

Summary of new Medicare Benefits Schedule (MBS) item numbers: general practice and allied health

- Bulk billing incentives
- Prevention
- Health assessment
- Care planning and case conferencing
- Allied health
- Mental health
- Service incentive payments
- Quality use of medicines
- Services that can be performed by a practice nurse, on behalf of a GP

About this resource

The Department of Human Services is working to provide information and support to Victorian primary health care agencies that may be looking to build or extend evidence-based models of care that incorporate MBS item numbers.

New MBS item numbers

Over the past nine years, a suite of new MBS item numbers have been progressively introduced to support new models of primary care. These item numbers focus on the prevention or management of chronic diseases and many mental health conditions.

The new items

- help to facilitate a more integrated approach to health care provision, including interagency care planning
- provide a catalyst for state-funded services to strengthen partnerships with general practice and other public and private primary health providers through the Primary Care Partnerships (PCP) planning framework, including divisions of general practice which have expertise in general practice engagement.

By working together, community health services, Aboriginal community-controlled health organisations and general practices can explore enhancing client access to primary care services by constructing service models that are supported by the MBS.

To enhance understanding within the primary health sector, the Department of Human Services has summarised¹ the new MBS item numbers and grouped them into nine categories:

1. Bulk billing incentives
2. Prevention
3. Health assessment
4. Care planning and case conferencing
5. Allied health
6. Service Incentive Payments
7. Mental health
8. Quality use of medicines
9. Services that can be performed by a practice nurse, on behalf of a GP

¹ All information provided in these documents is current as at 1 May 2008. Health professionals intending to use these items should refer to the Medicare Benefits Schedule (MBS) book or to the Allied Health MBS booklet for more comprehensive information, including the MBS requirements for each item. Alternatively, they can search for specific items at www9.health.gov.au/mbs or telephone Medicare Australia on 03 9605 7964 or contact their local division of general practice. The summaries have been endorsed by the Commonwealth Department of Health and Ageing.

About Medicare

Medicare was introduced by the Commonwealth Government in 1984 to provide eligible Australian residents with affordable, accessible and high quality health care. Medicare is based on the understanding that all Australians should contribute to the cost of health care according to their ability to pay. It is financed through progressive income tax and an income-related Medicare levy.

Mediguide is a booklet updated annually by Medicare Australia that explains the Medicare system and other Medicare Australia programs. It can be accessed at www.medicareaustralia.gov.au/providers/publications_guidelines/mediguide.shtml

Relevance to community health

- Models supporting effective chronic disease care are of particular relevance to the community health sector, because a high proportion of community health clients have chronic and/or complex conditions and co-morbidities.

- The case for integration across the sector is now stronger than ever before, with the State and Commonwealth governments having similar priorities for health. MBS item numbers may support integrated models of care that include general practice.

New service models

- Community health services should work with divisions of general practice and with the input of clients to determine which models are suitable. These decisions should be based on a local analysis of client characteristics and needs, the availability of local services and providers with whom models of care can be built, the likely future impact on currently funded client services, and existing strategies and programs in the region.
- It is important to identify the client's usual GP, and to strengthen relationships and enhance communication with health care workers within general practice so that they are actively participating in shared care approaches.
- The implementation of new multidisciplinary models of care that incorporate MBS services is relevant to all community health services, whether or not they manage medical clinics.

- Community health agencies should seek legal advice to ensure that any new service models are compliant with s19(2) of the *Health Insurance Act 1973 (Commonwealth)*.
- Models adopted should not result in a reduction of public allied health services.
- Services funded through the MBS are in addition to services funded by the Department of Human Services' Primary Health Branch. As the funding source is different, MBS-funded services should not be included by community health services as part of their reporting for Branch-funded activities.

Support for Aboriginal and Torres Strait Islander people to access Medicare

Medicare Australia has a communication strategy to help increase access to Medicare and other programs by Aboriginal and Torres Strait Islander people through health services. These include a dedicated telephone access line, consumer information flier, fact sheet, poster and a reference guide.

For support or for copies of published support materials, ring the Aboriginal and Torres Strait Islander Access Line on **1800 556 955**.

Bulk billing incentives: summary of MBS item numbers

Service type	Bulk billing incentive for unREFERRED general medical services		Bulk billing incentive for unREFERRED diagnostic imaging services		Bulk billing incentive for unREFERRED pathology services		
Client eligibility	For clients under the age of 16 or Commonwealth concession card holders ² for whom an unREFERRED ³ general medical service item number is being claimed		For clients under the age of 16 or Commonwealth concession card holders ² for whom an after hours unREFERRED ³ general medical service item number is being claimed		For clients under the age of 16 or Commonwealth concession card holders ² for whom an unREFERRED ³ pathology service item number is being claimed		
Relevant MBS item number	Bulk billing incentive payment for unREFERRED general medical services provided in any area #10990	Higher bulk billing incentive payment for unREFERRED general medical services provided in an eligible area ⁴ #10991	Bulk billing incentive payment for unREFERRED after hours general medical services, provided in an eligible area ^{4,5} #10992	Bulk billing incentive payment for unREFERRED diagnostic imaging services #64990	Bulk billing incentive payment for unREFERRED diagnostic imaging services, provided in an eligible area ⁴ #64991	Bulk billing incentive payment for unREFERRED pathology services #74990	Bulk billing incentive payment for unREFERRED pathology services, provided in an eligible area ⁴ #74991

2 Commonwealth concession card holder means a person listed on a Pensioner Concession Card, Health Care Card or Commonwealth Seniors Health Card issued by either Centrelink or the Department of Veterans' Affairs. Gold or White Cards issued by the Department of Veterans' Affairs do not attract the additional bulk billing payment. However, if a Gold or White Card holder also holds a recognised Commonwealth concession card and chooses to be treated under the Medicare arrangements, then that patient is an eligible concession card holder.

3 'UnREFERRED service' means a medical service provided to a client by, or on behalf of, a medical practitioner, being a service that has not been referred to that practitioner by another medical practitioner or person with referring rights.

4 The eligible areas are: Rural Remote and Metropolitan Areas (RRMAs) 3–7, Tasmania, and metropolitan areas with low doctor-to-population ratios and bulk billing rates. For maps of these areas, see www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=M1.1&qt=noteID

5 This item can only be claimed alongside the following after hours item numbers: 1, 97, 601, 697, 5003, 5007, 5010, 5023, 5026, 5028, 5043, 5046, 5049, 5063, 5064, 5067, 5220, 5223, 5227, 5228, 5240, 5243, 5247, 5248, 5260, 5263, 5265 or 5267.

Bulk billing incentives: summary of web links and explanatory notes

	Bulk billing incentive for unreferrred general medical services #10990, #10991	Bulk billing incentive for unreferrred general medical services, provided after hours #10992	Bulk billing incentive for unreferrred diagnostic imaging services #64990, #64991	Bulk billing incentive for unreferrred pathology services #74990, #74991
Steps that must be taken to claim the Medicare item, and associated rules	<ul style="list-style-type: none"> Provision of an unreferrred general medical service (listed in the General Medical Services table of the MBS) to a person who is under the age of 16 or is a Commonwealth concession card holder and who is not an admitted patient of a hospital or day hospital facility That service must be bulk billed, and then the bulk billing incentive item can be claimed alongside it. The bulk billing incentive must also be bulk billed 	<ul style="list-style-type: none"> Provision of an after hours unreferrred medical service (any of MBS items 1, 97, 601, 697, 5003, 5007, 5010, 5023, 5026, 5028, 5043, 5046, 5049, 5063, 5064, 5067, 5220, 5223, 5227, 5228, 5240, 5243, 5247, 5248, 5260, 5263, 5265 or 5267) to a person who is under the age of 16 or is a Commonwealth concession card holder and who is not an admitted patient of a hospital or day hospital facility That service must be bulk billed, and then the bulk billing incentive item can be claimed alongside it. The bulk billing incentive must also be bulk billed 	<ul style="list-style-type: none"> Provision of an unreferrred diagnostic imaging service (all services listed in Category 5—Diagnostic Imaging Services in the MBS) by a medical practitioner or specialist with dual qualifications to a person who is under the age of 16 or is a Commonwealth concession card holder and who is not an admitted patient of a hospital or day hospital facility That service must be bulk billed, and then the bulk billing incentive item can be claimed alongside it. The bulk billing incentive must also be bulk billed 	<ul style="list-style-type: none"> Provision of an unreferrred pathology service (listed in Group P9 of the Pathology Services table of the MBS, and unreferrred pathology services provided by category M laboratories) by a medical practitioner or specialist with dual qualifications to a person who is under the age of 16 or is a Commonwealth concession card holder and who is not an admitted patient of a hospital or day hospital facility That service must be bulk billed, and then the bulk billing incentive item can be claimed alongside it. The bulk billing incentive must also be bulk billed
Medicare rules relating to frequency of claims	As long as the business rules for the unreferrred medical service are met, and the business rules for the bulk billing bonus item number are also met, there are no limits as to the number of bulk billing bonus item numbers that can be claimed.			
Main information web link	www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=M1.1&qt=noteID			

Prevention: summary of MBS item numbers

Service type	▶▶▶	Prevention of the onset of chronic disease, when risk factor/s are present	Preventive service performed by a practice nurse or Aboriginal health worker on behalf of a GP and claimed by the GP					
Client eligibility	▶▶▶	For any client aged 45–49 years of age (inclusive) who is at risk of developing a chronic disease ⁶	For any client requiring an immunisation service	For female clients with a cervix due for a Pap test		For female clients with a cervix aged 20–69 years of age who have not had a Pap test in four years ⁷		
Relevant MBS item number	▶▶▶	45+ Health Check #717	Immunisation performed by an Aboriginal Health Worker #10988	Immunisation performed by a practice nurse #10993	Taking of a cervical smear only, by a practice nurse #10998	Taking of a cervical smear and provision of a preventive health check ⁸ , by a practice nurse #10994	Taking of a cervical smear only from an unscreened or under screened ⁹ client, by a practice nurse #10999	Taking of a cervical smear for an unscreened or under screened ⁹ client and provision of a preventive health check ⁸ , by a practice nurse #10995

6 The decision about whether an individual is at risk of developing a chronic disease rests with the clinical judgement of the GP, but a specific risk factor must be identified.

7 Claiming these items will also trigger an incentive payment, if the practice is participating in the Practice Incentives Program (PIP). See 'Service Incentive Payments' section.

8 The preventive health check is most likely to be associated with a woman's sexual and reproductive health. Specific types of checks are listed within the business rules for the item number.

9 For the purposes of this Medicare item number, an 'unscreened or under screened' client is defined as a woman aged 20–69, with a cervix, who has not had a Pap test in the last four years.

Prevention: summary of web links and explanatory notes

	45+ health check #717	Immunisation #10988, #10993	Taking of a cervical smear #10998, #10999	Taking of a cervical smear and provision of a preventive health check #10994, #10995
Steps that must be taken to claim the Medicare item	<ul style="list-style-type: none"> Information collection, including taking a client history and undertaking examinations and investigations as required Overall client assessment Interventions as indicated Providing advice and information to the client 	<ul style="list-style-type: none"> Administration of a registered vaccine to a client for any purpose other than as part of a mass immunisation of persons¹⁰ 	<ul style="list-style-type: none"> Taking of a cervical smear 	<ul style="list-style-type: none"> Taking of a cervical smear At least one preventive check
Medicare rules relating to frequency of service	One occasion only for each eligible client. This item is not an annual health check	Can be claimed only once per client visit	Can be claimed only once per client visit	Nil
Role of the GP	The GP is responsible for the overall health check, including reviewing/analysing information, investigations, making the overall assessment, referrals, and providing client advice	<ul style="list-style-type: none"> Delegation of service to the Aboriginal Health Worker or practice nurse 	<ul style="list-style-type: none"> Delegation of service to the practice nurse 	<ul style="list-style-type: none"> Delegation of service to the practice nurse
Roles that can be performed by practice nurses or Aboriginal health workers on behalf of and under the supervision of the GP	Identifying clients who may be eligible, collecting client information, providing advice to clients about recommended interventions	All components	All components	All components
Main information web link	45+ health check: www.health.gov.au/internet/main/publishing.nsf/Content/health-epc-45check Immunisation and Wound Management by Aboriginal health workers: http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=M5.1&qt=noteID Immunisation and Wound Management by a practice nurse: http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=M2.1&qt=noteID			

¹⁰ A registered vaccine means a vaccine that is included on the Australian Register of Therapeutic Goods. This includes all vaccines on the Australian Standard Vaccination Schedule and vaccines covered in the Australian Immunisation Handbook 8th edition.

Health assessments: summary of MBS item numbers

Service type ▶▶▶	Older age health assessment		Aboriginal and Torres Strait Islander (ATSI) health check				Refugee and other humanitarian entrants health check		Health assessment for people with an intellectual disability		Medical assessment for residents of an aged care facility
Client eligibility ▶▶▶	For clients aged 75 years or over, living in the community		Client is an Aboriginal or Torres Strait Islander aged 0–14 inclusive	Client is an Aboriginal or Torres Strait Islander aged 15–54 inclusive	Client is an Aboriginal or Torres Strait Islander aged 55 years or over		Client is a refugee or other humanitarian entrant who has arrived in Australia in the last 12 months		Client is a person with an intellectual disability ¹¹		For clients who are permanent residents of a Commonwealth-funded Residential Aged Care Facility
Relevant MBS item number ▶▶▶	Health assessment provided in a consulting room (also known as 75+ health assessment) #700	Health assessment provided outside consulting rooms, hospitals and residential aged care facilities #702	ATSI child health check #708	ATSI adult health check #710	ATSI older person's health check provided in a consulting room #704	ATSI older person's health check provided outside consulting rooms, hospitals and residential aged care facilities #706	Refugee and other humanitarian entrants health check provided in a consulting room #714	Refugee and other humanitarian entrants health check provided outside consulting rooms, hospitals and residential aged care facilities #716	Annual health assessment for a person with an intellectual disability, provided in a consulting room #718	Annual health assessment for a person with an intellectual disability, provided outside consulting rooms, hospitals and residential aged care facilities #719	Comprehensive medical assessment ¹² (also known as CMA) #712

11 For the purposes of this item, a person will be deemed to have an intellectual disability if they have significantly sub-average general intellectual functioning (two standard deviations below the average intelligence quotient (IQ)) and would benefit from assistance with daily living activities. Where GPs 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 practice in Australia or from a government-provided or funded disability service that has assessed the person's intellectual function.

12 The Comprehensive Medical Assessment (CMA) is available for new residents, or for existing residents where in the opinion of the medical practitioner there has been a significant change to the medical condition, physical and/or psychological function of the client.

Health assessments: summary of explanatory notes and web links

	Older age health assessments #700, #702	Aboriginal and Torres Strait Islander (ASTI) health checks #704, #706, #708, #710	Refugee and other humanitarian entrants health check #714, #716	Health assessment for people with an intellectual disability #718, #719	Comprehensive medical assessment (CMA) #712
Steps that must be taken to claim the Medicare item	<ul style="list-style-type: none"> Medical component, including blood pressure, medications, immunisation Physical component, including activities of daily living and mobility Psychological component, including cognition and mood Social component, including adequacy of social support, carers and formal help arrangements 	<ul style="list-style-type: none"> Taking the client's medical history Physical examination Undertaking or arranging any required investigations Assessing the client, using the information gained from medical history, physical examination and investigations Making or arranging necessary interventions and referrals Documenting a simple strategy for the good health of the client 	<ul style="list-style-type: none"> Taking the client's medical history Physical examination; Undertaking or arranging any required investigations Assessing the client, using the information gained from medical history, physical examination and investigations Making or arranging any necessary interventions and referrals Developing a plan 	<ul style="list-style-type: none"> Medical component, including blood pressure, medications, immunisation Physical component, including activities of daily living, exercise opportunities, reviewing growth and development, sexual activity, nutritional status Preventive component including cancer screening, checking risk factors for osteoporosis, thyroid disease, dysphagia, gastro-oesophageal disease Psychological component, including cognition and mood Social component, including social support, carers and help arrangements Dental component 	<ul style="list-style-type: none"> Taking a detailed relevant medical history and conducting comprehensive medical examination Developing a list of diagnoses or problems based on history and examination Providing a written summary of the outcomes of the CMA for the resident's records to inform the provision of care for the resident by the residential aged care facility and reviewing pharmacist
Medicare rules relating to frequency of service	Once per client for any 12-month period	#704/706 every 12 months, #708 every 9 months, #710 every 18 months	Benefits are available on one occasion only	Once per client for any 12-month period	Once per client for any 12-month period
Role of the GP	<ul style="list-style-type: none"> Determining client eligibility, gaining consent and initiating service, if appropriate Central coordinating role, including at least one client consultation Medical components that cannot be delegated 	<ul style="list-style-type: none"> Determining client eligibility and initiating the service, if appropriate Central coordinating role, including at least one client consultation Medical components that cannot be delegated 	<ul style="list-style-type: none"> Determining client eligibility and initiating the service, if appropriate Central coordinating role, including at least one client consultation Medical components that cannot be delegated 	<ul style="list-style-type: none"> Determining client eligibility and initiating the service, if appropriate Central coordinating role, including at least one client consultation Medical components that cannot be delegated 	<ul style="list-style-type: none"> To provide all services. The GP may be assisted by a practice nurse The client's usual GP may delegate the provision of a CMA to a medical locum, who would provide a written summary of CMA outcomes
Roles that can be performed by practice nurses (PNs) or Aboriginal health workers (AHWs) on behalf of and under the supervision of the GP	<ul style="list-style-type: none"> Explaining the item and any fees Information collection, including taking or reviewing medical history Investigations for which the PN/AHW is qualified 	<ul style="list-style-type: none"> Explaining components of the item and any fees to the client, and obtaining client consent Information collection, including taking or reviewing medical history Investigations and interventions for which the PN/AHW is qualified 	<ul style="list-style-type: none"> Explaining components of the item and any fees, obtaining client consent Information collection, including taking or reviewing medical history Investigations and interventions for which the PN/AHW is qualified 	<ul style="list-style-type: none"> Explaining components of the item and any fees to the client, and obtaining client consent Information collection, including taking or reviewing medical history Investigations and interventions for which the PN/AHW is qualified 	Practice nurses can assist the GP in obtaining information relevant to the CMA for the GP's consideration, in taking the resident's history and in the examination, but cannot replace the GP's involvement in any components of the CMA
Main information web link	www.health.gov.au/internet/main/publishing.nsf/Content/mha_700-719.htm				

GP-led care planning and access to MBS-rebatable allied health services

For clients with a chronic or terminal medical condition and complex care needs

Client eligibility for MBS-funded allied health services

Clients living in the community¹³ are eligible for up to five Medicare rebates per calendar year for allied health services provided by Medicare-registered providers if during the last two years their usual GP¹⁴ has prepared a care plan for them and:

- has claimed a GP Management Plan service (#721) and Team Care Arrangements (#723) service¹⁵
- or
- has claimed a Review of a GP Management Plan (#725) or Review of Team Care Arrangements (#727) service.

These types of care plans are sometimes referred to as Enhanced Primary Care (EPC) care plans. Note that the GP must refer to allied health providers using the specific form: EPC Referral Form for Allied Health Services under Medicare.

Client eligibility for GP Management Plans and Team Care Arrangements

- A client with a chronic or terminal medical condition is eligible for a GP Management Plan.

- A client with a chronic or terminal medical condition and complex care needs is eligible for a Team Care Arrangements service.

For the purposes of the GP-led care planning items, the Commonwealth defines a chronic medical condition as one that has been or is likely to be present for six months or longer, including but not limited to asthma, cancer, cardiovascular illness, diabetes mellitus, musculoskeletal conditions and stroke. For further guidance, see ‘Consolidated Questions and Answers’ at www.health.gov.au/internet/main/publishing.nsf/Content/pcd-programs-epc-chronicdisease

Working with general practice

When community health practitioners believe that a client could benefit from GP-led care plans and MBS-subsidised access to allied health services, they should identify the client’s usual general practice and then work with them to ascertain whether or not the client already has a care plan. If not, community health staff should communicate with the client’s usual GP regarding the likely benefits of a care plan. In these circumstances, it may be appropriate to request that an EPC care plan and referral to MBS-rebateable allied

health services be considered. When coordinating services in this way, it is important that community health managers, staff and GPs:

- understand the requirements of relevant item numbers and understand which clients are eligible for these services
- ensure that the client’s usual GP is aware of the services being provided or offered to the client in the community health setting
- recognise that the ultimate decision about whether to offer and deliver a GP-led care plan is that of the GP in consultation with the client
- build on existing local referral protocols that have been based upon the Victorian Service Coordination Practice Manual and agreed within Primary Care Partnerships or through programs such as the Australian Better Health Initiative—Primary Care Integration (ABHI-PCI) programs or Early Intervention in Chronic Disease in Community Health programs.

¹³ Clients living in a Commonwealth-funded residential aged care facility are also eligible if they are being managed under a care plan into which their usual GP has contributed (#731).

¹⁴ The term “usual GP” means the doctor (or practice) that has provided the majority of services to the client over the previous 12 months, and/or that will provide the majority of services over the coming twelve months.

¹⁵ It is acceptable for practices to claim remuneration for both of items at the same time, providing the Medicare criteria for both items have been fulfilled.

Care planning and case conferencing: summary of MBS item numbers

Service type ▶▶▶	Care planning by a GP ¹⁶ Chronic disease management (CDM) items		Case conferencing organised and coordinated by a GP				GP contribution to a care plan prepared by another provider Chronic disease management (CDM) items		GP participation in case conferencing organised and coordinated by another provider				Practice nurse or registered Aboriginal health worker monitoring and support
Client eligibility ▶▶▶	Client has a chronic or terminal medical condition and is living in the community ¹⁷	Client has a chronic or terminal medical condition and complex care needs and is living in the community	Client has a chronic or terminal medical condition and is living in the community	Client has cancer and is living in the community	Client is a resident of a Commonwealth funded residential aged care facility (RACF)	Client is an in-client being discharged from a hospital or day hospital facility into the community	Client is not a resident of a Commonwealth funded residential aged care facility (RACF)	Client is a resident of a Commonwealth funded residential aged care facility (RACF)	Client has a chronic or terminal medical condition and is living in the community	Client has cancer	Client is a resident of a Commonwealth funded residential aged care facility (RACF)	Client is an in-client being discharged from a hospital or day hospital facility into the community	Client has a chronic and/or terminal condition, has a GPMP, TCA or multi-disciplinary EPC care plan in place, and is not an admitted client of a hospital
Relevant MBS item number ▶▶▶	GP Management Plan (GPMP) #721 Review of GP Management Plan #725	Team Care Arrangements (TCA) #723 Review of Team Care Arrangements #727	Organise and coordinate a community case conference 15–30 mins #740 30–45 mins #742 >45 mins #744	Lead and coordinate a case conference of at least 10 mins duration where there are at least four medical practitioners from different areas of practice and, in addition, allied health providers #871	Organise and coordinate a case conference in a RACF 15–30 mins #734 30–45 mins #736 >45 mins #738	Organise and coordinate a discharge case conference 15–30 mins #746 30–45 mins #749 >45 mins #757	Contribution to a care plan, or a review of a care plan, being prepared by another provider ¹⁸ #729	Contribution to a care plan, or a review of a care plan, being prepared by the RACF or hospital from which the resident is being discharged #731	Participation in a case conference 15–30 mins #759 30–45 mins #762 >45 mins #765	Participation in a case conference of at least 10 mins duration and where there are at least four medical practitioners from different areas of practice and, in addition, allied health providers #872	Participate in a case conference in a RACF 15–30 mins #775 30–45 mins #778 >45 mins #779	Participate in a discharge case conference 15–30 mins #768 30–45 mins #771 >45 mins #773	Provision of monitoring and support for people with a chronic disease, on behalf of a GP #10997

16 Note: A GP may also refer a patient with at least two morbidities to a consultant physician (other than in psychiatry) to undertake a comprehensive assessment develop a treatment and management plan (#132 and #133).

17 Item 721 and 723 are also available to private in-patients (incl. residents of aged care facilities) being discharged from hospital, where their usual GP is providing in-patient care.

18 Note: If a community health service seeks to engage a GP in a community health-led care coordination plan, it may be better to request input through a #721 (GPMP) and #723 (TCA) (or a review of these items—#725 or #727) rather than a #729, because clients on a #729 are not eligible for MBS-subsidised (private) allied health services.

GP care planning: summary of web links and explanatory notes

	Care planning prepared by a GP				Practice nurse and Aboriginal health worker provision of monitoring and support #10997
	GP Management Plan (GPMP) #721	Review of GP Management Plan #725	Team Care Arrangements (TCA) #723	Review of Team Care Arrangements #727	
Steps that must be taken to claim the Medicare item	<ul style="list-style-type: none"> Assessing the client to identify and/or confirm needs, problems and conditions Explaining the service and any associated costs with the client, and gaining and recording consent to proceed Agreeing on management goals with the client for changes to be achieved by the treatment and services identified in the plan Identifying required client actions Identifying treatment and services that the client is likely to need, and making arrangements for them Services and ongoing management Preparation of a comprehensive written plan describing the client's needs, goals, client actions, treatment/services and a review date Offering a copy of the plan to the client and adding it to medical records 	<ul style="list-style-type: none"> Explaining the service and any associated costs with the client, and gaining and recording consent to proceed Reviewing the client's needs and goals, client actions and treatment/services Making relevant changes to the documented GPMP Adding a new review date Offering a copy of the plan to the client and adding it to medical records 	<ul style="list-style-type: none"> Explaining the service and any associated costs with the client, and gaining consent to proceed Discussing with the client which providers should collaborate with the GP (each of whom must provide a different kind of ongoing care), gaining client consent to share information Contacting the proposed providers, obtaining their agreement to participate, and providing them with relevant information or allowing time for them to see the client, if necessary Collaborating with the other providers to discuss potential treatments/services to be provided to achieve client goals Preparing a document that describes treatment and service goals, providers involved, client actions and that nominates a review date Providing copy of the TCA document to other providers (with consent), offering a copy to client/carer, and adding it to the medical records 	<ul style="list-style-type: none"> Explaining the service and any associated costs with the client, and gaining and recording consent to proceed Discussing with the client which providers should be asked to collaborate in the review Collaborating with the providers to establish client progress against care plan goals and reviewing the plan Documenting any changes to the plan Providing a copy to other providers (with consent), offering a copy to client/carer, and adding it to the medical records 	<ul style="list-style-type: none"> Assisting clients on an EPC Care Plan who require access to ongoing care, routine treatment and ongoing monitoring and support between the more structured reviews of the care plan by the client's usual GP. Note: Cannot be claimed at the same time as GP Care Planning items #721, #723, #725, #727, #729 or #731.
Medicare rules relating to frequency of service	Maximum of once per client in a 12-month period. The recommended frequency is one #721 every 2 years (if required) with 6-monthly reviews.	Maximum of once per client in a 3-month period. The recommended frequency is every 6 months.	Maximum of once per client in a 12-month period. The recommended frequency is one #723 every 2 years (if required) with 6-monthly reviews.	Maximum of once per client in a 3-month period. The recommended frequency is every 6 months.	A maximum of 5 services per client per calendar year.
Role of the GP	The GP has ultimate responsibility for delivery of the service, which must include a personal attendance by a single medical practitioner with a single client (the consultation may include the client's carer or representative as necessary)				The GP retains responsibility for the outcomes
Roles that can be performed by practice nurses or Aboriginal health workers on behalf of and under the supervision of a GP	<ul style="list-style-type: none"> Assist in aspects of client assessment, identification of client needs, and making arrangements for services Managing review appointments system Assistance to clients as per #10997 	<ul style="list-style-type: none"> Recalling the client for the care plan review Other tasks as per GPMP column 	<ul style="list-style-type: none"> Assist in aspects of client assessment, identification of client needs, and making arrangements for services Managing review appointments system Assistance to clients as per #10997 	<ul style="list-style-type: none"> Recalling the client for the care plan review Other tasks as per TCA column 	<ul style="list-style-type: none"> All tasks Check web link for examples of specific services
Main information web links	GP items: www.health.gov.au/internet/main/publishing.nsf/Content/pcd-programs-epc-chronicdisease Practice nurse item: http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=M2.1&qt=noteID				

GP case conferencing: summary of web links and explanatory notes

	Case conferencing prepared by a GP			
	Organise and coordinate a community case conference #740, #742, #744	Lead and coordinate a case conference for a patient with cancer #871	Organise and coordinate a case conference in a residential aged care facility #734, #736, #738	Organise and coordinate a discharge case conference #746, #759, #757
Steps that must be taken to claim the Medicare item	<ul style="list-style-type: none"> • Obtaining and recording client consent • Recording names of participants, date, start/end times, and minutes • Discussing the client's history and identifying their needs • Identifying outcomes to be achieved by members of the team, and tasks that need to be undertaken by each member • Assessing whether previously identified outcomes (if any) have been achieved • Placing all notes in the client's medical record and offering copies to the client, carer, and members of the team • Discussing outcomes with the client 	<ul style="list-style-type: none"> • Coordinating the participation of at least three other medical practitioners from different areas of medical practice, and allied health practitioners if appropriate • Ensuring that at least one of the practitioners has explained the nature of the meeting, gained client consent for it to occur and for information to be shared with members of the conference team, and explained any associated fees • Leading the development of a multidisciplinary treatment plan 	<ul style="list-style-type: none"> • Obtaining and recording consent • Organising participants, which must include a medical practitioner and at least two other members, each of whom provides a different kind of care to the client • Recording participant names, date, start/end times, and minutes • Discussing the client's history and identifying care needs • Identifying outcomes to be achieved by team members and tasks that need to be undertaken by each • Assessing whether previously identified goals have been achieved • Placing all notes in the client's medical record and offering copies to the client and/or their carer, to the client's regular GP if not a member of the team, and to the facility • Discussing outcomes with the client 	<ul style="list-style-type: none"> • Obtaining and recording client consent • Organising participants, which must include a medical practitioner and at least two other members each of whom provides a different kind of client care • Recording participant names, date, start/end times, and minutes • Discussing the client's history and identifying their needs • Identifying outcomes to be achieved by members of the team and tasks that need to be undertaken by each member • Assessing whether previously identified outcomes (if any) have been achieved • Placing all notes in the client's medical record and, with client consent, offering copies to the client and/or their carer, to the client's regular GP if not a member of the team, and to the hospital • Discussing outcomes with the client
Medicare rules relating to frequency of service	Not more than 5 case conferences in a 12-month period	Not more than 2 cancer case conferences per client in a 12-month period	Not more than 5 case conferences in a 12-month period	Not more than 5 case conferences in a 12-month period
Role of the GP	<ul style="list-style-type: none"> • Being a member of the case conference team (this cannot be delegated) • Discussing outcomes with the client • Medical components that cannot be delegated 	<ul style="list-style-type: none"> • Ensuring the client understands what is to occur and has provided consent • Leading the development of the treatment plan 	<ul style="list-style-type: none"> • Being a member of the case conference team (this cannot be delegated) • Discussing outcomes with the client • Medical components that cannot be delegated 	<ul style="list-style-type: none"> • Being a member of the case conference team (this cannot be delegated) • Discussing outcomes with the client • Medical components that cannot be delegated
Roles that can be performed by practice nurses or Aboriginal health workers on behalf of and under the supervision of a GP	<ul style="list-style-type: none"> • Gathering and documenting relevant information for the GP • Making arrangements for services • Managing appointments system 	<ul style="list-style-type: none"> • Gathering and documenting relevant information for the GP • Contacting other providers • Making arrangements for services • Managing appointments system 	<ul style="list-style-type: none"> • Gathering and documenting relevant information for the GP • Making arrangements for services • Managing appointments system 	<ul style="list-style-type: none"> • Gathering and documenting relevant information for the GP • Making arrangements for services • Managing appointments system
Main information web link	Case conferencing: www.health.gov.au/internet/main/Publishing.nsf/Content/health-epc-caseconf.htm Cancer case conferencing: www.nbcc.org.au/bestpractice/resources/MDCC_informationaboutthen.pdf			

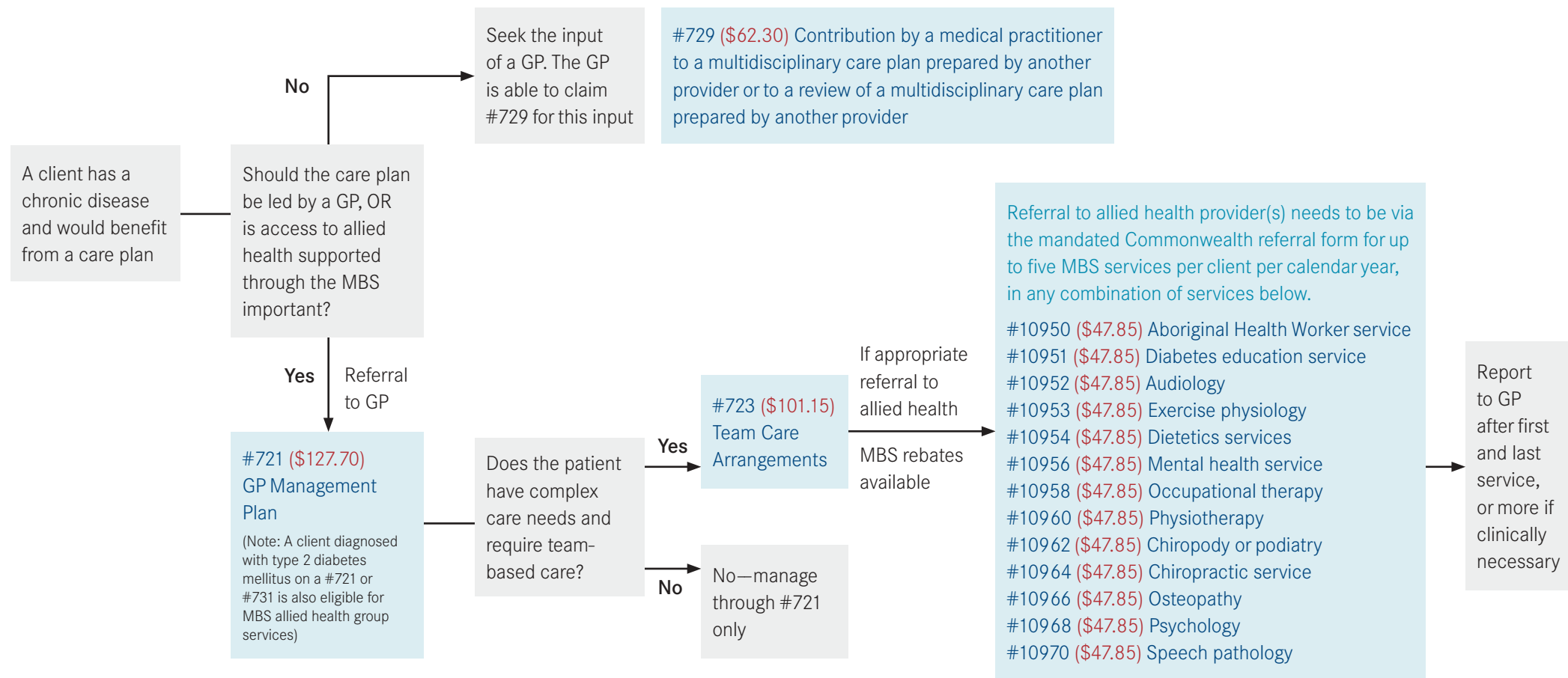
GP contribution to care plan prepared by another provider: summary of web links and explanatory notes

	GP contribution to care planning which is being prepared by another provider		Practice nurse/Aboriginal health worker provision of monitoring and support #10997
	Contribution to a care plan or to a review of a care plan, being prepared or reviewed by another provider #729	Contribution to a care plan or to a review of a care plan being prepared by the residential aged care facility (RACF) or hospital from which the resident is being discharged #731	
Steps that must be taken to claim the Medicare item	<ul style="list-style-type: none"> Gaining or confirming the client's agreement for the GP to contribute to the care plan, or to the review of the care plan and to share relevant information with the other providers Collaborating with the person preparing the care plan to set goals and specify the treatment/services to be provided by the GP Adding to the client's records a copy or notation of the GP's contribution to the plan (either the treatment/services to be provided by the GP or the GP's advice to the person preparing the plan) 	<ul style="list-style-type: none"> Responding to a request from the RACF or hospital to contribute to the care plan Gaining or confirming the resident's agreement for the GP to contribute to the care plan, or to the review of the care plan and to share relevant information with the other providers Collaborating with the person preparing the care plan to set goals and specify the treatment/services to be provided by the GP Adding to the client's medical records and the records at the RACF or hospital a copy or notation of the GP's contribution to the plan (either the treatment/services to be provided by the GP or the GP's advice to the person preparing the plan) 	<ul style="list-style-type: none"> Assisting clients on an EPC care plan who require access to ongoing care, routine treatment and ongoing monitoring and support between the more structured reviews of the care plan by the client's usual GP Note: Cannot be claimed at the same time as EPC care planning items #721, #723, #725, #727, #729 or #731
Medicare rules relating to frequency of service	One per client in a 3-month period. The recommended frequency is one every 6 months (if required). Other than in exceptional circumstances, a rebate will not be paid within 12 months of a GP Management Plan (GPMP) or Team Care Arrangements (TCA) claimed by the same practitioner for that client	One per client in a 3-month period. The recommended frequency is one every 6 months (if required). Other than in exceptional circumstances, a rebate will not be paid within 3 months of a GPMP or TCA claimed by the same practitioner for that client	A maximum of 5 services per client per calendar year
Role of the GP	<ul style="list-style-type: none"> Ultimate responsibility for the Medicare service 	<ul style="list-style-type: none"> Ultimate responsibility for the Medicare service 	<ul style="list-style-type: none"> The GP retains responsibility for the health, safety and clinical outcomes of the client.
Roles that can be performed by practice nurses or Aboriginal health workers on behalf of and under the supervision of a GP	<ul style="list-style-type: none"> Liaising with the person preparing the care plan to organise the collaboration, or to gather information necessary for consideration by the GP 	<ul style="list-style-type: none"> Liaising with the facility or hospital to organise the collaboration, or to gather information necessary for consideration by the GP 	<ul style="list-style-type: none"> All tasks Check web link for examples of specific services
Main information web link	GP Items: www.health.gov.au/internet/main/publishing.nsf/Content/pcd-programs-epc-chronicdisease Practice nurse Item: http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=M2.1&qt=noteID		

GP participation in case conferencing: summary of web links and explanatory notes

GP Participation in case conferencing organised and coordinated by another provider				
	Participation in a case conference #759, #762, #765	Participation in a case conference on a patient with cancer #872	Participate in a case conference in a residential aged care facility #775, #778, #779	Participate in a discharge case conference #768, #771, #773
Steps that must be taken to claim the Medicare item	<ul style="list-style-type: none"> Responding to a request to participate, and agreeing on timing Obtaining and recording client consent for GP involvement Recording all notes and decisions Discussing the client's history and identifying their needs Identifying outcomes to be achieved by members of the case conference team, and tasks that need to be undertaken by each member of the team Assessing whether previously identified outcomes (if any) have been achieved Placing all notes in the client's medical record and offering copies to the client and/or their carer 	<ul style="list-style-type: none"> Ensuring that at least one of the practitioners has explained the nature of the meeting, gained client consent for it to occur and for information that the practitioners intend to share, and explained any associated fees Contributing to the development of a multidisciplinary treatment plan 	<ul style="list-style-type: none"> Responding to a request to participate, and agreeing on timing Obtaining and recording client consent for GP involvement Recording all notes and decisions Discussing the client's history and identifying their needs Identifying outcomes to be achieved by members of the case conference team, and tasks that need to be undertaken by each member of the team Assessing whether previously identified outcomes (if any) have been achieved Placing all notes in the client's medical record and offering copies to the client and/or their carer, to the client's regular GP if not a member of the team, and to the facility 	<ul style="list-style-type: none"> Responding to a request to participate, and agreeing on timing Obtaining and recording client consent for GP involvement Recording all notes and decisions Discussing the client's history and identifying their needs Identifying outcomes to be achieved by members of the case conference team, and tasks that need to be undertaken by each member of the team Assessing whether previously identified outcomes (if any) have been achieved Placing all notes in the client's medical record and offering copies to the client and/or their carer
Medicare rules relating to frequency of service	Not more than 5 case conferences in a 12-month period	Not more than 2 cancer case conferences in a 12-month period per client	Not more than 5 case conferences in a 12-month period	Not more than 5 case conferences in a 12-month period
Role of the GP	<ul style="list-style-type: none"> Being a member of the case conference team (this cannot be delegated) Discussing outcomes with client Medical components that cannot be delegated 	<ul style="list-style-type: none"> Ensuring the client understands what is to occur and has provided consent Contributing to the development of the treatment plan 	<ul style="list-style-type: none"> Being a member of the case conference team (this cannot be delegated) Discussing outcomes with the client Medical components that cannot be delegated 	<ul style="list-style-type: none"> Being a member of the case conference team (this cannot be delegated) Discussing outcomes with client Medical components that cannot be delegated
Roles that can be performed by practice nurses or Aboriginal health workers on behalf of and under the supervision of a GP	<ul style="list-style-type: none"> Gathering and documenting relevant information for the GP Making arrangements for services Managing appointments system 	<ul style="list-style-type: none"> Gathering and documenting relevant information for the GP Contacting other providers Making arrangements for services Managing appointments system 	<ul style="list-style-type: none"> Gathering and documenting relevant information for the GP Making arrangements for services Managing appointments system 	<ul style="list-style-type: none"> Gathering and documenting relevant information for the GP Making arrangements for services Managing appointments system
Main information web link	GP Items: www.health.gov.au/internet/main/publishing.nsf/Content/pcd-programs-epc-chronicdisease			

Access to MBS-rebateable allied health services through GP-led care plans



Note: MBS rebates are increased annually on 1 November. The rebate amounts are current as at 1 November 2007 but will change—check at www9.health.gov.au/mbs

All remuneration shown is the benefit that the provider can claim from Medicare if the service is bulk-billed, or the rebate that the patient can claim from Medicare if the service is privately billed.

All information is current as at November 2007. Health professionals intending to use these items should refer to www.health.gov.au/internet/main/publishing.nsf/Content/health-medicare-health_pro-gp-pdf-allied-cnt.htm and/or the Medicare Benefits Schedule (MBS) book and/or to the Allied Health and Dental Services MBS booklet for more comprehensive information, including the MBS requirements for each item. Alternatively, search for specific items at www9.health.gov.au/mbs or telephone Medicare Australia on 03 9605 7964 or contact their local division of general practice.

Allied health: summary of MBS item numbers

Service type ▶▶▶	Allied health professional service (provided to an individual)							Allied health professional services (provided to a group)		
Client eligibility ▶▶▶	Client has a chronic medical condition ¹⁹ and complex care needs ²⁰ , is being managed by a GP under an EPC plan ²¹ and is not an admitted patient of a hospital							Client has been diagnosed with type 2 diabetes mellitus, is being managed in the community by a GP under a GP Management Plan service (#721) or, if a resident of a Commonwealth-funded aged care facility, is being managed under a multidisciplinary care plan to which the GP has contributed (#731), and is not an admitted patient of a hospital		
Relevant MBS item numbers ²² ▶▶▶	Aboriginal Health Worker service #10950	Diabetes education service #10951	Audiology #10952	Exercise physiology #10953	Dietetics services #10954	Mental health service #10956	Occupational therapy #10958	Assessment for Group Services		
								Diabetes education service—Assessment for group services #81100	Exercise physiology service—Assessment for group services #81110	Dietetics service—Assessment for group services #81120
	Physiotherapy #10960	Podiatry #10962	Chiropractic service #10964	Osteopathy #10966	Psychology #10968	Speech pathology #10970		Group services		
								Diabetes education service—Group service #81105	Exercise physiology service—Group service #81115	Dietetics service—Group service #81125

19 A chronic medical condition is one that has been or is likely to be present for six months or longer, including but not limited to asthma, cancer, cardiovascular illness, diabetes mellitus, musculoskeletal conditions and stroke. For more information/guidance, see 'Consolidated Questions and Answers' at www.health.gov.au/internet/main/publishing.nsf/Content/pcd-programs-epc-chronicdisease

20 Complex care needs means requiring care from a multidisciplinary team. Team Care Arrangements are likely to be indicated where a patient has complex health care needs and one or more of the following: little or no capacity to access or receive needed services by the usual referral process; an unstable or deteriorating condition and/or co-morbidities; increasing frailty and/or dependence; increasing incidence and/or complexity of health problems; complications, including falls or incontinence; significant change in social circumstances (such as death, illness or 'burnout' of carer); two or more hospital admissions for their chronic condition in the past six months; inability to comply with required treatment without ongoing management and coordination; a need to see other providers on regular, frequent and ongoing basis to manage the chronic condition. For more information/guidance, see 'Consolidated Questions and Answers' at www.health.gov.au/internet/main/publishing.nsf/Content/pcd-programs-epc-chronicdisease

21 The term 'EPC Plan' is a generic one. Clients are being managed under an EPC Plan if their GP has prepared and billed the following MBS Chronic Disease Management Items in the previous two years:

(a) A GP Management Plan—item 721 (or review item 725); AND (b) A Team Care Arrangements—item 723 (or review item 727).

Clients who are permanent residents of an aged care facility are being managed under an EPC plan if their GP has contributed to or reviewed a multidisciplinary care plan prepared for them by the aged care facility (item 731).

22 The item numbers can only be claimed for services provided by allied health practitioners and dental practitioners registered with Medicare Australia

Allied health (individual): summary of web links and explanatory notes

	Allied health professional (AHP) service (provided to an individual) #10950, #10951, #10952, #10953, #10954, #10956, #10958, #10960, #10962, #10964, #10966, #10968, #10970
Steps that must be taken to claim the Medicare item	<ul style="list-style-type: none"> • GP has placed the client on a multidisciplinary EPC care plan¹ and recommended this service as part of the plan • GP has referred the client to the AHP using the mandated Commonwealth EPC allied health referral form, or a form that substantially complies with it • Service of at least 20 minutes is provided by the AHP, individually and in person • Following the provision of first and last service/s, the AHP provides a written report to the referring GP
Medicare rules relating to frequency of service or capped benefits	A client is eligible for a maximum total of 5 services in any calendar year, in any combination of the AHP item numbers
Role of the GP	<ul style="list-style-type: none"> • Placing the client on an EPC care plan • If the care plan recommends allied health services, referral to allied health provider(s) using mandated referral form (or form which substantially complies) • Consideration of reports from allied health provider(s) and reviewing the client's care plan, if necessary
Roles that can be performed by practice nurses or Aboriginal health workers on behalf of and under the supervision of the GP	<ul style="list-style-type: none"> • Gathering and documenting relevant information for the GP • Arranging services and managing appointments • Monitoring client progress against the EPC care plan and a review of the plan
Main information web link	www.health.gov.au/internet/main/publishing.nsf/Content/Allied+Health+and+Dental+Care+initiative

Allied health (group): summary of web links and explanatory notes

Allied health services (provided to a group)	
Assessment for group services #81100, #81110, #81120	Group services #81105, #81115, #81125
Steps that must be taken to claim the Medicare item	<ul style="list-style-type: none"> Receipt of referral from the medical practitioner managing the client on an EPC care plan²³ Taking a comprehensive client history, identifying individual goals and preparing the client for an appropriate group service, if they are suitable (this service should be provided individually and in person, and last at least 45 minutes) Provision of written report back to the referring medical practitioner outlining the assessment undertaken, whether the client is suitable for group services and, if so, the nature of the group services to be delivered
Medicare rules relating to frequency of service	<ul style="list-style-type: none"> Receipt of the referral for group services form for each person to receive a group service Provision of service to a group of between 2 and 12 persons in size, lasting at least 60 minutes Provision of, or contribution to, a written report back to the referring GP in respect of each client, describing the group services provided and the outcomes achieved²⁴
Medicare rules relating to frequency of service	Once only in any calendar year
Role of the GP	<ul style="list-style-type: none"> Manage the client on a GP Management Plan Referral to the allied health practitioner using the referral form provided by the Commonwealth or one that substantially complies with it, with the client's care plan attached if the client has consented
Role of the GP	<ul style="list-style-type: none"> Receipt of written reports from the allied health practitioners and consideration of client progress in relation to a review of their existing care plan
Roles that can be performed by practice nurses or Aboriginal health workers on behalf of and under the supervision of the GP	<ul style="list-style-type: none"> Gathering and documenting relevant information for the GP Making arrangements for services Managing appointments system Monitoring client progress against the EPC care plan and assisting the GP in a review of the client's plan, if necessary
Main information web link	www.health.gov.au/internet/main/publishing.nsf/Content/health-pacd-epc-ahgs-diabetes.htm

23 Unlike the individual allied health services that attract a Medicare rebate under items #10950 to #10970, there is no additional requirement for the client to have Team Care Arrangements (#723) service in place in order to attract a rebate for these allied health group services. Having a care plan arranged under items #721 or #731 alone is sufficient to be eligible for Medicare rebateable allied health group services.

24 While each allied health professional is required to provide feedback to the GP in relation to the group services that they provide to the client, allied health professionals involved in the provision of a multidisciplinary program are encouraged to combine feedback into a single report to the referring GP.

Access to MBS-funded mental health services

Three new MBS items are available for GPs to provide continuing management of patients with ‘mental disorders’. There is also a suite of new items for mental health providers to lead or contribute to care.

Mental health services under this program include psychological assessment and therapy provided by eligible clinical psychologists, and focused psychological strategies provided by eligible psychologists, social workers occupational therapists and GPs with additional training.

A client is eligible to access Medicare rebates for up to 12 services (individual and/or group services) from a clinical psychologist or other allied mental health professional in a calendar year, regardless of whether they have been referred from one provider or many (for example, they may have been referred by a psychiatrist and/or a paediatrician and/or a GP).

These 12 rebates are for clients who are referred by:

- a medical practitioner managing the patient under a GP Mental Health Care Plan (#2710) or under a Psychiatrist Assessment and Management Plan (#291)
or
- a psychiatrist or paediatrician. These mental health MBS items are collectively referred to as the Better Access to Mental Health Services items.

Client eligibility for MBS-funded mental health services

Clients are eligible for these services if they are judged by a GP, psychiatrist or paediatrician to have a ‘mental disorder’. Mental disorder is a term used to describe a range of clinically diagnosable disorders that significantly interfere with an individual’s cognitive, emotional or social abilities (see footnote 25).

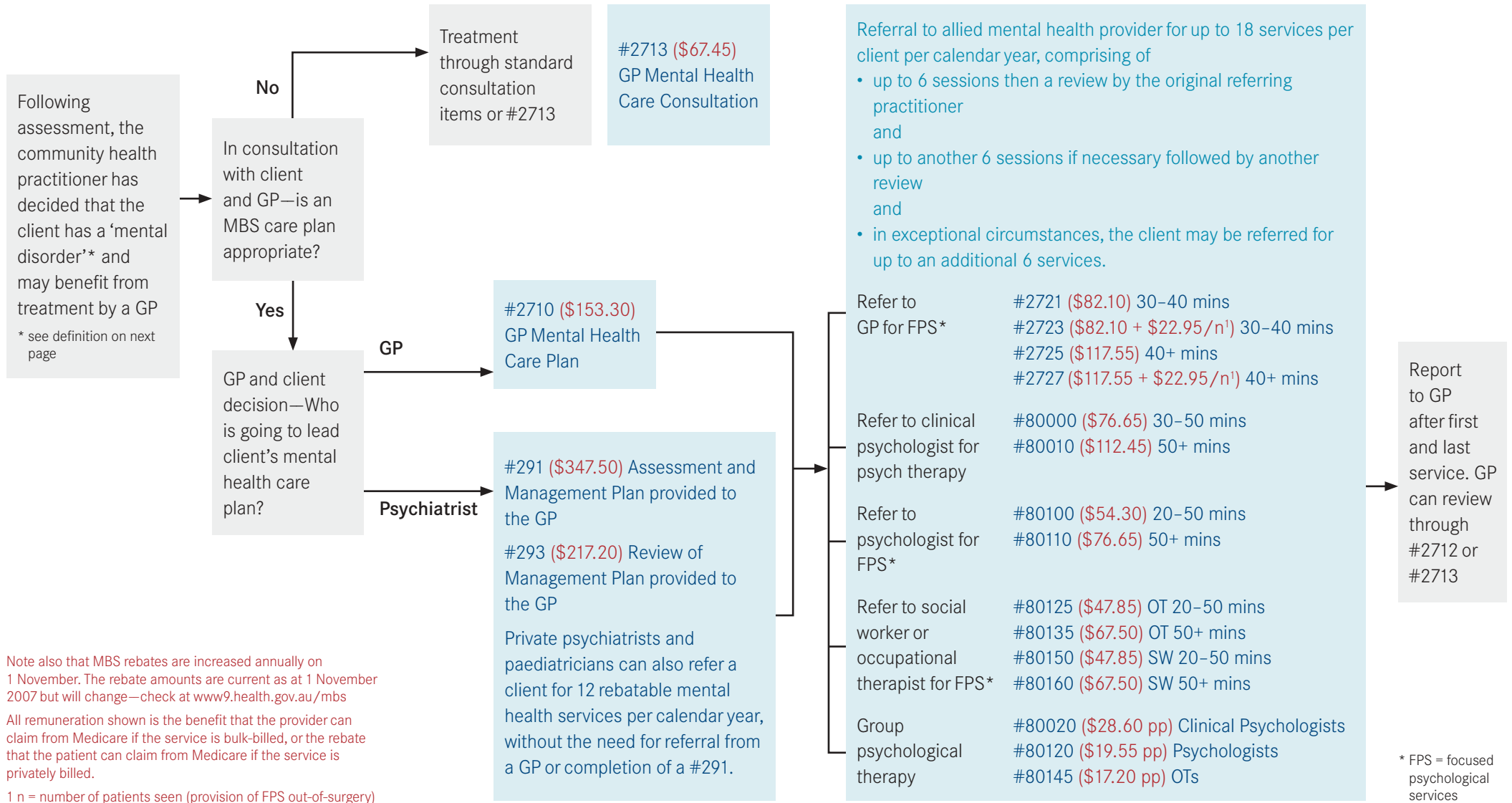
Limitations

The Better Access to Mental Health Services item numbers will not suit all community health clients with mental health problems, because:

- there may be substantial gap fees if the relevant private provider chooses to charge above the schedule fee
- access to Medicare-registered practitioners may be limited, particularly in rural and outer urban areas
- the item numbers do not fund
 - non-therapy interventions, such as casework
 - family therapy sessions where the client is not present.

Despite these limitations, the items have the potential to complement community health counselling.

Better Access to Mental Health items



Note also that MBS rebates are increased annually on 1 November. The rebate amounts are current as at 1 November 2007 but will change—check at www9.health.gov.au/mbs

All remuneration shown is the benefit that the provider can claim from Medicare if the service is bulk-billed, or the rebate that the patient can claim from Medicare if the service is privately billed.

1 n = number of patients seen (provision of FPS out-of-surgery)

Better Access to Mental Health—care plans: summary of MBS item numbers

Service type ▶▶▶	GP mental health care plans			Consultant psychiatrist assessment and management mental health care plans	
Client eligibility ▶▶▶	Client has a mental disorder ²⁵ and would benefit from a structured approach to the management of their care needs	Client has a mental disorder ²⁶ and would benefit from a structured approach to the management of their care needs, and is being managed through a #2710	Client has a mental disorder ²⁶	Client has a mental illness and has been referred from a GP for an assessment and management plan	Client is on a #291 has been referred from a GP for a review of the assessment and management plan previously provided by the same psychiatrist
Relevant MBS item number ▶▶▶	GP mental health care plan #2710	GP mental health care plan review #2712	GP mental health care consultation ²⁶ #2713	Referred patient assessment and management plan #291	Review of referred patient assessment and management plan #293

25 Mental disorder is a term used to describe a range of clinically diagnosable disorders that significantly interfere with an individual's cognitive, emotional or social abilities (refer to the World Health Organisation, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care: ICD 10 Chapter V Primary Care Version). Dementia, delirium, tobacco use disorder and mental retardation are not regarded as mental disorders for the purposes of these item numbers.

26 This item may be used for ongoing management of a patient with a mental disorder. This item should not be used for the development of a GP Mental Health Care Plan.

Better Access to Mental Health—psychological assessment and therapy: summary of MBS item numbers

Service type ▶▶▶	Provision of focussed psychological strategies (FPS) services on referral from a GP, psychiatrist or paediatrician							Provision of psychological therapy services by a clinical psychologist on referral from a GP, psychiatrist or paediatrician	
Client eligibility ▶▶▶	Client has a mental disorder ²⁷ and would benefit from a structured approach to the management of their care needs, and has been referred through a GP Mental Health Care Plan or Review (#2710 or #2712), or consultant psychiatrist Assessment and Management Plan or Review (#291 or #293), or by a psychiatrist or paediatrician							Client has a mental disorder ²⁷ , would benefit from a structured approach to the management of their care needs and has been referred through a #2710, #2712, #291 or #293, or referred by a psychiatrist or paediatrician	
Relevant MBS item number ▶▶▶	FPS provided by registered ²⁸ GPs #2721, #2723, #2725, #2727	FPS provided by registered ²⁹ psychologists #80100, #80105, #80110, #80115	FPS provided by registered ²⁹ Occupational Therapists #80125, #80130, #80135, #80140	FPS provided by registered ²⁹ Social Workers #80150, #80155, #80160, #80165	Group ³⁰ FPS provided by registered ²⁹ psychologists #80120	Group ³⁰ FPS provided by an registered ²⁹ occupational therapist #80145	Group ³⁰ FPS provided by a registered ²⁹ social worker #80170	Psychological assessment and therapy #80000, #80005, #80010, #80015	Group ³⁰ psychological therapy #80020

27 Mental disorder is a term used to describe a wide range of clinically diagnosable disorders that significantly interfere with an individual's cognitive, emotional or social abilities (refer to the World Health Organisation, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care: ICD 10 Chapter V Primary Care Version). Dementia, delirium, tobacco use disorder and mental retardation are not regarded as mental disorders for the purposes of these item numbers.

28 Focussed Psychological Strategies (FPS) services may only be provided by medical practitioners who are registered with Medicare Australia as having satisfied the requirements for higher level mental health skills for the provision of the service. The medical practitioner must provide the service in a general practice participating in the PIP and/or which is accredited. It is acceptable for a GP who is managing a client through a #2710 or #2712 to refer to themselves for the provision of FPS and use a GP FPS MBS item number if they are registered with Medicare Australia. Information about registration is available through the Medicare provider enquiry line, 132 150.

29 The allied health professional must be registered with Medicare Australia to provide this service. Information about registration is available through the Medicare provider enquiry line, 132 150.

30 For the purpose of these item numbers, a group means 6–10 persons. These sessions need to run for at least 60 minutes for a Medicare rebate to be available.

Better Access to Mental Health—care plans: summary of web links and explanatory notes

	GP mental health care plans and consultations			Consultant psychiatrist-led assessment and management mental health care plans	
	GP mental health care plan #2710	GP mental health care plan review #2712	GP mental health care consultation #2713	Referred patient assessment and management plan #291	Referred patient review of assessment and management plan #293
Steps that must be taken to claim the Medicare item	<ul style="list-style-type: none"> Client assessment, including consent, relevant history, mental state examination, using an outcome measurement tool if appropriate Diagnosis, including associated risk and any co-morbidities Preparation of a care plan, including discussing assessment, referral and treatment options with the client, agreeing goals and client actions, providing psycho-education, planning for crisis intervention and/or relapse prevention, arranging referrals, treatment, and support services and documenting this in the client's plan 	<ul style="list-style-type: none"> Recording the client's consent Reviewing progress against goals outlined in the client's care plan Modifying the care plan, if required Checking, reinforcing and expanding education Re-administering outcome measurement tool (if appropriate) 	Consultation of at least 20 minutes, including: <ul style="list-style-type: none"> taking relevant history and identifying presenting problems providing treatment, advice and/or referral for other services documenting outcomes in client record and relevant mental health plan (where applicable) 	Consultation of at least 45 minutes, at which: <ul style="list-style-type: none"> an outcome tool is used where appropriate a mental state examination is conducted a psychiatric diagnosis is made the consultant psychiatrist decides that the client can be appropriately managed by the referring GP without the need for ongoing treatment by the psychiatrist a 12-month management plan, appropriate to the diagnosis, is provided to the referring GP the diagnosis and management plan is explained and provided, unless clinically inappropriate, to the client and/or the carer (with the client's agreement) the diagnosis and management plan is communicated in writing to the referring GP within 2 weeks 	Consultation of at least 30 minutes but less than 45 minutes for a client for whom a #291 has been provided, at which: <ul style="list-style-type: none"> an outcome tool is used where appropriate a mental state examination is conducted a psychiatric diagnosis is made the management plan provided under #291 is reviewed/revised the reviewed management plan is explained and provided, unless clinically inappropriate, to the client and/or the carer (with the client's agreement) the reviewed management plan is communicated in writing to the referring GP within 2 weeks
Medicare rules relating to frequency of service	A new plan should not be prepared unless clinically required, and generally not within 12 months of a previous plan, unless needed due to exceptional circumstances (a significant change in the client's clinical conditions or care circumstances)	Initial review 4–24 weeks after initial care plan, and second review 3 months after the first—flexible according to client needs	Nil	May be claimed once only for each eligible client. In circumstances in which the psychiatrist is not sure in the initial consultation whether the client is eligible for a management plan, it is appropriate to bill other items and use #291 later if the client is eligible	Once per client for any 12-month period
Role of the GP	All consultations must be rendered by the GP			Refer a client to these services; receive written report and continue to provide overall management of the client's mental health care	
Roles that can be performed by practice nurses or Aboriginal health workers on behalf of and under the supervision of 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			Assistance to the GP in coordination of services	
Main information web link	www.health.gov.au/internet/main/publishing.nsf/Content/health-pcd-gp-mental-health-care-medicare				

Better Access to Mental Health—psychological assessment and therapy: summary of web links and explanatory notes

	Provision of focussed psychological strategies (FPS) services on referral from a GP, psychiatrist or paediatrician						Provision of psychological therapy services by a clinical psychologist on referral from a GP, psychiatrist or paediatrician		
	FPS provided by registered GPs #2721, #2723, #2725, #2727	FPS provided by registered psychologists #80100, #80105, #80110, #80115	FPS provided by registered Occupational Therapists #80125, #80130, #80135, #80140	FPS provided by registered Social Workers #80150, #80155, #80160, #80165	Group FPS provided by registered psychologists #80120	Group FPS provided by registered occupational therapists #80145	Group FPS provided by registered social workers #80170	Psychological assessment and therapy #80000, #80005, #80010, #80015	Group psychological therapy #80020
Services that must be performed to claim the Medicare item	<p>A range of acceptable strategies has been approved for use by practitioners in this context, such as</p> <ul style="list-style-type: none"> • psycho-education • cognitive-behavioural therapy • relaxation strategies • skills training • interpersonal therapy <p>There is flexibility to include narrative therapy for Aboriginal and Torres Strait Islander people.</p> <p>Following an initial course of therapy (up to 6 services), a report should be provided back to the referring GP that includes:</p> <ul style="list-style-type: none"> • information on assessments carried out on the client • treatment provided • recommendations on future management of the client's disorder <p>Reports must also be provided back to the referring medical practitioner following any subsequent referred courses of treatment.</p>						<p>In addition to psycho-education, it is recommended that cognitive behaviour therapy be provided. However, other evidence-based therapies, such as interpersonal therapy, may be used if considered clinically relevant.</p> <p>Following an initial course of therapy (up to 6 services), a report should be provided back to the referring practitioner which includes:</p> <ul style="list-style-type: none"> • Information on assessments carried out on the client • Treatment provided • Recommendations on future management of the client's disorder • Reports must also be provided back to the referring practitioner following any subsequent referred courses of treatment 		
Medicare rules relating to frequency of service	<p>Up to 12 services per client per calendar year.</p> <p>An additional 6 services per client per calendar year may be available in exceptional circumstances (such as a significant change in client's clinical condition or care circumstances).</p>								
Role of the GP	<p>Refer a client to these services, receive written report and continue to provide overall management of the client's mental health care.</p>								
Roles that can be performed by practice nurses or Aboriginal health workers on behalf of and under the supervision of the GP	<p>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.</p>								
Main information web link	<p>www.health.gov.au/internet/main/publishing.nsf/Content/health-pcd-programs-amhpm</p>								

Service incentive payments (SIPs): summary of MBS item numbers

Service type ▶▶▶	Provision of good care for a client with diabetes mellitus ³¹ (completion of a diabetes cycle of care)	Provision of best practice care for a client with moderate to severe ³² asthma (completion of an asthma cycle of care)	Provision of a cervical cancer screening service for a woman who is unscreened or significantly underscreened ³³
Client eligibility ▶▶▶	Client has been diagnosed with diabetes mellitus	Client has been diagnosed with moderate to severe ³² asthma	Client is female, has a cervix, has had intercourse, is aged 20–69 inclusive, and has not had a cervical smear within the last four years
MBS item numbers ³⁴ if cycle is completed in consulting rooms ▶▶▶	Level 'B' type attendance #2517 Level 'C' type attendance #2521 Level 'D' type attendance #2525	Level 'B' type attendance #2546 Level 'C' type attendance #2552 Level 'D' type attendance #2558	Level 'A' type professional attendance #2497 Level 'B' type professional attendance #2501 Level 'C' type professional attendance #2504 Level 'D' type professional attendance #2507 If the service is performed by a Practice Nurse, it is appropriate to claim #10995 or #10999 instead of one of the items above (see Prevention section)
MBS item numbers ³⁴ if cycle is completed out-of-surgery ▶▶▶	Level 'B' type attendance #2518 Level 'C' type attendance #2522 Level 'D' type attendance #2526	Level 'B' type attendance #2547 Level 'C' type attendance #2553 Level 'D' type attendance #2559	Level 'B' type professional attendance #2503 Level 'C' type professional attendance #2506 Level 'D' type professional attendance #2509
Additional billing information ▶▶▶	All visits as part of the cycle of care should be billed under normal/usual attendance items, with the exception of the visit that <u>completes</u> all of the minimum requirements of the relevant annual cycle of care. This 'completing' visit should be billed using one of the item numbers listed above, which will trigger an incentive payment through the Practice Incentives Program (PIP) in addition to attracting the usual Medicare rebate.		Any of the GP items above, or the practice nurse cervical screening items (#10995 or #10999), will trigger an incentive payment through the Practice Incentives Program (PIP) in addition to attracting the usual Medicare rebate.

31 The requirements for claiming this item are the minimum needed to provide good care for a client with diabetes. Additional levels of care will be needed by insulin-dependent clients and those with abnormal review findings, complications and/or co-morbidities. Refer to clinical guidelines at www.racgp.org.au/guidelines/diabetes

32 Generally, clients who meet the following criteria can be assumed to have been assessed as having moderate to severe asthma: symptoms on most days or use of preventer medication or bronchodilator use at least 3 times per week or hospital attendance or admission following an acute exacerbation of asthma.

33 For the purposes of this Medicare item number, an 'unscreened or under screened' client is defined as a woman aged 20–69, with a cervix, who has had intercourse, and who has not had a Pap test in the last four years.

34 Note that these MBS item numbers are claimable for services provided by General Practitioners, as defined within Note 4 (General Practice) of the MBS. Practicing community medical practitioners who are not Vocationally Registered (VR) are able to access remuneration for these initiatives through other item numbers. In surgery, the corresponding item numbers are #2620, #2622, and #2624 for diabetes; #2664, #2666 and #2668 for asthma; and #2598, #2600, #2603 and #2606 for cervical cancer screening. Out of surgery, the corresponding item numbers are #2631, #2633 and #2635 for diabetes; #2673, #2675 and #2677 for asthma; and #2610, #2613 and #2616 for cervical cancer screening. See www9.health.gov.au/mbs for a detailed description of these items for non-VR medical practitioners.

Service incentive payments (SIPs): summary of web links and explanatory notes

	Provision of good care for a client with diabetes mellitus ³⁵ (completion of a diabetes cycle of care) #2517, #2518, #2521, #2522, #2525, #2526, #2620, #2622, #2624, #2631, #2633, #2635	Provision of best practice care for a client with moderate to severe ³⁶ asthma (completion of an asthma cycle of care) #2546, #2547, ##2552, #2553, #2558, #2559, #2664, #2666, #2668, #2673, #2675, #2677	Provision of a cervical cancer screening service for a woman who is unscreened or significantly under-screened #2497, #2501, #2503, #2504, #2506, #2507, #2509, #2598, #2600, #2603, #2606, #2610, #2613, #2616, #10995, #10999
Steps that must be taken to claim the Medicare item (many of these elements may be performed by qualified allied health professionals)	<p>At least twice every cycle of care:</p> <ul style="list-style-type: none"> Measure weight and height, calculate BMI, measure blood pressure, examine feet <p>At least once yearly:</p> <ul style="list-style-type: none"> Assess diabetes control by measuring HbA1c Measure total cholesterol, triglycerides and HDL cholesterol Test for microalbuminuria <p>At least once every two years:</p> <ul style="list-style-type: none"> Comprehensive eye examination <p>Also:</p> <ul style="list-style-type: none"> Provide self-care education and education re diabetes management Review diet, physical activity, smoking status and client medication, and provide advice 	<ul style="list-style-type: none"> At least two asthma-related consultations by a GP within 12 months, one of which (the review consultation) was planned at a previous consultation Documented diagnosis and assessment of level of asthma control, and severity of asthma Review of the client's use of and access to asthma-related medication and devices Provision to the client of a written asthma action plan (or if the client is unable to use a written plan, discussion about an alternative method of providing an action plan, and documentation of this discussion in client's medical record) Provision of asthma self-management education to the client Review of the written or documented action plan 	<ul style="list-style-type: none"> Ensuring the client, who is aged 20–69 inclusive, has not had a cervical smear in the last four years Taking a cervical smear Completing any other requirements of the relevant item number being claimed (see details of the relevant item number at www9.health.gov.au/mbs)
Medicare rules relating to frequency of service	Once per client for any 11 to 13-month period	Once per eligible client for any 12-month period, unless a further cycle is clinically indicated by exceptional circumstances	Can only be claimed when provided to a woman aged between 20–69 years inclusive who has not had a cervical smear in the last four years
Role of the GP	<ul style="list-style-type: none"> Determining client eligibility and initiating the service if appropriate Central coordinating role, including at least two consultations with the client Medical components that cannot be delegated Formulating and agreeing on the plan in consultation with the client Reviewing the plan in consultation with the client 	<ul style="list-style-type: none"> Determining client eligibility and initiating the service if appropriate Central coordinating role, including at least two consultations with the client Medical components that cannot be delegated Formulating and agreeing on the plan in consultation with the client Reviewing the plan in consultation with the client 	<ul style="list-style-type: none"> Ensure client is unscreened or significantly under screened for the purpose of claiming these items. If not eligible yet still due for a smear, another item number can be claimed The GP is able to perform the smear and claim one of the items above, or delegate performance to a qualified practice nurse Help decide which item should be billed from list above, based on services provided
Roles that can be performed by practice nurses or Aboriginal health workers on behalf of and under the supervision of a GP	<ul style="list-style-type: none"> Assessing the client to determine needs Gathering and documenting all relevant information for the GP Making arrangements for services Managing review appointments system Monitoring the client's progress between consultations with GP Establishing/utilising a client recall/reminder system 	<ul style="list-style-type: none"> Assessing the client to determine needs Gathering and documenting all relevant information for the GP Making arrangements for services Managing review appointments system Monitoring client progress between consultations with GP 	<ul style="list-style-type: none"> Identify eligible clients and arrange appointments If appropriately trained, a practice nurse is able to perform the smear and then a practice nurse cervical screening item number can be claimed Establish/manage client recall/reminder systems
Main information web link	<p>Summary of PIP payments, including SIPs—see www.medicareaustralia.gov.au/provider/incentives/pip/index.jsp</p> <p>Commonwealth presentation about the PIP program: www.health.gov.au/internet/main/publishing.nsf/content/40e5e0cbcfb2450fca25730800056fdf/\$file/pip-presentation%20%20vicki%20doherthy.pdf</p>		

35 The requirements for claiming this item are the minimum needed to provide good care for a client with diabetes. Additional levels of care will be needed for insulin-dependent clients and those with abnormal review findings, complications and/or co-morbidities.

36 Generally, clients who meet the following criteria can be assumed to have been assessed as having moderate to severe asthma: symptoms on most days, or use of preventer medication, or bronchodilator use at least 3 times per week, or hospital attendance or admission following an acute exacerbation of asthma.

Quality use of medicines: summary of MBS item numbers

Service type	▶▶▶	Maximisation of an individual client's benefit from their medication regimen, and prevention of medication-related adverse events ³⁷	
Client eligibility	▶▶▶	For clients living in the community, and at risk of medication-related adverse events ³⁷	For clients living in a Commonwealth-funded residential aged care facility, and at risk of medication-related adverse events ³⁷
Relevant MBS item number	▶▶▶	Domiciliary Medication Management Review (also known as home medicines review or HMR) #900	Residential Medication Management Review #903

³⁷ Examples of risk factors known to predispose people to medication related adverse events are listed under eligibility requirements at www.health.gov.au/internet/main/publishing.nsf/Content/health-epo-dmmr-answers.htm

Quality use of medicines: summary of web links and explanatory notes

	Domiciliary Medication Management Review (DMMR) (also known as home medicines review) #900	Residential Medication Management Review (RMMR) #903
Steps that must be taken to claim the Medicare item	<ul style="list-style-type: none"> • Determine client eligibility, assessing medication management needs and referring to community pharmacy • Discuss review results with the reviewing pharmacist • Develop a written medication management plan with the client 	<ul style="list-style-type: none"> • Discuss and seek consent from resident • Provide relevant clinical information for the RMMR to the reviewing pharmacist • Develop or revise a written medication management plan, following discussion with the pharmacist • Discuss with resident
Medicare rules relating to frequency of service	Once per client in any 12-month period ³⁸	Once per resident in any 12-month period ³⁸
Role of the GP	<ul style="list-style-type: none"> • Determine client eligibility and initiating service, if appropriate • Discuss of findings with pharmacist; • Agree on and finalise plan with the client 	All, in collaboration with the reviewing pharmacist
Roles that can be performed by practice nurses or Aboriginal health workers on behalf of and under the supervision of the GP	<ul style="list-style-type: none"> • Identify clients who may be eligible • Organise appointments • Facilitate the referral to community pharmacy 	Nil
Main information web link	www.health.gov.au/internet/main/publishing.nsf/Content/health-epc-dmmr-answers.htm	www.health.gov.au/internet/main/Publishing.nsf/Content/health-epc-dmmrqa.htm

³⁸ Except where there has been a significant change in the client's condition or medication regimen requiring a new service.

Summary of practice nurse MBS item numbers

About practice nurse MBS item numbers (#10993–#19999)

Medicare rebates are now available where practice nurses provide specific types of services on behalf of a GP. As at 1 May 2008, these items are for

- immunisation services
- wound management services
- pap smear services and preventive health checks
- provision of monitoring and support for a person with a chronic disease on a GP Management Plan, Team Care Arrangements, or an MBS multidisciplinary care plan
- antenatal service provided from an eligible practice location in a regional, rural or remote area.

A summary of the MBS items from Schedule 8 of the Medicare Benefits Schedule is provided on the next page. As with all MBS items, health professionals intending to use these should refer to the Medicare Benefits Schedule (MBS) book for more comprehensive information, including the MBS requirements for each item.

Alternatively, search for specific items at www9.health.gov.au/mbs or telephone Medicare Australia on 03 9605 7964 or contact the local Division of General Practice.

Item 10993

Immunisation provided to a person by a practice nurse if:

- (a) the immunisation is provided on behalf of, and under the supervision of, a medical practitioner: and
- (b) the person is not an admitted patient of a hospital or approved day hospital facility

Item 10994

Services provided by a practice nurse, being the taking of a cervical smear **and** preventive checks, if:

- (a) the service is provided on behalf of, and under the supervision of, a medical practitioner; and
- (b) the person is not an admitted patient of a hospital or approved day hospital facility.

This item cannot be claimed with items 2497–2509, 2598–2616, 10995, 10998 or 10999.

Item 10995

Service provided by a practice nurse, being the taking of a cervical smear from a woman between the ages of 20 and 69 inclusive, who has not had a cervical smear in the last 4 years, **and** preventive checks if:

- (a) the service is provided on behalf of, and under the supervision of, a medical practitioner; and
- (b) the person is not an admitted patient of a hospital or approved day hospital facility.

This item cannot be claimed with items 2497–2509, 2598–2616, 10994, 10998 or 10999.

Item 10996

Treatment of a person's wound (other than normal aftercare) provided by a practice nurse if:

- (a) the treatment is provided on behalf of, and under the supervision of, a medical practitioner: and
- (b) the person is not an admitted patient of a hospital or day-hospital facility

Item 10997

Service provided to a person with a chronic disease by a practice nurse or registered Aboriginal Health Worker if:

- (a) the service is provided on behalf of and under the supervision of a medical practitioner; and
- (b) the person is not an admitted patient of a hospital; and
- (c) the person has a GP Management Plan, Team Care Arrangements or Multidisciplinary Care Plan in place; and
- (d) the service is consistent with the GP Management Plan, Team Care Arrangements or Multidisciplinary Care Plan to a maximum of 5 services per patient in a calendar year

Item 10998

Service provided by a practice nurse, being the taking of a cervical smear from a person, if:

- (a) the service is provided on behalf of, and under the supervision of, a medical practitioner; and
- (b) the person is not an admitted patient of a hospital or approved day hospital facility.

This item cannot be claimed with items 2497–2509, 2598–2616, 10994, 10995 or 10999.

Item 10999

Service provided by a practice nurse, being the taking of a cervical smear from a woman between the ages of 20 and 69 inclusive, who has not had a cervical smear in the last 4 years, if:

- (a) the service is provided on behalf of, and under the supervision of, a medical practitioner; and
- (b) the person is not an admitted patient of a hospital or approved day hospital facility.

This item cannot be claimed with items 2497–2509 and 2598–2616, 10994, 10995 or 10998.

Item 16400

Antenatal service provided by a midwife, nurse or a registered Aboriginal Health Worker if:

- (a) the service is provided on behalf of, and under the supervision of, a medical practitioner;
- (b) the service is provided at, or from, a practice location in a regional, rural or remote area RRMA 3–7;
- (c) the service is not performed in conjunction with another antenatal attendance item (same patient, same practitioner on the same day);
- (d) the service is not provided for an admitted patient of a hospital to a maximum of 10 services per pregnancy.

This document is also available on the internet at
www.health.vic.gov.au/communityhealth/gps/mbs.htm

Published by the Victorian Government Department of Human Services, Melbourne, Victoria
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