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Current as of February 2007.

The aim is to provide an introduction to the MBS Items, it should not be used instead of the Medicare Benefits Schedule.

General Information for Standard Items

This is standard information for GPs working in general practice.
The following are the most commonly used Item Numbers under the MBS (Medicare Benefits Schedule).

Item Number
Level A – Item No 3 Short consult less than 10 minutes
Level B – Item No 23 Standard less than 20 minutes
Level C – Item No 36 20-40 mins duration
Level D – Item No 44 At least 40 mins

Cervical Screening

- GPs working in PIP practice that have signed on for the cervical screening incentive will receive a service incentive payment (SIP-Cervical) for **screening women between 20-69 years who have not had a cervical smear within the last 4 years** (considered high risk).

- Upon completion of a cervical smear for women meeting the above criteria, GPs claim the appropriate item number below to receive payment for consult plus SIP payment of $35.00.

Item Numbers	Level B	Level C	Level D
	2501	2504	2507

SIP Payment = $35.00

- This SIP Payment is also claimable where the cervical smear is undertaken by a Practice Nurse on behalf of the GP under Items 10995 and 10999. (See pages 33 and 35)

Diabetes 12 month cycle of care

- At the completion of a 12 month cycle, claim Diabetes item number listed below
- The minimum requirements of care are:

6 Monthly	Yearly	Bi-Annually	Other Considerations
Weight, Height, BMI	HbA1C	Eye Examination	Self Care Education
Blood Pressure	Total Cholesterol, Triglycerides & HDL cholesterol		Review Physical Activity levels
Foot Examination	Microalbuminuria		Review Diet
			Medication Review
			Smoking Status

Item Numbers	Level B	Level C	Level D
	2517	2521	2525

Diabetes Outcome Payment – Practices where 20% of their patients have been provided with an annual cycle of care will receive $5 per quarter per patient with diabetes (SWPE). It is expected that the coverage rate will increase over time to encourage increased levels of care for patients with diabetes.

SIP Payment = $40.00

Asthma Cycle Of Care

For patients with moderate to severe asthma.

Patients must receive the following treatment:

- 2 asthma related consultations within 12 months
- At least 1 of which (the review consultation) is a consultation that was planned at a previous consultation
- Document diagnosis and assessment of level of asthma control and severity of asthma
- Review of patients use of and access to asthma-related medication.
- Provision to the patient of a written asthma action plan
- Provision of asthma self-management education to the patient
- Review of the written or documented asthma action plan
- Asthma Cycle of Care should be provided to a patient by one GP or in exceptional circumstances by another GP within the same practice
- Patient's medical record should include documentation of each of these requirements and the clinical content of the patient-held written asthma action plan
- Minimum requirements of the Asthma Cycle of care may be carried out in two (2) visits or if necessary as many visits as clinically required
- All visits should be billed under the normal attendance items with the exception of the visit that completes all of the minimum requirements of the Asthma Cycle of Care
- Item number listed below to be claimed at final visit at the completion of the Asthma Cycle of Care.

Item Numbers	Level B	Level C	Level D
	2546	2552	2558

SIP Payment = $100.00

Spirometry

Measurement of respiratory function involving a permanently recorded tracing performed before and after inhalation of bronchodilator – each occasion at which 1 or more such tests are performed.

Item Number	11506

Focused Psychological Strategies (FPS)

- FPS are specific mental health care treatment strategies, derived from evidence based psychological therapies.
- They have been shown to integrate the best research evidence of clinical effectiveness with general practice expertise.
- FPS include Psycho-education, Cognitive Behavioral Therapy (CBT) and Interpersonal Therapies.
- These strategies are required to be provided to patients by a credentialed medical practitioner and are time limited; being deliverable in up to 6 planned sessions. In some instances, following review by the GP managing the patient's Mental Health Care Plan, a further 6 sessions may be approved in any 12 month period to an individual patient.

FPS MBS Item	Item Number
FPS (in surgery, 30-40 mins)	2721
FPS (out of surgery, 30-40 mins)	2723
FPS (in surgery, >40 mins)	2725
FPS (out of surgery)	2727

Only GPs who have completed the required Level 2 training of the Better Outcomes in Mental Health Care Initiative, and are registered with Medicare Australia for this Initiative can provide this service. The GP must be providing the service from a registered PIP or accredited practice. More information about registration and training programs can be obtained from your local Division of General Practice.

GP Mental Health Care Plans

Preparation by a medical practitioner of a GP Mental Health Care Plan for a patient.

This item covers both the assessment and preparation of the GP Mental Health Care Plan.

An assessment of a patient must include:

- Recording the patient's agreement for the GP Mental Health Care Plan service;
- Taking relevant history (biological, psychological, social) including the presenting complaint;
- Conducting a mental state examination;
- Assessing associated risk and any co-morbidity;
- Making a diagnosis and/or formulation; and
- Administering an outcome measurement tool, except where it is considered clinically inappropriate.

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

- Discussing the assessment with the patient, including the mental health formulation and/or diagnosis;
- Identifying and discussing referral and treatment options with the patient, including appropriate support services;
- Agreeing goals with the patient – what should be achieved by the treatment – and any actions the patient will take;
- Provision of psycho-education;
- A plan for crisis intervention and/or for relapse prevention, if appropriate at this stage;

- Making arrangements for required referrals, treatment, appropriate support services, review and follow-up; and
- Documenting this (results of assessment, patient needs, goals and actions, referrals and required treatment/services, and review date) in the patient's GP Mental Health Care Plan.

Treatment options can include referral to a psychiatrist; referral to a clinical psychologist for psychological therapies, or to an appropriately trained GP or allied mental health professional for provision of focused psychological strategy services; pharmacological treatments; and co-ordination with community support and rehabilitation agencies, mental health services and other health professionals.

Item Number	2710

Review of GP Mental Health Care Plan

Medical practitioner to review a GP Mental Health Care Plan for a patient.

A patient's GP Mental Health Care Plan should be reviewed at least once.

The review must include:

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

Item Number	2712

GP Mental Health Care Consultation

Medical practitioner taking relevant history, identifying problem(s), providing treatment, advice and/or referral for other services or treatments and documenting the outcomes of the consultation, on a patient in relation to a mental disorder and lasting at least 20 minutes.

The GP Mental Health Care Consultation item is for an extended consultation with a patient where the primary treating problem is related to a mental disorder.

A GP Mental Health Care Consultation must include:

- Taking relevant history and identifying the patient's presenting problem(s) (if not previously documented);
- Providing treatment, advice and/or referral for other services or treatment; and
- Documenting the outcomes of the consultation in the patient's medical records and other relevant mental health plan (where applicable).

Item Number	2713

Home Medicines Review

Guide for Patient Selection

- Currently taking 5 or more regular medications.
- Taking more than 12 doses of medication / day.
- Significant changes made to medication regimen in the last 3 months.
- Medication with a narrow therapeutic index or medications requiring therapeutic monitoring.
- Symptoms suggestive of an adverse drug reaction.
- Sub-therapeutic response to treatment with medicines.
- Suspected non-compliance or inability to manage medication related therapeutic devices.
- Patients having difficulty managing their own medicines because of literacy or language difficulties, dexterity problems or impaired sight, confusion/dementia or other cognitive difficulties.
- Attending a number of different doctors, both general practitioners and specialists.
- Recent discharge from a facility /hospital (in the last 4 weeks).
- Other medication issues / problems.

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

Item Number	900

Process:

1. Identify suitable patients (see above).
2. Patient can be charged for initial consult only if attending for matter unrelated to HMR.
3. Obtain patient consent.
4. Complete referral form (available in HMR kit).
5. Forward referral form to patient's chosen community pharmacist.
6. Following the pharmacist review in the patient home the pharmacist will forward a report to you.
7. GP and accredited pharmacist MUST DISCUSS the report (face to face or over the phone).
8. Using report, draft a patient medication plan (available in HMR kit).
9. Recall patient to discuss and agree to the medication plan.
10. Patient, Community Pharmacist and GPs all provided with copies of the medication plan.
11. Implementation of agreed actions with appropriate follow-up and monitoring.
12. Patient charged MBS item number 900.

Other Points to consider:

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

Residential Medication Management Review

- This item applies to residents of a Residential Aged Care Facility (RACF) who are likely to benefit from a review.
- Available to new residents on admission into a RACF; and
- Available for existing residents where there has been a significant change in medical condition, or medication regimen requiring a RMMR.
- Maximum of 1 per resident every 12 months.

Examples of why there could be a need for a RMMR:

- Discharge from an acute care facility in previous 4 weeks.
- Significant changes to medication regimen in the last 3 months.
- Change in medical conditions or abilities (including falls, cognition, physical function).
- Prescription of medication with a narrow therapeutic index or requiring therapeutic monitoring.
- Presentation of symptoms suggestive of an adverse drug reaction.
- Sub-therapeutic response to treatment.
- Suspected non-compliance or problems with managing drug related therapeutic devices; or
- At risk of inability to continue managing own medications (eg due to changes with dexterity, confusion or impaired sight).

→ A resident's consent must be obtained before proceeding.

→ A RMMR should generally be initiated by the resident's 'usual' GP.

→ Undertaken by pharmacist, contracted to the facility to undertake review.

Activities to be undertaken by the medical practitioner as part of the RMMR include:

- Discussing and seeking consent from the resident.
- Initiating the RMMR and collaborating with the reviewing pharmacist regarding the pharmacy component of the review.
- Providing input from the resident's Comprehensive Medical Assessment (CMA), or if a CMA has not been undertaken, providing relevant clinical information for the resident's RMMR and for the residents records.
- Participating in a post-review discussion (either face to face or by telephone) with the pharmacist to discuss the outcomes of the review including:
- The findings of the pharmacist's review;
- Medication management strategies; and
- Means to ensure the strategies are implemented and reviewed, including any issues for implementation and normal follow-up.
- Developing and/or revising the resident's Medication Management Plan after discussion with the reviewing pharmacist and finalising the plan after discussion with the resident.
- Offering a copy of the Medication Management Plan to the resident (and/or their carer or representative), providing a copy for the resident's records and for the nursing staff of the RACF, and discussing the plan with nursing staff if necessary.

Item Number	903

Comprehensive Medical Assessments

- This item applies to residents of a Residential Aged Care Facility (RACF).
- Available to new residents on admission into a RACF (preferably within first 6 weeks).
- Available for existing residents where there has been a significant change in medical condition, physical and/or psychological function.
- Maximum of 1 per resident every 12 months.
- A CMA must include:
  - Taking of detailed medical history;
  - Conducting a comprehensive medical examination of the resident;
  - Developing a list of diagnoses or problems; and
  - Providing a written summary of the outcomes for the resident's records to inform the provision of care for the resident by the RACF and to assist the reviewing pharmacist in providing medication management review services.

Item Number	712

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

Health Assessments

- Is an **assessment of the patient's health and physical, psychological and social function** and whether preventive health care and education should be offered.
- not for in-patients of hospital, day hospital or aged care residents.

It should include:

- Measurement of blood pressure, pulse rate and rhythm.
- Assessment of patient's medication.
- Assessment of the patient's continence.
- Assessment of immunisation status (influenza, tetanus & pneumococcus).
- Assessment of physical function (daily living and whether they have had a fall in last 3 months).
- Assessment of the psychological function (cognition and mood—measured with a recognised tool).
- Assessment of social function (including availability and adequacy of paid and unpaid help, & if patient is caring for another person).

Additional components may include:
Multi-system review, fitness to drive, hearing, vision, oral health, diet and nutritional status, smoking, foot care, sleep, need for community services, home safety, cardio-vascular risk factors and alcohol use.

The **information collection component** of the assessment may be rendered **by a nurse or other assistant** in accordance with accepted medical practice, acting under the supervision of the GP. The other components must include a personal attendance by the GP.

- It is **not** a health screening service.
- Should not include **category 5 (diagnostic imaging) services or category 6 (pathology) services** unless the health assessment detects problems that require clinically relevant diagnostic imaging or pathology services.

The assessment must also include keeping a written record of assessment, signed by patient, and provision of a written report to the patient with recommendations about matters covered.

Annual Health Assessments		
	In consulting room	Not at consulting room, hospital or Aged Care Facility
Others 75 & Over	Item 700	Item 702
Aboriginal & Torres Strait Islanders 55 & over	Item 704	Item 706

Aboriginal & Torres Strait Islander Health Check

- Item applies to an Aboriginal and/or Torres Strait Islander person **between 15 years and 54 years of age** (inclusive).
- Complements the existing health assessment.
- An Aboriginal and Torres Strait Islander Adult Health Check means the assessment of an Aboriginal and/or Torres Strait Islander patient's health and physical, psychological and social function, and whether preventive health care, education and other assistance should be offered to that patient, to improve the patient's health and physical, psychological or social function.
- This item **does not apply to people who are in-patients of a hospital, day hospital facility or care recipients in a residential aged care facility.**
- A person is an Aboriginal and/or Torres Strait Islander if the person **identifies himself or herself as being of Aboriginal and/or Torres Strait Islander descent**. Patients should be asked to self-identify their status and their age for the purposes of these items, either verbally or by completing a form.
- Item should generally be undertaken by the patient's usual doctor.
- Patient must **consent** to health check and this must be noted in the patient's record.

Health Check must include:

- Taking the patient's medical history;
- Examining the patient;
- Undertaking or arranging any required investigation;
- Assessing the patient using the information gained in the health check ;
- Making or arranging any necessary interventions and referrals, and
- Documenting a simple strategy for the good health of the patient.

*The information collection component of the health check may be undertaken by a health worker, nurse or other qualified professional as long as the patient has already consented to the health check and consented to a 3rd party collecting the information for the assessment.

- Item can be claimed once every 18 months.

Item Number	710

45 Year Old Health Check

- Health Check is targeted at people between 45 and 49 years of age (inclusive) who are at risk of developing a chronic disease. A chronic disease or condition is one that has been or is likely to be present for at least 6 months, including, but not limited to asthma, cancer, cardiovascular illness, diabetes, mellitus, mental health conditions, arthritis and musculoskeletal conditions. The aim of the health check is to assist with detection and prevention of chronic disease and enable early intervention strategies to be implemented where appropriate.
- 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.

Factors to consider may include but are not limited to:

- *Lifestyle Risk Factors*
    - Smoking
    - Physical Inactivity
    - Poor Nutrition
    - Alcohol Misuse
- *Biomedical Risk Factors*
    - High Cholesterol
    - High Blood Pressure
    - Impaired Glucose Metabolism
    - Excess Weight
- *Family History of Chronic Disease*

Health Check must include:

- Patient must consent to health check and this must be noted in the patent's chart;
- Taking patient's history (or updating an existing one);
- Examination (tailored to the patient's individual needs and risk factors);
- Investigations as clinically indicated ;
- Overall assessment of the patient;
- Interventions e.g. referrals as indicated;
- Provide advice and information to the patient.

- Practice Nurses, Aboriginal Health Workers and other health professionals may assist the GP in performing the health check, in accordance with accepted medical practice and under the supervision of the GP.
- Item can only be claimed once for any eligible patient.

Item Number	717

Case Conference

Case Conference is a discussion process by which a multidisciplinary team carries out the following activities:

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

A case conferencing team includes:

- a medical practitioner; and
- at least 2 other contributing members, each of whom provides a different kind of care (one who may be a medical practitioner providing a different kind of care).

The minimum 3 care providers must be communicating at the one time for the whole of the conference, either face to face, via video-conferencing, by telephone, or a combination.

A Case Conference applies only to a service in relation to a **patient who suffers from at least one medical condition that has been (or is likely to be) present for at least 6 months**, or that is terminal, and is not an in-patient of a hospital or day hospital.

To **organise and coordinate** the case conference involves:

- explaining to the patient the nature of the conference.
- obtaining and recording consent.
- recording day, times, names of participants.
- recording all matters mentioned.
- providing a summary to patient and team members.

When **participating** in a case conference organised by another, the medical practitioner should:

- inform the patient that his/her medical history, diagnosis and care preferences will be discussed with other providers.
- provide an opportunity for them to specify what may be conveyed or withheld from others.

Patients should be informed that they will incur a charge for this service, for which a Medicare rebate will be payable.

It is expected that a patient would **not require more than five case conferences in a 12 month period**.

Organise & Coordinate Case Conference			
Time	15-30 min	30-45 min	>45 min
In the Community (not in-patient of hospital/day hospital or RACF	Item **740**	Item **742**	Item **744**
On Discharge	Item **746**	Item **749**	Item **757**
In Aged Care Facility (RACF)	Item **734**	Item **736**	Item **738**

Participate in a Case Conference			
Time	15-30 min	30-45 min	>45 min
In the Community (not in-patient of hospital/day hospital or RACF	Item 759	Item 762	Item 765
On Discharge	Item 768	Item 771	Item 773
In Aged Care Facility (RACF)	Item 775	Item 778	Item 779

CDM Items:
GP Management Plan
Team Care Arrangements

GP Management Plans and Team Care Arrangements should be comprehensive documents that set out and enable evidence-based management of the patient's health and care needs.

Patients with a chronic or terminal medical condition are eligible for a GP Management Plan item. Patients who also have complex needs requiring care from a multidisciplinary team are eligible for a Team Care Arrangements item.

A GP Management Plan and Team Care Arrangements, together, broadly equate to an EPC multidisciplinary plan.

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

GPs can be assisted by practice nurses, aboriginal health workers and other health professionals in providing the new CDM items. The GP must review and confirm all assessments and elements of the service and must see the patient as part of the service.

For patients to be eligible to access rebates under the allied health and dental care items (item numbers 10950 to 10977 inclusive) they must have **both a GP Management Plan and a Team Care Arrangements in place and claimed on Medicare.**

However, residents of aged care facilities are eligible to access rebates under the allied health and dental care items where their **GP has contributed to a care plan** prepared for them (Item 731) and the contribution item has been claimed on Medicare.

Name	Item Number	Recommended frequency
Preparation of a GP Management Plan	721	2 yearly
Preparation of Team Care Arrangements	723	2 yearly
Review of a GP Management Plan	725	6 monthly
Coordination or Review of Team Care Arrangements	727	6 monthly
Contribution to a multidisciplinary care plan or Team Care Arrangements	729	6 monthly
Contribution to a multidisciplinary care plan by an Aged Care Facility	731	6 monthly

Further information

Additional information on these items is available from the Department of Health and Ageing web site at www.health.gov.au (and use the A-Z Index tool to go to Chronic Disease Management) or by calling (02) 6289 8735.

GP Management Plan

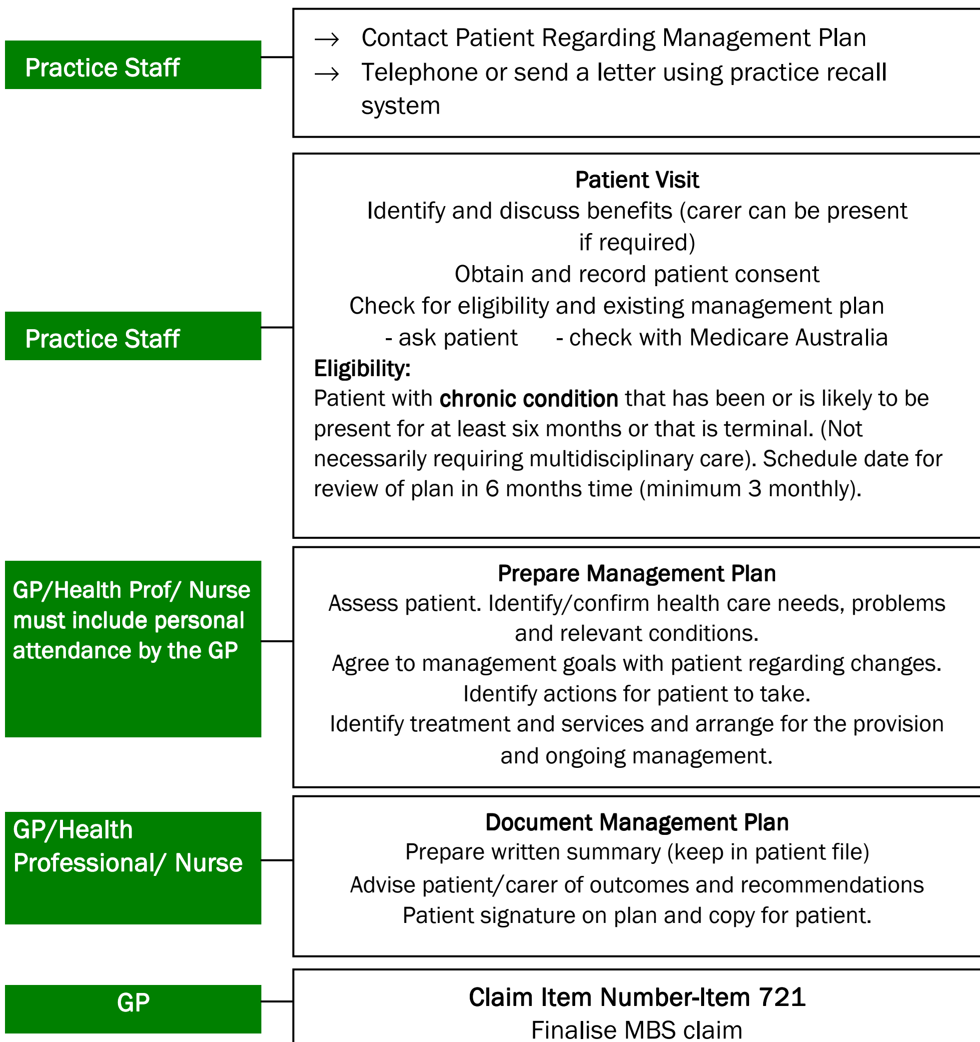
GP Management Plan

Patient with chronic or terminal condition that has or is likely to be present for at least six months or that is terminal (not necessarily requiring multidisciplinary care)

Preparation Item 721
- Claimed by GP with assistance of RN or other
- Recommended every 2 years (minimum 12 months)

→

Review Item 725
- Claimed by GP with assistance of RN or other
- Recommended every 6 months (minimum 3 monthly) or when clinically required



Team Care Arrangements

Team Care Arrangement

Patient with chronic or terminal condition with complex care needs that requires multidisciplinary care

Coordination Item 723
- Can be claimed with a GP management plan
- Claimed by GP with assistance of RN or other

→

Review Item 727
- Claimed by GP with assistance of RN or other

→

Contribution Item 729
- When Team Care Arrangement prepared by another provider
- Claimed by GP with assistance of RN or other

Responsibility	Task
Practice Staff	Contact Patient Regarding Team Care Arrangement. Telephone or send a letter using practice recall system. Arrange a time to see the patient for initial assessment.
Practice Staff	**Patient Visit** Identify and discuss benefits (carer can be present if required) Obtain and record patient consent Check for eligibility and existing care plan - Ask patient - Check with Medicare Australia **Eligibility:** Patient with chronic or terminal condition with complex care needs requiring multidisciplinary care. Schedule date for review of plan in 6 months time (minimum 3 months).
Practice Staff	**Contact Other Health Professionals** Advise professionals involved about patient. Obtain their agreement to provide services.
GP/Health Prof/ Nurse must include personal attendance by the GP	**Prepare Team Care Arrangement** Document goals. Document collaboration with other health professionals. Document treatment/ services they have agreed to provide. Document patient actions. Write EPC Referral for services eligible for Medicare rebates.
Practice Staff	Request and send a copy of relevant information to other health professionals involved in Team Care Arrangement.
Practice Staff	Advise patient and carer of outcomes.
GP/Practice Staff	**Claim Item Number-Item 723** Finalise MBS claim

Preparation of a GP Management Plan (Item 721)

Must include:

- GP Management Plans are available to all patients with a chronic or terminal medical condition—they do not need to have complex care needs.
- Assessing the patient to identify and/or confirm their health care needs, problems and relevant conditions.
- Agreeing management goals with the patient for the changes to be achieved by the treatment and services identified in the plan.
- Identifying any actions to be taken by the patient.
- Identifying treatment and services that the patient is likely to need, and making arrangements for the provision of these services and ongoing management; and
- Documenting the patient needs, goals, patient actions, treatment/services and a review date, ie completing the GPMP document.
- The patient's progress against the plan should be periodically reviewed using the GP Management Plan Review items, and ongoing management and care provided through normal consultation items.
- ***Recommended frequency is once every two years***, supported by regular review services.
- The GP may be assisted by their ***practice nurse***, Aboriginal Health Worker or other health professional in the GP's medical practice or health service.

Coordinating the development of Team Care Arrangements (Item 723)

Steps must include:

- Discussing with the patient which treatment/service providers should be asked to collaborate with the GP in completing the Team Care Arrangement.
- Gaining the patients agreement to share relevant information about their medical history, diagnoses, GP Management Plan etc with the proposed providers.
- Contacting the proposed providers and obtaining their agreement to participate, realising that they may wish to see the patient before they provide input but that they may decide to proceed after considering relevant documentation, including any current GP Management Plan.
- Collaborating with the participating providers to discuss potential. treatment/services they will provide to achieve management goals for the patient
- Documenting the goals, the collaborating providers, the treatment/services they have agreed to provide, patient actions and a review date.
- Providing the relevant parts of the Team Care Arrangement to the collaborating providers and to any other persons, who under the Team Care Arrangement will give the patient the treatment/services mentioned in the Team Care Arrangement.
- Communication between GP and providers must be two-way, and preferably oral, but can be in writing (fax, email).
- Must include at least 2 health or care providers who will be providing ongoing treatment to the patient.
- ***Recommended frequency is once every two years***, supported by regular reviews.

GP Management Plan and Team Care Arrangement:

- Are available to patients in the community, private in patients being discharged (including residential aged care facility patients) where their usual GP who prepares the GMMP is providing in-patient care.
- Not available to public in-patients being discharged from hospital.
- Not available to residents of aged care facilities, except where they are private in-patients being discharged from hospital.

Review of a GP Management Plan (Item 725)

- Provides a rebate for a GP to review a GP Management Plan.
- Practice nurse or other can assist.
- Involves reviewing the patient's GP Management Plan, documenting any changes and setting the next review date.
- ***Recommended frequency once every 6 months.***

Coordination of a Review of Team Care Arrangements (Item 727)

- For patients who have a current Team Care Arrangement and require a review of this.
- Involves the GP (who may be assisted by their practice nurse or other) collaborating with the participating providers on progress against treatment/services and documenting any changes to the patient's Team Care Arrangement.
- ***Recommended frequency once every 6 months.***

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

- For patients who are having a multidisciplinary care plan prepared or reviewed by another health or care provider (other than their usual GP) including on discharge from hospital.
- Involves the GP (who may be assisted by their practice nurse or other) collaborating with the providers preparing or reviewing the plan and including their contribution with the patient's records.

Contribution to another provider's multidisciplinary care plan or contributing to a review of a multidisciplinary care plan for a patient who is a resident of an aged care facility (Item 731)

- This is for patients in residential aged care facilities and is otherwise identical to Item 729 (immediately above).
- This service can only be provided to a resident where the multidisciplinary plan is being prepared by the aged care facility or by a hospital from which the resident is being discharged.

Transitional Arrangements and Reviewing EPC Multidisciplinary Care Plans from 1 July 2005

- Where a patient was being managed under an active EPC multidisciplinary care plan (Item 720 or 722) before 1 July 2005, that patient will be regarded as having both a GP Management Plan and Team Care Arrangements in place from the date on which the active multidisciplinary care plan was completed and claimed.
- In order to review an existing EPC multidisciplinary care plan from 1 July 2005, a GP can use the relevant CDM review items (a GP Management Plan Review item, for review by a GP alone, or a Team Care Arrangement Review item, for review with input from a multidisciplinary team).

Allied Health Services for Chronic or Complex Conditions

Patients who have both a GP Management Plan and a Team Care Arrangements service (which, together, are broadly equivalent to an EPC multidisciplinary care plan) have access to the allied health and dental care items on the Medicare Benefits Schedule and may be eligible for up to 5 allied health services per year on referral from their GP (as do patients who previously had an EPC care plan — Item 720 or 722).

A GP Management Plan & Team Care Arrangement must be claimed through Medicare before allied/dental items can be claimed.

Services from Aboriginal health workers, audiologists, chiropractors, chiropodists, dietitians, mental health workers, occupational therapists, osteopaths, physiotherapists, podiatrists, psychologists and speech pathologists, are included under these items. Allied health services are provided by private allied health professionals registered with Medicare Australia for the purpose of this initiative. This process is not to be used for referral to publicly funded allied health services.

GPs must use the allied health referral form to refer patients to an eligible allied health professional. When referring a patient to more than one allied health professional, a separate referral from for each referral is required.

Overview:

- Patients must have a GP Management Plan and a Team Care Arrangement plan developed by their GP (MBS Items 721, 723). These two items together, are broadly equivalent to an EPC multidisciplinary care plan.
- GP must use the allied health referral form to refer patient (download from www.medicareaustralia.gov.au/providers/incentives_allowances/medicare_initiatives/allied_health.htm or phone 1800 067 307 to reorder further quantities of this form).
- Person referred is not an admitted patient of a hospital or day-hospital facility.
- Allied Health Professional must be registered with Medicare Australia.
- Maximum of 5 services per year.
- Allied health professional to provide a written report on the service to the referring practitioner.
- Referral form signed by servicing allied health professional must accompany all Medicare claims.

Allied Health Professional Type	Item No.	Allied Health Professional Type	Item No.
Aboriginal Health Worker	10950	Occupational Therapist	10958
Audiologist	10952	Osteopath	10966
Chiropractor	10964	Physiotherapist	10960
Diabetes Nurse Educator	10951	Podiatrist or Chiropodist	10962
Dietitian	10954	Psychologist	10968
Mental Health Worker	10956	Speech Pathologist	10970

Eligibility	Patients with chronic or terminal conditions qualify for a GP Management Plan. Patients with chronic conditions and complex needs requiring multidisciplinary care are eligible for both a GP Management Plan and/or Team Care Arrangements.
Service delivery	GPs can now provide a GP Management Plan to patients with chronic or terminal conditions, without needing to collaborate with other care providers. GPs can still collaborate with other providers if the patient has complex multidisciplinary care needs and would benefit from Team Care Arrangements.
Frequency of services	Minimum time limits apply, but CDM services can also be provided more frequently in 'exceptional circumstances - where there has been a significant change in the patient's clinical condition or care.
GP assistance	GPs can be assisted by a Practice Nurse, Aboriginal Health Worker or other health professional. Plans can be reviewed by the same GP, a GP from the same practice or, in the event that the patient has moved practices, by a GP from the new practice.
Reviews	GPs can choose most appropriate review item for circumstances of patient—GP review if reviewing alone; Team Care review if reviewing with team input.
Access to allied health and dental care services (MBS Items 10950—10977)	Patients can access MBS Items 10950—10977 after their GP has completed their GP Management Plan and Team Care Arrangements or, after the GP has completed their contribution to an aged care resident's care plan. Access also retained for patients who have an EPC multidisciplinary care plan.
Residents in aged care facilities	GPs can contribute to aged care facility care plans and also contribute to multidisciplinary discharge care plans for aged care residents (public or private patients) being discharged from hospital.
Methods of collaboration with other providers	Collaboration with other providers for Team Care Arrangement items can be face to face, in writing, by fax, phone, videoconference or email.

Immunisation provided by a practice nurse

Immunisation provided to a person by a practice nurse: if

- The immunisation is provided on behalf of, and under the supervision of, a medical practitioner; and
- The immunisation is provided:
  - In the consulting rooms of a general practice
  - In a residential aged care facility; or
  - During a home visit to the person; or
  - In an institution (other than a hospital or day facility)
- Can only be claimed once per patient per visit, even if more than one vaccine is administered.
- The practice nurse must be appropriately qualified and trained to provide immunisations.
- The medical practitioner under whose supervision the immunisation is provided retains responsibility for the health, safety and clinical outcomes of the patient.
- Immunisation means the administration of a registered vaccine to a patient for any purpose other than as part of a mass immunisation of persons.
- A registered vaccine means a vaccine that is included on the Australian Register of Therapeutic Goods.

Item Number	10993

Wound management services provided by a practice nurse

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

- The treatment is provided on behalf of, and under the supervision of, a medical practitioner; and
- The person is not an admitted patient of a hospital or day-hospital facility.
- Can only be claimed once per patient per visit, even if more than one wound is treated during the same patient visit.
- The practice nurse must be appropriately qualified and trained to treat wounds.
- The medical practitioner under whose supervision the wound management is provided retains responsibility for the health, safety and clinical outcomes of the patient.
- The medical practitioner does not need to be present during the treatment of the wound.
- Where a practice nurse provided ongoing wound management, the medical practitioner is not required to see the patient during each subsequent visit.
- Where the medical practitioner also provided a service to the patient prior to the treatment by the practice nurse, the medical practitioner will still be able to claim for the professional service they provide to the patient.

Item Number	10996

Pap Smear Service provided by a practice nurse

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.

Item 10998 only applies where:

- The practice nurse is appropriately qualified and trained to take a cervical smear; and
- The medical practitioner under whose supervision the smear is taken retains responsibility for the health, safety and clinical outcomes of the person.
- The medical practitioner does not need to see the patient first, or be present when the smear is being taken.
- If the medical practitioner does see the patient first, they are entitled to claim for that professional service.
- Item 10998 can be claimed in conjunction with the bulk billing incentive.
- The medical practitioner who claims item 10998 will need to ensure that their medical indemnity insurance covers circumstances where a practice nurse takes a Pap smear on their behalf.

Item 10999 applies where:

- All of the above are met and
- The women is between the ages of 20 and 69 years of age and has not had a cervical smear in the last 4 years
- GP and Nurse working in PIP practice that has signed on for the cervical screening incentive

Item Number	10998
Item Number	10999

See Also SIP Payment Information on Page 2.

Pap Smear Service and Preventive Checks provided by a practice nurse

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

(c) The service is provided on behalf of, and under the supervision of, a medical practitioner; and

(d) The person is not an admitted patient of a hospital or approved day hospital facility.

Item 10994 only applies where:

- The practice nurse is appropriately qualified and trained to take cervical smears and provide preventive health checks; and
- The medical practitioner under whose supervision the smear is taken retains responsibility for the health, safety and clinical outcomes of the person.
- The medical practitioner does not need to see the patient first, or be present when the smear is being taken.
- If the medical practitioner does see the patient first, they are entitled to claim for that professional service.
- Item 10994 can be claimed in conjunction with the bulk billing incentive.
- The medical practitioner who claims item 10994 will need to ensure that their medical indemnity insurance covers circumstances where a practice nurse takes a Pap smear on their behalf.

Services for Item 10994 must include a ***pap smear and at least one preventive check from the following:***

- Checks for sexually transmitted infections (including Chlamydia)
- Taking of a sexual and reproductive history
- Advice on contraception
- Breast awareness education
- Advice on post natal issues
- Continence advice and education;

And may also include:

- Smoking, Nutrition, Alcohol and Physical Activity (SNAP) behavioral risk factor assessment
- Blood pressure measurement

Item 10995 applies where:

- All of the above are met and
- The women is between the ages of 20 and 69 years inclusive and has not had a cervical smear in the last 4 years
- GP and Nurse working in PIP practice that has signed on for the cervical screening incentive

Item Number	10994
Item Number	10995

See Also SIP Payment Information on Page 2.

Medicare Plus – Bulk Billing Children and Concessional Patients

There are three MBS items to receive an additional payment) for GPs who bulk bill concessional patients and children under the aged of 16.

GPs working in Urban Locations

Item 10990 — to be used when a medical practitioner provides a medical service (other than a diagnostic imaging or pathology service).

Item 64990 — to be used where a medical practitioner provides an unreferred diagnostic imaging service under the MBS.

Item 74990 — to be used where a medical practitioner provides an unreferred pathology service under the MBS.

GPs working in Rural and Remote Locations (RRMA 3-7) and areas covered by a Statistical Subdivision (SSD) or Statistical Local Area (SLA) that is listed at Item 10991 in the MBS.

To clarify if your practice location is eligible contact Medicare Australia 132 150.

Item 10991– to be used when a medical practitioner provides a medical service (other than a diagnostic imaging or pathology service).

Item 64991– to be used where a medical practitioner provides an unreferred diagnostic imaging service under the MBS.

Item 74991– to be used where a medical practitioner provides an unreferred pathology service under the MBS.

These items cannot be claimed in respect of patients being treated under the DVA arrangements, but the supplementary veteran payment is payable. However, if the Gold or White card holder is also the holder of a Commonwealth concession card and they choose to be treated under the Medicare arrangements then the bulk billing incentive item can be claimed.

Incentives

Region	MBS Item Number
Urban	10990
	64990
	74990
Rural/remote	10991
	64991
	74991

Medicare Plus – Dental Care for Chronic or Complex Conditions

People with chronic conditions and complex care needs who are being managed through a GP Management Plan and a Team Care Arrangements service are eligible for up to 3 dental care services per year on referral from their GP, as are patients who previously had an EPC care plan (Item 720 or 722).

Residents of aged care homes whose GP has contributed to a care plan prepared by the aged care home (item 730 or new item 731) have access to the dental care items.

GPs can refer these patients to an eligible dentist for a dental care plan where the patient has a dental problem that is significantly adding to the seriousness of the chronic condition for which the multidisciplinary care plan was formed. Dental services are provided by private dentists registered with HIC for the purpose of this Initiative. This process is not to be used for referral to publicly funded dental services.

GPs must use the EPC dental care referral form to refer patients to an eligible dentist.

There are three MBS items for services provided by dentist. The first two are for services provided directly by a registered Dentist on referral from a GP (Item 10975—Dental Assessment and report; Item 10976—Dental Treatment). The third item (Item 10977) is for services provided by another registered Dentist of Dental Specialist on referral from the Dentist who provided the original dental assessment (Item 10975)

Overview:

- Residents of aged care homes whose GP has contributed to a care plan prepared by the aged care home (item 730 or new item 731) have access to the dental care items.
- GP must use the dental care referral form to refer patient (download from www.medicareaustrailai.gov.au/providers/incentives_allowances/medicare_initiatives/allied_health.htm or phone 1800 067 307.
- All patients must have a dental assessment (MBS Item 10975).
- Dentists and Dental Specialists must be registered with Medicare Australia.
- Maximum of three dental care services per 12 month period.
- Dentist to provide a written report on the service to the referring practitioner.
- Dentists may set their own fee. Where the fee is greater than the scheduled fee the patient will be required to pay the additional costs.
- A GP Management Plan & Team Care Arrangement must be claimed through Medicare before allied/dental items can be claimed.

Item 10975—Dental Assessment & Report

- This item must be provided for all eligible patients before either Item 10976 or 10977 is provided.
- The assessment should include an evaluation of all teeth, their supporting structures and the oral tissues; and a written report to the referring GP.

Item 10976—Dental Treatment

- To be provided on referral from a medical practitioner for treatment of a condition that is exacerbating a patient's chronic medical condition (managed though an EPC care plan) and where the patient has had a dental assessment under Item 10975 within 12 months of the date of the first service.

Item 10977—Dental Assessment or treatment and report by a registered Dentist or Dental Specialist

- This service may only be provided where the patient has had a dental assessment under Item 10975 and it has been determined by the dental provider that further assessment or treatment from a dental specialist was required.
- A written report on the service should be provided to both referring dentist and GP.

Medicare Plus – For other Medical Practitioners (OMPs) Program

The MedicarePlus for Other Medical Practitioners (OMPs) Program provides access to the higher A1 Medicare rebate for services provided by pre 1996 non-vocationally registered medical practitioners, also known as OMPs, who provide services in an area of workforce shortage.

The intent of the program is to provide an extra incentive for OMPs currently working in adequately supplied workforce areas to relocate to areas of workforce shortage for a period of time. OMPs who provide services in an area of workforce shortage for five years will continue to attract the higher rebate regardless of where they are subsequently located.

OMPs who are already working in a designated area of workforce shortage under the current eligible program may be able to have this time count towards their five years.

Eligibility—to be eligible for this Program a doctor:

- Must be a non-vocationally registered medical practitioner registered with a State or Territory Medical Registration Board before 1 November 1996;
- Must be assessing Medicare rebates in general medical services prior to 1 November 1996;
- Must be providing medical services in a defined area of workforce shortage; **and**
- Must not have previously been on the Vocational Register or the Fellows List.

Areas of workforce shortage

- Have been determined nationwide by using a population to 'full-time equivalent (FTE)' general practitioner ratio.
- Areas with a population ratio of more than the national average (approx. 1385) per FTE GP may be eligible for the Program.
- Defined areas of workforce shortage will be updated annually to include changes in Program eligibility.
- Further information on which areas have been identified as areas of workforce shortage:
  contact Medicare Australia on 132 150

Continuing Professional Development (CPD) Requirements

- To maintain eligibility for the MedicarePlus for OMPs Program, medical practitioners will be required to register and undertake CPD activities within 3 months of commencing the Program.
- CPD activities assist general practitioners to maintain and improve the quality of care they give to patients and to promote the highest possible standards of care to the community. It is the responsibility of the individual practitioners to ensure they are meeting their CPD requirements.

Application Process

- Application forms for this Program are available through Medicare Australia or the Dept of Health & Ageing websites.
- Applicants should return completed application forms to Medicare Australia. It is the responsibility of individual doctors to ensure they are registered on the MedicarePlus for OMPs Program before billing at the higher rate.
- Medicare Australia will process applications within 21 days of receipt of completed Application forms. Successful applicants will be advised of the commencement date of payment of the higher Medicare rebate in the letter advising approval for the Program.

For further information on this program call 1800 667 677
or go to www.health.gov.au/medicare/index.htm

Medicare Plus – Practice Incentive Program Procedural Payment

This item is one component of the Supporting Rural and Remote Procedural General Practitioners initiative. It aims to support GPs in maintaining local access to surgical, anesthetic and obstetric services and providing safety and continuity of care in rural and remote communities. Practices participating in the Practice Incentive Program (PIP) in rural and remote areas will be eligible to receive a PIP payment to support them in providing procedural services.

Eligibility

- The practice must participate in the Practice Incentive Program.
- The principal practice location must be within the target area
  - Rural, Remote and Metropolitan Area Classification (RRMA) 3-7.
- At least one GP from the practice must provide one or more of the procedural services described in the definition of a procedural GP.

Definition of a procedural GP

- A procedural GP provides non-referred services, normally in a hospital theatre, maternity care setting or appropriately equipped facility, which in urban settings are typically the province of a specific referral based specialty.
- These services are provided in obstetrics, surgery and anaesthetics.

Procedural services are:

- Obstetric delivery.
- General anaesthetic, major regional blocks.
- Abdominal surgery, gynaecological surgery requiring general anaesthetic, endoscopy.

Elements essential to procedural medicine include the use of facilities and resources which are centralised and involve a team of health professionals and the active engagement of the practitioner in an appropriate skills maintenance program in the relevant procedural areas. Minor procedures, such as aspiration of a knee joint, do not fit into the intent of this Initiative.

- Procedural Payments reflect the range and extent of procedures provided under each tier.
- Tier payments will be paid as a flat fee per eligible GP to a nominated PIP practice.
- Payments are not cumulative and a GP will only qualify for one tier and only one procedural payment per annum.

Tier 1: $1,000

The GP provides any service covered by the definition of a procedural GP.

Tier 2: $2,000

The GP provides services covered by the definition of a procedural GP and includes:

- After-hours procedural service provision on a regular or rostered basis.

Tier 3: $5,000

The GP provides services covered by the definition of a procedural GP and includes:

- After-hours procedural service provision on a regular or rostered basis; **and**
- Surgical &/or anaesthetic &/or obstetric services totaling more than 50 eligible procedures per year (averaged over 12 months)