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SOUTH WESTERN SYDNEY

An Australian Government Initiative

FREQUENTLY USED DESKTOP GUIDE TO ITEM NUMBERS

for General Practice Services

August 2017

PO Box 5919 Minto DC, NSW 2566

Head Office
Level 3, 1 Bolger St
Campbelltown, NSW 2560

6b Mona Rd
Bowral, NSW 2576

Suite 4, Level 8, 66-72 Rickard Rd
Bankstown, NSW 2200

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ITEM NUMBERS

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PRACTICE INCENTIVE AND SERVICE INCENTIVE ITEMS

FREQUENTLY USED DESKTOP GUIDE TO ITEM NUMBERS

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

Commonly Used Item Numbers			
Item	**Name**	**$**	**Description / Recommended Frequency**
3	Level A	$16.95	Brief - see MBS for complexity of care requirements
23	Level B	$37.05	< 20 min - see MBS for complexity of care requirements
36	Level C	$71.70	≥ 20 min - see MBS for complexity of care requirements
44	Level D	$105.55	≥ 40 min - see MBS for complexity of care requirements
10990	Bulk Billing item	$7.30	DVA, under 16's and Commonwealth Concession Card holders. Can be claimed concurrently for eligible patients.
10991	Bulk Billing item	$11.00	DVA, under 16's and Commonwealth Concession Card holders. Can be claimed concurrently for eligible patients.
11506	Spirometry	$20.55	Measurement of respiratory function before and after inhalation of bronchodilator

Chronic Disease Management			
Item	**Name**	**$**	**Description / Recommended Frequency**
721	GP Management Plan (GPMP)	$144.25	Management plan for patients with a chronic or terminal condition. Not more than once yearly
723	Team Care Arrangement (TCA)	$114.30	Management plan for patients with a chronic or terminal condition and complex needs requiring ongoing care from a team including the GP and at least 2 other health or care providers. Enables referral for 5 rebated allied health services. Not more than once yearly
732	Review of GP Management Plan and/or Team Care Arrangement	$72.05	The recommended frequency is every 6 months. If a GPMP and TCA are both reviewed on the same date item 732 can be claimed twice on the same day
729	GP Contribution to, or Review of, Multidisciplinary Care Plan	$70.40	Contribution to, or review of, a multidisciplinary care plan prepared by another provider (e.g. community, home or allied health providers, specialists), for patients with a chronic or terminal condition and complex needs requiring ongoing care from a team including the GP and at least 2 other health or care providers. Not more than once every 3 months
731	GP Contribution to, or Review of, Multidisciplinary Care Plan prepared by RACF	$70.40	GP contribution to, or review of, a multidisciplinary care plan prepared by RACF, at the request of the facility, for patients with a chronic or terminal condition and complex needs requiring ongoing care from a team including the GP and at least 2 other health or care providers. Not more than once every 3 months

Health Assessments			
Item	**Name**	**$**	**Description / Recommended Frequency**
701	Brief Health Assessment	$59.35	lasting not more than 30 minutes
703	Standard Health Assessment	$137.90	>30 - 44 minutes - see MBS for complexity of care requirements
705	Long Health Assessment	$190.30	>45 - <60 minutes - see MBS for complexity of care requirements
707	Prolonged Health Assessment	$268.80	> 60 minutes - see MBS for complexity of care requirements
715	Aboriginal and Torres Strait Islander Health Assessment	$212.25	Not timed

Practice Nurse Item (PNIP) Numbers			
Item	***Name***	***$***	**Description / Recommended Frequency**
10987	Follow Up Health Services for Indigenous people	$24.00	Follow up services for an Indigenous person who has received a Health Assessment, not an admitted patient of a hospital. Maximum of 10 services per patient, per calendar year
10997	Chronic Disease Management	$12.00	Monitoring and support for patients being managed under a GPMP or TCA. Not more than 5, per patient, per year

Medication Management			
Item	**Name**	**$**	**Description / Recommended Frequency**
900	Home Medicines Review (HMR)	$154.80	Review of medications in collaboration with a pharmacist for patients at risk of medication related misadventure. Once every 12 months
903	Residential Medication Management Review (RMMR)	$106.00	For permanent residents of Residential Aged Care Facilities who are at risk of medication related misadventure. Performed in collaboration with the resident's pharmacist. Once every 12 months

FREQUENTLY USED DESKTOP GUIDE TO ITEM NUMBERS CON'T

Mental Health Item Numbers			
Item	**Name**	**$**	**Description / Recommended Frequency**
2700	GP Mental Health Treatment Plan	$71.70	Min 20 mins – Prepared by GP who has **not** undertaken Mental Health Skills Training. Assessment of patient and preparation of a care plan with option to refer for rebated psychological services. Not more than once yearly
2701	GP Mental Health Treatment Plan	$105.55	Min 40 mins – Prepared by GP who has **not** undertaken Mental Health Skills Training. Assessment of patient and preparation of a care plan with option to refer for rebated psychological services. Not more than once yearly
2715	GP Mental Health Treatment Plan	$91.05	Min 20 mins - Prepared by GP who **has** undertaken Mental Health Skills Training. Assessment of patient and preparation of a care plan with option to refer for rebated psychological services. Not more than once yearly
2717	GP Mental Health Treatment Plan	$134.10	Min 40 mins - Prepared by GP who **has** undertaken Mental Health Skills Training. Assessment of patient and preparation of a care plan with option to refer for rebated psychological services. Not more than once yearly
2712	Review of GP Mental Health Treatment Plan	$71.70	Plan should be reviewed between 1 - 6 months and no more than 2 per year
2713	Mental Health Consultation	$71.70	Consult ≥ 20 min, for the ongoing management of a patient with mental disorder. No restriction on the number of these consultations per year
2721	GP Focussed Psychological Strategies	$92.75	30 - 40 minutes. Provision of focussed psychological strategies by an appropriately trained and registered GP working in an accredited practice
2723	GP Focussed Psychological Strategies	derived fee	Out of surgery consultation. 30 - 40 minutes. Provision of focussed psychological strategies by an appropriately trained and registered GP working in an accredited practice
2725	GP Focussed Psychological Strategies	$132.75	> 40 minutes. Provision of focussed psychological strategies by an appropriately trained and registered GP working in an accredited practice
2727	GP Focussed Psychological Strategies	derived fee	Out of surgery consultation. > 40 minutes. Provision of focussed psychological strategies by an appropriately trained and registered GP working in an accredited practice

ALLIED HEALTH SERVICES

FOR CHRONIC CONDITIONS REQUIRING TEAM CARE

Allied Health Services for Chronic Conditions Requiring Team Care

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

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

Item	Name	Description / Recommended Frequency
10950	Aboriginal Health Worker Services	Allied Health Provider must be Medicare registered. Maximum of 5 allied health services per patient each calendar year. Can be 5 sessions with one provider or a combination e.g. 3 dietitian and 2 diabetes education sessions. GP refers to allied health professional using 'Referral Form for Chronic Disease Allied Health (Individual) Services under Medicare' or a referral form containing all components. One for each provider. Services must be of at least 20min duration and provided to an individual not a group. Allied health professionals must report back to the referring GP after first and last visit.
10951	Diabetes Educator Services	
10952	Audiologist Services	
10953	Exercise Physiologist Services	
10954	Dietitian Services	
10958	Occupational Therapist Services	
10960	Physiotherapist Services	
10962	Podiatrist Services	
10964	Chiropractor Services	
10966	Osteopath Services	
10970	Speech Pathologist Services	
10956	Mental Health Worker Services	For mental health conditions use Better Access Mental Health Care items - 10 sessions For chronic physical conditions use GPMP and TCA - 5 sessions Better access and GPMP can be used for the same patient where eligible.
10968	Psychologist Services	

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

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

Assessment and Provision of services

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

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

Item	Name	Description / Recommended Frequency
81300	Aboriginal and Torres Strait Islander Health Service	Allied Health Provider must be Medicare registered. Maximum of 5 allied health services per patient each calendar year (in addition to the 5 services eligible from TCA 10950-10970). Services must be of at least 20min duration. GP refers to allied health professional using a 'Referral form for follow-up allied health services under Medicare for People of Aboriginal or Torres Strait Islander descent' or a referral form containing all components. One for each provider. Allied health professionals must report back to the referring GP after the first and last services.
81305	Diabetes Education	
81310	Audiology	
81315	Exercise Physiology	
81320	Dietetics	
81325	Mental Health	
81330	Occupational Therapy	
81335	Physiotherapy	
81340	Podiatry	
81345	Chiropractic	
81350	Osteopathy	
81355	Psychology	
81360	Speech Pathology	

ALLIED HEALTH GROUP SERVICES FOR PATIENTS WITH TYPE 2 DIABETES

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

Assessment and Provision of Group Services *GP must have completed a GP Management Plan (721), or reviewed an existing GPMP (732), or contributed to, or reviewed, a Multidisciplinary Care Plan in a Residential Aged Care Facility (731)*		
Item	**Name**	**Description / Recommended Frequency**
81100	Assessment for Group Services by Diabetes Educator	One assessment session only by either Diabetes Educator, Exercise Physiologist or Dietitian, per calendar year Medicare Allied Health Group Services for Type 2 Diabetes Referral Form
81110	Assessment for Group Services by Exercise Physiologist	
81120	Assessment for Group Services by Dietitian	
81105	Diabetes Education Group Services	8 group services per calendar year, can be 8 sessions with one provider or a combination e.g. 3 diabetes education, 3 dietitian and 2 exercise physiology sessions. Medicare Allied Health Group Services for Type 2 Diabetes Referral Form

AFTER-HOURS SERVICES

Attendance Period			**Item No**	**MBS Payment**	**Brief Guide**
Urgent attendance – after hours			597	$129.80	• These items can only be used for the first patient, if more than one patient is seen on the one occasion, standard (non-urgent) after hours items apply • The urgent after-hours items can only be used where the patient has a medical condition that requires urgent treatment, which could not be delayed until the next in-hours period • For consultations at the health centre, it is necessary for the practitioner to return to, and specially open the consulting rooms for the attendance
Mon-Fri 7am-8am or 6pm-11pm	**Sat** 7am-8am or 12noon-11pm	**Sun & Pub Holidays** 7am-11pm			
Urgent attendance – unsociable hours			599	$153.00	
Mon-Fri 11pm-7am	**Sat** 11pm-7am	**Sun & Pub Holidays** 11pm-7am			
Non-urgent after hours at a place other than consulting rooms			5023 (1 patient) 5043 (1 patient) 5028 (1 patient) 5028 (2 patients) 5028 (3 patients) 5049 (1 patients) 5049 (2 patients) 5049 (3 patients)	$74.95 $109.90 $95.70 $72.35 $64.57 $130.65 $107.30 $99.52	
Mon-Fri Before 8am or after 6pm	**Sat** Before 8am or After 12pm	**Sun & Pub Holidays** All day			
Non-urgent after hours at consulting rooms			5000 (Level A) 5020 (Level B <20min) 5040 (Level C >20min) 5060 (Level D >40min)	$29.00 $49.00 $83.95 $117.75	
Mon-Fri Before 8am or After 8pm	**Sat** Before 8am or After 1pm	**Sun & Pub Holidays** All day			

GP MULTIDISCIPLINARY CASE CONFERENCES

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

HEALTH ASSESSMENTS

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

There are 8 Health Assessment target groups:

Health Assessment - Type 2 Diabetes Risk Evaluation

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

Health Assessment - 45 - 49 Year Old

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

Health Assessment - 75 Years and Older

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

Health Assessment - Comprehensive Medical Assessment

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

Health Assessment for patient with an Intellectual Disability

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

Health Assessment for Refugees and other Humanitarian Entrants

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

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

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

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

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

Item	Name	Description / Recommended Frequency
701	Brief Health Assessment **<30mins**	a) Collection of relevant information, including taking a patient history; b) A basic physical examination; c) Initiating interventions and referrals as indicated; and d) Providing the patient with preventive health care advice and information.
703	Standard Health Assessment **30 - 44 minutes**	a) Detailed information collection, including taking a patient history; b) An extensive physical examination; c) Initiating interventions and referrals as indicated; and d) Providing a preventive health care strategy for the patient.
705	Long Health Assessment **45 - 59 minutes**	a) Comprehensive information collection, including taking a patient history; b) An extensive examination of the patient's medical condition and physical function; c) Initiating interventions and referrals as indicated; and d) Providing a basic preventive health care management plan for the patient.
707	Prolonged Health Assessment **> 60 minutes**	a) Comprehensive information collection, including taking a patient history; b) An extensive examination of the patient's medical condition, and physical, psychological and social function. c) Initiating interventions and referrals as indicated; and d) Providing a comprehensive preventive health care management plan for the patient.
715	Aboriginal and Torres Strait Islander Health Assessment No designated time / complexity requirements	**Aboriginal and Torres Strait Islander Child Health Assessment** Health Assessment for Aboriginal and Torres Strait Islander patients 0 - 14 years old. Not available to in-patients of a hospital or RACF. Not more than once every 9 months **Aboriginal and Torres Strait Islander Adult Health Assessment** Health Assessment for Aboriginal and Torres Strait Islander patients aged 15 – 54 years old. Not available to in-patients of a hospital or RACF. Not more than once every 9 months **Aboriginal and Torres Strait Islander Health Assessment for an Older Person** Health Assessment for Aboriginal and Torres Strait Islander patients aged 55 years and over. Not available to in-patients of a hospital or RACF. Not more than once every 9 months

RESIDENTIAL AGED CARE FACILITY ITEM NUMBERS

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

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

CMA Activities:

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

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

- Obtain and record resident's consent
- Information collection, including taking patient history and undertaking or arranging examinations and investigations as required
- Making an overall assessment of the patient
- Recommending appropriate interventions
- Providing advice and information to the patient
- Keeping a record of the Health Assessment - CMA, and offering the patient a written report about the health assessment, with recommendations about matters covered by the Health Assessment - CMA

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

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

Activities:

- Obtain and record resident's consent
- Prepare part of the plan or amendments to the plan and add a copy to the patient's medical records; or

Give advice to a person (e.g. Nursing staff in RACF) who prepares or reviews the plan and record in writing, on the patient's medical records, any advice provided.

RESIDENTIAL AGED CARE FACILITY ITEM NUMBERS CONTD

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

Activities:

Time based items 735 - 743 Organise and Coordinate requires:

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

Telehealth - Residential MBS Items

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

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

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

Time based items 2125,2138,2179 and 2220

Residential Medication Management Review (RMMR)

Item 903

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

Activities:

Obtain and record resident's consent

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

SYSTEMATIC CARE CLAIMING RULES

Legend MBS Item Numbers

	No claiming restrictions	**2517**	Diabetes Annual Cycle of Care SIP
721	GP Management Plan (GPMP)	**2546**	Asthma Cycle of Care SIP
723	Team Care Arrangement (TCA)	**2700 / 2701**	GP Mental Health Treatment Plan
732	Review of GPMP and/or TCA	**2715 / 2717**	GP Mental Health Treatment Plan
900	Home Medication Review	**2712**	Review of GP Mental Health Treatment Plan
		2713	GP Mental Health Consultation

MONTHS UNTIL NEXT CLAIM FOR SERVICE

***721**	24		6			12				
***723**		24	6							
****732**	6	6	6		3	3				
900				12						
†**2517**			3		11-13					
††**2546**	12		3			12				
2700/2701							12	3		
§**2712**							3	3	3	
2713										
2715/2717									12	
MBS Item Numbers	***721**	***723**	****732**	**900**	†**2517**	††**2546**	**2700/ 2701**	§**2712**	**2715/ 2717**	**2713**

Additional Claiming Rules

***721 & 723** Recommended claiming period 24 months, minimum claiming period 12 months

****732** Recommended claiming period 6 months, minimum claiming period 3 months. Can be claimed twice on the same day if review of both GPMP and TCA are completed, in this case the patient invoice and Medicare claim should be annotated.

† 2517 Recommended not to be claimed within 3 months of Review Item 732, as services overlap

††2546 Recommended not to be claimed within 12 months of claiming Item 721 alone, as services significantly overlap. Can be claimed on the same day if both 721 and 723 are completed, as the patient has multidisciplinary care needs. Recommended not to be claimed within 3 months of Review Item 732, as services overlap.

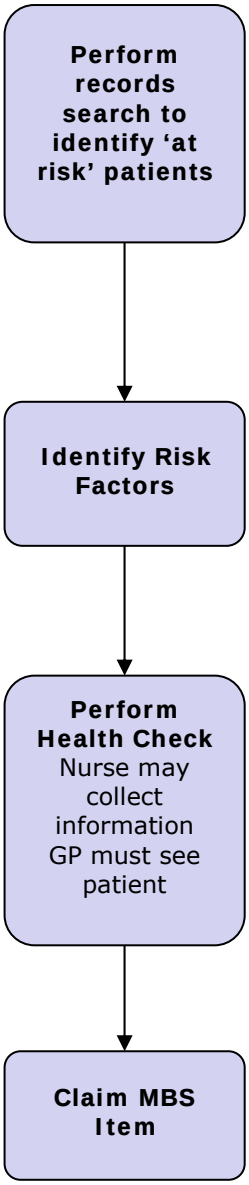
§2712 Review recommended 1 month - 6 months after 2700,2701,2715,2717,with not more than 2 reviews in a 12 month period

Notes Where a service is provided earlier than minimum claiming periods the patient invoice and Medicare claim should be annotated. For example; clinically indicated/required, hospital discharge, exceptional circumstances, significant change.

Standard consultations, health assessments, care plans and medication reviews should not be claimed on the same day. If provided on the same day the patient invoice and Medicare claim should be annotated, for example; clinically indicated/required, separate service.

Acknowledgement and thanks to Northern Sydney Medicare Local

TYPE 2 DIABETES RISK EVALUATION – HEALTH ASSESSMENT ITEMS 701 / 703 / 705 / 707



Eligibility Criteria

Patients with newly diagnosed or existing diabetes are **not** eligible

Patients aged 40 to 49 years inclusive

Patients must score ≥12 points (high risk) on Australian Type 2 Diabetes Risk Assessment Tool (AUSDRISK)

Not for patients in hospital

Clinical Content

Explain Health Assessment process and gain consent

Evaluate the patient's high risk score determined by the AUSDRISK, which has been completed within a period of 3 months prior to undertaking Type 2 Diabetes Risk Evaluation

Update patient history and undertaking physical examinations and clinical investigations in accordance with relevant guidelines

Make an overall assessment of the patient's risk factors, and results of relevant examinations and investigations

Initiate interventions where appropriate, and follow-up relating to management of any risk factors identified

Provide advice and information, such as Lifescripts resources, including strategies to achieve lifestyle and behaviour changes

Essential Documentation Requirements

Record patient's consent to Health Assessment

Completion of AUSDRISK is mandatory, with a score of ≥12 points required to claim; Update patient history

Record the Health Assessment and offer the patient a copy

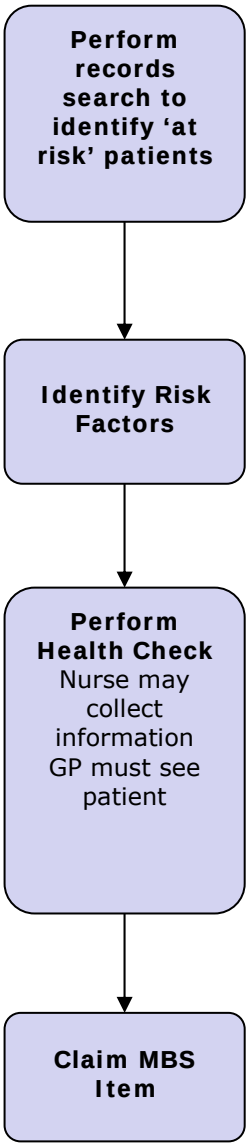
Claiming

All elements of the service must be completed to claim

Requires personal attendance by GP with patient

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

45 - 49 YEAR OLD – HEALTH ASSESSMENT
ITEMS 701 / 703 / 705 / 707



Eligibility Criteria

Patients aged 45 to 49 years inclusive

Must have an identified risk factor for chronic disease

Not for patients in a hospital

Risk Factors

Include, but are not limited to:

Lifestyle: Smoking; Physical inactivity; Poor nutrition; Alcohol use

Biomedical: High cholesterol; High BP; Impaired glucose metabolism; Excess weight

Family history of chronic disease

Clinical Content

Mandatory

Explain Health Assessment process and gain consent

Information collection – takes patient history; undertake examinations and investigations as clinically required

Overall assessment of the patient's health, including their readiness to make lifestyle changes

Initiate interventions and referrals as clinically indicated

Advice and information about lifestyle modification programs and strategies to achieve lifestyle and behaviour changes

Non-Mandatory:

Written patient information such as the Lifescripts resources, are recommended

Essential Documentation Requirements

Record patient's consent to Health Assessment

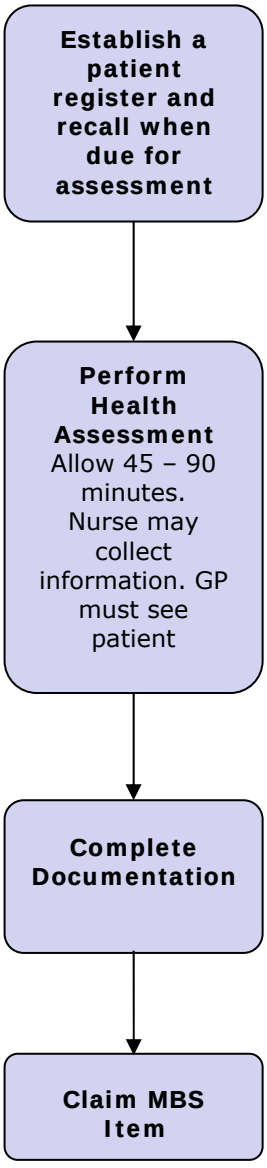
Record the Health Assessment and offer the patient a copy

Claiming

All elements of the service must be completed to claim

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

75 YEARS AND OLDER – HEALTH ASSESSMENT ITEMS 701 / 703 / 705 / 707



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

Eligibility Criteria

Patients aged 75 years and older

Patient seen in consulting rooms and/or at home

Not for patients in hospital

Clinical Content

Mandatory

Explain Health Assessment process and gain patient's/carer's consent

Information collection– takes patient history; undertake examinations and investigations as clinically required

Measurement of: BP, Pulse rate and Rhythm

Assessment of: Medication; Continence; Immunisation status for influenza, tetanus and pneumococcus; Physical function including activities of daily living and falls in the last 3 months; Psychological function including cognition and mood; and Social function including availability and adequacy of paid and unpaid help and the patient's carer responsibilities

Overall assessment of patient

Recommend appropriate interventions

Provide advice and information

Discuss outcomes of the assessment and any recommendations with patient

Non-Mandatory

Consider: Need for community services; Social isolation; Oral health and dentition; and Nutrition status

Additional matters as relevant to the patient

Essential Documentation Requirements

Record patient's/carer's consent to Health Assessment

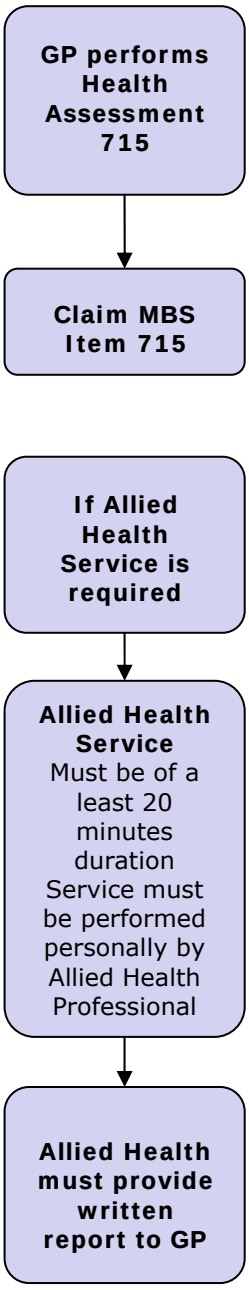
Record the Health Assessment and offer the patient a copy (with consent, offer to carer)

Claiming

All elements of the service must be completed to claim

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

ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH ASSESSMENT Item 715



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

Items 81300 to 81360 – Allied Health Service

Eligibility Criteria

Items 81300 to 81360 with the exception of 81305 (which does not require a health assessment) are in addition to items 10950 to 10970 and provide an alternative to the referral pathway to access Allied Health Services

Items available to individual patients only, not a group service

The person is not an admitted patient of a hospital

Eligible patients may access Medicare rebates for up to 5 allied health services in a calendar year. Allied health professionals may set their own fees. Charges in excess of the Medicare benefit for these items are the responsibility of the patient

Essential Documentation Requirements

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

Mandatory

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

Information collection of patient history and undertaking examinations and investigations as required;

Overall assessment of the patient;

Recommending appropriate interventions

Providing advice and information to the patient

Recording the health assessment; and

Offering the patient a written report with recommendations about matters covered by the health assessment

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

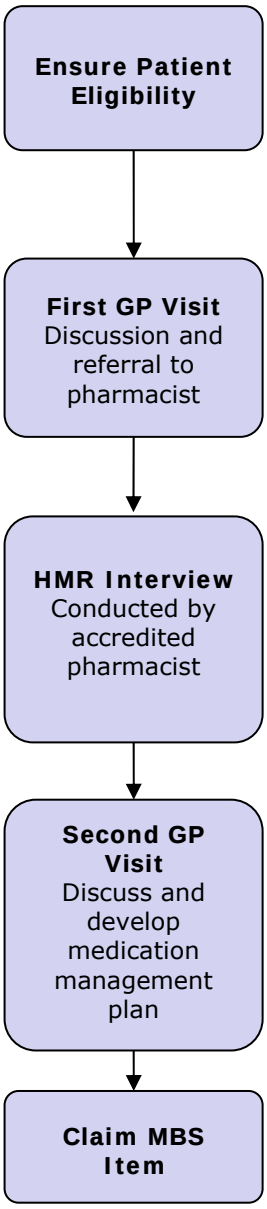
** Refer to page 7*

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

Acknowledgement and thanks to Northern Sydney Medicare Local

HOME MEDICINES REVIEW (HMR) ITEM 900

Also known as Domiciliary Medication Management Review (DMMR)



Eligibility Criteria

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

Initial Visit with GP

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

HMR Interview

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

Second GP Visit

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

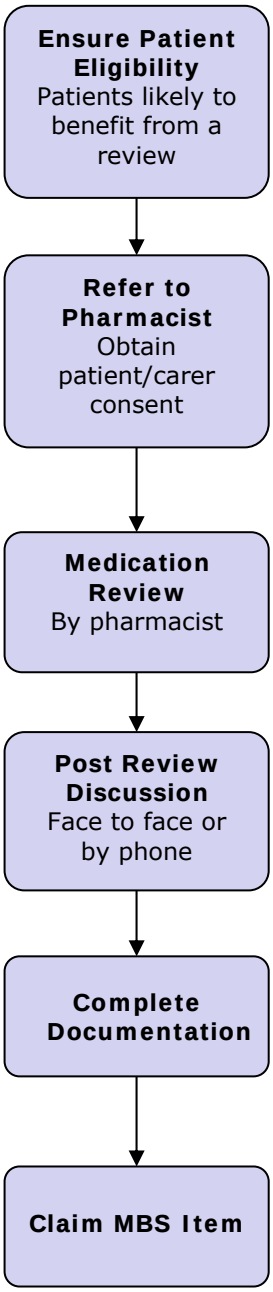
Claiming

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

MBS item	*Name*	*Recommended Frequency*
900	Home Medicines Review	Once every 12 months

RESIDENTIAL MEDICATION MANAGEMENT REVIEW (RMMR)

ITEM 903



Eligibility Criteria

For permanent residents (new or existing) of a Commonwealth funded Residential Aged Care Facility (includes veterans)

Patients at risk of medication related misadventure because of significant change in their condition or medication regimen, or for whom quality use of medicines may be an issue

Not for patients in a hospital or respite patients in RACF

GP Initiates Service

Explain RMMR process and gain resident's consent

Send referral to accredited pharmacist to request collaboration in medication review

Provide input from Comprehensive Medical Assessment or relevant clinical information for RMMR and the resident's records

Accredited Pharmacist Component

Review resident's clinical notes and interview resident

Prepare Medication Review report and send to GP

GP and Pharmacist Post Review Discussion

Discuss: Findings and recommendations of the Pharmacist;

Medication management strategies; issues; implementation; follow up; outcomes

If no (or only minor) changes recommended a post review discussion is not mandatory

Essential Documentation Requirements

Record resident's consent to RMMR

Develop and/or revise Medication Management Plan which should identify medication management goals and medication regimen

Finalise Plan after discussion with resident

Offer copy of Plan to resident/carer, provide copy for resident's records and for nursing staff at RACF, discuss plan with nursing staff if necessary

Claiming

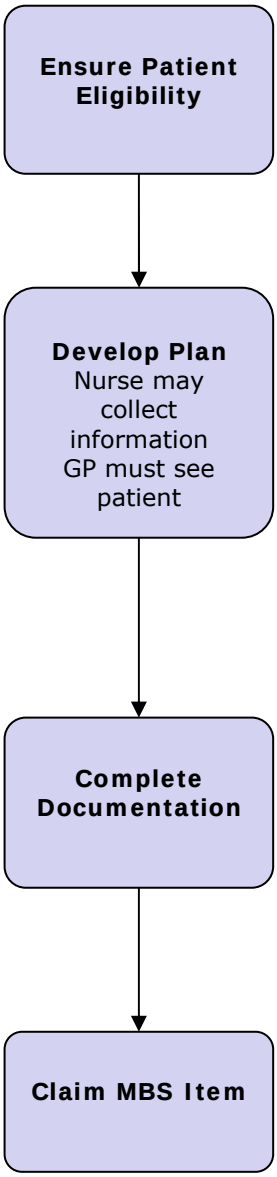
All elements of the service must be completed to claim

Derived fee arrangements do not apply to RMMR

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

Acknowledgement and thanks to Northern Sydney Medicare Local

GP MANAGEMENT PLAN (GPMP) – ITEM 721



Eligibility Criteria

- No age restrictions for patients
- Patients with a chronic or terminal condition
- Patients who will benefit from a structured approach to their care
- Not for public patients in a hospital or patients in a Residential Aged Care Facility
- A GP Mental Health Treatment Plan (Item 2700/2701/2715/2717) is suggested for patients with a mental disorder only

Clinical Content

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

Essential Documentation Requirements

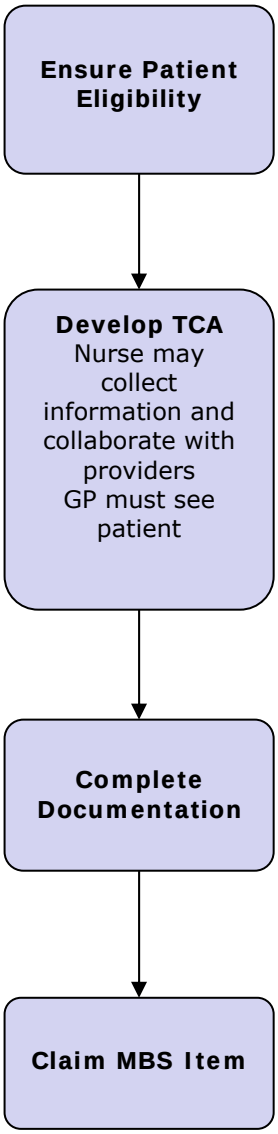
- Record patient's consent to GPMP
- Patient needs and goals, patient actions, and treatments/services required
- Set review date
- Offer copy to patient (with consent, offer to carer), keep copy in patient file

Claiming

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

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

TEAM CARE ARRANGEMENT (TCA) – ITEM 723



Eligibility Criteria

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

Clinical Content

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

Essential Documentation Requirements

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

Claiming

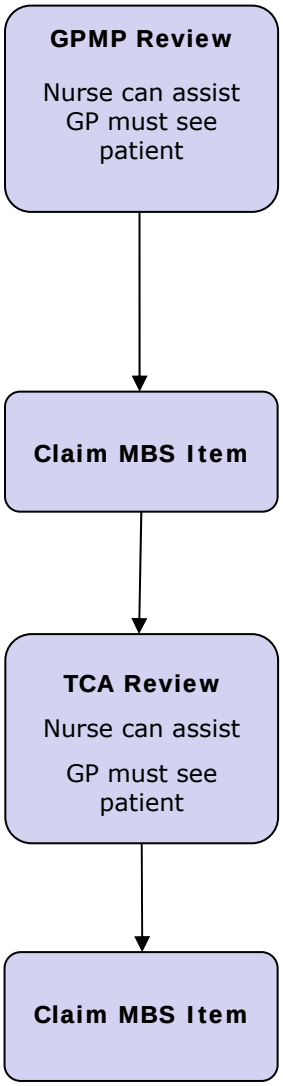
All elements of the service must be completed to claim
Requires personal attendance by GP with patient
Review using item 732 at least once during the life of the plan

Claiming a GPMP and TCA enables patients to receive 5 rebated services from allied health.

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

Acknowledgement and thanks to Northern Sydney Medicare Local

REVIEWING A GP MANAGEMENT PLAN (GPMP) AND/OR TEAM CARE ARRANGEMENT (TCA) – ITEM 732



Reviewing a GP Management Plan (GPMP)

Clinical Content

Explain steps involved in the review and gain consent

Review all matters in relevant plan

Essential Documentation Requirements

Record patient's agreement to review

Make any required amendments to plan

Set new review date

Offer copy to patient (with consent, offer to carer), keep copy in patient file

Claiming

All elements of the service must be completed to claim

Item 732 should be claimed at least once over the life of the gpmp

Cannot be claimed within 3 months of a gpmp (item 721)

Item 732 can be claimed twice on same day if review of both gpmp and tca are completed, in this case the medicare claim should be annotated

Reviewing a Team Care Arrangement (TCA)

Clinical Content

Explain steps involved in the review and gain consent

Consult with 2 collaborating providers to review all matters in plan

Essential Documentation Requirements

Record patient's consent to review

Make any required amendments to plan

Set new review date

Send copy of relevant parts of amended tca to collaborating providers

Offer copy to patient (with consent, offer to carer), keep copy in patient file

Claiming

All elements of the service must be completed to claim

Requires personal attendance by gp with patient

Item 732 should be claimed at least once over the life of the tca

Cannot be claimed within 3 months of a tca (item 723)

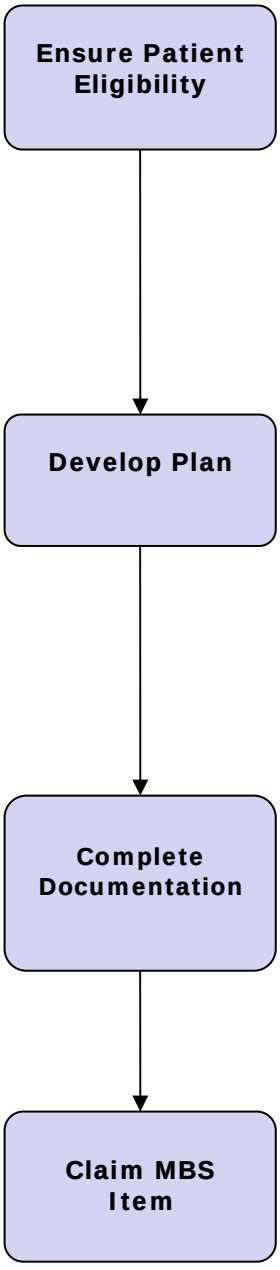
Item 732 can be claimed twice on same day if review of both GPMP and TCA are completed, in this case the medicare claim should be annotated

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

Acknowledgement and thanks to Northern Sydney Medicare Local

MENTAL HEALTH TREATMENT PLAN – ITEM 2700/2701/2715/2717

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



Eligibility Criteria

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

Clinical Content

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

Essential Documentation Requirements

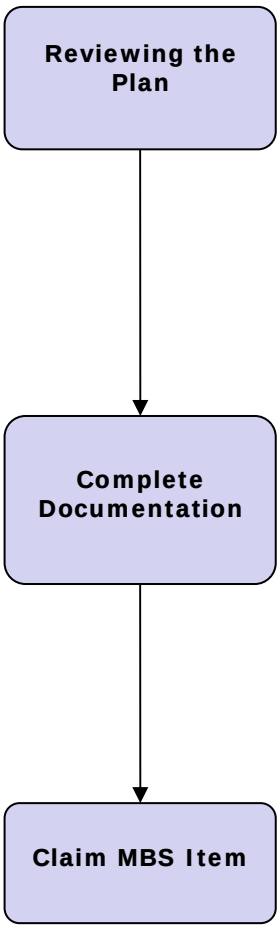
- Record patient's consent to GP Mental Health Treatment Plan
- Document diagnosis of mental disorder
- Results of outcome measurement tool
- Patient needs and goals, patient actions, and treatments/services required
- Set review date
- Offer copy to patient (with consent, offer to carer), keep copy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

Claiming

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

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

REVIEW OF THE MENTAL HEALTH TREATMENT PLAN – ITEM 2712



Clinical Content

Explain steps involved, possible out of pocket costs and gain patient's consent

Review patient's progress against goals outlined in the GP Mental Health Treatment Plan

Check, reinforce and expand psycho-education

Plan for crisis intervention and/or relapse prevention, if appropriate and if not previously provided

Re-administer the outcome measurement tool used when developing the GP Mental Health Treatment Plan (item 2700/2701/2715/2717), except where considered clinically inappropriate.

Essential Documentation Requirements

Record patient's consent to Review

Results of re-administered outcome measurement tool

Document relevant changes to GP Mental Health Treatment Plan

Offer copy to patient (with consent, offer to carer), keep copy in patient file

Claiming

All elements of the service must be completed to claim

Requires personal attendance by GP with patient

Item 2712 should be claimed at least once over the life of the GP Mental Health Treatment Plan

According to the FAQ's on The Australian Government Department of Health Website (2012) it is not mandatory for the GP to see the patient to do a referral for the further 4 allied mental health sessions.

A review can be claimed 1–6 months after completion of the GP Mental Health Treatment Plan

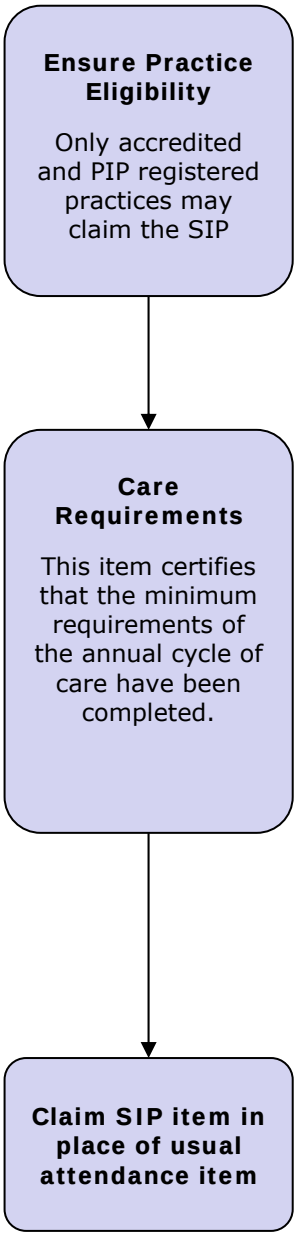
If required, an additional review can be performed 3 months after the first Review

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

Acknowledgement and thanks to Northern Sydney Medicare Local

DIABETES ANNUAL CYCLE OF CARE

SERVICE INCENTIVE PAYMENT (SIP)



Eligibility Criteria

No age restrictions for patients

Patients with established Diabetes Mellitus

For patients in the community and in Residential Aged Care Facilities

Essential Clinical and Documentation Requirements

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

6 Monthly

Measure height, weight and calculate BMI

Measure BP

Examine feet

Yearly

Measure HbA1c, eGFR, total cholesterol, triglycerides and HDL cholesterol

Test for microalbuminuria

Provide patient education regarding diabetes management including self-care education

Review diet and levels of physical activity - reinforce information about appropriate dietary choices and levels of physical activity

Check smoking status - encourage smoking cessation

Review medication

2 Yearly

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

Claiming

Available to GPs in accredited practices, registered for the Diabetes SIP

All elements of the service must be completed to claim

Only paid once every 11 – 13 month period

		MBS item			
Name	***Frequency***	***In surgery***	***Out of surgery***	***SIP***	***Rebate***
Diabetes SIP - Standard Consult. (Level B)	11-13 monthly	2517	2518	$40.00	+ Level B
Diabetes SIP - Long Consult. (Level C)	11-13 monthly	2521	2522	$40.00	+ Level C
Diabetes SIP - Prolonged Consult. (Level D)	11-13 monthly	2525	2526	$40.00	+ Level D

Acknowledgement and thanks to Northern Sydney Medicare Local

ASTHMA CYCLE OF CARE
SERVICE INCENTIVE PAYMENT (SIP)

Ensure Practice Eligibility
Only accredited and PIP registered practices may claim the SIP

↓

Note: A specialist consultation does not constitute one of the two visits - both must be with the same GP or in exceptional circumstances with another GP from the same practice

↓

Claim SIP item in place of usual attendance item

Eligibility Criteria

No age restrictions for patients

Patients with moderate to severe asthma

For patients in the community and in Residential Aged Care Facilities

Essential Requirements

At least 2 asthma consultations within 12 months

One of the consultations must be for a Review

Review must be planned during previous consultation

Clinical Content

Explain Cycle of Care process and gain patient's consent

Diagnosis and assessment of level of asthma control and severity

Review use of and access to asthma-related medication and devices

Give patient written Asthma Action Plan (if the patient is unable to use a written Asthma Action Plan, discussion with the patient about an alternative method of providing an Asthma Action Plan)

Provide asthma self-management education

Review of written or documented Asthma Action Plan

Essential Documentation Requirements

Record patient's consent to Cycle of Care

Document diagnosis and assessment of level of asthma control and severity

Include documentation of the above requirements and clinical content in the patient file, including clinical content of the patient-held written Asthma Action Plan

Claiming

Available to GPs in accredited practices, registered for the Asthma SIP

All elements of the service must be completed to claim

Only paid once every 12 months

		MBS item			
Name	***Frequency***	***In surgery***	***Out of surgery***	***SIP***	***Rebate***
Asthma SIP - Standard Consult. (Level B)	12 monthly	2546	2547	$100	+ Level B
Asthma SIP - Long Consult. (Level C)	12 monthly	2552	2553	$100	+ Level C
Asthma SIP - Prolonged Consult. (Level D)	12 monthly	2558	2559	$100	+ Level D

Acknowledgement and thanks to Northern Sydney Medicare Local