss suitability with pharmacist or an accredited pharmacist

MBS item 10991 (bulk billing incentive) may also be claimed for eligible patients

For further information about this item on the MBS Online website click here

INCENTIVE PROGRAMS

Practice Incentive Program and Service Incentive Payments

Payments Summary

Item	Activity	Item number & type of consultation	PIP ($ PER SWPE)	Notes (PIP Enquiry Line 1800 222 032) humanservices.gov.au
My Health Record	**Requirement 1:** Integrating Healthcare Identifiers into Electronic Practice Records. **Requirement 2:** Secure messaging capability. **Requirement 3:** Data records and clinical coding. **Requirement 4:** Electronic transfer prescriptions. **Requirement 5:** My Health Record system.		$6.50 per SWPE, per annum Capped at $12,500 per quarter	To qualify, practices must meet each of the requirements: **Requirement 1:** • Apply for a Health Care Provider Identifier-Organisation (HPI-O) • Ensure each GP within the practice has a Healthcare Provider Identifier –Individual (HPI-I) • Use a compliant clinical software system to access, retrieve and store verified individual Healthcare Identifiers (IHI) for patients **Requirement 2:** • Apply for a NASH PKI Certificate • Have a standards-compliant secure messaging capability and use it where feasible • Work with your secure messaging vendor to ensure it is installed and configured correctly • Have a written policy to encourage its use **Requirement 3:** • 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 • Provide written policy to this effect to all GPs **Requirement 4:** • Use a software system that is able to send an electronic prescription to a Prescription Exchange Service (PES) • The majority of prescriptions are sent electronically to a (PES) **Requirement 5:** • Use compliant software to access the My Health Record system and create and post Shared Health Summaries (SHS) and Event Summaries • Apply to participate in the My Health Record system upon obtaining a HPI-O • Upload Shared Health Summaries for a minimum of 0.5 % of the practice's SWPE count of patients per PIP payment quarter Please refer to the ePIP incentive guidelines released by Medicare Australia: servicesaustralia.gov.au/organisations/health-professionals/services/medicare/practice-incentives-program

Practice Incentive Program and Service Incentive Payments (Cont)

Item	Activity	Item number & type of consultation	PIP ($ PER SWPE)	Notes (PIP Enquiry Line 1800 222 032) humanservices.gov.au
Quality Improvement	The PIP QI Incentive rewards practices for participating in continuous quality improvement activities in partnership with their local PHN		Maximum payment of $12,500 per quarter, based on $5.00 SWPE	To be eligible to receive PIP QI payment, general practices must: • Be eligible for the PIP • Register for the PIP QI Incentive (via PRODA) from 01/08/19 • Electronically submit the de-identified PIP Eligible Data Set to their local PHN quarterly via agreed Data Extraction Tool • Undertake continuous quality improvement activities in partnership with their local PHN. **Commenced on 1 August 2019.** Further informtion: https://www1.health.gov.au/internet/main/publishing.nsf/Content/PIP-QI_Incentive_guidance
Teaching	Aims to encourage general practices to provide teaching sessions to undergraduate and graduate medical students preparing for entry into the Australian Medical profession		$100.00 per session	Practices can access a maximum of $100.00 for each three hour teaching session provided to medical students. Each practice can claim a maximum of two sessions per GP, per day.
Aged Care Access	**Tier 1:** GP completes the Qualifying Service Level (QSL) 1 – 60 MBS services in RACF claimed in a financial year. **Tier 2:** GP completes the Qualifying Service Level (QSL) 2 – 140 MBS services in RACF claimed in a financial year.			MBS items that count towards QSLs include attendances in RACF, contributions to multidisciplinary care plans and Residential Medication Management Reviews. GPs need to provide the service using their PIP linked Medicare provider number. 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.
Idigenous Health	Provision of better health care for Indigenous patients, including best practice management of chronic disease. Sign-on payment.		$1,000	One-off payment only. Practice must be registered for PIP. The practice must: • seek consent to register their Aboriginal and/or Torres Strait Islander (ATSI) 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 • establish a mechanism to ensure their ATSI patients aged 15 years and over with chronic disease, are followed up e.g. recall/reminder system to ensure they return for ongoing care • undertake cultural awareness training within 12 months of joining incentive • annotate PBS prescriptions for eligible ATSI patients for the PBS Co-payment

Practice Incentive Program and Service Incentive Payments (Cont)

Item	Activity	Item number & type of consultation	PIP ($ PER SWPE)	Notes (PIP Enquiry Line 1800 222 032) humanservices.gov.au
Indigenous Health (cont'd)	Annual patient registration payments		$250.00 per registered ATSI patient, per calendar year	• Practice registers their eligible ATSI patients with Medicare for the PIP Indigenous Health Incentive or PBS Co-payment measure • Practice must actively plan and manage care of their ATSI patients with chronic disease for a calendar year • Payment made to practice for each ATSI patient who: > Is aged 15 years or over & has chronic disease > Has had (or has been offered) the 715 ATSI Health Assessment > Has provided informed consent to be registered for the PIP Indigenous Health Incentive • The patient's registration period commences from the day 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: Outcomes payment: Chronic Disease Management		$100.00 per registered patient per calendar year.	Payment made to practices that (in a calendar year): • 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 • Undertake two 732 Reviews of GPMP or TCA; or • Complete 731 contribute to, or review, a care plan for a patient in a RACF, on two occasions
	Tier 2: Outcomes payment: Total Patient Care		$150.00 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 minimum of 5 MBS services) in a calendar year. This may include the MBS services provided for Tier 1.
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 servicesaustralia.gov.au/organisations/health-professionals/services/medicare/workforce-incentive-program-wip-practice-stream for complete WIP guidelines.

Practice Incentive Program and Service Incentive Payments (Cont)

Item	Activity	Item number & type of consultation	PIP ($ PER SWPE)	Notes (PIP Enquiry Line 1800 222 032) humanservices.gov.au

After Hours Incentive

The After Hours Incentive aims to support general practices to provide their patients with appropriate access to after hours care.

After hours periods:

For PIP the complete after hours period is:
- Outside 8 am to 6 pm weekdays
- Outside 8 am to 12 noon on Saturdays
- All day on Sundays and public holidays

The complete after-hours period is broken into:
- Sociable after hours period: 6 pm to 11 pm weeknights
- Unsociable after hours period: 11 pm to 8 am weekdays, hours outside of 8 am and 12 noon Saturdays, and all day Sundays and public holidays

Core Eligibility Requirements

To be eligible for the PIP After Hours Incentive, practices must meet hte following core eligibility requirements:

1. Be registered for the PIP and meet the requirements for the payment level claimed for the entire quarter before the payment month
2. Provide after hours care for patients in accordance with the RACGP Standards for general practices
3. Clearly communicate after hours arrangements to patients, including information available within the practice, on the practice website or through a telephone answering machine

Guidelines and requirements for the new PIP After Hours Incentive are available at the Department of Human Services website. Please visit humanservices.gov.au/health-professionals/services/practice-incentives-programme/pip-after-hours-incentive or contact the PIP Enquiry Line on 1800 222 032.

Payment level and amount	Description
Level 1 Participation $1 per SWPE	Practices must have formal arrangements in place to ensure that practice patients have access to care in the complete after hours period (hours outside of 8 am to 6pm weeknights; hours outside of 8am to 12 pm Saturdays; and all day Sundays and public holidays).
Level 2 Sociable after hours cooperative coverage $4 per SWPE	Practices must participate in cooperative arrangement with other general practices that provide after hours care to practice patients in the sociable after hours period (6pm to 11 pm weeknights) and ensure formal arrangements are in place to cover the unsociable after hours period (11pm to 8am weekdays, hours outside of 8 am to 12 pm Saturdays and all day Sundays and public holidays).
Level 3 Sociable after hours practice coverage $5.50 per SWPE	Practices must provide after hours care to practice patients directly through the practice in the sociable after hours period (6pm to 11pm weeknights); and ensure formal arrangements are in place to cover the unsociable after hours period (11pm to 8am weekdays, hours outside of 8am and 12pm Saturdays and all day Sundays and public holidays).
Level 4 Complete after hours cooperative coverage $5.50 per SWPE	Practices must participate in a cooperative arrangement with other general practices that provides after hours care to practice patients for the complete after hours period (hours outside of 8 am to 6pm weeknights; hours outside of 8am to 12 pm Saturdays; and all day Sundays and public holidays).
Level 5 Complete after hours practice coverage $11 per SWPE	To be eligible for the Level 5 Complete After Hours Practice Coverage Payment, practices must provide after hours care to practice patients in the complete after hours period (hours outside of 8 am to 6 pm weeknights; hours outside of 8 am to 12 pm Saturdays; and all day Sundays and public holidays).

CANCER SCREENING

Cervical screening

In December 2017, the Cervical Screening Test replaced the Pap test in Australia.
Cervical cancer is one of the most preventable cancers. Routine cervical screening is the best protection against cervical cancer. The Cervical Screening Test is expected to protect up to 30% more women.

The Cervical Screening Test is more effective than the Pap test at preventing cervical cancers, because it detects the human papillomavirus (known as HPV), whereas the Pap test looked for cell changes in the cervix. HPV is a common infection that can cause cervical cell changes that may lead to cervical cancer. The new test is just as safe to be done every five years instead of every two.

Patient Eligibility

- Women between 24 years and 9 months and less than 74 years
- 'Under screened' women who have not had a cervical smear in the last four years

Self Collection

Self collection of a sample for screening is only available for women between the ages of 30 and 74 years of age who are overdue for screening by two or more years (i.e. being 4 years since their last Pap test). Self collection should only be offered to an eligible person who refuses to have a sample collected by their requesting practitioner.

Cervical screening (Cont)

Item	Activity	Description
2497	Level A Cervical Screening	Short surgery consultation: see MBS for complexity of care requirements. Screening of a woman aged at least 24 years and 9 months but less than 75 years of age who is 'under-screened'.
2501	Level B Cervical Screening	<20 min surgery consultation: see MBS for complexity of care requirements. Screening of a woman at least 24 years and 9 months but less than 75 years of age who is 'under-screened'.
2503	Level B Cervical Screening	< 20 min out of surgery: see MBS for complexity of care requirements. Screening of a woman aged at least 24 years and 9 months but less than 75 years of age who is 'under-screened'.
2504	Level C Cervical Screening	> 20 min surgery consultation: see MBS for complexity of care requirements. Screening of a woman aged at least 24 years and 9 months but less than 75 years of age who is 'under-screened'.
2506	Level C Cervical Screening	> 20 min out of surgery: see MBS for complexity of care requirements. Screening of a woman aged at least 24 years and 9 months but less than 75 years of age who is 'under-screened'.
2507	Level D Cervical Screening	> 40 min surgery consultation: see MBS for complexity of care requirements. Screening of a woman aged at least 24 years and 9 months but less than 75 years of age who is 'under-screened'.
2509	Level D Cervical Screening	> 40 min out of surgery: see MBS for complexity of care requirements. Screening of a woman aged at least 24 years and 9 months but less than 75 years of age who is 'under-screened'.

Cervical screening resources

Resource details	Publication details
Various information resources	NSW Cervical Screening Program 131 556 or csp.nsw.gov.au
National Cancer Screening Register	ncsr.gov.au P: 1800 627 701

MENTAL HEALTH

MBS Better Access Initiative

The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access) initiative aims to improve outcomes for people with a clinically-diagnosed mental disorder through evidence-based treatment. Under this initiative, Medicare rebates are available to patients for selected mental health services provided by general practitioners (GPs), psychiatrists, psychologists (clinical and registered) and eligible social workers and occupational therapists.

What Medicare services can be provided under the Better Access initiative?

Medicare rebates are available for up to ten individual* and ten group allied mental health services per calendar year to patients with an assessed mental disorder who are referred by:

- A GP managing the patient under a GP Mental Health Treatment Plan or
- Under a referred psychiatrist assessment and management plan or
- A psychiatrist or paediatrician.

For more information about the Better Access Initiative go to the Department of Health website.

**From 9 October 2020 until 30 June 2022, 10 additional individual psychological therapy sessions, previously available only to people whose movement was restricted by a state or territory public health order, are now available each calendar year to all eligible patients under the existing Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS (Better Access) initiative. Full change descriptor can be found here: mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/240DC3AF97EEAF79CA2585BC00827909/$File/Factsheet-Practitioners-Mental-Health-Services-COVID-19.pdf.*

SHORT TERM PSYCHOLOGICAL THERAPIES

Description of Services

There are three (3) categories of services available for Short term psychological therapies.

- **Short term psychological therapies** provided to people who have mild to moderate mental illness, or are at risk of suicide or self-harm.
- **Group therapy programs** for people with mild to moderate mental illness who would benefit from group therapy. Available groups include: Perinatal depression, Dialectical Behavioural Therapy for young people and adults and Hoarding Disorder treatment.
- **Short term psychological therapies** for people from a Chinese background, including culturally appropriate services in English, Cantonese, Mandarin and Shanghainese.

For more information please go to our website:
http://sydneynorthhealthnetwork.org.au/mentalhealthtriage/short-term-psychological-therapies/

Mental Health item numbers

Item	Name	Description/recommended frequency
2700	GP Mental Health Treatment Plan	Prepared by GP who has not undertaken Mental Health Skills Training. Assessment of patient taking between 20 – 39 mins. Not more than once yearly.
2701	GP Mental Health Treatment Plan	Prepared by GP who has not undertaken Mental Health Skills Training. Assessment of patient taking more than 40 mins. Not more than once yearly.
2715	GP Mental Health Treatment Plan	Prepared by GP who has undertaken Mental Health Skills Training. Assessment of patient taking between 20 – 39 mins. Not more than once yearly.
2717	GP Mental Health Treatment Plan	Prepared by GP who has undertaken Mental Health Skills Training. Assessment of patient taking more than 40 mins. Not more than once yearly.
2712	Review of GP Mental Health Treatment Plan	Plan should be reviewed after one (1) – six (6) months.
2713	GP Mental Health Consultation	Consult > 20 mins for the ongoing management of a patient with a mental disorder. No restriction on the number of these consultations per year.
2721	GP focused Psychological Strategies	30 – 40 mins. Provision of focused psychological strategies by an appropriately trained and registered GP working in an accredited practice.
2723	GP focused Psychological Strategies	Out of surgery consultation. 30 – 40 mins. Provision of focused psychological strategies by an appropriately trained and registered GP working in an accredited practice.
2725	GP focused Psychological Strategies	> 40 mins. Provision of focused psychological strategies by an appropriately trained and registered GP working in an accredited practice.
2727	GP focused Psychological Strategies	Out of surgery consultation > 40 mins. Provision of focused psychological strategies by an appropriately trained and registered GP working in an accredited practice.

Preparation of a Mental Health Treatment Plan

Items 2700, 2701, 2715 & 2717

Preparation of a GP Mental Health Treatment Plan involves both assessing the patient and preparing the GP Mental Health Treatment Plan document.

What must be included in the Assessment?
Assessment of a patient for the GP Mental Health Treatment Plan 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.

A formulation is important for the development of a GP Mental Health Treatment Plan and includes an assessment of the biological, psychological and social factors predisposing, precipitating and/or protecting against a mental health problem.

Where the patient has a carer, the GP may find it useful to have the carer present for the assessment or components thereof (subject to patient agreement). The assessment can be part of the same consultation in which the GP Mental Health Treatment Plan is developed, or they can be undertaken in different visits.

Where separate visits are undertaken for the purpose of assessing the patient and developing the GP Mental Health Treatment Plan, they are part of the GP Mental Health Treatment Plan service and are included in items 2700, 2701, 2715 or 2717. That is, for separate visits that are undertaken to assess the patient and develop the plan, no MBS item would be claimed for the first visit and item 2700, 2701, 2715 or 2717 would be claimed for the second visit (see A.40.9 to A.40.17 of the Explanatory Notes of the Nov 2009 MBS Book).

What must a GP Mental Health Treatment Plan include?
The development of a mental health plan must include:

- Discussion of the assessment with the patient, including the mental health formulation and/or 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;
- 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; and
- Offering a copy of the written GP Mental Health Treatment Plan to the patient and/or carer (with patient's agreement).

A GP Mental Health Treatment Plan sample template for the Better Access Program can be accessed here.

Can a Practice Nurse assist with the Plan?
All consultations conducted as part of the GP Mental Health Care items must be rendered by the GP. A specialist mental health nurse, other allied health practitioner or Aboriginal Health Worker with appropriate mental health qualifications and training may provide general assistance to GPs in provision of mental health care where the GP considers that they have skills appropriate to the assistance required.

Review of a Mental Health Treatment Plan

Item 2712

The review is the key component for assessing and managing the patient's progress once a GP Mental Health Treatment Plan has been prepared, along with ongoing management through the GP Mental Health Consultation item and/or standard consultation items. A patient's GP Mental Health Treatment Plan should be reviewed at least once.

What must the review include?
The review stage must include:

- Recording the patient's agreement for the service;
- Reviewing the patient's progress against the goals outlined in the GP Mental Health Treatment Plan;
- Modifying the 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;
- Re-administration of the outcome measurement tool used in the assessment stage, except where considered clinically inappropriate.

Note: This review is a formal review point only and it is expected that in most cases there will be other consultations between the patient and the GP as part of the ongoing management.

When should a review of a GP Mental Health Care be done?
The initial review should take place a minimum of four (4) weeks and a maximum of six (6) months after the completion of a GP Mental Health Treatment Plan. If required, an additional review three (3) months after the first review is allowed within a 12 month period.

GP Mental Health Care Consultation: Item 2713

When can I use the GP Mental Health Care Consultation item?
The GP Mental Health Care Consultation item applies to surgery consultations, which are of at least 20 minutes duration and where the primary treating problem is related to a mental disorder.

This item is for the ongoing management of patients with a mental disorder, including patients being managed under a GP Mental Health Treatment Plan. However, it can be used whether or not a patient has a mental health Treatment Plan. This item should not be used for the patient assessment or preparation of a GP Mental Health Treatment Plan. There are no restrictions on how often this item can be used.

What must a GP Mental Health Care Consultation 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; and
- Documenting the outcomes of the consultation in the patient's medical records and other relevant mental health plan (where applicable).

A patient may be referred from a GP Mental Health Care Consultation for other treatment and services as per normal GP referral arrangements. This does not include referral for Medicare rebate-able services by focused 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 (item 291).

REFERRAL AND TREATMENT OPTIONS

Medicare Items for Psychologists and Other Allied Mental Health Professionals
Once a GP Mental Health Treatment Plan (item 2700, 2701, 2715 & 2717) or a referred psychiatrist assessment and management plan (item 291) has been completed and claimed on Medicare, patients are eligible to receive up to 10 individual and 10 group allied mental health services per calendar year.

GP Mental Health Treatment: Plan and Review

Item 2700/2701/2715/2717/2712
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

Only a specialist Mental Health Nurse may assist in the development of the 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
- Not for patients in a hospital or a 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 psychological 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 the GP Mental Health Treatment Plan
- Document diagnosis of mental disorder
- Results of outcome measurement tool
- Patient's needs and goals, patient actions and treatments/services required
- Set review date
- Offer copy to patient (with consent, offer to carer) keep copy in file

Claiming
- All elements of the service must be completed to claim
- Review using 2712 at least once during the life of the plan
- Requires personal attendance by GP with patient
- Claiming a 2700 / 2701 / 2712 / 2717 enables patients to receive up to ten (10) rebated individual and up to ten (10) group psychology services per calendar year

Item	Name	Recommended frequency
2700 / 2701 / 2715 / 2717	GP Mental health Treatment Plan	Not more than once yearly

MBS item 10991 (bulk billing incentive) may also be claimed for eligible patients

GP Mental Health Treatment: Plan and Review (Cont)

2712 Review of a GP Mental Health Treatment Plan

Reviewing the plan

Only a specialist Mental Health Nurse may assist in the review of 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 psychological education
- Plan for crisis intervention and/or relapse prevention if appropriate and if not previously provided
- Re-administered the outcome measurement tool used when developing the GP Mental Health Treatment Plan (Item 2007 / 2701 / 2715 / 2717), except where considered clinically appropriate

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
- Claiming a 2712 enables patients to receive a second set of six (6) individual or six (6) group psychology services
- Item 2712 should be claimed at least once over the life of the GP Mental Health Treatment Plan
- A review can be claimed one (1) – six (6) months after completion of the GP Mental Health Treatment Plan if required and additional review can be performed three (3) months after the first review

Item	Name	Recommended frequency
2712	Review of GP Mental Health Treatment Plan	1 – 6 months after GP Mental Health Treatment Plan

MBS item 10991 (bulk billing incentive) may also be claimed for eligible patients

Checklist for GP Mental Health Treatment Plan

Assessment (As part of a GP Mental Health Treatment Plan) The assessment should include:	◆ Patient's agreement for the GP Mental Health Treatment Plan service ◆ Relevant history ◆ Mental state examination ◆ Assess risk and co-morbidity ◆ A diagnosis and/or formulation ◆ Administer outcome measurement tool (unless clinically inappropriate)
Plan The Plan should include:	◆ Discussion of the assessment with the patient, including the mental health formulation and/or diagnosis ◆ Identifying and discussing referral and treatment options with the patient ◆ Agreeing goals with the patient ◆ Provision of psycho-education ◆ Crisis intervention and/or for relapse prevention plan if appropriate ◆ Referrals, treatment, appropriate support services, review and follow-up ◆ Documenting results in the patient's GP Mental Health Treatment Plan ◆ Offer a copy of the plan to the patient
Review The Review should include:	◆ Recording the patient's agreement for this service ◆ Review patient's progress against the goals outlined in the GP Mental Health Treatment Plan ◆ Modify GP Mental Health Treatment Plan if required ◆ Check, reinforce and expand education ◆ Crisis intervention and/or relapse prevention plan if appropriate and if not previously provided ◆ Re-administration of the outcome measurement tool (unless clinically inappropriate) **The Review is conducted one (1) month to six (6) months from when the GP Mental Health Treatment Plan was prepared**
Consultation The Consultation should 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 of treatment ◆ Documenting the outcomes of the consultation in the patient's medical records and other relevant mental health plan (where applicable)

MENTAL STATE EXAMINATION	
Appearance and General Behaviour	**Mood** (Depressed / Labile)
Thinking (Content / Rate / Disturbances)	**Affect** (Flat / Blunted)
Perception (Hallucinations etc.)	**Sleep** (Initial Insomnia / Early Morning Wakening)
Cognition (Level of Consciousness / Delirium / Intelligence)	**Appetite** (Disturbed Eating Patterns)
Attention / Concentration	**Motivation / Energy**
Memory (Short and Long term)	**Judgement** (Ability to make rational decisions)
Insight (capacity to organise and understand problem, symptom or illness)	**Anxiety Symptoms** (Physical and Emotional)
Orientation (Time / Place / Person)	**Speech** (Volume / Rate / Content)

PROCEDURAL ITEMS

Procedural item numbers

Dislocations

Item	Service or Procedure
47018	ELBOW, treatment of dislocation of, by closed reduction
47036	INTERPHALANGEAL JOINT, treatment of dislocation of, by closed reduction
47000	MANDIBLE, treatment of dislocation of, by closed reduction
47042	METACARPOPHALANGEAL JOINT, treatment of dislocation of, by closed reduction
47057	PATELLA, treatment of, by closed reduction
47024	RADIOULNAR JOINT, DISTAL or PROXIMAL, treatment of dislocation of, by closed reduction, not being a service associated with fracture or dislocation in the same region
47015	SHOULDER, treatment of dislocation of, not requiring general anesthesia
47069	TOE, treatment of dislocation of by closed reduction

Fractures

Item	Service or Procedure
47354	CARPAL SCAPHOID, treatment of fracture of, not being a service to which item 47357 applies
47348	CARPUS (excluding scaphoid), treatment of fracture of, not being a service to which item 47351 applies
47462	CLAVICLE, treatment of fracture of, not being a service to which item 47465 applies
47516	FEMUR, treatment of fracture of, by closed reduction or traction
47576	FIBULA, treatment of fracture of
47444	HUMERUS, shaft of, treatment of fracture of, not being a service to which item 47447 or 47450 applies
47633	METATARSAL, one (1) of, treatment of fracture of
47636	METATARSAL, one (1) of, treatment of fracture of, by closed reduction
47579	PATELLA, treatment of fracture of, not being a service to which item 47582 or 47585 applies
47663	PHALANX OF GREAT TOE, treatment of fracture of, by closed reduction
47546	TIBIA, plateau of, treatment of medial or lateral fracture of, by closed reduction
47543	TIBIA, plateau of, treatment of medical or lateral fracture of, not being a service to which item 47546 or 47549 applies
47561	TIBIA, shaft of, treatment of, by cast immobilization, not being a service to which item 47564, 47567, 47570 or 47573 applies
47564	TIBIA, shaft of, treatment of fracture of, by closed reduction, with or without treatment of fibular fracture

Procedural item numbers (Cont)

Obstetrics

Item	Service or Procedure
16500	ANTENATAL ATTENDANCE
16407	POSTNATAL ATTENDANCE by a GP or obstetrician

Operations

Item	Service or Procedure
30219	HAEMATOMA, FURUNCLE, SMALL ABSCESS OR SIMILAR LESION not requiring admission to a hospital – INCISION WITH DRAINAGE OF (excluding after-care)
51300	Assistance at any operation identified by the word "assist" for which the fee does not exceed $558.30 or at a series or combination of operations identified by the word "assist" where the fee for the serious or combination of operations identified by the word "assist" does not exceed $558.30
51306	Assistance at the delivery involving Caesarean section
30071	DIAGNOSTIC BIOPSY OF SKIN OR MUCOUS MEMBRANE, as an independent procedure, where the biopsy specimen is sent for pathological examination
41500	EAR, foreign body (other than ventilating tube) in, removal of, other than by simply syringing
41659	NOSE, removal of FOREIGN BODY IN, other than by simple probing
30064	SUBCUTANEOUS FOREIGN BODY, removal of, requiring incision and exploration, including closure of wound if performed, as an independent procedure
30061	SUPERFICIAL FOREIGN BODY, REMOVAL OF, (including from cornea or sclera), as an independent procedure
30216	HAEMATOMA, aspiration of
47915	INGROWING NAIL OF TOE, wedge resection for, including removal of segment of nail, ungula fold and portion of the nail bed
42575	TARSAL CYST, extirpation of
46513	DIGITAL NAIL OF FINGER OR THUMB, removal of, not being a service to which item 46516 applies
47904	DIGITAL NAIL OF TOE, removal of, not being a service to which item 47906 applies

Procedural item numbers (Cont)

Operations (Cont)

Item	Service or Procedure
30195	BENIGN NEOPLASM OF SKIN, other than viral verrucae (common warts) seborrheic keratosis, cysts and skin tags, treatment by electrosurgical destruction, simple curettage or shave excision, or laser photocoagulation, not being a service to which item 30196, 30197, 30202, 30203 or 30205 applies (one (1) or more lesions)
32147	PERIANAL THROMBOSIS, incision of
30186	PALMAR OR PLANTAR WARTS (less than ten), definitive removal of, excluding ablative methods alone, not being a service to which item 30185 or 30187 applies
30099	SINUS, excision of, involving superficial tissue only
45400	FREE GRAFTING (split skin) of a granulating area, small
45200	SINGLE STAGE LOCAL FLAP, where indicated to repair one (1) defect, simple and small, excluding flap for male pattern baldness and excluding H-flap or double advancement flap not in association with any of items 31356 to 31376
30213	TELANGIECTASES OR STARBURST VESSELS on the head or neck where lesions are visible from four (4) metres, diathermy or sclerosant injection of, including associated consultation – limited to a maximum of six (6) sessions (including any session to which items 14100 to 14118 and 30213 apply) in any 12 month period – for a session of at least 20 minutes duration

Pathology or diagnostic tests

Item	Service or Procedure
13839	ARTERIAL PUNCTURE and collection of blood for diagnostic purposes
11707	TWELVE-LEAD ELECTROCARDIOGRAPHY, trace only
73806	Pregnancy test by one (1) or more immunochemical methods
12000	SKIN SENSITIVITY TESTING for allergens, using one (1) to 20 allergens, other than a service associated with a service to which item 12012, 12017, 12021, 12022 or 12024 applies
11505	MEASUREMENT OF RESPIRATORY FUNCTION involving a permanently recorded tracing performed before and after inhalation of bronchodilator – each occasion at which one (1) or more such tests are performed. Performed to confirm diagnosis of asthma, COPD, or another cause of airflow limitation.
11506	MEASUREMENT OF RESPIRATORY FUNCTION involving a permanently recorded tracing performed before and after inhalation of bronchodilator – each occasion at which one (1) or more such tests are performed

Procedural item numbers (Cont)

Procedures

Item	Service or Procedure
30003	LOCALISED BURNS, dressing of, (not involving grafting) each attendance at which the procedure is performed, including any associated consultation
14206	HORMONE OR LIVING TISSUE IMPLANTATION by cannula
14203	HORMONE OR LIVING TISSUE IMPLANTATION, by direct implantation involving incision & suture
30628	HYDROCELE, tapping of
35503	INTRAUTERINE CONTRACEPTIVE DEVICE, INTRODUCTION OF, not being a service associated with a service to which another item in this group applies (other than a service mentioned in item 30062)
32072	SIGMOIDOSCOPIC EXAMINATION (with rigid sigmoid scope), with or without biopsy
30207	SKIN LESIONS, multiple injections with hydrocortisone or similar preparations

Skin lesions, excisions, biopsies and wounds

Item	Service or Procedure	Size of lesion	Schedule Fee	85% rebate
Benign skin lesions (other than common warts and seborrheic keratosis) for diagnostic purposes				
31357	Nose, eyelid, eyebrow, lip, ear, digit, genitalia or a contiguous area	<6mm	$109.70	$93.25
31360	Nose, eyelid, eyebrow, lip, ear, digit, genitalia or a contiguous area	6mm +	$168.05	$142.85
31362	Face, neck, scalp, nipple-areola, distal lower/upper limb	<14mm	$133.90	$113.85
31364	Face, neck, scalp, nipple-areola, distal lower/upper limb	14mm +	$168.05	$142.85
31366	Body, other than above	<15mm	$95.45	$81.15
31368	Body, other than above	15 - 30mm	$125.55	$106.75
31370	Body, other than above	>30mm	$143.55	$122.05

Item	Service or Procedure	Size of lesion	Schedule Fee	85% rebate
Malignant skin lesions (malignancy confirmed from the excised specimen or previous biopsy)				
31356	Nose, eyelid, eyebrow, lip, ear, digit, genitalia or a contiguous area	<6mm	$221.35	$188.15
31358	Nose, eyelid, eyebrow, lip, ear, digit, genitalia or a contiguous area	6mm +	$270.85	$230.25
31361	Face, neck, scalp, nipple-areola, distal lower/upper limb	<14mm	$186.70	$158.70
31363	Face, neck, scalp, nipple-areola, distal lower/upper limb	14mm+	$244.30	$207.70
31365	Body, other than above	<15mm	$158.30	$134.60
31367	Body, other than above	15 - 30mm	$213.60	$181.60
31369	Body, other than above	>30mm	$245.90	$209.05

Procedural item numbers (Cont)

Skin lesions, excisions, biopsies and wounds (Cont)

Item	Service or Procedure	Size of lesion	Schedule Fee	85% rebate
Malignant melanoma, appendageal carcinoma, connective tissue tumour of skin or merkel cell carcinoma of skin (malignancy confirmed from the excised specimen or previous biopsy)				
31371	Nose, eyelid, eyebrow, lip, ear, digit, genitalia or a contiguous area	6mm+	$357.00	$303.45
31372	Face, neck, scalp, nipple-areola, distal lower/upper limb	<14mm	$308.70	$262.40
31373	Face, neck, scalp, nipple-areola, distal lower/upper limb	14mm+	$356.80	$303.30
31374	Body, other than above	<15mm	$281.90	$239.65
31375	Body, other than above	15 - 30mm	$213.60	$181.60
31376	Body, other than above	>30mm	$351.60	$298.90

Item	Service or Procedure	Size of lesion	Schedule Fee	85% rebate
Tumour, cyst, ulcer, scar, removal and suture (^other than common warts and seborrheic keratosis				
31206	Mucous membrane	<10mm	$95.45	$81.15
31211	Mucous membrane	10 - 20mm	$123.10	$104.65
31216	Mucous membrane	>20mm	$143.55	$122.05
31220	4 to 10 lesions – skin^	Each <10mm	$214.55	$182.40
31221	4 to 10 lesions – mucous membrane^	Each <10mm	$214.55	$182.40
31225	>10 lesions – skin or mucous membrane ^	Each >10mm	$381.30	$324.15

Item	Service or Procedure	Size of lesion	Schedule Fee	85% rebate
Biopsy for diagnostic purposes				
30071	Biopsy of skin		$52.20	$44.40
30072	Biopsy of mucous membrane		$52.20	$44.40

Procedural item numbers (Cont)

Skin lesions, excisions, biopsies and wounds (Cont)

Item	Service or Procedure	Size of lesion	Schedule Fee	85% rebate
Skin wounds and other				
30026	Wound, superficial, other than on face or neck	<7cm	$52.20	$44.40
30029	Wound, deep, other than on face or neck	<7cm	$90.00	$76.50
30032	Wound, superficial, face or neck	<7cm	$82.50	$70.15
30035	Wound, deep, face or neck	<7cm	$117.55	$99.95
30038	Wound, superficial, other than on face or neck	>7cm	$90.00	$76.50
30042	Wound, deep, other than on face or neck	>7cm	$185.60	$157.80
30045	Wound, superficial, face or neck	>7cm	$117.55	$99.95

Item	Service or Procedure	Size of lesion	Schedule Fee	85% rebate
Skin wounds and other				
30023	Repair of soft tissue wound - deep, including debridement and suture		$326.05	$277.15
30052	Full thickness laceration of ear, eyelid, nose or lip		$254.00	$215.90
30111	Removal of large bursa, including olecranon, calcaneum or patella		$371.50	$315.80

VETERANS' CARE

Coordinated Veterans' Care Program (CVC)

About the CVC Program

The Department of Veterans' Affairs (DVA) new Coordinated Veterans' Care Program (known as the CVC Program) commenced on 1 May 2011. The CVC Program:

- Uses a proactive approach to improve the management of participants' chronic diseases and quality of care
- Involves a care team of a general practitioner (GP) plus a nurse coordinator who work with the participant (and their carer if applicable) to manage their ongoing care
- Provides new payments to GPs for initial and ongoing care.

Eligibility

The program is aimed at veterans, war widows, war widowers and dependants who are Gold Card holders and are at risk of being admitted or readmitted to hospital.
GPs can enroll participants in the program if they:

- Pass an eligibility assessment
- Give their informed consent to be involved in the program.

Payments for GPs

By participating in the program, GPs can claim the following payments through existing payment arrangements with Medicare Australia:

- Initial Incentive Payment for enrolling a participant in the program
- Quarterly Care Payments for ongoing care

Guide for General Practice

The DVA has developed a Guide to help with the implementation of the Coordinated Veterans' Program. It can be downloaded here. The CVC Program items are DVA only items and do not appear in the MBS Schedule.

UP01 Initial Payment – LMO/GP with Practice Nurse Coordinator

Item Description	Business Rules
The payment is to an LMO/GP, with a Practice Nurse coordinator, for enrolling a person in the CVC Program and having done all things necessary for the enrollment as described in the Guide for General Practice or Notes for CVC Program Providers and summarised as follows: ◆ The LMO/GP has made any required changes to the Practice before enrolling the participant in the Program. ◆ The participant has been assessed by the LMO/GP as meeting the eligibility criteria for participation in the Program. ◆ The LMO/GP has explained the Program and the person has provided informed consent to being enrolled in the Program and to the sharing of health and medical information. ◆ A care coordinator employed by the general practice has been appointed: either a Practice Nurse or an Aboriginal Health Worker. ◆ A comprehensive needs assessment of the participant has been carried out by the care coordinator or the LMO/GP. ◆ A care plan (GP Management Plan – GPMP) has been prepared and agreed with the participant and a patient friendly copy provided to the participant and any carer/family as agreed.	This item will be claimed on enrolment of a participant in the CVC Program. Only one (1) claim of either UP01 or UP02 will be paid per participant regardless of a change in LMO/GP or in Practice Nurse arrangements. Where a person ceases to be a participant and later re-enters the Program, the initial incentive payment (UP01 or UP02) will not be payable. The date of service is the date of enrolment in the Program which is the date that all steps necessary for enrolment in the Program have been completed.

NSW WORKERS COMPENSATION REGULATION RATES FOR GPS

From 1 January 2016
AMA Codes must be used for all consultations and medical services. **NOTE:** From **1 September 2015**, Insurance and Care NSW (iCare) is the organisation responsible for workers compensation insurance.

Consultation: at surgery standard opening hours:

Item	Name	Description/recommended frequency
AA010	Level A Consultation	AMA codes must be used for all consultations and medical treatment services. The rate for consultation fee applies for services provided on or after 1 January 2016. GST should not be charged on the consultation fee. For further information on the criteria for Level A, B, C and D consultation services please consult the AMA List of Medical Services and Fees (1 November 2015). Out-of-hours fees are only payable for emergency attendance and emergency treatment of a worker at a time when the practice is not usually open.
AA020	Level B Consultation	
AA030	Level C Consultation	
AA040	Level D Consultation	
WCO001	Certificate of capacity	One (1) certification fee may be charged for the initial certificate only. No fee is payable for subsequent certificates. To order certificates of capacity call SIRA on 13 10 50.
WCO002	Maximum hourly rate payable to General Practitioner	This fee is to remunerate for any time spent by the medical practitioner, in addition to the usual medical management, to assist the worker to recover at or return to work. These rates may cover, for example, discussions with employers, case conferences (see definition below), visits to worksites, time spent reviewing injury management or return to work plans and providing additional reports requested from treating doctors (where it was pre-approved by the insurer). These should be billed to reflect the time taken (to the nearest five (5) minutes) to deliver the service.
	Case conference	Case conference means a face-to-face meeting, video conference or teleconference with any or all of the following parties: workplace rehabilitation provider, employer, insurer or other treatment provider(s) delivering services to the worker. Discussion must seek to clarify the worker's capacity for work, barriers to return to work, and strategies to overcome these barriers via an open forum to ensure parties are aligned with respect to expectations and direction of the injured worker's recovery at work or return to suitable employment. If the discussion is with the worker, it must involve a third party to be considered a case conference. Discussions between the worker's nominated treating doctor and other treating practitioners (e.g. allied health practitioners, medical specialists/surgeons) relating to treatment are considered a normal interaction between referring doctor and practitioner. This is not to be charged as a case conference.
WCO004	Other Medical Items	The cost of all bandages and dressings etc.
PHS001	Pharmaceutical Services	Payments for pharmaceutical services.
WCO005	Medical Records	Fee for providing copies of medical records (including treating general practitioner, specialist or consulting surgeon notes and reports). If the clinical records are provided electronically, a flat fee applies.

Note: these item numbers to be used for Motor Vehicle Accident consultations.

AFTER-HOURS SERVICES ITEM NUMBERS

<table>
<tr><th colspan="3">ATTENDANCE PERIOD</th><th>ITEM NUMBER</th><th>MBS PAYMENT</th><th>BRIEF GUIDE</th></tr>
<tr><td colspan="3">Urgent attendance - after hours</td><td rowspan="2">585 (GP)

588 (Non-VR GP, rural area)

591 (Non-VR GP, metropolitan area)

594 (additional patients at one location)</td><td rowspan="2">$133.90

$133.90

$92.80

$43.25</td><td rowspan="6">• 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

• The urgent after- hours items can only be used where the patient has a medical condition that requires urgent assessment which could not be delayed until the next in-hours period

• 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
7 – 8am or 6 – 11pm</td><td>Sat
7 – 8am or 12noon – 11pm</td><td>Sun & Pub Holidays
7am – 11pm</td></tr>
<tr><td colspan="3">Urgent attendance - unsociable hours</td><td rowspan="2">599 (GP)
600 (Non-VR GP)</td><td rowspan="2">$157.80
$126.10</td></tr>
<tr><td>Mon – Fri
11pm – 7am</td><td>Sat
11 pm – 7am</td><td>Sun & Pub Holidays
11 pm – 7am</td></tr>
<tr><td colspan="3">Non-urgent after hours at a place other than consulting rooms</td><td>Home

GP:
5003
5023
5043
5063

Non-VR GP:
5220
5223
5227
5228</td><td>RACFs

GP:
5010
5028
5049
5067

Non-VR GP:
5260
5263
5265
5267</td></tr>
<tr><td rowspan="2">Mon – Fri
Before 8am or after 6pm</td><td rowspan="2">Sat
Before 8am or after 12pm</td><td rowspan="2">Sun & Pub Holidays
All day</td><td colspan="2">*The above MBS Payments are for the 1st patient only. Please refer to MBS Online for multiple patient fee schedules.</td></tr>
<tr><td colspan="3">Non-urgent after hours at consulting rooms</td><td rowspan="2">GP
5000 (Level A)
5020 (Level B < 20 min)
5040 (Level C > 20 min)
5060 (Level D > 40 min)

Non-VR GP
5200 (Level A)
5203 (Level B < 20 min)
5207 (Level C > 20 min)
5208 (Level D > 40 min)</td><td rowspan="2">Refer to MBS online for further information</td></tr>
<tr><td>Mon – Fri
Before 8am or after 8pm</td><td>Sat
Before 8am or after 1pm</td><td>Sun & Pub Holidays
All day</td></tr>
</table>

CONTACT DETAILS FOR KEY ORGANISATIONS

Asthma
National Asthma Council
W: nationalasthma.org.au
T: 03 8699 0476 / 1800 032 495

Best Practice
W: bpsoftware.net
T: (07) 4155 8888

Cancer Screening
(Breast, Bowel and Cervical Screening)
W: cancerscreening.gov.au

Cervical Screening
NSW Pap Test Infoline
T: 1800 671 693

NSW Cervical Screening Program
W: cancer.nsw.gov.au/cervical-screening-nsw

Services Australia
W: servicesaustralia.gov.au
T: 132 150

Practice Incentives Program (PIP)
T: 1800 222 032

Diabetes
Diabetes Australia NSW
W: diabetesnsw.com.au
T (Customer Care Line): 1300 342 238

My Health Record
W: myhealthrecord.gov.au
T: 1800 723 471

Medical Director
W: medicaldirector.com
T: 1300 300 161

PracSoft
W: medicaldirector.com/products/pracsoft
T: 1300 300 161

Immunisation
Australian Immunisation Register (AIR)
Immunisation information
T: 1800 653 809

Quality Use of Medicines
NPS MedicineWise
W: nps.org.au
T: 02 8217 8700

SNHN Health Pathways
W: sydneynorth.communityhealthpathways.org.au

APPENDIX: COVID-19 TEMPORARY MBS TELEHEALTH SERVICES

COVID-19 Temporary MBS Telehealth Services: GPs and other medical practitioners

- Commencing 13 March 2020 and extending until 31 March 2021, temporary MBS telehealth items have been made available to help reduce the risk of community transmission of COVID-19 and provide protection for patients and health care providers.
- The temporary MBS telehealth items are available to GPs, medical practitioners, specialists, consultant physicians, nurse practitioners, participating midwives, allied health providers and dental practitioners in the practice of oral and maxillofacial surgery.
- The temporary MBS telehealth items are for out-of-hospital patients.
- It is a legislative requirement that GPs and Other Medical Practitioners (OMPs) working in general practice can only perform a telehealth or telephone service where they have an established clinical relationship with the patient. There are limited exemptions to this requirement.
- GP and OMP COVID-19 telehealth services are eligible for MBS incentive payments when provided as bulk billed services to Commonwealth concession card holders and children under 16 years of age.
- The temporary GP and OMP bulk billing incentive items for patients who are vulnerable to COVID-19 and the temporary doubling of all Medicare bulk-billing incentive fees ceased as of 1 October 2020.

What are the changes?
From 1 October 2020:
- GPs and OMPs providing COVID-19 telehealth services are not required to bulk bill their patients.
- Temporary MBS COVID-19 bulk billing incentive items 10981 (for GPs) and 10982 (for OMPs) ceased.
- The temporary doubling of fees for MBS bulk billing incentive items 10990, 10991, 10992, 64990, 64991, 74990 and 74991 ceased.

A list of telehealth items is provided on p.63 of this General Practice Manual. Factsheet available on MBS Online.

Why are the changes being made?
The Government has extended its national COVID-19 emergency health response for a further six months, to 31 March 2021. This will ensure that patients continue to have access to key health initiatives, including Medicare-subsidised telehealth services.

The temporary MBS telehealth items allow people to access essential Medicare funded health services in their homes and reduce their risk of exposure to COVID-19 within the community. Previous updates made on 20 July 2020 ensure patients receive care from a GP, an OMP or a general practice with whom they have an established clinical relationship.

Please note that the information provided is a general guide only. It is ultimately the responsibility of treating practitioners to use their professional judgment to determine the most clinically appropriate services to provide, and then to ensure that any services billed to Medicare fully meet the eligibility requirements outlined in the legislation.

This sheet is current as of the Last updated date shown above, and does not account for MBS changes since that date.

COVID-19: Temporary MBS Telehealth Items

GENERAL PRACTITIONER ATTENDANCES			
SERVICE	**EXISTING ITEMS** face-to-face	**TELEHEALTH ITEMS** via video-conference	**TELEPHONE ITEMS** - for when video-conferencing is not available
Standard GP Attendance Items introduced 13 March 2020			
Attendance for an obvious problem	3	91790	91795
Attendance less than 20 minutes	23	91800	91809
Attendance at least 20 minutes	36	91801	91810
Attendance at least 40 minutes	44	91802	91811
Health assessment for people of Aboriginal or Torres Strait Islander descent Items introduced 30 March 2020			
Health assessment	715	92004	92016
Chronic Disease Management Items introduced 30 March 2020			
Preparation of a GP management plan (GPMP)	721	92024	92068
Coordination of Team Care Arrangements (TCAs)	723	92025	92069
Contribution to a Multidisciplinary Care Plan, or to a review of a Multidisciplinary Care Plan, for a patient who is not a care recipient in a residential aged care facility	729	92026	92070
Contribution to a Multidisciplinary Care Plan, or to a review of a multidisciplinary care plan, for a resident in an aged care facility	731	92027	92071
Review of a GPMP or Coordination of a Review of TCAs	732	92028	92072
Autism, Pervasive Developmental Disorder and Disability Services Items introduced 30 March 2020			
Assessment, diagnosis and preparation of a treatment and management plan for patient under 13 years with an eligible disability, at least 45 minutes.	139	92142	92145
Pregnancy Support Counselling program Items introduced 30 March 2020			
Non-directive pregnancy support counselling, at least 20 minutes	4001	92136	92138
Eating Disorder Management Items introduced 30 March 2020			
GP without mental health skills training, preparation of an eating disorder treatment and management plan, lasting at least 20 minutes, but less than 40 minutes	90250	92146	92154
GP without mental health skills training, preparation of an eating disorder treatment and management plan, at least 40 minutes	90251	92147	92155
GP with mental health skills training, preparation of an eating disorder treatment and management plan, lasting at least 20 minutes, but less than 40 minutes	90252	92148	92156
GP with mental health skills training, preparation of an eating disorder treatment and management plan, at least 40 minutes	90253	92149	92157
Review of an eating disorder treatment and management plan	90264	92170	92176

COVID-19: Temporary MBS Telehealth Items (Cont)

Eating disorder psychological treatment (EDPT) service, lasting at least 30 minutes, but less than 40 minutes	90271	92182	92194
EDPT service, at least 40 minutes	90273	92184	92196
Mental Health Services Items introduced 30 March 2020			
GP without mental health skills training, preparation of a GP mental health treatment plan, lasting at least 20 minutes, but less than 40 minutes	2700	92112	92124
GP without mental health skills training, preparation of a GP mental health treatment plan, at least 40 minutes	2701	92113	92125
Review of a GP mental health treatment plan or Psychiatrist Assessment and Management Plan	2712	92114	92126
Mental health treatment consultation, at least 20 minutes	2713	92115	92127
GP with mental health skills training, preparation of a GP mental health treatment plan, lasting at least 20 minutes, but less than 40 minutes	2715	92116	92128
GP with mental health skills training, preparation of a GP mental health treatment plan, at least 40 minutes	2717	92117	92129
Items introduced 13 March 2020			
Focussed Psychological Strategies (FPS) treatment, lasting at least 30 minutes, but less than 40 minutes	2721 and 2729	91818	91842
FPS treatment, at least 40 minutes	2725 and 2731	91819	91843
Urgent After Hours Attendance Items introduced 30 March 2020			
Urgent attendance, unsociable after hours	599	92210	92216

OTHER MEDICAL PRACTITIONER ATTENDANCES			
SERVICE	**EXISTING ITEMS** face-to-face	**TELEHEALTH ITEMS** via video-conference	**TELEPHONE ITEMS** - for when video-conferencing is not available
Standard Attendance Items introduced 13 March 2020			
Attendance of not more than 5 minutes	52	91792	91797
Attendance of more than 5 minutes but not more than 25 minutes	53	91803	91812
Attendance of more than 25 minutes but not more than 45 minutes	54	91804	91813
Attendance of more than 45 minutes	57	91805	91814
Attendance of not more than 5 minutes	179	91794	91799
Attendance of more than 5 minutes but not more than 25 minutes. Modified Monash 2-7 area	185	91806	91815
Attendance of more than 25 minutes but not more than 45 minutes. Modified Monash 2-7 area	189	91807	91816
Attendance of more than 45 minutes. Modified Monash 2-7 area	203	91808	91817
Health assessment for people of Aboriginal or Torres Strait Islander descent Items introduced 30 March 2020			
Health assessment	228	92011	92023

COVID-19: Temporary MBS Telehealth Items (Cont)

Chronic Disease Management Items introduced 30 March 2020			
Preparation of a GP management plan (GPMP)	229	92055	92099
Coordination of Team Care Arrangements (TCAs)	230	92056	92100
Contribution to a Multidisciplinary Care Plan, or to a review of a Multidisciplinary Care Plan, for a patient who is not a care recipient in a residential aged care facility	231	92057	92101
Contribution to a Multidisciplinary Care Plan, or to a review of a Multidisciplinary Care Plan, for a resident in a residential aged care facility	232	92058	92102
Review of a GPMP or Coordination of a Review of TCAs	233	92059	92103
Pregnancy support Counselling program Items introduced 30 March 2020			
Non-directive pregnancy support counselling of at least 20 minutes	792	92137	92139
Eating Disorder Management Items introduced 30 March 2020			
Medical Practitioner without mental health skills training, preparation of an eating disorder treatment and management plan, lasting at least 20 minutes, but less than 40 minutes	90254	92150	92158
Medical Practitioner without mental health skills training, preparation of an eating disorder treatment and management plan, at least 40 minutes	90255	92151	92159
Medical Practitioner with mental health skills training, preparation of an eating disorder treatment and management plan, lasting at least 20 minutes, but less than 40 minutes	90256	92152	92160
Medical Practitioner with mental health skills training, preparation of an eating disorder treatment and management plan, at least 40 minutes	90257	92153	92161
Review of an eating disorder treatment and management plan	90265	92171	92177
Eating disorders psychological treatment (EDPT) service, lasting at least 30 minutes, but less than 40 minutes	90275	92186	92198
EDPT service, at least 40 minutes	90277	92188	92200
Urgent After Hours Attendance Items introduced 30 March 2020			
Urgent attendance, unsociable after hours	600	92211	92217
Mental Health Services Items introduced 30 March 2020			
Medical Practitioner without mental health skills training, preparation of a GP mental health treatment plan, lasting at least 20 minutes, but less than 40 minutes	272	92118	92130
Medical Practitioner without mental health skills training, preparation of a GP mental health treatment plan, at least 40 minutes	276	92119	92131
Review of a GP mental health treatment plan or Psychiatrist Assessment and Management Plan	277	92120	92132
Medical Practitioner mental health treatment consultation, at least 20 minutes	279	92121	92133

COVID-19: Temporary MBS Telehealth Items (Cont)

Medical Practitioner with mental health skills training, preparation of a GP mental health treatment plan, lasting at least 20 minutes, but less than 40 minutes	281	92122	92134
Medical Practitioner with mental health skills training, preparation of a GP mental health treatment plan, at least 40 minutes	282	92123	92135
Items introduced 13 March 2020			
Focussed Psychological Strategies (FPS) treatment, lasting at least 30 minutes, but less than 40 minutes	283 and 371	91820	91844
FPS treatment, at least 40 minutes	286 and 372	91821	91845

For more information and the complete factsheet on telehealth item numbers please go to MBS Online: mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-TempBB

If you are seeking advice in relation to Medicare billing, claiming, payments, or obtaining a provider number, please go to the Health Professionals page on the Services Australia website or contact Services Australia on the Provider Enquiry Line – 13 21 50.