Key MBS Item Numbers for Primary Care

CURRENT AS AT JULY 2013

Tasmania Medicare Local has evolved from the former General Practice Tasmania network which comprised the three Divisions of General Practice and General Practice Tasmania Limited. From 1 November 2011 the core business of the four organisations is now delivered through a single statewide organisation. Tasmania Medicare Local is funded to better coordinate the primary health care system in Tasmania and to meet the needs of local communities.

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Tasmania Medicare Local Limited ABN 47 082 572 629

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The MBS Item Number flip chart is provided for you by
Tasmania Medicare Local

- This flip chart should be read in conjunction with the Medicare Benefits Schedule, available online at www.health.gov.au/mbsonline
- This flip chart resource can be downloaded at www.tasmedicarelocal.com.au
- Further information on the Practice Incentive Program (PIP) can be found on the Medicare Australia Website at www.medicareaustralia.gov.au/provider/incentives/pip/index.jsp
- Further information on utilisation of the Clinical Audit Tool to assist with targeting specific patient populations can be found at www.clinicalaudit.com.au/how

*If you have any queries or concerns please do not hesitate to contact your Medicare Local Branch office*

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**Acknowledgement**
This document was adapted from a resource developed by Yorke Peninsula Division of General Practice

**This resource was funded by the Australian Government Department of Health and Ageing under the Australian Better Health Initiative**

The information contained in this resource has been obtained from a variety of external sources and, while every effort has been made to ensure its accuracy, Tasmania Medicare Local assumes no responsibility for its use.
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Bulk Billing Concession Card Holders and Children
Not applicable to inpatients of hospital/day hospital

TASMANIA’S GPS MAY RECEIVE AN ADDITIONAL $9.10 BENEFIT FOR BULK BILLING CONCESSIONAL CARDHOLDERS AND CHILDREN UNDER THE AGE OF 16.

Eligible Concession Cards: Pensioner Concession Card
Health Care Card
Commonwealth Seniors Health Card

Item 10991
To be used when a medical practitioner provides a bulk-billed medical service at or from a practice location, including services performed either at the medical practitioner’s surgery, or those services performed away from the surgery using the provider number for that surgery (eg home visits or RACFs). Can be claimed in conjunction with attendance items, procedural items or services provided by a Practice Nurse on behalf of a GP (other than a diagnostic imaging or pathology service).

Item 10992
An after hours unreferred bulk-billed medical service to which Item 597, 598, 599, 600, 5003-5267 applies outside of consulting rooms or hospital.

Gold or White Cards issued by the Department of Veterans’ Affairs do not attract the additional bulk billing payment. However, if a Gold or White Card holder also holds a recognised concession card and chooses to be treated under Medicare arrangements then that patient is eligible. Children under 16 years are eligible.

Item 64991
For provision of a bulk-billed unreferred diagnostic imaging service under the MBS.

Item 74991
For provision of a bulk-billed unreferred pathology service under the MBS.

Further Information and Support

TASMANIA’S GPS MAY RECEIVE AN ADDITIONAL $9.10 BENEFIT FOR BULK BILLING CONCESSIONAL CARDHOLDERS AND CHILDREN UNDER THE AGE OF 16.
The Practice Nurse Incentive Program (PNIP) commenced on 1 January 2012 to provide incentive payments to practices to support an expanded and enhanced role for nurses working in general practice. The PNIP consolidates funding arrangements under the Practice Incentive Program (PIP) Practice Nurse Incentive and six of the Medicare Benefits Schedule (MBS) practice nurse items (10993, 10994, 10995, 10996, 10998, 10999) and redirects them into a single payment to eligible general practices. The program also includes:

- support for all accredited practices to employ an Aboriginal Health Worker instead of, or in addition to, a practice nurse (RN or EN)
- support for practices in urban areas of workforce shortage and Aboriginal Medical Services and Aboriginal Community Controlled Health Services to employ an allied health professional, such as a physiotherapist, dietitian or occupational therapist, instead of, or in addition to a practice nurse and/or Aboriginal Health Worker
- a rural loading of up to 50% based on the Australian Standard Geographical Classification-Remoteness Areas (ASGC-RA)
- a one-off $5000 incentive to support eligible non-accredited practices to become accredited.
- Grandparenting arrangements for the first three years of the program (1 May 2012 to 31 Dec 2014) to ensure that practices are not financially disadvantaged by the restructure of the Practice Incentives Program Practice Nurse Incentive and the removal of six of the MBS Benefits Schedule practice nurse items.
- A loading for practices that provide GP services to DVA Gold Card holders
- a loading for Aboriginal Medical Services and Aboriginal Community Controlled Health Services

Eligibility
To be eligible to participate in the PNIP, a practice must:

- meet the RACGP definition of a ‘general practice’ as defined in the current RACGP Standards for general practices;
- maintain full accreditation or be registered for accreditation against the RACGP Standards for general practices;
- achieve full accreditation within 12 months of joining the PNIP and maintain full accreditation thereafter;
- maintain current public liability insurance;
- ensure that all practice GPs maintain current professional indemnity cover;
- ensure that all practice nurses, Aboriginal Health Workers and allied health professionals (where applicable) are covered by appropriate professional indemnity insurance arrangements as required by the Australia Health Practitioner Regulation Agency or by the profession’s registration board;
- employ or otherwise retain the services of eligible practice nurses and/or Aboriginal Health Workers; and
- employ or otherwise retain the services of a GP. This may include less than one full time GP.

Consent
PNIP needs practices and general practitioners (GPs) to give their consent for a number of program components. Any practice participating in the Practice Incentives Program (PIP) can consent to the Department using its practice information, including its SWPE for the purposes of PNIP. GPs at the practice also need to give consent for the Department to use their MBS billing data or service data for some PNIP calculations. More information on the PNIP can be found in the PNIP Guidelines at www.medicareaustralia.gov.au/provider/incentives/files/pnip_guidelines_1106.pdf.

Incentive payment
The level of incentive payment a general practice will be entitled to depends on the practice’s Standardised Whole Patient Equivalent (SWPE) value and the hours worked by practice nurses at the practice. The SWPE value of a practice is the sum of the fractions of care provided to practice patients, weighted for the age and gender of each patient. The average full time GP has 1,000 SWPEs per year. The PNIP will provide incentive payments to eligible practices of:

- $25 000 per year, per 1,000 SWPE where a Registered Nurse works at least 12 hours 40 minutes per week
- $12 500 per year, per 1,000 SWPE where an Enrolled Nurse works at least 12 hours and 40 minutes per week.

Incentives will be capped at five per practice, meaning that practices will be eligible to receive up to $125,000 per year to support their practice nurse workforce. More information on the calculation of payments can be found in the Practice Nurse Incentive Program Guidelines.

Top-up payment
Top-up payments will be available for accredited practices receiving the incentive payment for the first three years of the program (1 May 2012 to 31 Dec 2014) to make sure that practices are not financially disadvantaged by the end of the PIP PNIP and/or the six removed MBS practice nurse items.

Medicare Australia will assess if a practice is eligible for a top-up payment. These payments will be made quarterly at the same time PNIP incentive payments are made.

Further Information and Support
Practice Nurse Incentive Program resources www.amlalliance.com.au/__data/assets/pdf_file/0005/45293/20120402_rsc_PNIP-Resources.pdf

Practice Nurse Incentive Program & Items

Practice Nurse Items

Eligibility
To be eligible to participate in the PNIP, a practice must:

- meet the RACGP definition of a ‘general practice’ as defined in the current RACGP Standards for general practices;
- maintain full accreditation or be registered for accreditation against the RACGP Standards for general practices;
- achieve full accreditation within 12 months of joining the PNIP and maintain full accreditation thereafter;
- maintain current public liability insurance;
- ensure that all practice GPs maintain current professional indemnity cover;
- ensure that all practice nurses, Aboriginal Health Workers and allied health professionals (where applicable) are covered by appropriate professional indemnity insurance arrangements as required by the Australia Health Practitioner Regulation Agency or by the profession’s registration board;
- employ or otherwise retain the services of eligible practice nurses and/or Aboriginal Health Workers; and
- employ or otherwise retain the services of a GP. This may include less than one full time GP.

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PNIP needs practices and general practitioners (GPs) to give their consent for a number of program components. Any practice participating in the Practice Incentives Program (PIP) can consent to the Department using its practice information, including its SWPE for the purposes of PNIP. GPs at the practice also need to give consent for the Department to use their MBS billing data or service data for some PNIP calculations. More information on the PNIP can be found in the PNIP Guidelines at www.medicareaustralia.gov.au/provider/incentives/files/pnip_guidelines_1106.pdf.

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Practice Nurse Items

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- maintain full accreditation or be registered for accreditation against the RACGP Standards for general practices;
- achieve full accreditation within 12 months of joining the PNIP and maintain full accreditation thereafter;
- maintain current public liability insurance;
- ensure that all practice GPs maintain current professional indemnity cover;
- ensure that all practice nurses, Aboriginal Health Workers and allied health professionals (where applicable) are covered by appropriate professional indemnity insurance arrangements as required by the Australia Health Practitioner Regulation Agency or by the profession’s registration board;
- employ or otherwise retain the services of eligible practice nurses and/or Aboriginal Health Workers; and
- employ or otherwise retain the services of a GP. This may include less than one full time GP.

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Further Information and Support
Practice Nurse Incentive Program resources www.amlalliance.com.au/__data/assets/pdf_file/0005/45293/20120402_rsc_PNIP-Resources.pdf
As at 1 November 2010, Medicare benefits are payable for services provided by privately practising participating nurse practitioners in collaboration with other health care providers.

Participating nurse practitioners can also request certain pathology and diagnostic imaging services for their patients and refer patients to a specialist, as the clinical need arises. This measure does not include referral by a nurse practitioner for allied health care. If a participating nurse practitioner refers a patient to an allied health practitioner, no benefits would be payable for that service provided by the allied health professional. A referral given by a participating nurse practitioner is valid until 12 months after the first service given in accordance with the referral.

To provide services under Medicare, the legislation requires that a nurse practitioner be a participating nurse practitioner. A participating nurse practitioner is an eligible nurse practitioner who has a Medicare provider number and who provides Medicare services in a collaborative arrangement or collaborative arrangements with one or more medical practitioners, of a kind or kinds specified in the regulations.

To access the Medicare arrangements, eligible nurse practitioners will need to apply to Medicare Australia for a provider number. A separate provider number is required for each location at which a nurse practitioner practices. Advice about registering with Medicare is available from the Medicare Australia provider inquiry line on 132 150.

Services provided by participating nurse practitioners are covered by MBS items 82200, 82205, 82210, 82215.

These items cover four time-tiered specific types of service that allow the participating nurse practitioner to perform:

- professional attendance for an obvious problem, straight forward in nature, with limited examination and management required (Item 82200)
- professional attendance for a patient presenting with clinical signs and symptoms with an easily identifiable underlying cause following a short consultation lasting less than 20 minutes duration (Item 82205)
- professional attendance for a patient presenting with clinical signs and symptoms with no obvious underlying cause requiring a more detailed consultation lasting at least 20 minutes duration (Item 82210)
- professional attendance for a patient presenting with multiple clinical signs and symptoms with the possibility of multiple causes and outcomes requiring an extensive consultation of at least 40 minutes (Item 82215)

Professional attendance for MBS items 82200, 82205, 82210, 82215, may be provided in an appropriate setting that includes but not limited to: the patient’s home, a nurse practitioner group practice, a nurse practitioner’s rooms or a medical practice.

**Residential Medication Management Reviews**

RMARs are collaborative services available to residents of a Residential Aged Care Facility (RACF) who are likely to benefit from such a review. This includes residents for whom quality use of medicines may be an issue or who are at risk of medication misadventure because of a significant change in their condition or medication regimen.

An RMAR is available to existing residents of a RACF where it is required in the opinion of the resident’s medical practitioner because of a significant change in the resident’s medical condition or medication regimen, for example (but not limited to):

- discharge from an acute care facility in the 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)

**Process**

1. **Identify** suitable patients - this may be done through a Comprehensive Medical Assessment (CMA).
2. Patient can be charged for initial consult only if attending for matter unrelated to RMAR.
3. A resident’s consent should be obtained consistent with provision of medical services, prior to initiating the RMAR.
4. Complete referral form (available in MD or from TML). Include a copy of the CMA, if recently completed.
5. Ensure delivery of referral form to visiting accredited Pharmacist.
6. Accredited Pharmacist to conduct the review and provide the referring GP with a written report.
7. GP and reviewing Pharmacist should establish an agreed communication process including post-review discussions: this may be done on a facility-by-facility basis.
8. Using information from the report, the GP drafts a patient medication plan (available from TML).
9. Patient recalled to discuss and agree to the medication plan.
10. RACF, accredited Pharmacist and GP records all provided with copies of the medication plan. A copy of the plan is also offered to the resident. Implementation of agreed actions with appropriate follow-up and monitoring.
11. Patient charged MBS item number 903.

**Further Information and Support**


**Medication Management Reviews: DMMR and RMMR**
A DMMR (Item 900) may only be initiated by a patient’s GP after assessing the patient’s need for the service.

Examples of risk factors known to predispose patients to medication-related adverse events:
- Currently taking 5 or more regular medications
- Taking more than 12 doses of medication per 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-optimal 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 GPs and specialists
- Recent discharge from a facility/hospital (in the last 4 weeks)

1. Identify suitable patients
2. Patient can be charged for initial consultation only if attending for matter unrelated to HMR.
3. Obtain informed consent consistent with normal clinical practice from patient, explaining charging procedure and document in medical record.
4. Complete referral form (available in MD or from TML). Include medication and medical history and recent blood test (eg blood electrolytes and other biochemical test results).
5. Ensure delivery of referral form to patient’s chosen community Pharmacist. Patient can deliver referral form if appropriate.
6. The community Pharmacist, if not accredited, will arrange for an accredited Pharmacist to conduct the home review and provide the referring GP with a written report.
7. GP and accredited Pharmacist MUST DISCUSS the report either face-to-face or over the phone.
8. Using information from the report, the GP drafts a patient medication plan (available on MD and in HMR kit).
9. Patient recalled to discuss and agree to the medication plan.
10. Patient, community Pharmacist and GP records 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.
Counselling or Advice to Patients or Relatives
For Items 5020 to 5067 'implementation of a management plan' includes counselling services. Items 5000 to 5067 include advice to patients and/or relatives during the course of an attendance. The advising of relatives at a later time does not extend the time of attendance.

Recording Clinical Notes
In relation to the time taken in recording appropriate details of the service, only clinical details recorded at the time of the attendance count towards the time of consultation. It does not include information added at a later time, such as reports of investigations.

Other Services at the Time of Attendance
Where, during the course of a single attendance by a general practitioner, both a consultation and another medical service are rendered, Medicare benefits are generally payable for both the consultation and the other service. Exceptions are in respect of medical services which form part of the normal consultative process, or services which include a component for the associated consultation.
Practice Incentive Payments and Service Incentive Payments
Cervical Screening Incentive

**Cervical Screening Incentive**

**Sign-on payment**
A one-off sign-on payment of $0.25 per SWPE† is made to practices that undertake to engage with the State/Territory Cervical Screening Register. The payment is made to practices in the quarterly payments following sign-on. To be eligible for the PIP Cervical Screening Incentive, the practice must:
- Be accredited or registered for accreditation and participate in the PIP
- Meet the requirements of each component of the Cervical Screening Incentive
- Be signed on to the Cervical Screening Incentive for the practice to be eligible for the outcomes payments and GPs to be eligible for the Service Incentives Payments (SIPs)

**Outcomes Payment**
An outcomes payment of $3 per year per eligible female where at least 70% of eligible females in the practice are screened in a 30-month period.

The target 70% of the practice’s female patients aged between 20 and 69 years being screened in a 30 month reference period, is measured by the use of relevant Medicare Benefits Schedule (MBS) pathology service items, with the patient’s age determined as at the last day of the reference period.

**Service Incentive Payment**
$35 for each cervical smear taken from a woman aged between 20 to 69 years who has not had a Pap smear in the last four years. Payments made quarterly.
GPs must use one of the following cervical smear MBS Item numbers:
2497, 2501, 2503, 2504, 2506, 2507, 2509, 2598, 2600, 2603, 2606, 2610, 2613, 2616

**Further Information and Support**
Clinical Audit Tool recipe to identify eligible females with no Pap smear recorded in the last four years
National Cervical Screening Program, Department of Health and Ageing

†Standardised Whole Patient Equivalent (SWPE) is used to measure practice size and includes a weighting factor for the age and gender of patients. Average load for 1 FTE GP is 1,000 SWPEs per year.
Aboriginal and Torres Strait Islander people experience a burden of disease two-and-a-half times that of other Australians. A large part of the burden of disease is due to chronic diseases such as cardiovascular disease, diabetes, cancer, chronic respiratory disease and chronic kidney disease. Chronic diseases and associated risk factors are responsible for about two-thirds of the life expectancy gap between Indigenous and non-Indigenous Australians (estimated to be 17 years). Aboriginal and Torres Strait Islander people are more likely to die from these conditions than non-Indigenous Australians with the same condition. 1.5 times more likely to die from cancer; 12 times more likely to die from diabetes. Tobacco smoking alone is responsible for 20% of all deaths for Aboriginal and Torres Strait Islander people.

Aboriginal and Torres Strait Islander patients should be provided with the option of accessing information and services specifically designed to meet their needs. This can only be ensured if all patients are given an opportunity to respond to the standard Indigenous status question. Medicare promotes self-identification by Aboriginal and Torres Strait Islander peoples through its Voluntary Indigenous Identifier scheme. Brochures are available for placement within practices.

### Practice Incentive Payments

Practice Incentive sign-on, patient registration and outcomes payments are available under the Indigenous Health Incentive for participating accredited practices (see p28 for further information).

### Indigenous-specific MBS Items

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<th>Item</th>
<th>Follow-up service (after health check) up to 10 services per calendar year</th>
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<th>Item</th>
<th>CDM care plan follow-up (with GPMP, TCA, MDC) up to 5 services per year</th>
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### The standard Indigenous status question

The following question should be asked of all patients to establish their Aboriginal and/or Torres Strait Islander or non-Indigenous status.

**Are you of Aboriginal or Torres Strait Islander origin?**

Standard response options are:

- Yes, Aboriginal
- Yes, Torres Strait Islander
- Yes, both Aboriginal and Torres Strait Islander
- No
- Not stated/inadequately described.

Practice data management systems should be able to identify those records coded as not stated/inadequately described, because of situations where it was impossible to ask the question during the contact episode and other situations where the response was left blank or incomplete. These records require follow up and therefore should be distinguished from records that were coded as 9 due to the patient declining to respond.

### Further Information and Support


RACGP National Faculty of Aboriginal and Torres Strait Islander Health [www.racgp.org.au/aboriginalhealth](http://www.racgp.org.au/aboriginalhealth)


Australian Bureau of Statistics identification poster and brochures [www.abs.gov.au/ausstats/abs@.nsf/31121.0.web/Aboriginal+and+Torres+Strait+Islander+Peoples+] [www.abs.gov.au/web/Aboriginal+and+Torres+Strait+Islander+Peoples+/+Other+Related+Sources+of+Information](http://www.abs.gov.au/ausstats/abs@.nsf/31121.0.web/Aboriginal+and+Torres+Strait+Islander+Peoples+/+Other+Related+Sources+of+Information)

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2. ABS, AIHW. The Health and Welfare of Australia’s Aboriginal and Torres Strait Islander Peoples 2008. ABS cat no. 4844.0-ABS cat no. 4844.0-ABS cat no. 4844.0
3. ibid.
4. ibid.
Four time-based MBS Health Assessment Items

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Time Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>701</td>
<td>BRIEF to undertake SIMPLE health assessments</td>
<td>&lt; 30 mins</td>
</tr>
<tr>
<td>703</td>
<td>STANDARD to undertake STRAIGHTFORWARD health</td>
<td>&gt;30 but &lt; 45 mins</td>
</tr>
<tr>
<td></td>
<td>assessments</td>
<td></td>
</tr>
<tr>
<td>705</td>
<td>LONG to undertake EXTENSIVE health assessments</td>
<td>&gt;45 but &lt; 60 mins</td>
</tr>
<tr>
<td>707</td>
<td>PROLONGED to undertake COMPLEX health assessments</td>
<td>&gt;60 mins</td>
</tr>
</tbody>
</table>

The time period includes the time taken by the doctor and the Practice Nurse or registered Aboriginal Health Worker to undertake the health assessment.

Consent

The patient or their parent/guardian must be given an explanation of the health assessment process and its likely benefits, and must be asked by the medical practitioner, Practice Nurse or registered Aboriginal Health Worker whether they consent to the health assessment being performed. Consent must be noted on the patient record.

Components of a Health Assessment

Health assessments are generally made up of the following elements:

- Information collection, including taking a 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, offering the patient a written report about the health assessment, with recommendations about matters covered; and
- Offering the patient’s carer (if considered appropriate and the patient agrees) a copy of the report or extracts of the report relevant to the carer.

Associated Items

Item 10990 or 10991 (bulk billing incentives) can be claimed in conjunction with any health assessment, provided the conditions of those items are satisfied.

Seven target groups for Health Assessments

<table>
<thead>
<tr>
<th>Group</th>
<th>Description</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy Kids Check</td>
<td>for children aged 3-5 years who have received their 4 year old immunisation</td>
<td>Once only</td>
</tr>
<tr>
<td></td>
<td>(old Item no 709 (GP) and 711 (PN) - new Item no 10986) See p11 for more details.</td>
<td></td>
</tr>
<tr>
<td>Type 2 Diabetes Risk Evaluation</td>
<td>for people aged 40-49 years (incl) with a high risk of developing type 2 diabetes (old Item no 713)</td>
<td>Once every 3 years</td>
</tr>
<tr>
<td></td>
<td>See p12 for more details.</td>
<td></td>
</tr>
<tr>
<td>Health assessment for people</td>
<td>aged 45-49 years (incl) who are at risk of developing chronic disease</td>
<td>Once only</td>
</tr>
<tr>
<td></td>
<td>(old Item no 717) See p13 for more details.</td>
<td></td>
</tr>
<tr>
<td>Health assessment for people</td>
<td>aged 75 years and older (old Item 700, 702)</td>
<td>Annually</td>
</tr>
<tr>
<td></td>
<td>See p14 for more details.</td>
<td></td>
</tr>
<tr>
<td>A comprehensive medical</td>
<td>assessment for permanent residents of residential aged care facilities</td>
<td>Annually</td>
</tr>
<tr>
<td></td>
<td>(old Item no 712) See p15 for more details.</td>
<td></td>
</tr>
<tr>
<td>Health assessment for people</td>
<td>who have an intellectual disability (old Item no 718, 719)</td>
<td>Annually</td>
</tr>
<tr>
<td></td>
<td>See p17 for more details.</td>
<td></td>
</tr>
<tr>
<td>Humanitarian entrants</td>
<td>who are resident in Australia with access to Medicare services, including</td>
<td>Once only</td>
</tr>
<tr>
<td></td>
<td>Refugees and Special Humanitarian Program and Protection entrants. (Old Item No. 716) See p18 for more details.</td>
<td></td>
</tr>
</tbody>
</table>

Restrictions

Medical practitioners should not conduct a separate consultation in conjunction with an MBS health assessment item, unless it is clinically necessary (ie the patient has an acute problem that needs to be managed separately from the assessment). Exceptions to this are:

- the Healthy Kids Check, where the 4 year old immunisation can be conducted on the same occasion; and
- the Comprehensive Medical Assessment, where, if this health assessment is undertaken during the course of a consultation for another purpose, the health assessment item and the relevant item for the other consultation may both be claimed.
The aim of the Healthy Kids Check is to improve the health and wellbeing of Australian children. The Healthy Kids Check promotes early detection of lifestyle risk factors, delayed development and illness, and provides the opportunity to introduce guidance for healthy lifestyles and early intervention strategies. The Healthy Kids Check is an assessment of a child’s physical health, general wellbeing and development, with the purpose of initiating medical interventions as appropriate.

Consent
Parental or guardian consent must be obtained prior to undertaking the health check and noted on the patient record.

Components
The Check must include:
- Information collection
- An overall assessment of the child
- Recommending appropriate interventions
- Providing advice and information to the child’s parents or carer
- Keeping a record of the health check and offering the child’s parent or carer a written report about the health assessment with recommendations; and
- Updating any relevant records, such as a parent-held child health record.

Examinations and assessments must include:
- height and weight (plot and interpret growth curve, calculate BMI)
- eyesight
- hearing
- oral health (teeth and gums)
- toileting; and
- allergies

Associated Items
MBS Item 10988 (immunisation by registered Aboriginal Health Worker) can be claimed in conjunction with the Healthy Kids Check. MBS Items 10990 or 10991 (bulk billing incentives) can also be claimed in conjunction with the Healthy Kids Check provided the conditions of these items are satisfied.

The GP, Practice Nurse, or registered Aboriginal Health Worker is also required to note that:
- the four year old immunisation has been given (including evidence provided).
- a copy of the Get Set 4 Life—Habits for Healthy Kids guide has been provided to the child’s parents/guardian.

Restrictions
A Medicare rebate is payable for this item only once for any eligible patient. This item is not an annual health check. The Medicare rebate is payable only after both the assessment has been undertaken and the four year old immunisation delivered. Where a parent/guardian chooses not to immunise their child, the Healthy Kids Check cannot be provided as a service for which an MBS rebate may be claimed.

Further Information and Support


4 Year Old Healthy Kids Check

For children aged at least 3 years and less than 5 years of age, who have received or who are receiving their 4 year old immunisation.
The aim of the Type 2 Diabetes Risk Evaluation is to identify those patients aged 40 to 49 years of age who are at high risk of developing type 2 diabetes, and supports the GP to initiate interventions to assist with the prevention of type 2 diabetes.

Eligibility
- The Type 2 Diabetes Risk Evaluation is for people aged 40 to 49 years (inclusive) who are at high risk of developing type 2 diabetes.
- Patients with newly diagnosed or existing diabetes are not eligible for this assessment.
- Aboriginal and Torres Strait Islander patients are able to access the Aboriginal and Torres Strait Health Check (MBS Item 715) and the Type 2 Diabetes Risk Evaluation Item if they meet the patient eligibility requirements.

Associated Items
The Diabetes Risk Evaluation Health Assessment Items can be claimed in conjunction with the bulk-billing Item 10991 for eligible patients.

Exclusions
The Diabetes Risk Evaluation Health Assessment Items cannot be claimed in conjunction with another GP attendance item on the same day, except where this is clinically relevant (ie for a health issue unrelated to diabetes risk assessment).

Clinical risk factors that the medical practitioner must consider when providing this health assessment include:
- Lifestyle, eg smoking, physical inactivity, poor nutrition;
- Biomedical risk factors, eg high blood pressure, impaired glucose metabolism and excess weight;
- Any relevant recent diagnostic test results; and
- A family history of chronic disease.

Further Information and Support
- AUSDRISK tool can be downloaded from the Australian Government Department of Health and Ageing website
- Diabetes Australia [www.diabetesaustralia.com.au]
- Get Healthy Coaching and Information Service [www.gethealthy.tas.gov.au]
- Diabetes Prevalence in Australia: an assessment of national data sources: AIHW
  [www.aihw.gov.au/publication-detail/?id=6442468288]
The aim of the 45-49 year health check is to identify patients at risk of developing a chronic disease.

Practice Nurses or Aboriginal Health Workers may assist the GP undertake the health check, in accordance with accepted medical practice and under the supervision of the GP. The time taken to conduct the assessment will include both the GP and Practice Nurse or Aboriginal Health Worker time.

**Patient Eligibility**

A patient who is at risk of developing a chronic disease or condition which has been or is likely to be present for at least six months, including but not limited to: asthma, cancer, cardiovascular illness, diabetes mellitus, mental health conditions, arthritis and musculoskeletal conditions.

Benefits are payable on one occasion only for each eligible patient. This item is not an annual health check.

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 GPs may consider include, but are not limited to:

- Lifestyle risk factors such as smoking, physical inactivity, poor nutrition or alcohol use
- Biomedical risk factors, such as high cholesterol, high blood pressure, impaired glucose metabolism or excess weight; or
- Psychological risk factors, such as depression
- A family history of a chronic disease

**Investigations**

Investigations GPs may consider as clinically indicated in patients at risk of developing a chronic disease (eg asthma, cancer, cardiovascular illness, mental health conditions, arthritis) include but are not limited to:

- Blood lipids
- Blood glucose
- Pap smear
- Mammography
- Skin cancer check
- Bone mineral densitometry
- Testicular examination
- Prostate assessment

The patient’s risk of developing diabetes is determined using the AUSDRISK Tool, by which the patient answers a short list of questions to determine the patient’s score.

**Associated Items**

The 45-49 year old Health Check can be claimed in conjunction with the bulk billing Item 10991 for eligible patients.

**Exclusions**

This Health Check Item cannot be claimed in conjunction with another GP attendance item on the same day, unless clinically required (ie the patient has an acute problem that needs to be managed separately from the assessment).

For patients with an existing chronic condition, the Chronic Disease Management (CDM) Items (721 - 732) provide a suite of items for the management and review of chronic conditions.

**Components**

The health assessment must include the following:

- Information collection, including taking a patient history and undertaking examinations and investigations as required
- Making an overall assessment of the patient
- Interventions as indicated
- Providing advice and information to the patient.

**Further Information and Support**

- Get Healthy Information & Coaching Service® (Tas) ph 1300 806 258
- National Heart Foundation [www.heartfoundation.org.au](http://www.heartfoundation.org.au) ph 1300 362 787
- Cancer Council Helpline ph 13 11 20
- Diabetes Tasmania Infoline within Tasmania 1300 136 588 (local call cost)
- Quit Tasmania [www.quittas.org.au](http://www.quittas.org.au/)

**45-49 Year Old Health Check**
The aim of the Aged Health Assessment is to identify any risk factors exhibited by an elderly patient that may require further health management.

Practice Nurses or Aboriginal Health Workers may assist GPs in performing the health check, in accordance with accepted medical practice and under the supervision of the GP. The time taken to conduct the assessment will include both the GP and Practice Nurse or Aboriginal Health Worker time.

Patient Eligibility
A health assessment for a person aged 75 years and older can take place in the patient's home or in the doctor's consulting rooms. The health assessment is not available to admitted patients of a hospital or day-hospital facility. The Aged Health Assessment may be claimed annually for eligible patients.

When conducting the health assessment for residents of aged care facilities, medical practitioners should follow the requirements for the Comprehensive Medical Assessment for residents of residential aged care facilities.

Associated Items
The Aged Health Assessment can be claimed in conjunction with the bulk billing Item 10991 for eligible patients.

Exclusions
This health check item cannot be claimed in conjunction with another GP attendance item on the same day, unless clinically required (ie the patient has an acute problem that needs to be managed separately from the assessment).

Components
An aged health assessment 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 psychological function (cognition and mood—measured with a recognised tool), and
- Assessment of social function (including availability and adequacy of paid and unpaid help, and if patient is caring for another person)

Medical literature and consensus medical opinion support the following additional components:
- Multi-system review
- Fitness to drive
- Hearing
- Vision
- Oral health and dentition
- Diet and nutritional status
- Smoking
- Foot care
- Sleep
- Need for community services
- Home safety
- Social isolation
- Cardiovascular risk factors, and
- Alcohol use

The annual health assessment should not take the form of a health screening service, in particular the assessment 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.

Aged (75 Years and over)
The Comprehensive Medical Assessment (CMA) is a review of a permanent resident, including assessment of the resident’s health, physical and psychological functioning. This assessment should be provided by the resident’s usual GP.

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 GP’s consideration, in taking the resident’s history and in the examination, but cannot replace the GP’s involvement in these components of the CMA.

Eligibility
CMAs are available to new residents, including veterans, on admission to an aged care facility, providing they have not already had this assessment at another facility within the previous 12 months. Existing residents can have a CMA at 12-monthly intervals, where it is required in the opinion of the resident’s medical practitioner. There are no age restrictions on resident eligibility.

GPs who provide services on a facility-wide contract basis, and/or who are registered to provide services to aged care facilities as part of aged care panel arrangement, may also undertake CMAs for residents as part of their services.

Consent
The medical practitioner undertaking a comprehensive medical assessment must ensure consent to the assessment has been given by the resident or a representative with an enduring power of attorney.

Where the resident has an informal or family carer, the medical practitioner may find it useful to consider having the carer present for the assessment or for some of its components, with the resident’s consent. The carer can provide useful information on matters such as medication usage and compliance and psychological and physical function, including specific matters such as continence.

Components
A comprehensive medical assessment must include:

- Personal attendance by the resident’s usual GP
- A written summary of the comprehensive medical assessment
- Developing a list of diagnoses and medical problems based on the medical history and examination
- Providing a copy of the summary to the residential aged care facility
- Offering the resident a copy of the summary

In undertaking the assessment, the GP should also consider the following, as appropriate to the resident:

- Cardiovascular and respiratory systems, and other systems as indicated
- Physical causes of acute and chronic pain
- An assessment of the resident’s physical function, including activities of daily living
- Psychological function, including cognition and mood
- Oral health, nutrition status and dietary needs
- Skin integrity.

The comprehensive medical assessment may also cover matters of particular relevance to the resident. For example:

- Hearing and vision
- Smoking and alcohol use
- Foot care
- Sleep
- Falls

Further Information and Support
Information to support the provision of CMAs is available from www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare_mbsitem_cma


Comprehensive Medical Assessment

May be completed over one or more visits, providing all CMA components are undertaken before the item is claimed. Only one CMA per resident is payable by Medicare in any twelve month period.
Aboriginal and Torres Strait Islander Health Checks

Item Number 715 (not time-based)
APPLICABLE TO ALL AGE GROUPS

The aim of this health assessment is to help ensure that Aboriginal and Torres Strait Islander people receive primary health care matched to their needs, by encouraging early detection, diagnosis and intervention for common and treatable conditions that cause morbidity and early mortality. For the purpose of this item, a person is an Aboriginal or Torres Strait Islander person if they, or their parent or carer, identify them as being of Aboriginal or Torres Strait Islander descent.

The major causes of early mortality in this population are:
- Circulatory conditions (including ischaemic heart disease, hypertension, cerebrovascular disease and rheumatic heart disease)
- External causes (including accidents, injury to self and others and substance use)
- Respiratory conditions (related to infection and tobacco use)
- Endocrine causes (mainly type 2 diabetes and complications)
- Cervical cancer (a significant cause of death in this under-screened population).

A registered Aboriginal Health Worker or Practice Nurse can assist the practitioner in the information collection stage of the health assessments and with providing patients with information about recommended interventions at the direction of the GP.

Components
An Aboriginal and Torres Strait Islander Health Check must include:
- Information collection—patient history, 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, offering the patient a written report of the health assessment, with recommendations about matters covered by the health assessment
- Offering the patient’s carer (if any, and if the medical practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report relevant to the carer

Exclusions
This health check item cannot be claimed in conjunction with another GP attendance item on the same day, unless clinically required (ie the patient has an acute problem that needs to be managed separately from the assessment).

Practice Incentive and Service Outcome Payments
Accredited practices may choose to participate in the Practice Incentive Program Indigenous Health Incentive (PIP IHI) which provides incentive payments aimed at achieving target levels of care for registered Aboriginal and Torres Strait Islander patients 15 years and over with a chronic disease. Please see the PIP IHI tab for further details.

Associated Items
Patients who have had an Aboriginal and Torres Strait Islander health check are eligible to receive (per calendar year):
- up to ten (10) follow-up Practice Nurse or Aboriginal Health Worker services (item 10987).
- up to five (5) Allied Health services comprising one or a combination of the following:
  - 81300 Aboriginal Health Worker
  - 81303 Diabetes Educator
  - 81310 Audiologist
  - 81315 Exercise Physiologist
  - 81320 Dietitian
  - 81325 Mental Health Worker
  - 81330 Occupational Therapist
  - 81335 Physiotherapist
  - 81340 Podiatrist
  - 81345 Chiropractor
  - 81350 Osteopath
  - 81355 Psychologist
  - 81360 Speech Pathologist
- The Aboriginal Health Check can be claimed in conjunction with the bulk billing item 10991 for eligible patients.
- up to five (5) chronic disease management follow-up services delivered by a Practice Nurse or Aboriginal Health Worker (item 10997) for patients requiring a GP Management Plan (item 721), Team Care Arrangements (item 723) or Multidisciplinary Care Plan (item 729).

Further Information and Support
The National Guide to a Preventative Health Assessment in Aboriginal and Torres Strait Islander Peoples National Aboriginal Community Controlled Health Organisation (NACCHO) and RACGP endorsed: www.naccho.org.au/promote-health/national-guide-to-a-preventive-health-assessment/
Follow-up allied health services for Aboriginal and/or Torres Strait Islanders, including referral form www.health.gov.au/internet/main/publishing.nsf/Content/allied_health_ATSI_descent
Intellectual Disability Health Assessment

Item Number 701 (brief), 703 (standard), 705 (long), 707 (prolonged)
Not applicable to inpatients of hospital/day hospital or aged care facility residents
Benefits payable annually

JULY 2013

Intellectual Disability Health Assessment
This health assessment aims to provide people with an intellectual disability with a comprehensive assessment and to identify any medical intervention and preventative health care required.

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

Consent
The patient must be given an explanation of the health assessment process and its likely benefits. Should the patient not have sufficient understanding to comprehend or make decisions about the health assessment, or cannot communicate their consent, then the practitioner must get consent from the patient’s legal guardian and note on the medical record.

Restrictions
Medical practitioners should not conduct a separate consultation in conjunction with a health assessment unless it is clinically necessary (ie the patient has an acute problem that needs to be managed separately from the assessment).

Other Requirements
Where the patient has a carer, the practitioner may find it useful to consider having the carer present for the assessment or components of the assessment (subject to the patient’s agreement) to provide information about the efficacy and side effects of medication and the patient’s symptomatology.

It may be relevant to consult with or refer to disability professionals. For example, case managers who have responsibility for assessing and facilitating appropriate accommodation, and disability support services and psychologists who have responsibility for developing strategies to address challenging behaviours.

The medical practitioner should keep a record of the health assessment and offer a copy of a written report about the health assessment to the relevant people involved with the patient, including the patient’s carer and relevant disability professionals.

Components
The health assessment must include the following items as relevant to the patient or his or her representative:

- Check dental health (including dentition)
- Conduct aural examination (arrange formal audiometry if audiometry has not been conducted within 5 years)
- Assess ocular health (arrange review by an ophthalmologist or optometrist if a comprehensive eye examination has not been conducted within 5 years)
- Assess nutritional status (including weight and height measurements) and a review of growth and development
- Assess bowel and bladder function (particularly for incontinence or chronic constipation)
- Assess medications (including non-prescription medicines taken by the patient, prescriptions from other doctors, medications prescribed but not taken, interactions, side effects and review of indications)
- Advise carers of the common side effects and interactions
- Consider the need for a formal medication review
- Check immunisation status, including influenza, tetanus, hepatitis A and B, Measles, Mumps and Rubella (MMR) and pneumococcal vaccinations
- Check exercise opportunities (with the aim of moderate exercise for at least 30 minutes per day)
- Check whether the support provided for activities of daily living adequately and appropriately meets the patient’s needs, and consider formal review if required
- Consider the need for breast examination, mammography, Pap smears, testicular examination, lipid measurement and prostate assessment as for the general population
- Check for dysphagia and gastro-oesophageal disease (especially for patients with cerebral palsy), and arrange for investigation or treatment as required
- Assess risk factors for osteoporosis (including diet, exercise, Vitamin D deficiency, hormonal status, family history, medication fracture history) and arrange for investigation or treatment as required
- For patients diagnosed with epilepsy, review of seizure control (including anticonvulsant drugs) and consider referral to a neurologist at appropriate intervals
- Check for thyroid disease at least every two years (or yearly for patients with Down syndrome)
- For patients without a definitive aetiological diagnosis, consider referral to a genetic clinic every 5 years
- Assess or review treatment for co-morbid mental health issues
- Consider timing of puberty and management of sexual development, sexual activity and reproductive health
- Consider whether there are any signs of physical, psychological or sexual abuse

Further Information and Support
Humanitarian Entrant Health Assessment

Item Number 701 (brief), 703 (standard), 705 (long), 707 (prolonged)
Not applicable to inpatients of hospital/day hospital or aged care facility residents
Benefits payable once

The purpose of this health assessment is to introduce new refugees and other humanitarian entrants to the Australian primary health care system, as soon as possible after their arrival in Australia (within twelve months of arrival).

Eligibility

The health assessment applies to humanitarian entrants who are resident in Australia with access to Medicare services. This includes Refugees, Special Humanitarian Program and Protection Program entrants with the following visas:

Offshore Refugee Category including:

a) 200 Refugee
b) 201 In Country Special Humanitarian
c) 203 Emergency Rescue
d) 204 Women at Risk
e) Offshore - Special Humanitarian Program
f) 202 Global Special Humanitarian

Offshore - Temporary Humanitarian Visas (THV) including:

g) Subclass 695 (Return Pending)
h) Subclass 070 (Removal Pending Bridging)

Onshore Protection Program including:

i) 866 Permanent Protection Visa (PPV)
j) 785 Temporary Protection Visa (TPV)

Patients should be asked to provide proof of their visa status and date of arrival in Australia. Medical practitioners may telephone Medicare Australia on 132011, with the patient present, to check eligibility.

Interpreter and Proposer Assistance

Under the Special Humanitarian Program, subclass visa 202 holders are usually ‘proposed’ to come to Australia. A proposer is a friend, relative or community organisation who agrees to assist the person to settle in Australia. A proposer may be able to provide useful information about the patient but should not be used as an interpreter.

Interpreters can be accessed through the Australian Government’s Translating and Interpreting Service (TIS). The Doctors’ Priority Line (1300 131 450) is a free telephone interpreting service for medical practitioners in private practice. It is available 24 hours a day, seven days a week for the cost of a local call.

An on-site interpreter can be arranged for any location in Australia. Requests for an on-site interpreter must be in writing using a form provided by the Australian Government’s Translating and Interpreting Service (TIS) which can be faxed through on 1300 654 151 or emailed to tis@immi.gov.au. It is advisable to make the booking well in advance of the appointment date (4 weeks) to ensure availability of an interpreter. To be eligible for these fee-free services, the medical practitioner must be in a private practice and provide a Medicare service to permanent residents who do not speak English.

Not all refugees arrive in Australia with medical records. For those who have, it may be useful to obtain a copy of any undertaken pre-departure. Some refugees may receive medical records prior to their flight to Australia if their pre-departure health assessment found any health problems, or they had received treatment, or they had signed a “health undertaking” document at the time of the visa grant.

A patient with a “health undertaking” has been assessed as having specific health issues such as hepatitis or inactive tuberculosis that needs to be addressed in Australia. By signing the undertaking, the refugee agrees to report to the Health Undertaking Service and for follow-up with their respective State or Territory health authority.

Components

The health assessment must include the assessment of the patient’s physical, psychological and social functioning and whether preventative health care and education should be offered to the patient to improve their health.

The medical practitioner should keep a record of the health assessment and offer to provide the patient with a written report about the health assessment. Patient consent to the health assessment should be documented in the patient’s record.

In addition to the general requirements for health assessments, this assessment should include the development of a management plan to address any issues and/or conditions, including arranging for any necessary interventions or referrals to other health care providers. This plan should be developed in collaboration with the patient, and documented in a written report that is offered to the patient.

The management plan should include:

- planned follow-up of issues and/or conditions found in history, examination and investigations, including initiating management to meet identified needs
- initial recommendation of immunisation, nutrition, vitamins and medications
- consideration of referrals to allied health professionals, approved professionals and/or specialist clinics to address issues of torture and trauma and
- consideration of contraception advice and review of Pap smear/sexually transmitted disease screening

Further Information and Support

MBS Health assessment for refugees and other humanitarian entrants


Promoting Refugee Health: A guide for doctors and other health care providers caring for people from refugee backgrounds


Department of Immigration & Citizenship (DIAC) Complex Case Support


TIS Doctor’s Priority Line 1300 131 450

Red Cross Asylum Seeker Assistance Scheme Hobart ph 03-62356077

www.redcross.org.au/services_aroundtheworld_tracingrefugeeservices_ASAS.htm

Migrant Resource Centres

Hobart 03-62210999 Launceston 03-63322211 Burnie 03-64319476


DIAC Pre-Departure Medical Screening Fact Sheet www.immi.gov.au/media/fact-sheets/67a-dhc.htm


JULY 2013

Humanitarian Entrant
Chronic Disease Management: GPMPs and TCAs

Preparation of a GP Management Plan (GPMP)

Item 721
- Provides a rebate for a GP to prepare a management plan for a patient with a chronic or terminal condition (including patients who have multiple chronic conditions and multidisciplinary care needs).
- The GP (who may be assisted by their practice nurse, Aboriginal health worker or other health professional) assesses the patient, agrees management goals, identifies actions to be taken by the patient, identifies treatment and ongoing services to be provided, and documents these in the GP Management Plan.
- Recommended frequency is once every two years, supported by regular review services every 6 months.
- Bulk-billed services may also claim the incentive payment for eligible patients (10991).

Review of a GPMP or Coordination of a Review of a TCA

Item 732
- Provides a rebate for a GP to review a GPMP or TCA.
- Practice nurse, Aboriginal health worker or other health professional can assist.
- Involves reviewing the patient’s GPMP or TCA, collaborating with TCA participating providers on progress against treatment/services; and documenting any changes and setting the next review date.
- Recommended frequency is once every six months; can be earlier if clinically required.
- Item 732 can be claimed twice on the same day for reviewing GPMP and TCA in accordance with MBS item descriptors and explanatory notes.

Coordination of Team Care Arrangements (TCA)

Item 723
- Provides a rebate for a GP to coordinate the preparation of Team Care Arrangements for a patient with a chronic or terminal medical condition who also requires ongoing care from a multidisciplinary team of at least two health or care providers.
- In most cases the patient will already have a GPMP in place but this is not mandatory.
- Involves a GP (who may be assisted by their practice nurse, Aboriginal health worker or other health professional) collaborating with the participating providers on required treatment/services and documenting this in the patient’s TCA.
- Recommended frequency is once every two years, supported by regular review services every six months.
- Bulk-billed services may also claim the incentive payment for eligible patients (10991).

Access to allied health items

Item No’s 10950-10970 (see p21 for details)

Patients who have both a GPMP and a TCA service and have claimed these services on Medicare have access to the allied health items on the Medicare Benefits Schedule. Similarly, RACF residents whose GP has contributed to a care plan prepared by the aged care facility (Item 731) will continue to have access to the allied health items. Eligible patients can claim a maximum of five allied health services per 12 month period.
Chronic Disease Management
Item Numbers 729 (not RACF), 731 (RACF residents)

July 2013

Contribution to a Multidisciplinary Care Plan (MCP) being prepared by another health or care provider
Item 729
- For patients with a chronic or terminal medical condition who are having an MCP prepared or reviewed by another health or care provider (other than their usual GP)
- Available to patients in the community, and private and public inpatients being discharged from hospital (not RACF)
- Recommended frequency is once every six months; minimum claiming period three months
- Involves the GP (who may be assisted by their practice nurse, Aboriginal health worker or other health professional) collaborating with two other providers preparing or reviewing the plan and including their contribution with the patient’s records
- Bulk-billed services may also claim the incentive payment for eligible patients (10991)

Contribution to an MCP being prepared by another health care provider for a resident of an aged care facility
Item 731
- This is for patients in residential aged care facilities and is otherwise similar to Item 729
- Available to residents in an aged care facility
- Bulk-billed services may also claim the incentive payment for eligible patients (10991)

Resources
The Australian Government Department of Health and Ageing website provides more information and a range of resources on the MBS Primary Care items including:
- Fact sheets (for providers and patients)
- Questions and answers on the CDM items
- Quick Reference Guide for providers
- Sample forms for MBS CDM items (these can be customised to meet the needs of patients and practitioners in your practice).


New MBS Online Checker available via Medicare Health Professional Online Services to assess patient eligibility to claim Medicare benefits for items 721, 723, 729, 731, 732

or call Medicare on 1800 700 199

Further Information and Support
Detailed information to support the provision of CDM items is available at http://www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-chronicdiseasemanagement, or can be ordered by calling (02) 6289 8735

Clinical Audit Tool Recipe to identify all active stroke/TIA patients eligible for a GPMP

The following organisations offer support and information for providers and consumers. Visit their websites or phone for information on the range of services available in your area.

Diabetes Australia www.diabetesaustralia.com.au Infoline within Tasmania 1300 136 588 (local call cost)
Kidney Health Australia www.kidney.org.au ph 1800 454 3639
National Heart Foundation www.heartfoundation.org.au ph 1300 362 787

Chronic Disease Management: GPMPs and TCAs
Medicare benefits are available for certain services provided by eligible allied health professionals to treat people with chronic conditions and complex care needs who are being managed under certain Chronic Disease Management (CDM) MBS Items. The allied health services must be recommended in the patient’s plan as part of the management of their chronic condition.

Eligible patients
Patients who have both a chronic medical condition and complex care needs, i.e., both a GP Management Plan (Item 721) or review (Item 732) and a Team Care Arrangement (Item 723 or review Item 732), or who are a permanent Commonwealth funded resident of an aged care facility managed under a Multidisciplinary Care Plan (Item 731) have access to the Allied Health Items under the Medicare Benefits Schedule.

Allied Health Items (10950 - 10970)
The Allied Health Items cover a range of services from allied health providers:

- 10950 Aboriginal Health Worker
- 10951 Diabetes Educator
- 10952 Audiologist
- 10953 Exercise Physiologist
- 10954 Dietitian
- 10955 Mental Health Worker
- 10956 Occupational Therapist
- 10957 Occupational Therapist
- 10960 Physiotherapist
- 10962 Podiatrist
- 10964 Chiropractor
- 10966 Osteopath
- 10968 Psychologist
- 10970 Speech Pathologist

Eligible Allied Health Service Providers
- Allied health providers must be registered with Medicare Australia for the purpose of this initiative.
- Attendances by the allied health provider must be of at least 20 minutes duration and be provided to an individual patient.
- Allied health services funded by other Commonwealth or State programs or provided to an admitted patient of a hospital are not eligible for Medicare rebates, except where a subsection 19(2) exemption has been granted.

Referral
- GPs must refer to services recommended in the patient’s care plan using the Referral Form for Individual Allied Health Services under Medicare issued by the Department of Health and Ageing. When referring a patient to more than one allied health professional, a separate referral form for each referral is required.
- The allied health services must be directly related to the management of the patient’s chronic condition/s and the need for the service/s must be identified in the patient’s care plan.
- Patients may access a maximum of five (5) allied health services per patient per 12 month calendar year, either as one type of service, or a combination of different types.

Reporting
Allied health professionals are to provide a written report back to the referring practitioner after the first and last service or more often if clinically necessary.

Further Information and Support
Allied Health Services (Group, Aboriginal & Torres Strait Islanders)

Medicare benefits are payable for group services provided by eligible diabetes educators, exercise physiologists and dietitians for patients with type 2 diabetes, on referral from a GP. The Allied Health Items (81100 - 81125) provide another referral option for GPs in the management of patients with type 2 diabetes. These services are in addition to the five individual allied health services available to eligible patients each calendar year. Eligible patients are able to claim a maximum of one assessment and up to eight group sessions per calendar year.

Eligible patients
Patients must have type 2 diabetes and have a relevant care plan in place, either
- a GP Management Plan (item 721) or GPMP review (item 732); OR
- for residents of an aged care facility, the GP must have contributed to, or reviewed, a multidisciplinary care plan (item 731) prepared by the facility.

Patients being referred by a GP for allied health group services under Items 81100 to 81125 DO NOT need to have a Team Care Arrangement (Item 723).

Eligible Allied Health Providers
Only diabetes educators, exercise physiologists and dietitians who are registered with Medicare Australia are eligible to provide services under Items 81100 - 81125.

Referral
Patients need to be referred using the Referral Form for Group Allied Health Services under Medicare for patients with type 2 diabetes issued by the Department of Health and Ageing. GPs are also encouraged to attach a copy of the relevant part of the patient’s care plan.

Assessment
The allied health professional will conduct an individual assessment under items 81100, 81110 or 81120 to prepare the patient for an appropriate group services program. A Medicare rebate is only payable for one allied health assessment service each calendar year.

Services
If the patient is assessed by an eligible allied health professional as suitable for group services, the patient may receive up to eight (8) group services, from one or a combination of providers each calendar year (Items 81105, 81115, 81125)

Reporting
On completion of both the assessment service and group services program, the allied health professional must provide, or contribute to, a written report back to the referring GP in respect of each patient.

Further Information and Support
Diabetes Australia www.diabetesaustralia.com.au
Exercise physiologists www.essa.org.au
Dietitians www.daa.asn.au

Allied Health Services for Aboriginal and Torres Strait Islanders

Medicare benefits are payable for provision of follow-up allied health services (Items 81300-81360) to Aboriginal and Torres Strait Islander people who have had a Health Check (Item 715). Allied Health Items (81300 – 81360)
The Allied Health Items cover the following range of allied health services:

81300 Aboriginal Health Worker 81330 Occupational Therapist
81305 Diabetes Educator 81335 Physiotherapist
81310 Audiologist 81340 Osteopaths
81315 Exercise Physiologist 81345 Chiropractor
81320 Dietitian 81350 Physiotherapist
81325 Mental Health Worker 81355 Psychologist
81330 Occupational Therapist 81360 Speech Pathologist
81335 Physiotherapist 81365 Occupational Therapist
81340 Osteopath 81370 Podiatrist
81345 Chiropractor 81375 Podiatrist
81350 Physiotherapist 81380 Podiatrist
81355 Psychologist 81385 Podiatrist
81360 Speech Pathologist 81390 Podiatrist

A maximum of five (5) services of at least 20 minutes duration each may be claimed in a calendar year, made up of one type or service or a combination of services.

Eligible patients
People of Aboriginal and Torres Strait Islander descent who have had a health assessment (MBS Item 715) may be referred by a GP for allied health services under Items 81300 - 81360. For the purposes of these items, a person is of Aboriginal or Torres Strait Islander descent if they self-identify. Patients should be asked to self-identify their Aboriginal or Torres Strait Islander status either verbally or by completing a form. These items are not applicable to hospital inpatients.

Eligible Allied Health Service Providers
Allied health providers must be registered with Medicare Australia for the purpose of this initiative.

Referral
Patients need to be referred using the Referral form for follow-up allied health services under Medicare for People of Aboriginal or Torres Strait Islander descent issued by the Department of Health and Ageing. The referral is valid for the stated number of services. If all services are not used during the calendar year, the unused services can be used in the next calendar year.

Reporting
Allied health professionals are to provide a written report back to the referring practitioner after the first and last service or more often if clinically necessary.

Associated Items
In addition to the follow-up Allied Health services, an Aboriginal or Torres Strait Islander who has had a health assessment (Item 715) may also be eligible for:
- A maximum of ten (10) follow-up services per calendar year by a Practice Nurse or registered Aboriginal Health Worker (Item 10987)
- A maximum of five (5) individual allied health services (Items 10950-10970) per calendar year for patients with a GPMP or review (item 721 or 732) AND TCA or review (Item 723 or 732)
- A maximum of eight (8) Group allied health services (Items 81105, 81115, 81125) for people with type 2 diabetes after individual assessment (Items 81100, 81110, 81120)
- A maximum of ten (10) allied mental health services (Items 2721-2727 and/or 80000-80170) per calendar year

Further Information and Support
Case Conferences

Item Numbers 735, 739, 743 and 747, 750, 758

For patients with medical condition that has been or is likely to be present for at least six months or that is terminal

Case conferences can be undertaken for patients in the community, for patients being discharged into the community from hospital and for people living in residential aged care facilities (RACF)

Case Conferences

The case conferencing items are for GPs to organise and coordinate, or participate in, a meeting or discussion held to ensure that their patient's multidisciplinary care needs are met through a planned and coordinated approach.

A case conferencing team includes a GP and at least two (2) other contributing members, each of whom provides a different kind of care or service to the patient (one may be another medical practitioner providing a different kind of care).

Patient Eligibility/Exclusions

Patients with a chronic or terminal medical condition and complex care needs requiring care or services from their usual GP and at least two other health or care providers are eligible for a case conference service.

A ‘chronic medical condition’ is one that has been or is likely to be present for at least six months.

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.

It is expected that a patient would not require more than five (5) case conferences in a 12 month period.

Case Conferencing Process

For all categories of case conferences the GP must:

- discuss a patient’s history and identify the patient’s multidisciplinary care needs
- identify outcomes to be achieved by each team member
- identify tasks that need to be undertaken to achieve these outcomes and allocate those tasks to members of the case conference team
- assess whether previously identified outcomes (if any) have been achieved

When organising and coordinating a case conference, a GP must:

a) explain to the patient the nature of a multidisciplinary case conference, and ask the patient for their agreement to the conference taking place
b) record the patient’s agreement to the conference
c) record the day on which the conference was held, and the times at which the conference started and ended
d) record the names of the participants
e) offer the patient and the patient’s carer (if any, and if the practitioner considers it appropriate and the patient agrees) a summary of the conference and provide this summary to other team members
f) discuss the outcomes of the conference with the patient and the patient’s carer (if any, and if the practitioner considers it appropriate and the patient agrees)
g) record all matters discussed and identified by the case conferencing team and put a copy of that record in the patient’s medical records

When participating in a case conference, a GP must:

a) explain to the patient the nature of a multidisciplinary case conference, and ask the patient whether they agree to the medical practitioner’s participation in the conference
b) record the patient’s agreement to the medical practitioner’s participation
c) record the day on which the conference was held, and the times at which the conference started and ended
d) record the names of the participants
e) record all matters discussed and identified by the case conferencing team and put a copy of that record in the patient’s medical records

Further Information and Support

Mental Health Treatment

Item Numbers 2700, 2701, 2712, 2713, 2715, 2717; Allied Mental Health Services Items 80000 - 80170

Eligible patients in the community, private inpatients incl RACF residents

JULY 2013

GP Mental Health Treatment Plan Items Numbers

These items define services for which Medicare rebates are payable where GPs undertake early intervention, assessment and management of patients with mental disorders. The GP Mental Health Treatment Plan items incorporate a model for best practice primary health treatment of patients with mental disorders, including patients with both chronic or non-chronic disorders, that comprises assess and plan; provide and/or refer for appropriate treatment and services; review and ongoing management as required. Mental disorder describes a range of clinically diagnosable disorders that significantly interfere with an individual’s cognitive, emotional or social abilities (Refer to the World Health Organization, 1992, Diagnostic and Management Guidelines for Mental Disorders in Primary Care: ICD-10 C5 V Primary Care Version.) Dementia, delirium, tobacco use disorder and mental retardation are not regarded as mental disorders for the purposes of these items. The GP Mental Health Treatment Plan, Review and Consultation items are available for use in general practice by medical practitioners, including general practitioners but excluding specialists or consultant physicians.

GP Mental Health Treatment Plan Items 2700, 2701, 2715, 2717

A rebate is paid upon completion of an assessment and preparation of a GP Mental Health Treatment Plan (GPMHTP). From November 2011 there are four GPMHTP MBS items. Access to each item depends on the duration of the GPMHTP and whether a GP has undertaken mental health skills training recognised through the General Practice Mental Health Standards Collaboration.

Mental health skills training† 20 to <40 mins ≥40 mins
Yes Item 2715 Item 2717
No Item 2700 Item 2701

GPMHTP must include:

**Assessment**
- Recording the patient’s agreement
- Relevant history (biological, psychological, social) including presenting complaint
- Conducting a mental state examination
- Assessing associated risk and any comorbidity
- Making a diagnosis and/or formulation
- Administering an outcome measurement tool, except where it is considered clinically inappropriate.

**Preparation**
- Discussing assessment with patient
- Identifying and discussing referral and treatment options with the patient, including support services
- Agreeing to goals and actions with the patient
- Provision of psycho-education
- A plan for crisis intervention and/or for relapse prevention
- Making arrangements for required referrals, treatment, appropriate support services, review and follow-up
- Documenting the outcomes in the GPMHTP

† Mental health skills training as recognised through the General Practice Mental Health Standards Collaboration

**GP Mental Health Treatment Plan Review Item 2712**

The review item is a key component for assessing and managing the patient’s progress once a GPMHTP has been prepared.

The recommended frequency for the review service, allowing for variation in patients’ needs, is: an initial review, which should occur between four weeks to six months after the completion of a GPMHTP; and if required, a further review can occur three months after the first review. In general, most patients should not require more than two reviews in a 12 month period.

A review must include:
- Recording the patient’s agreement for this service
- A review of the patient’s progress against the goals outlined in the GPMHTP
- Modification of the documented GPMHTP if required
- Checking, reinforcing and expanding education
- A plan for crisis intervention and/or for relapse prevention, if appropriate and if not previously provided
- Re-administration of the outcome measurement tool used in the assessment stage, except where considered clinically inappropriate

**GP Mental Health Treatment Consultation Item 2713**

- Consultations associated with this item must be at least 20 minutes duration
- Where the primary treating problem is related to a mental disorder, including for a patient being managed under a GPMHTP.
- This item may be used for ongoing management of a patient with a mental disorder. This item should not be used for the development of a GPMHTP.
- A 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
  - Documenting the outcomes of the consultation
- A patient may be referred from a GP Mental Health Consultation for other treatment and services as per normal GP referral arrangements (this does not include referral for Medicare rebatable services for focused psychological strategy services, clinical psychology or other allied mental health services, unless the patient is being managed by the GP under a GPMHTP or under a referred psychiatrist assessment and management plan).

**Allied Mental Health Services Items 80000-80170**

MBS items are available to patients with a mental disorder (excluding dementia, delirium, tobacco use disorder, mental retardation) who have been referred by a medical practitioner managing the patient under a:
- GPMHTP
- Psychiatrist assessment and management plan; or
- On referral from a psychiatrist or paediatrician up to a maximum of 10 individual and 10 group allied mental health services per calendar year.

The 10 services may consist of psychological therapy (80000-80015); and/or focused psychological strategies- allied mental health services (80100-80115, 80120-80140, 80150-80165) Group therapy services for 6-10 patients are accessible under items 80020 clinical psychologist; and for focused psychological strategies under the items 80120 psychologist 80145 occupational therapist 80170 social worker

Further Information and Support

GP Mental Health Care Plan fact sheet: RACGP


Focussed Psychological Strategies (FPS), Medicare item numbers 2721 - 2727, may only be claimed by GPs who are registered with Medicare Australia as having satisfied the requirements for higher level mental health skills for the provision of the service as accredited by the General Practice Mental Health Standards Collaboration.

Focussed psychological strategies are specific mental health care management strategies, derived from evidence-based psychological therapies that have been shown to integrate the best research evidence of clinical effectiveness with general practice expertise. Recommendation of FPS must be made in the context of either a GPMHTP or a psychiatrist assessment and management plan. These strategies are required to be provided to patients by a credentialed medical practitioner and are time limited; being deliverable in up to ten planned sessions per calendar year.

A mental disorder may be defined as a significant impairment of an individual’s cognitive, affective and/or relational abilities which may require intervention and may be a recognised, medically diagnosable illness or disorder (this definition is informed by the World Health Organisation, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care: ICD - 10 Chapter V Primary Care Version). Dementia, delirium, tobacco use disorder and mental retardation are not regarded as mental disorders for the purposes of these items.

Patients will in general be permitted to claim Medicare rebates for up to ten allied mental health services under these item numbers per calendar year. The ten services may consist of: GP focussed psychological strategies services (items 2721 to 2727); and/or psychological therapy services (items 80000 to 80015); and/or focused psychological strategies – allied mental health services (items 80100 to 80115; 80125 to 80140; 80150 to 80165).

Continued access to Item numbers 2721 - 2727 will be dependent on the practitioner meeting the ongoing mental health education requirements as determined by the General Practice Mental Health Standards Collaboration.

**Specific Focussed Psychological Strategies**

A range of acceptable strategies has been approved for use by medical practitioners in this context. These are:

1. Psycho-education (including motivational interviewing)
2. Cognitive-behavioural therapy including:
   - Behavioural interventions
   - Behaviour modification
   - Exposure techniques
   - Activity scheduling
   - Cognitive interventions
   - Cognitive therapy
3. Relaxation strategies
   - Progressive muscle relaxation
   - Controlled breathing
4. Skills training
   - Problem solving skills and training
   - Anger management
   - Social skills training
   - Communication training
   - Stress management
   - Parent management training
5. Interpersonal Therapy

**Further Information and Support**

Better Outcomes in Mental Health Care Program, Australian Government

Mental Health, All about providing Focussed Psychological Strategies (FPS) RACGP
Diabetes Incentive

Sign-on payment
A one-off sign-on payment of $1.00 per SWPE† is made to practices that register for the Incentive. The payment is made to practices in the quarterly payments following sign-on. To be eligible for the PIP Diabetes Incentive, the practice must:
- Be accredited or registered for accreditation and participate in the PIP
- Meet the requirements of each component of the Diabetes Incentive as outlined
- Be signed on to the Diabetes Incentive for the practice to be eligible for the outcomes payments and GPs to be eligible for the Service Incentives Payments (SIPs)
- Practice is required to use a register of patients with diabetes and an active recall/reminder system

Diabetes Cycle of Care

GPs must provide the minimum requirements of care outlined below within an 11 to 13 month period. Additional levels of care will be needed by insulin-dependent patients and those with abnormal review findings, complications and/or comorbidities.

<table>
<thead>
<tr>
<th>Six-Monthly</th>
<th>Annually</th>
<th>Biannually</th>
<th>Must also include</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight, Height, BMI</td>
<td>HbA1c</td>
<td>Eye Examination</td>
<td>Self Care Education</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>Total Cholesterol, Triglycerides &amp; HDL Cholesterol</td>
<td>Review Physical Activity Levels</td>
<td></td>
</tr>
<tr>
<td>Foot Examination</td>
<td>Microalbuminuria</td>
<td>Review Diet</td>
<td></td>
</tr>
<tr>
<td>eGFT † from October 2013</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* At initial Consult then weight only required

Item Numbers
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 Diabetes Cycle of Care. Item numbers to signify completion of the minimum requirements of a cycle of care for a patient with established diabetes mellitus within an 11 to 13 month period are:

In Surgery | Out of Surgery
--- | ---
Level B Standard | 2517, 2620 | 2518, 2631
Level C Long | 2521, 2622 | 2522, 2633
Level D Prolonged | 2525, 2624 | 2526, 2635

Diabetes Outcome Payment
An outcomes payment of $20.00 per diabetic SWPE per year is received by practices where at least 2% of practice patients are diagnosed with diabetes mellitus and a diabetes cycle of care has been completed on at least 50% of these patients.

Service Incentive Payment
$40 per Diabetes Cycle of Care completed. Payable once per year per patient. Payments made quarterly.

Further Information and Support
For further information, visit the Medicare PIP website at www.medicareaustralia.gov.au/provider/incentives/pip/files/9520-1208en.pdf


Diabetes Australia www.diabetesaustralia.com.au
Infoline within Tasmania 1300 136 588 (local call cost)


† Standardised Whole Patient Equivalent (SWPE) is used to measure practice size and includes a weighting factor for the age and gender of patients. Average load for 1 FTE GP is 1,000 SWPEs per year.
Asthma Cycle of Care

Patients with moderate to severe asthma must receive the following treatment:

- At least two asthma-related consultations within 12 months
- At least one of these consultations must be planned recalls
- Documented diagnosis and assessment of severity and level of asthma control
- Review of the patients use of and access to asthma-related medication and devices
- Provision of written asthma action plan (if patient is unable to use a written action plan, discuss alternative and record the discussion in the patient’s medical records)
- Provision of asthma self-management education to the patient, and
- Review of the written or documented asthma action plan

The patient’s medical record should include documentation of each of these requirements and the clinical content of the patient-held written action plan.

Item Numbers

The first time the patient is seen they are billed as normal. The second time the GP can bill using the Asthma cycle of care item numbers below, providing that the minimum requirements of care have been met. This will trigger the Asthma Service Incentive Payment.

<table>
<thead>
<tr>
<th></th>
<th>In Surgery</th>
<th>Out of Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level B Standard</td>
<td>2546, 2664</td>
<td>2547, 2673</td>
</tr>
<tr>
<td>Level C Long</td>
<td>2552, 2666</td>
<td>2553, 2675</td>
</tr>
<tr>
<td>Level D Prolonged</td>
<td>2558, 2668</td>
<td>2559, 2677</td>
</tr>
</tbody>
</table>

The 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.

For patients with asthma alone, GPs can choose to use either GPMP Item 721 or an Asthma Cycle of Care, not both. For those with asthma and complex needs, a GP may provide team-based care under Items 721 and 723 and the Asthma Cycle of Care.

Service Incentive Payment

$100 per Asthma Cycle of Care completed. Payable once per year per patient with moderate to severe asthma. Payments made quarterly.

Further Information and Support

Asthma Foundation of Tasmania www.asthmatas.org.au/

Asthma Management Handbook, National Asthma Council 2006

†Standardised Whole Patient Equivalent (SWPE) is used to measure practice size and includes a weighting factor for the age and gender.
The Indigenous Health Incentive (IHI) commenced in May 2010, designed to support practices and Aboriginal community-controlled health services provide better health care for Indigenous Australians. This incentive is a key component of the Closing the Gap Indigenous Chronic Disease Package.

### Indigenous Health Incentive

#### Sign-on payment
A one-off sign-on payment of $1,000 is made to practices that register for the IHI. To be eligible for the PIP IHI, the practice must be accredited or registered for accreditation and participate in the PIP, and agree to:
- Undertake cultural awareness training within 12 months of joining the PIP IHI†
- Seek consent from Aboriginal and Torres Strait Islander patients who have, or are at risk of, chronic disease to register with Medicare Australia
- Annotate PBS prescriptions for eligible Aboriginal and Torres Strait Islander patients to access the PBS Co-payment measure effective 1 July 2010
- Practice is required to use a recall/reminder system for follow-up of Aboriginal and Torres Strait Islander patients aged 15 and over with a chronic disease

### Patient Registration

A patient registration payment of $250 is made for each Aboriginal and Torres Strait Islander patient that:
- Is a “usual” patient of the practice
- Is aged 15 years and over
- Has a chronic disease
- Has had (or been offered) a health check for Aboriginal and Torres Strait Islander patients (MBS Item 715)
- Has a current Medicare card
- Has provided informed consent to be registered annually for the PIP IHI.

### Outcomes Payments

#### Tier 1  Chronic disease management payment
$100 payment per registered patient for whom a target level of care is provided by the practice in a calendar year to:
- Develop a General Practice Management Plan (GPMP) (MBS Item 721) or coordinate the development of Team Care Arrangement (TCA) (MBS Item 723) and undertake at least one review of the GPMP or TCA (MBS Item 732) or
- Undertake two reviews of the GPMP or TCA (MBS Item 732) or
- Contribute to a review of a multidisciplinary care plan for a patient in a residential aged care facility (MBS Item 731) on two occasions.

#### Tier 2  Total patient care payment
$150 payment for provision of the majority of MBS services for the patient (minimum of any five MBS services) in the registration period. This may include the services provided to qualify for the Tier 1 outcomes payment.

### PBS Copayment measure
This measure is aimed at providing assistance with reduction of the cost of PBS medicines for registered Aboriginal and Torres Strait Islander patients living with or at risk of chronic disease, effective 1 July 2010. Available to eligible patients regardless of age. Only available through PIP IHI participating practices.

#### Eligibility for PBS Copayment
The patient must:
- Identify as being of Aboriginal and/or Torres Strait Islander origin
- Present with an existing chronic disease or chronic disease risk factor
- In the opinion of the practitioner, be likely to experience setbacks in the prevention or ongoing management of chronic disease if he/she did not take the prescribed medicine
- Be unlikely to adhere to their medicines regimen without assistance through this measure.

### Registration
Registration for the PIP IHI and the PBS Copayment measures are independent of each other. A patient can choose to participate in the PBS Copayment Measure but not participate in the PIP IHI, and vice versa. Registration for the PBS is only required once. (NB: Patient re-registration is required each calendar year for the PIP IHI). Patients may also choose to notify consent withdrawal.

### Further Information and Support

- **Information on the Australian Government's Closing the Gap Indigenous Chronic Disease Package and the GP resource kit can be found at**
- **PIP IHI Forms and Guidelines**
- **PIP IHI FAQ**
- Please contact TML for templates of the patient consent forms to load directly into your Medical software.
- For assistance with completing the registration forms, please call 1800 222 032 during business hours

†A minimum of one GP and one other staff member are required to undertake RACGP or NACCHO endorsed cultural awareness training to satisfy this requirement.
Telehealth
Specialist video consultations under Medicare

Telehealth provides financial incentives to eligible health professionals and aged care services that help patients have a video consultation with a specialist, consultant physician or consultant psychiatrist.

There are two types of telehealth incentive available:

- **On board incentive** - a two part payment paid after the first and tenth telehealth video consultations are claimed.
- **Telehealth Service incentive** - an ongoing payment based on the MBS claims paid and number of video consultations provided over a quarterly period.

### Eligibility
- A specialist must be involved in a private capacity
- Patients in all areas of Tasmania
- Patient and specialist must be at least 15km apart at the time of consultation
- An eligible health professional may be present with the patient although not mandatory

### Exclusions
- Patient to GP teleconferences
- Patient to Allied Health teleconferences
- Admitted hospital patients

Minimum distance limits do not apply to patients at Residential Aged Care Facilities or Aboriginal Medical Services

### Incentives

<table>
<thead>
<tr>
<th></th>
<th>2012-13</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Telehealth On-Board instalment</td>
<td>$1,600</td>
<td>$1,300</td>
</tr>
<tr>
<td>Second Telehealth On-Board instalment (after 10th consultation)</td>
<td>$3,200</td>
<td>$2,600</td>
</tr>
<tr>
<td><strong>Total On-Board Incentive</strong></td>
<td><strong>$4,800</strong></td>
<td><strong>$3,900</strong></td>
</tr>
</tbody>
</table>

A telehealth consultation will involve a single specialist or consultant physician attending to the patient, with the possible participation of another medical practitioner, a participating nurse practitioner, a participating midwife, practice nurse or Aboriginal health worker at the patient end. The item numbers below provide for patient-end support services in various settings including consulting rooms or eligible residential aged care facilities.

### GP Item Numbers

<table>
<thead>
<tr>
<th>Level</th>
<th>GP No.</th>
<th>Surgery</th>
<th>Home Visit</th>
<th>RACF</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Brief</td>
<td>2100</td>
<td>2100</td>
<td>2100</td>
<td>2100</td>
</tr>
<tr>
<td>B Standard</td>
<td>2126</td>
<td>2126</td>
<td>2126</td>
<td>2126</td>
</tr>
<tr>
<td>C Long</td>
<td>2143</td>
<td>2143</td>
<td>2143</td>
<td>2143</td>
</tr>
<tr>
<td>D Prolonged</td>
<td>2195</td>
<td>2195</td>
<td>2195</td>
<td>2195</td>
</tr>
</tbody>
</table>

### Practice Nurse Item Numbers

<table>
<thead>
<tr>
<th>Practice Nurse</th>
<th>Item No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>10983</td>
</tr>
<tr>
<td>RACF</td>
<td>10984</td>
</tr>
</tbody>
</table>

### Nurse Practitioner Item Numbers

<table>
<thead>
<tr>
<th>Nurse Practitioner</th>
<th>Item No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>82220, 82221, 82222</td>
</tr>
<tr>
<td>RACF</td>
<td>82223, 82224, 82225</td>
</tr>
</tbody>
</table>
## MBS Primary Care Items & Fees Quick Reference Guide

### In Surgery Consultations

<table>
<thead>
<tr>
<th>Description</th>
<th>Schedule Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>A Brief $16.60</td>
</tr>
<tr>
<td>23</td>
<td>B Standard &lt; 20 mins $36.30</td>
</tr>
<tr>
<td>36</td>
<td>C Long 20 to &lt;40 mins $70.30</td>
</tr>
<tr>
<td>44</td>
<td>D Prolonged ≥ 40 mins $103.50</td>
</tr>
</tbody>
</table>

### Out of Surgery Consultations

<table>
<thead>
<tr>
<th>Description</th>
<th>Schedule Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>5000</td>
<td>A Brief $28.45</td>
</tr>
<tr>
<td>5020</td>
<td>B Standard $48.05</td>
</tr>
<tr>
<td>5040</td>
<td>C Long $82.30</td>
</tr>
<tr>
<td>5060</td>
<td>D Prolonged $115.45</td>
</tr>
</tbody>
</table>

### After Hours Consultations

- **Non-urgent**: After Hours Consultation $127.25
- **Urgent**: Unsociable Hours Consult 11pm-7am $150.00

### Practice Nurse Items

- 10986 4 year Health Check $58.20
- 10987 Follow up Indigenous (10 svcs yr) $24.00
- 10997 CMD service (5 svcs yr) $12.00

### Nurse Practitioner Items

- 82200 Brief $9.60
- 82205 Standard <20 mins $20.95
- 82210 Long 20 to <40 mins $39.75
- 82215 Prolonged ≥ 40 mins $58.55

### Medication Review

- 900 Domiciliary Medication Mgt Rev $151.75
- 903 Residential Medication Mgt Rev $103.90

### Health Assessments

- 701 Brief <30 mins $58.20
- 703 Standard 30 to <45 mins $135.20
- 705 Long 45 to < 60 mins $186.55
- 707 Prolonged ≥60 mins $263.55
- 715 Indigenous $208.10
- 10986 4 year Health Check (PN) $58.20

### Chronic Disease Management

- 721 GP Management Plan (GPMP) $141.40
- 723 Team Care Arrangement (TCA) $112.05
- 729 Multidisciplinary Care Plan (MCP)/Rev $69.00
- 731 MCP/Review at RACF $69.00
- 732 Review of GPMP or TCA $70.65

### Case Conferences (RACF, community, discharge)

- 735 Organise case conf 15 to <20 mins $69.25
- 739 Organise case conf 20 to <40 mins $118.60
- 743 Organise case conf ≥40 mins $197.70
- 747 Participate case conf 15 to <20 mins $50.90
- 750 Participate case conf 20 to <40 mins $87.25
- 758 Participate case conf ≥40 mins $145.30

### Mental Health Treatment

- 2700 Mental Health Treatment Plan 20 to <40 mins $70.30
- 2701 Mental Health Treatment Plan ≥40 mins $103.50
- 2712 Review Mental Health Plan $70.30
- 2713 Mental Health Consultation ≥20 mins $70.30
- 2715 Mental Health Treatment Plan 20 to <40 mins $90.95
- 2717 Mental Health Treatment Plan ≥40 mins $131.45

### Focused Psychological Strategies (Level 2 training)

- 2721 FPS in surgery 30 to 40 mins $90.95
- 2723 FPS out of surgery 30 to 40 mins $90.95 + Note 1
- 2725 FPS in surgery ≥40 mins $130.15
- 2727 FPS out of surgery ≥ 40 mins $130.15 + Note 1

### Bulk Billing (all Tasmania)

**Concession Card Holders and Children under 16 years** Benefit $9.10

### Notes

1. 1-19 pts = Plus $25.45/number of pts seen; ≥27 pts = Plus $1.95 per pt
2. 20-60 pts = Plus $45.80/number of pts seen; ≥27 pts = Plus $3.25 per pt

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**Out of Surgery Consultations**

<table>
<thead>
<tr>
<th>Description</th>
<th>Schedule Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>5003</td>
<td>A Brief $28.45 + Note 1</td>
</tr>
<tr>
<td>5023</td>
<td>B Standard $48.05 + Note 1</td>
</tr>
<tr>
<td>5043</td>
<td>C Long $82.30 + Note 1</td>
</tr>
<tr>
<td>5063</td>
<td>D Prolonged $115.45 + Note 1</td>
</tr>
</tbody>
</table>

### After Hours Consultations

- **Non-urgent**: After Hours Consultation $127.25
- **Urgent**: Unsociable Hours Consult 11pm-7am $150.00

### Residential Aged Care Facility

(excludes self-contained unit)

- 20 A Brief $16.60 + Note 2
- 35 B Standard $36.30 + Note 2
- 43 C Long $70.30 + Note 2
- 51 D Prolonged $103.50 + Note 2

### Allied Health Services

Fee $62.25 to max 5 services per calendar year

- 10950 Aboriginal Health Worker $10950 Physiotherapist
- 10951 Diabetes Educator $10952 Podiatrist
- 10952 Audiologist $10953 Osteopath
- 10954 Dietitian $10956 Psychologist
- 10956 Mental Health Worker $10958 Speech Pathologist
- 10958 Occupational Therapist

### Aboriginal and Torres Strait Islander (post-Health Check Item 715)

Fee $62.25 to max 5 services per calendar year

- 81300 Aboriginal Health Worker $81335 Physiotherapist
- 81305 Diabetes Educator $81340 Podiatrist
- 81310 Audiologist $81345 Chiropractor
- 81315 Exercise Physiologist $81350 Osteopath
- 81320 Dietitian $81355 Psychologist
- 81325 Mental Health Worker $81360 Speech Pathologist
- 81330 Occupational Therapist

### Group Services for Chronic/Complex Conditions

**Assessment Fee $79.85**

- 81100 Diabetes assessment $81105 Diabetes group service
- 81105 Diabetes Educator $81105 Diabetes group service
- 81110 Exercise physiology assessment $81115 Exercise physiol group service
- 81120 Dietitian assessment $81125 Dietitian group service

### PAP Smear (+ $35 SIP payment )

- 2501 B Standard (incl Pap 20-69 yo) $36.30
- 2504 C Long (incl Pap 20-69 yo) $70.30
- 2507 D Prolonged (incl Pap 20-69 yo) $103.50

### Diabetes Cycle of Care (+ $40 SIP payment)

- 2517 B Standard $36.30
- 2521 C Long $70.30
- 2525 D Prolonged $103.50

### Asthma Cycle of Care (+ $100 SIP payment)

- 2546 B Standard $36.30
- 2552 C Long $70.30
- 2558 D Prolonged $103.50

### Allied Health Services

Fee $62.25 to max 5 services per calendar year

- 10950 Aboriginal Health Worker $10960 Physiotherapist
- 10951 Diabetes Educator $10962 Podiatrist
- 10952 Audiologist $10964 Chiropractor
- 10953 Exercise Physiologist $10966 Osteopath
- 10954 Dietitian $10968 Psychologist
- 10956 Mental Health Worker $10970 Speech Pathologist
- 10958 Occupational Therapist

### Aboriginal and Torres Strait Islander

(post-Health Check Item 715)

Fee $62.25 to max 5 services per calendar year

- 81300 Aboriginal Health Worker $81335 Physiotherapist
- 81305 Diabetes Educator $81340 Podiatrist
- 81310 Audiologist $81345 Chiropractor
- 81315 Exercise Physiologist $81350 Osteopath
- 81320 Dietitian $81355 Psychologist
- 81325 Mental Health Worker $81360 Speech Pathologist
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### Group Services for Chronic/Complex Conditions

**Assessment Fee $79.85**

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*Updated: NOVEMBER 2012*