Frequently used Desktop Guide to MBS Item Numbers

For Primary Health Care Services

July 2024

Western Queensland PHN acknowledges the traditional owners of the country on which we work and live and recognises their continuing connection to land, waters and community.

phn WESTERN QUEENSLAND

An Australian Government Initiative

Contents

This guide outlines the most used MBS Item Numbers in Primary Care and aims to assist with the correct utilisation when claiming MBS Item Numbers. Each item number in this guide contains a link which provides item number criteria and fact sheets. Also included is an outline of Practice Incentive Payments and useful flow charts.

MBS ONLINE

Search for Item Number
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MBS News and Information

PROFESSION DEVELOPMENT

MBS Education for Health Professionals

To discuss further, or for more information contact your WQPHN Coordinator or admin@wqphn.com.au.

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This desktop guide was created in line with the latest MBS Online information. Whilst every effort has been made to ensure that the information included in this Guide is current and up to date, you should exercise your own independent skill and judgement before relying on it. Refer to MBS Online for latest information.

FREQUENTLY USED DESKTOP GUIDE TO ITEM NUMBERS

COMMONLY USED ITEM NUMBERS			
ITEM	**NAME**	**BENEFIT**	**DESCRIPTION / RECOMMENDED FREQUENCY**
3	Level A	$19.60	Short - see MBS for complexity of care requirements
23	Level B	$42.85	< 20 min - see MBS for complexity of care requirements
36	Level C	$82.90	≥ 20 min - see MBS for complexity of care requirements
44	Level D	$122.15	≥ 40 min - see MBS for complexity of care requirements
10990	Bulk Billing Item	$8.40	For patients U16 years or a concessional beneficiary for services provided in a practice location of MMM1
10991	Bulk Billing Item	$12.70	U16s and CC Card holders. Used in conjunction with items in the GMS Table of the MBS. Can be claimed concurrently for eligible patients Region specific MMM2.
11505	Spirometry (Diagnosis)	$46.90	To confirm diagnosis of Asthma, COPD or another cause of airflow limitation – once in a 12 month period
11506	Spirometry Monitoring	$23.45	Measurement of spirometry before and after inhalation of bronchodilator to confirm diagnosis of Asthma, COPD other causes.
11309	Audiometry	$29.95	Audiogram, air conduction
11707	ECG	$20.95	12 lead electrocardiography, tracing only by medical practitioner
73806	Pregnancy test	$10.15	Pregnancy test by one or more immunochemical methods
16500	Antenatal attendance	$53.70	Antenatal attendance
14206	Implant (Implanon)	$40.55	Hormone or living tissue implant (implanon) by cannula
30062	Implant (Implanon) removal	$69.20	Removal of Etonogestrel subcutaneous implant (eg. implanon)

BULK BILLING ITEMS: MM7 – MM1

75858	Bulk Billing Item	$16.10	For patients U16 years or a concessional beneficiary for services provided in a practice location of MMM7. Practice location is associated with provider number & can be also used for services away from the practice. (EG home or Aged Care Facility visit)
75857	Bulk Billing Item	$15.10	For patients U16 years or a concessional beneficiary for services provided in a practice location of MMM6. Practice location is associated with provider number & can be also used for services away from the practice. (EG home or Aged Care Facility visit)
75856	Bulk Billing Item	$14.35	For patients U16 years or a concessional beneficiary for services provided in a practice location of MMM5
75855	Bulk Billing Item	$13.45	For patients U16 years or a concessional beneficiary for services provided in a practice location of MMM3 or MMM4
10991	Bulk Billing Item	$12.70	For patients U16 years or a concessional beneficiary for services provided in a practice location of MMM2 (MyMedicare registered)
10990	Bulk Billing Item	$8.40	For patients U16 years or a concessional beneficiary for services provided in a practice location of MMM1 (MyMedicare registered)

NEW Bulk Billing Items

ITEM	NAME	BENEFIT	DESCRIPTION / RECOMMENDED FREQUENCY
75870	Bulk Billing Item MMM1	$25.10	For patients U16 years or a concessional beneficiary for services provided where not admitted to hospital and service is bulk-billed. This item can be claimed with face-to-face level B, C, D and E general attendance items, and level B telehealth and telephone general attendance items. *This is a general overview, please click on the link to assess eligibility.*
75871	Bulk Billing Item MMM2	$38.20	For patients U16 years or a concessional beneficiary for services provided where not admitted to hospital and service is bulk-billed. This item can be claimed with face-to-face level B, C, D and E general attendance items, and level B telehealth and telephone general attendance items. *This is a general overview, please click on the link to assess eligibility.*
75872	Bulk Billing Item MMM2, 3, 4, 5, 6 & 7	$38.20	For patients U16 years or a concessional beneficiary for services provided where not admitted to hospital and service is bulk-billed. *This is a general overview, please click on the link to assess eligibility.*
75873	Bulk Billing Item MMM3 & 4	$33.35	For patients U16 years or a concessional beneficiary for services provided where not admitted to hospital and service is bulk-billed. This item can be claimed with face-to-face level B, C, D and E general attendance items, and level B telehealth and telephone general attendance items. *This is a general overview, please click on the link to assess eligibility.*
75874	Bulk Billing Item MMM5	$43.10	For patients U16 years or a concessional beneficiary for services provided where not admitted to hospital and service is bulk-billed. This item can be claimed with face-to-face level B, C, D and E general attendance items, and level B telehealth and telephone general attendance items. *This is a general overview, please click on the link to assess eligibility.*
75875	Bulk Billing Item MMM6	$45.50	For patients U16 years or a concessional beneficiary for services provided where not admitted to hospital and service is bulk-billed. This item can be claimed with face-to-face level B, C, D and E general attendance items, and level B telehealth and telephone general attendance items. *This is a general overview, please click on the link to assess eligibility.*
75876	Bulk Billing Item MMM7	$48.30	For patients U16 years or a concessional beneficiary for services provided where not admitted to hospital and service is bulk-billed. This item can be claimed with face-to-face level B, C, D and E general attendance items, and level B telehealth and telephone general attendance items. *This is a general overview, please click on the link to assess eligibility.*
75880	Bulk Billing Item MMM1 MyMedicare	$25.10	**MyMedicare** service is provided to MyMedicare enrolled patient. For patients U16 years or a concessional beneficiary for services provided where not admitted to hospital and service is bulk-billed. This item can be claimed with level C, D, and E telehealth general attendance items, and level C and D telephone general attendance items, where the patient is registered with MyMedicare. *This is a general overview, please click on the link to assess eligibility.*
75881	Bulk Billing Item MMM2 MyMedicare	$38.20	**MyMedicare** service is provided to MyMedicare enrolled patient. For patients U16 years or a concessional beneficiary for services provided where not admitted to hospital and service is bulk billed. This item can be claimed with level C, D, and E telehealth general attendance items, and level C and D telephone general attendance items, where the patient is registered with MyMedicare. *This is a general overview, please click on the link to assess eligibility.*
75882	Bulk Billing Item MMM3 & 4 MyMedicare	$40.55	**MyMedicare** service is provided to MyMedicare enrolled patient. For patients U16 years or a concessional beneficiary for services provided where not admitted to hospital and service is bulk billed. This item can be claimed with level C, D, and E telehealth general attendance items, and level C and D telephone general attendance items, where the patient is registered with MyMedicare. *This is a general overview, please click on the link to assess eligibility.*
75883	Bulk Billing Item MMM5 MyMedicare	$43.10	**MyMedicare** service is provided. For patients U16 years or a concessional beneficiary for services provided where not admitted to hospital and service is bulk-billed. This item can be claimed with level C, D, and E telehealth general attendance items, and level C and D telephone general attendance items, where the patient is registered with MyMedicare. *This is a general overview, please click on the link to assess eligibility.*
75884	Bulk Billing Item MMM6 MyMedicare	$45.50	**MyMedicare service** is provided, if:(a) the attendance service is provided to a patient:(i) who is enrolled in MyMedicare at the general practice through which the attendance service is provided; and(ii) who is under the age of 16 or who is a

			concessional beneficiary; and(b) the patient is not an admitted patient of a hospital; and(c) the attendance service is bulk-billed. This item can be claimed with level C, D, and E telehealth general attendance items, and level C and D telephone general attendance items, where the patient is registered with MyMedicare. **This is a general overview, please click on the link to assess eligibility.*
75885	Bulk Billing Item MMM7 MyMedicare	$48.30	Professional attendance at which a **MyMedicare** service is provided, practice location in a **Modified Monash 7 area;** other than an attendance service associated with a service to which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75870, 75871, 75872, 75873, 75874, 75875, 75876, 75880, 75881, 75882, 75883 or 75884. This item can be claimed with level C, D, and E telehealth general attendance items, and level C and D telephone general attendance items, where the patient is registered with MyMedicare. **This is a general overview, please click on the link to assess eligibility.*

VIDEO CONSULTATIONS AND TELEHEALTH SERVICES

ITEM	NAME	BENEFIT	DESCRIPTION / RECOMMENDED FREQUENCY
91790	Short Consultation video conference only	$19.60	Telehealth attendance by a general practitioner requiring a short patient history and limited management. Must have an established clinical relationship with patient
91800	Consultation video conference only	$42.85	Telehealth attendance by general practitioner lasting less than 20 mins. Must have an established clinical relationship with patient
91801	Consultation video consultation only	$82.90	Telehealth attendance by general practitioner lasting longer than 20 mins. Must have an established clinical relationship with patient
91890	Short Consultation Telephone	$19.60	Phone attendance by a general practitioner lasting less than 6 minutes requiring a short patient history and if required limited management. Must have an established clinical relationship
91891	Consultation Telephone ≥ 6 minutes	$42.85	Phone attendance lasting at least 6 minutes and includes any of the following that are clinically relevant: short patient history, investigations, implementing a management plan and appropriate preventative health
92004	Health Assessment for Aboriginal and or Torres Strait Islander people via videoconference	$241.85	92004 is the videoconference equivalent of existing face to face item 715
92024	Preparation of GP Management Plan via videoconference	$164.35	92024 is the videoconference equivalent of existing face to face item 721
92025	Coordination of Team Care Arrangement via videoconference	$130.25	92025 is the videoconference equivalent of existing face to face item 721
92026	Care Plan via videoconference	$80.20	Contribution to a Care Plan or to a review of Care Plan prepared by another provider or a review prepared by another provider. 92026 is the videoconference equivalent of existing face to face item 729
92027	Care Plan for RACF patient via videoconference	$80.20	Contribution to a Care Plan or to a review of Care plan for a patient being discharge from hospital or in a residential aged care facility. Service must be performed by pts usual GP. 92026 is the videoconference equivalent of existing face to face item 731
92028	Review or coordinate a review of GPMP or TCA via videoconference	$82.10	Attendance by the GP to review or coordinate a review of GPMP or TCA Must be performed by the patient's usual GP
92142	Management Plan for patient with a disability <13 yrs via videoconference	$153.25	Assessment, diagnosis and preparation of treatment and management plan, applicable only once.92142 is the equivalent existing face to face item 139

VIDEO CONSULTATIONS AND TELEHEALTH SERVICES Continued

ITEM	NAME	BENEFIT	DESCRIPTION / RECOMMENDED FREQUENCY
92136	Non-directive pregnancy support >20mins via videoconference	$87.25	92136 is the videoconference equivalent of existing face to face item 4001 GP required to meet credentialing requirements for this item
92138	Non-directive pregnancy support >20mins via telephone	$87.25	92138 is the telehealth equivalent of existing face to face item 4001 GP required to meet credentialing requirements for this item
92731	Professional attendance < 5 minutes for sexual or reproductive health check via telephone	$19.60	Consultation for the provision of services related to blood borne virus, sexual or reproductive health by a GP less than 5 minutes. Note assisted reproductive technology & antenatal care are outside these items
92715	Consultation < 5 minutes for sexual or reproductive health check via videoconference	$19.60	Consultation for the provision of services related to blood borne virus, sexual or reproductive health by a GP less than 5 minutes. Note assisted reproductive technology & antenatal care are outside these items
92734	Consultation 5 -20 minutes for sexual or reproductive health check via telephone	$42.85	Consultation for the provision of services related to blood borne virus, sexual or reproductive health by a GP between 5 -20 minutes. Note assisted reproductive technology & antenatal care are outside these items
92718	Consultation 5 -20 minutes for sexual or reproductive health check via videoconference	$42.85	Consultation for the provision of services related to blood borne virus, sexual or reproductive health by a GP between 5 – 20 minutes. Note assisted reproductive technology & antenatal care are outside these items
92737	Consultation 21-40 minutes for sexual or reproductive health check via telephone	$82.90	Consultation for the provision of services related to blood borne virus, sexual or reproductive health by a GP between 20-40 minutes. Note assisted reproductive technology & antenatal care are outside these items
92721	Consultation 21-40 minutes for sexual or reproductive health check via videoconference	$82.90	Consultation for the provision of services related to blood borne virus, sexual or reproductive health by a GP between 20-40 minutes. Note assisted reproductive technology & antenatal care are outside these items
92740	Consultation ≥ 40 minutes for sexual or reproductive health check via telephone	$122.15	Consultation for the provision of services related to blood borne virus, sexual or reproductive health by a GP for at least 40 minutes. Note assisted reproductive technology & antenatal care are outside these items
92724	Consultation ≥ 40 minutes for sexual or reproductive health check via videoconference	$122.15	Consultation for the provision of services related to blood borne virus, sexual or reproductive health by a GP for at least 40 minutes. Note assisted reproductive technology & antenatal care are outside these items
14206	Implant (implanon)	$40.55	Hormone or living tissue implant (implanon) by cannula
30062	Implant (Implanon) removal	$69.20	Removal of Etonogestrel subcutaneous implant (e.g. Implanon)

NEW VIDEO CONSULTATIONS AND TELEHEALTH SERVICES

Bulk Billing incentives for eligible patients from 1 November 2023 – modified Monash 1 (Metropolitan Area)

Applicable BBI item	10990	75870	75880 (myMedicare enrolled patients only)
Standard hours consultations			
In consulting rooms	3	23, 36, 44, 123	
Out of consulting rooms	4	24, 37, 47, 124	
Residential aged care facility	90020	90035, 90043, 90051, 90054	
Telehealth			
Video	91790 (all) 91801, 91802, 91920 if not MyMedicare enrolled	91800	91801, 91802, 91920
Phone	91890	91891	91900, 91910
After hours consultations			
In consulting rooms	5000	5020, 5040, 5060, 5071	
Out of consulting rooms	5003[4]	5023[5], 5043[5], 5063[5], 5076[5]	
Residential aged care facility	5010[4]	5028[5], 5049[5], 5067[5], 5077[5]	
Other	All other "unreferred services"[6], including but not limited to: chronic disease management items, Better Access mental health items, health assessments, minor procedures etc		

Bulk billing incentives for eligible patients from 1 November 2023 – Modified Monash 2 (Regional Centre)

Applicable BBI item	10991	75871	75881 (myMedicare enrolled patients only)
Standard hours consultations			
In consulting rooms	3	23, 36, 44, 123	
Out of consulting rooms	4	24, 37, 47, 124	
Residential aged care facility	90020	90035, 90043, 90051, 90054	
Telehealth			
Video	91790 (all) 91801, 91802, 91920 if not MyMedicare enrolled	91800	91801, 91802, 91920
Phone	91890	91891	91900, 91910
After hours consultations			
In consulting rooms	5000	5020, 5040, 5060, 5071	
Out of consulting rooms	5003	5023, 5043, 5063, 5076	
Residential Aged Care Facility	5010	5028, 5049, 5067, 5077	
Other	All other "unreferred services"[4], including but not limited to: chronic disease management items, Better Access mental health items, health assessments, minor procedures etc		

Bulk billing incentives for eligible patients from 1 November 2023 – Modified Monash 5 (Small Rural Towns)

Applicable BBI item	75856	75874	75883 (myMedicare enrolled patients only)
Standard hours consultations			
In consulting rooms	3	23, 36, 44, 123	
Out of consulting rooms	4	24, 37, 47, 124	
Residential aged care facility	90020	90035, 90043, 90051, 90054	
Telehealth			
Video	91790 (all) 91801, 91802, 91920 if not MyMedicare enrolled	91800	91801, 91802, 91920
Phone	91890	91891	91900, 91910
After hours consultations			
In consulting rooms	5000	5020, 5040, 5060, 5071	
Out of consulting rooms	5003	5023, 5043, 5063, 5076	
Residential aged care facility	5010	5028, 5049, 5067, 5077	
Other	All other "unreferred services"[4], including but not limited to: chronic disease management items, Better Access mental health items, health assessments, minor procedures etc		

Bulk billing incentives for eligible patients from 1 November 2023 – Modified Monash 3 and 4 (Medium and Large Rural Towns)

Applicable BBI item	75855	75873	75882 (myMedicare enrolled patients only)
Standard hours consultations			
In consulting rooms	3	23, 36, 44, 123	
Out of consulting rooms	4	24, 37, 47, 124	
Residential aged care facility	90020	90035, 90043, 90051, 90054	
Telehealth			
Video	91790 (all) 91801, 91802, 91920 if not MyMedicare enrolled	91800	91801, 91802, 91920
Phone	91890	91891	91900, 91910
After hours consultations			
In consulting rooms	5000	5020, 5040, 5060, 5071	
Out of consulting rooms	5003	5023, 5043, 5063, 5076	
Residential aged care facility	5010	5028, 5049, 5067, 5077	
Other	All other "unreferred services"[4], including but not limited to: chronic disease management items, Better Access mental health items, health assessments, minor procedures etc		

Bulk billing incentives for eligible patients from 1 November 2023 – Modified Monash 6 (Remote Communities)

Applicable BBI item	75857	75875	75884 (myMedicare enrolled patients only)
Standard hours consultations			
In consulting rooms	3	23, 36, 44, 123	
Out of consulting rooms	4	24, 37, 47, 124	
Residential aged care facility	90020	90035, 90043, 90051, 90054	
Telehealth			
Video	91790 (all) 91801, 91802, 91920 if not MyMedicare enrolled	91800	91801, 91802, 91920
Phone	91890	91891	91900, 91910
After hours consultations			
In consulting rooms	5000	5020, 5040, 5060, 5071	
Out of consulting rooms	5003	5023, 5043, 5063, 5076	
Residential aged care facility	5010	5028, 5049, 5067, 5077	
Other	All other "unreferred services"[4], including but not limited to: chronic disease management items, Better Access mental health items, health assessments, minor procedures etc		

Bulk billing incentives for eligible patients from 1 November 2023 – Modified Monash 7 (Very Remote Communities)

Applicable BBI item	75858	75876	75885 (myMedicare enrolled patients only)
Standard hours consultations			
In consulting rooms	3	23, 36, 44, 123	
Out of consulting rooms	4	24, 37, 47, 124	
Residential aged care facility	90020	90035, 90043, 90051, 90054	
Telehealth			
Video	91790 (all) 91801, 91802, 91920 if not MyMedicare enrolled	91800	91801, 91802, 91920
Phone	91890	91891	91900, 91910
After hours consultations			
In consulting rooms	5000	5020, 5040, 5060, 5071	
Out of consulting rooms	5003	5023, 5043, 5063, 5076	
Residential aged care facility	5010	5028, 5s049, 5067, 5077	
Other	All other "unreferred services"[4], including but not limited to: chronic disease management items, Better Access mental health items, health assessments, minor procedures etc		

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[1] *Includes all medical practitioners eligible to claim MBS GP items ie fellows of the RACGP or ACRRM, medical practitioners undertaking a training placement approved by the RACGP or ACRRM or a training placement under the Remote Vocational Training Scheme, practitioners listed on the Vocational Register of General Practitioners, a medical practitioner who has successfully completed the requirements of the MedicarePlus for Other Medical Practitioners Program or is providing services under that program, or a medical practitioner providing services in accordance with the Other Medical Practitioners Extension Program*

[2] *Bulk billing incentives can be claimed you bulk bill a child under 16 or a Commonwealth Concession Card holder www.servicesaustralia.gov.au/concession-and-health-care-cards*

[3] *Practice located in Modified Monash area www.health.gov.au/resources/apps-and-tools/health-workforce-locator/app*

[4] *If service is provided in an MM 2 – 7 area by a GP whose practice is located in an MM 1 area, then BBI item number 10992 is claimed*

[5] *If service is provided in an MM 2 – 7 area by a GP whose practice is located in an MM 1 area, then BBI item number 75872 is claimed*

[6] *Bulk billing incentives cannot be claimed for the provision of COVID vaccine support services*

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[1] *Includes all medical practitioners eligible to claim MBS GP items ie fellows of the RACGP or ACRRM, medical practitioners undertaking a training placement approved by the RACGP or ACRRM or a training placement under the Remote Vocational Training Scheme, practitioners listed on the Vocational Register of General Practitioners, a medical practitioner who has successfully completed the requirements of the MedicarePlus for Other Medical Practitioners Program or is providing services under that program, or a medical practitioner providing services in accordance with the Other Medical Practitioners Extension Program*

[2] *Bulk billing incentives can be claimed you bulk bill a child under 16 or a Commonwealth Concession Card holder www.servicesaustralia.gov.au/concession-and-health-care-cards*

[3] *Practice located in Modified Monash area www.health.gov.au/resources/apps-and-tools/health-workforce-locator/app*

[4] *Bulk billing incentives cannot be claimed for the provision of COVID vaccine support services*

CHRONIC DISEASE MANAGEMENT

CHRONIC DISEASE MANAGMENT			
ITEM	**NAME**	**BENEFIT**	**DESCRIPTION / RECOMMENDED FREQUENCY**
721	GP Management Plan (GPMP)	$164.35	Management plan for patients with a chronic or terminal condition. Not more than once yearly unless clinically required, e.g. patient unable to meet the goals set due to chronic condition or hospital stay. GP needs to indicate in the clinical notes on the Medicare Bulk Bill form prior to billing the service.
723	Team Care Arrangement (TCA)	$130.25	Management plan for patients with a chronic or terminal condition and complex needs requiring ongoing care from a team, including the GP and at least 2 other health or care providers. Enables referral for 5 rebated allied health services. Not more than once yearly unless clinically required, e.g. patient unable to meet the goals set due to chronic condition or hospital stay. GP needs to indicate in the clinical notes on the Medicare Bulk Bill form prior to billing the service.
732	Review of GP Management Plan and/or Team Care Arrangement	$82.10	The recommended frequency is every 6 months. Minimum claiming period is 3 months. If a GPMP and TCA are both reviewed on the same date item 732 can be claimed twice on the same day
729	GP Contribution to, or Review of, Multidisciplinary Care Plan	$80.20	Contribution by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), to a multidisciplinary care plan prepared by another provider or a review of a multidisciplinary care plan prepared by another provider (other than a service associated with a service to which any of items 735 to 758 apply). Not more than once every 3 months.
731	GP Contribution to, or Review of, Multidisciplinary Care Plan prepared by RACF	$80.20	GP contribution to, or review of, a multidisciplinary care plan prepared by RACF, at the request of the facility, for patients with a chronic or terminal condition and complex needs requiring ongoing care from a team including the GP and at least 2 other health or care providers. Not more than once every 3 months (other than a service associated with a service to which items 735 to 758 apply).

For a comprehensive explanation of each MBS Item number please refer to the Medicare Benefits Schedule online at

www.health.gov.au/mbsonline

HEALTH ASSESSMENTS

HEALTH ASSESSMENTS			
ITEM	**NAME**	**BENEFIT**	**DESCRIPTION / RECOMMENDED FREQUENCY**
699	Heart Health Assessment	$82.90	30 + years Lasting at least 20 minutes – see MBS for complexity of care req.*
701	Brief Health Assessment	$67.60	Brief health assessment, lasting not more than 30 minutes
703	Standard Health Assessment	$157.10	>30 - 45 minutes - see MBS for complexity of care requirements
705	Long Health Assessment	$216.80	>45 - <60 minutes - see MBS for complexity of care requirements
707	Prolonged Health Assessment	$306.25	> 60 minutes - see MBS for complexity of care requirements
715	Aboriginal and Torres Strait Islander Health Assessment	$241.85	Not timed – Frequency 9-12 months

MEDICATION MANAGEMENT

MEDICATION MANAGEMENT			
ITEM	**NAME**	**BENEFIT**	**DESCRIPTION / RECOMMENDED FREQUENCY**
900	Domiciliary Medication Management Review (DMMR)	$176.40	Intended to maximize an individual patient's benefit from their medication regimen, and prevent medication-related problems through a team approach, once every 12 months except if there has been a significant change in the patient's condition or medication regimen requiring a new DMMR
903	Residential Medication Management Review (RMMR)	$120.80	For permanent residents of residential aged care facilities who are at risk of medication related misadventure. Performed in collaboration with the resident's pharmacist. Once every 12 months

PRACTICE NURSE/ABORIGINAL & TORRES STRAIT ISLANDER HEALTH PRACTIONERS (ATSIHP) * ITEM NUMBERS AS OF NOVEMBER 2015

PRACTICE NURSE/ABORIGINAL & TORRES STRAIT ISLANDER HEALTH PRACTIONERS (ATSIHP)* ITEM NUMBERS AS OF NOVEMBER 2015.			
ITEM	**NAME**	**BENEFIT**	**DESCRIPTION / RECOMMENDED FREQUENCY**
10987	Follow Up Health Services for Indigenous people	$27.30	Follow-up services provided by Practice Nurse or Aboriginal and Torres Strait Islander Health Practitioner for an Indigenous person who has received a Health Assessment (715), not an admitted patient of a hospital. Maximum of 10 services per patient, per calendar year.
10988	Immunisation	$13.65	Immunisation provided to a person on behalf of the medical practitioner by an Aboriginal and Torres Strait Islander Health Practitioner. Claimed once per patient visit even if multiple vaccines given
10989	Wound Treatment	$13.65	Treatment of wound (other than normal after care) provided by an Aboriginal and Torres Strait Islander Health Practitioner if the treatment is provided on behalf of, and under supervision of, a medical practitioner and the person is not admitted to hospital
10997	Chronic Disease Management	$13.65	Monitoring and support for patients being managed under a GPMP or TCA. Not more than 5, per patient, per calendar year

**From 1 July 2023, restrictions preventing First Nations people claiming a heart health assessment service within 12 months of an Aboriginal and Torres Strait Islander Peoples health assessment service will be removed.*

**A practice nurse means a registered or enrolled nurse or nurse practitioner who is employed by, or whose services are otherwise retained by a general practice on behalf of and under supervision of Medical Practitioner*

An Aboriginal and Torres Strait Islander health practitioner means a person who has been registered as an Aboriginal and Torres Strait Islander health practitioner by the Aboriginal and Torres Strait Islander Health Practice Board of Australia and meets the Board's registration standards. The Aboriginal and Torres Strait Islander health practitioner must be employed or retained by a general practice, or by an Aboriginal & Torres Strait Health Service that has an exemption to claim Medicare benefits under subsection 19(2) of the Health Insurance Act 1973.

MENTAL HEALTH NUMBERS

MENTAL HEALTH ITEM NUMBERS			
ITEM	**NAME**	**BENEFIT**	**DESCRIPTION / RECOMMENDED FREQUENCY**
2700	GP Mental Health Treatment Plan	$81.70	>20mins -<40mins – Professional attendance by a general practitioner (including a general practitioner who has **not** undertaken mental health skills training) of at least 20 minutes but less than 40 minutes in duration for the preparation of a GP *
2701	GP Mental Health Treatment Plan	$120.25	>20mins -<40mins – Professional attendance by a general practitioner (including a general practitioner who has **not** undertaken mental health skills training) of at least 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient *
2715	GP Mental Health Treatment Plan	$103.70	>20mins -<40mins Professional attendance by a general practitioner (including a general practitioner who has undertaken mental health skills training of at least 20 minutes but less than 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient *
2717	GP Mental Health Treatment Plan	$152.80	>20mins -<40mins - Professional attendance by a general practitioner (including a general practitioner who has undertaken mental health skills training) of at least 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient.
2712	Review of GP Mental Health Treatment Plan	$81.70	Professional attendance by a general practitioner to review a GP mental health treatment plan which he or she, or an associated general practitioner has prepared, or to review a Psychiatrist Assessment and Management Plan.
2713	Mental Health Consultation	$81.70	Consult >20mins -<40mins Professional attendance by a general practitioner in relation to a mental disorder and of at least 20 minutes in duration, involving taking relevant history and identifying the presenting problem (to the extent not previously recorded), providing treatment and advice and, if appropriate, referral for other services or treatments, and documenting the outcomes of the consultation
2721	GP Focused Psychological Strategies	$105.65	>30mins -<40mins Professional attendance at consulting rooms by a general practitioner, for providing focussed psychological strategies for assessed mental disorders by a general practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 30 minutes, but less than 40 minutes.
2700	GP Mental Health Treatment Plan	$81.70	>20mins -<40mins – Professional attendance by a general practitioner (including a general practitioner who has **not** undertaken mental health skills training) of at least 20 minutes but less than 40 minutes in duration for the preparation of a GP *
2701	GP Mental Health Treatment Plan	$120.25	>20mins -<40mins – Professional attendance by a general practitioner (including a general practitioner who has **not** undertaken mental health skills training) of at least 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient *
2715	GP Mental Health Treatment Plan	$103.70	>20mins -<40mins Professional attendance by a general practitioner (including a general practitioner who has undertaken mental health skills training of at least 20 minutes but less than 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient *

*Many patients will not require a new plan after their initial plan has been prepared. A new plan should not be prepared unless clinically indicated, and generally not within 12 months of a previous plan. Ongoing management can be provided through the GP Mental Health Treatment Consultation and standard consultation items, as required, and reviews of progress through the GP Mental Health Treatment Plan Review item. A rebate for preparation of a GP Mental Health Treatment Plan will not be paid within 12 months of a previous claim for the patient for the same or another Mental Health Treatment Plan item or within three months following a claim for a GP Mental Health Treatment Review (item 2712 or former item 2719), other than in exceptional circumstances.

+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 GP Mental Health Treatment Plan; 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, with ongoing management through the GP Mental Health Treatment Consultation and standard consultation items, as required.

ALLIED HEALTH SERVICES FOR CHRONIC CONDITIONS REQUIRING TEAM CARE

ALLIED HEALTH SERVICES FOR CHRONIC CONDITIONS REQUIRING TEAM CARE

GP must have completed a GP Management Plan (721) and Team Care Arrangement (723), or contributed to a Multidisciplinary Care Plan in a Residential Aged Care Facility (731) or have had a Review of a GPMP & TCA item 732 and completed a referral containing all components of form which can be found **HERE**. Patient must have a chronic or terminal medical condition and complex care needs requiring care from a multidisciplinary team consisting of their GP and at least two other health or care providers.

ITEM	NAME	DESCRIPTION / RECOMMENDED FREQUENCY
10950	Aboriginal & Torres Strait Health Workers (ATSIHW) or Aboriginal & Torres Strait Islander Health Practitioner (ATSIHP) Services	ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH SERVICE Aboriginal or Torres Strait Islander health service provided to a person by an eligible Aboriginal health worker or eligible Aboriginal and Torres Strait Islander health practitioner $70.95 Aboriginal & Torres Strait Health Workers (ATSIHW) or Aboriginal & Torres Strait Islander Health Practitioner (ATSIHP) Services and Allied Health Providers must have a Medicare Provider number. Maximum of five services (including any services to which items 10950 to 10970, 93000, 93013, 93501 to 93513 and 93524 to 93538 apply) in a calendar year. Can be 5 sessions with one provider or a combination, e.g., 3 dietitians' and 2 diabetes educators' sessions. GP refers to allied health professional using 'Referral Form for Chronic Disease Allied Health (Individual) Services under Medicare' or a referral form containing all components. One for each provider. Allied health professionals must report back to the referring GP after first and last visit.
10951	Diabetes Educator Services	
10952	Audiologist Services	
10953	Exercise Physiologist Services	
10954	Dietitian Services	
10958	Occupational Therapist Services	
10960	Physiotherapist Services	
10962	Podiatrist Services	
10964	Chiropractor Services	
10966	Osteopath Services	
10970	Speech Pathologist Services	
10956	Mental Health Worker	For mental health conditions use Better Access Mental Health Care items - 10 sessions For chronic physical conditions use GPMP and TCA - 5 sessions >20mins per calendar year Better access and GPMP can be used for the same patient where eligible.
10968	Psychologist	For mental health conditions, use Better Access Mental Health Care items – 10 sessions For chronic physical conditions, use GPMP and TCA – 5 sessions per calendar year Better Access and GPMP can be used for the same patient, where eligible.

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

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

ASSESSMENT AND PROVISION OF SERVICES

A person who is of Aboriginal or Torres Strait Islander descent may be referred by their GP for follow- up allied health services under items 81300 to 81360 **when the GP has undertaken a health assessment (Items 701, 703, 705, 707 or 715) and identified a need for follow-up allied health services**.

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

ITEM	NAME	DESCRIPTION / RECOMMENDED FREQUENCY
81300	Aboriginal & Torres Strait Health Worker or Aboriginal & Torres Strait Islander Health Practitioner Services	Aboriginal & Torres Strait Health Workers, or Aboriginal & Torres Strait Islander Health Practitioners and Allied Health Providers must have a current Medicare Provider number for each location in which they practice. $70.95 Maximum of 5 allied health services per patient each calendar year (in addition to the 5 services eligible from TCA 10950- 10970). Services must be of at least 20min duration and medical notes need to reflect same GP refers to allied health professional using a 'Referral form for follow-up allied health services under Medicare for People of Aboriginal or Torres Strait Islander descent' or a referral form containing all components. One for each provider. Allied health professionals must report back to the referring GP after the first and last services. This also includes health professionals using the same clinical software, an internal process of feedback must be in place for the GP to review the medical notes and enter if any further action is required e.g., recall patient, as they did not attend service or further action not required, recall patient for health assessment in 9-12months
81305	Diabetes Education	
81310	Audiology	
81315	Exercise Physiology	
81320	Dietetics	
81325	Mental Health	
81330	Occupational Therapy	
81335	Physiotherapy	
81340	Podiatry	
81345	Chiropractic	
81350	Osteopathy	
81355	Psychology	
81360	Speech Pathology	

For a comprehensive explanation of each MBS Item number please refer to the Medicare Benefits Schedule online at

www.health.gov.au/mbsonline

ALLIED HEALTH GROUP SERVICES FOR PATIENTS WITH TYPE 2 DIABETES

ASSESSMENT AND PROVISION OF GROUP SERVICES GP must have completed a GP Management Plan (721), or reviewed an existing GPMP (732), or contributed to, or reviewed a Multidisciplinary Care Plan in a Residential Aged Care Facility (731) and completed a referral containing all components of form. **For more information Click HERE**		
ITEM	**NAME**	**DESCRIPTION / RECOMMENDED FREQUENCY**
81100	Assessment for Group Services by Diabetes Educator	One assessment session only by either Diabetes Educator, Exercise Physiologist or Dietitian, per calendar year Medicare Allied Health Group Services for Type 2 Diabetes Referral Form A report is required to be provided to the referring GP that identifies if the patient would benefit from Group Services, before the group services are provided to the patient. $91.05
81110	Assessment for Group Services by Exercise Physiologist	
81120	Assessment for Group Services by Dietitian	
81105	Diabetes Education Group Services	8 group per calendar year, can be 8 sessions with one provider or a combination e.g. 3 diabetes education, 3 dietitians and 2 exercise physiology sessions. Medicare Allied Health Group Services for Type 2 Diabetes Referral Form. Ensure all participants sign the Medicare Assignment of Benefits form after the group sessions. A report back to the referring GP is required at the completion of the group services and all providers who provided Group Services must contribute to this report. $22.65

GP MULTIDISCIPLINARY CARE CONFERNCES

ITEM	NAME	DESCRIPTION / RECOMMENDED FREQUENCY
735	Organise and coordinate a case conference	>15 -<20 minutes. GP organises and coordinates case conference with at least 2 other members, each of whom provide a different kind of care or service to the patient and is not a family carer of the patient, and 1 of whom may be another medical practitioner in RACF or community, or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs $80.55
739	Organise and coordinate a case conference	>20 - <40 minutes. GP organises and coordinates case conference in RACF or community, or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs. $137.75
743	Organise and coordinate a case conference	> 40 minutes. GP organises and coordinates case conference in RACF or community, or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs. $229.65
747	Participate in a case conference	>15 - <20 minutes. GP participates in a case conference in RACF or community or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs. $59.20
750	Participate in a case conference	>30 - <40 minutes. GP participates in a case conference in RACF or community or on discharge. For patients with a chronic or terminal condition complex, and multidisciplinary care needs. $101.45
758	Participate in a case conference	> 40 minutes. GP participates in a case conference in RACF or community or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs. $168.80

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

HEALTH ASSESSMENT TARGET GROUPS

Pages 15 to 22 will provide a more comprehensive overview of each target group and the health assessment criteria, clinical content, essential documentation and claiming requirements. The table below provides an overview of the Health Assessment target groups and frequency of assessments.

TARGET GROUP	FREQUENCY
Patient aged 30 years and over can have a Heart Health Assessment lasting at least 20 minutes (item 699)	Once Annually
People aged 45- 49 years (inclusive) who are at risk of developing a chronic disease. Pts may also receive a type 2 diabetes risk evaluation if they are at high risk of developing type 2 diabetes and meet the relevant eligibility criteria.	Once only
People aged 40-49 years (inclusive) or 15-54 years (inclusive) for Aboriginal and Torres Strait Islander people with a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool (AUSDRISK)	Once every 3 years only
People aged 75 years and older.	Provided annually
Comprehensive medical assessment for permanent residents of a Residential Aged Care Facility (new and existing)	Provided annually
People who have an intellectual disability	Provided annually
This health assessment is for refugees and other humanitarian entrants who arrive in Australia with complex and unusual medical conditions resulting from their area of origin or previous living conditions. This assessment is separate from, and in addition to, a medical assessment specifically for the grant of a Refugee or Humanitarian visa.	Voluntary, one-off service and must be provided within twelve months of the person's arrival in Australia or grant of visa
Health Assessment for patients that have identified as Aboriginal &/or Torres Strait Islander	Once every 9-12 Months
Former serving members of the Australian Defence Force including former members of permanent and reserve forces	Once only

Further Information

- https://www1.health.gov.au/internet/main/publishing.nsf/Content/mha_resource_kit

- A health assessment should generally be undertaken by the patient's 'usual doctor', that is, the medical practitioner (or medical practitioner in the same practice) who has provided the majority of services to the patient in the past 12 months, and/or is likely to provide the majority of services in the following 12 months. Should a medical practitioner other than the patient's 'usual doctor' or practice nurse undertake the health assessment, a copy of the health assessment record should be forwarded to the patient's 'usual doctor' or practice, subject to the agreement of the patient or their parent/guardian.

- Medical practitioners should establish a register of patients who require annual health assessments and remind these patients when their next health assessment is due. If an assessment identifies that a patient has a chronic medical condition and complex care needs, it may be appropriate for the GP to involve other health professionals in the patient's care using the MBS Chronic Disease Management items.

- Items 701,703,705 &707 may be used to undertake a health assessment. Item 699 used for Heart Health Assessment

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

HEALTH ASSESSMENT ITEM NUMBERS

ITEM	NAME	DESCRIPTION / RECOMMENDED FREQUENCY
701	Brief Health Assessment <30mins	Professional attendance by a general practitioner to perform: Collection of relevant information, including taking a patient history and A basic physical examination and Initiating interventions and referrals as indicated and Providing the patient with preventive health care advice and information.
703	Standard Health Assessment 30 - 44 minutes	Professional attendance by a general practitioner to perform: Detailed information collection, including taking a patient history and An extensive physical examination and Initiating interventions and referrals as indicated and Providing a preventive health care strategy for the patient.
705	Long Health Assessment 45 - 59 minutes	Professional attendance by a general practitioner to perform: Comprehensive information collection, including taking a patient history and An extensive examination of the patient's medical condition and physical function and Initiating interventions and referrals as indicated; and Providing a basic preventive health care management plan for the patient.
707	Prolonged Health Assessment Lasting at least 60 minutes	Professional attendance by a general practitioner to perform: Comprehensive information collection, including taking a patient history and Extensive examination of the patient's medical condition, and physical, psychological, and social function and Initiating interventions and referrals as indicated and Providing a comprehensive preventive health care management plan for the patient.
715	Aboriginal and Torres Strait Islander Peoples Health Assessment No designated time / complexity requirements	Professional attendance by a general practitioner at consulting rooms or in another place other than a hospital or residential aged care facility to perform: For children aged 0 - 14 years old. Adults between 15- 54 years of age Older people over 55 years 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; Recommending appropriate interventions; Providing advice and information to the patient; and Keeping a record of the health assessment, and offering the patient, and/or patient's carer, a written report about the health assessment with recommendations about matters covered by the health assessment; and Offering the patient's carer (if any, and if the general practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report relevant to the carer

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

RESIDENTIAL AGED CARE FACILITY ITEM NUMBERS

ITEM	NAME	DESCRIPTION / RECOMMENDED FREQUENCY
731	GP Contribution or review of a Multidisciplinary Care Plan	Contribution by a General Practitioner to: • a multidisciplinary care plan for a patient in a residential aged care facility, prepared by that facility, or to a review of such a plan prepared by such a facility; or • a multidisciplinary care plan prepared for a patient by another provider before the patient is discharged from a hospital, or to a review of such a plan prepared by another provider
701-707	Health Assessment	Comprehensive medical assessment for permanent residents of a Residential Aged Care Facility (new and existing)

- Health assessments are not available to people who are in-patients of a hospital or care recipients in a residential aged care facility (with the exception of a comprehensive medical assessment provided to a permanent resident of a residential aged care facility).
- Before a health assessment is commenced, the patient (and/or the patient's parent(s), carer or representative, as appropriate) must be given an explanation of the health assessment process and its likely benefits. The patient must be asked whether they consent to the health assessment being performed. In cases where the patient is not capable of giving consent, consent must be given by the patient's parent(s), carer or representative. Consent to the health assessment must be noted in the patient's records.
- A health assessment may only be claimed by a general practitioner.

A health assessment must include the following elements:

a. information collection, including taking a patient history and undertaking or arranging examinations and investigations as required;

b. making an overall assessment of the patient;

c. recommending appropriate interventions;

d. providing advice and information to the patient;

e. keeping a record of the health assessment, and offering the patient a written report about the health assessment, with recommendations about matters covered by the health assessment; and

f. offering the patient's carer (if any, and if the general practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report relevant to the carer.

903	Residential Medication Management Reviews	Available new residents on admission and existing permanent residents on a “as required” basis to people who are likely to benefit from such a review. This includes residents for whom quality use of medicines may be an issue or residents who are at risk of medication misadventure because of a significant change in their condition or medication regimen.

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

RESIDENTIAL AGED CARE FACILITY ITEM NUMBERS

ITEM	NAME	DESCRIPTION / RECOMMENDED FREQUENCY
735	Organise and coordinate a case conference	15 – 19 minutes GP to organise and coordinate, or participate in, multidisciplinary case conferences for patients in the community or patients being discharged into the community from hospital or people living in residential aged care facilities
739	Organise and coordinate a case conference	20 - 39 minutes. GP to organise and coordinate, or participate in, multidisciplinary case conferences for patients in the community or patients being discharged into the community from hospital or people living in residential aged care facilities
743	Organise and coordinate a case conference	At least 40 minutes. GP to organise and coordinate, or participate in, multidisciplinary case conferences for patients in the community or patients being discharged into the community from hospital or people living in residential aged care facilities
747	Participate in a case conference	15 - 19 minutes. Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to participate in:a community case conference or a multidisciplinary case conference in a residential aged care facility or a multidisciplinary discharge case conference;
750	Participate in a case conference	30 - 40 minutes. GP participates in a case conference in RACF or community or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs
758	Participate in a case conference	> 40 minutes. GP participates in a case conference in RACF or community or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs

- Items 735-758 are for patients who have at least one medical condition that has been (or likely to be) present for at least 6 months, is terminal and require ongoing care from a multidisciplinary case conference team who includes a medical practitioner and at least two other members, each providing a different kind of care and is not a family carer of the patient
- Should generally be undertaken by the patient's usual general practitioner that has provided the majority of services to the patient over the previous 12 months and/or will be providing the majority of services to the patient over the coming 12 months.
- May include allied health professionals such as, but not limited to: Aboriginal health care workers; asthma educators; audiologists; dental therapists; dentists; diabetes educators; dietitians; mental health workers; occupational therapists; optometrists; orthoptists; orthotists or prosthetists; pharmacists; physiotherapists; podiatrists; psychologists; registered nurses; social workers; speech pathologists.
- A team may also include home and community service providers, or care organisers, such as: education providers; "meals on wheels" providers; personal care workers (workers who are paid to provide care services); probation officers.
- The patient's informal or family carer may be included as a formal member of the team in addition to the minimum of three health or care providers. The patient and the informal or family carer do not count towards the minimum of three.
- Organisation and coordination of a multidisciplinary discharge case conference (items 735, 739 and 743) may be provided for private in-patients being discharged into the community from hospital.

For a comprehensive explanation of each MBS Item number please refer to the Medicare Benefits Schedule online at
MBS Online - MBS Online

TYPE2 DIABETES RISK EVALUATION – HEALTH ASSESSMENT – ITEMS 701 / 703 / 705 / 707

Eligibility Criteria
Patients with newly diagnosed or existing diabetes are not eligible. Patients aged 40 to 49 years inclusive.
Patients must score ≥12 points (high risk) on Australian Type 2 Diabetes Risk Assessment Tool (AUSDRISK).
Not for patients in hospital.

Clinical Content
Explain Health Assessment process and gain consent.
Evaluate the patient's risk score determined by the AUSDRISK, which has been completed within a period of 3 months prior to undertaking Type 2 Diabetes Risk Evaluation.
Update patient history and undertaking physical examinations and clinical investigations in accordance with relevant guidelines.
Make an overall assessment of the patient's risk factors, and results of relevant examinations and investigations.
Initiate interventions where appropriate, and follow-up relating to management of any risk factors identified.
Provide advice and information, including strategies to achieve lifestyle and behaviour changes.

Essential Documentation Requirements
Record patient's consent to Health Assessment.
Completion of AUSDRISK is mandatory, with a score of ≥12 points required to claim, update patient history.
Record the Health Assessment and offer the patient a copy.

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

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

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

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

Eligibility Criteria
Patients aged 45 to 49 years inclusive
Must have an identified risk factor for chronic disease Not for patients in a hospital

Risk Factors
Include, but are not limited to:
Lifestyle: Smoking; Physical inactivity; Poor nutrition; Alcohol use
Biomedical: High cholesterol; High BP; Impaired glucose metabolism; Excess weight
Family history of chronic disease

Clinical Content Mandatory
Explain Health Assessment process and gain consent
Information collection – takes patient history; undertake examinations and investigations as clinically required
Overall assessment of the patient's health, including their readiness to make lifestyle changes
Initiate interventions and referrals as clinically indicated
Advice and information about lifestyle modification programs and strategies to achieve lifestyle and behaviour changes

Non-Mandatory
Written patient information is recommended

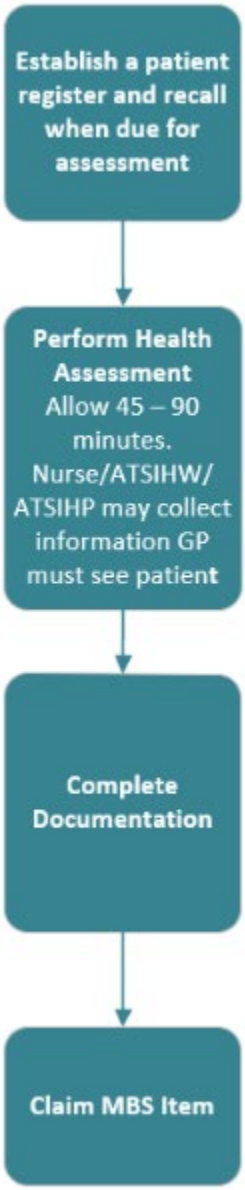
Essential Documentation Requirements
Record patient's consent to Health Assessment
Record the Health Assessment and offer the patient a copy

Claiming
All elements of the service must be completed to claim

MBS Item	Name	Age Range	Recommended Frequency
701 / 703 / 705 / 707	Health Assessment – 45-49	40 – 49 years	Once only

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

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



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

Eligibility Criteria
Patients aged 75 years and older
Patient seen in consulting rooms and/or at home Not for patients in hospital

Clinical Content Mandatory
Explain Health Assessment process and gain patient's/ carer's consent Information collection– takes patient history; undertake
examinations and investigations as clinically required Measurement of BP, Pulse rate and Rhythm
Assessment of: Medication; Continence; Immunisation status for influenza, tetanus and pneumococcus; Physical function including activities of daily living and falls in the last 3 months; Psychological function including cognition and mood; and social function including availability and adequacy of paid and unpaid help and the patient's carer responsibilities
Overall assessment of patient Recommend appropriate interventions Provide advice and information
Discuss outcomes of the assessment and any recommendations with patient

Non-Mandatory
Consider: Need for community services; Social isolation; Oral health and dentition; and Nutrition status
Additional matters as relevant to the patient

Essential Documentation Requirements
Record patient's/carer's consent to Health Assessment
Record the Health Assessment and offer the patient a copy (with consent, offer to carer)

Claiming
All elements of the service must be completed to claim

MBS Item	Name	Age Range	Recommended Frequency
701 / 703 / 705 / 707	Health Assessment – 75 years +	75 years and older	Once only

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

ABORIGINAL AND TORRES STRAIT ISLANDER - HEALTH ASSESSMENT – ITEM 715

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

Eligibility Criteria
Aboriginal and Torres Strait Islander children who are less than 15 years old
An Aboriginal or Torres Strait Islander person who is aged between 15 years and 54 years
Aboriginal and Torres Strait Islander older people who are aged 55 years and over

Mandatory
Health Assessment includes physical, psychological and social wellbeing. It also assesses what preventative health care, education and other assistance that should be offered to improve the patient's health and wellbeing. It must include:
Information collection of patient history and undertaking examinations and investigations as required. Overall assessment recommending any appropriate intervention provide advice and information
Recording the health assessment.
Offering the patient, a written report with recommendations about matters cover by the health assessment

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

Essential Documentation Requirements
If referred to an Allied Health Professional, they must provide a written report to the GP after the first and last service (more often if clinically required)

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

HOME MEDICINES REVIEW (HMR) - ITEM 900

Also known as Domiciliary Medication Management Review (DMMR)

Eligibility Criteria
Patients at risk of medication related problems or for whom quality use of medicines may be an issue.
Not for patients in a hospital or a Residential Aged Care Facility.
DMMRs are targeted at patients who are likely to benefit from such a review: patients for whom quality use of medicines may be an issue or; patients who are at risk of medication misadventure because of factors such as their co-morbidities, age or social circumstances, the characteristics of their medicines, the complexity of their medication treatment regimen, or a lack of knowledge and skills to use medicines to their best effect.

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

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

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

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

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

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

RESIDENTIAL MEDICATION MANAGEMENT REVIEW (RMMR) - ITEM 903

Eligibility Criteria
For permanent residents (new or existing) of a Commonwealth funded Residential Aged Care Facility (includes veterans).
Patients at risk of medication related misadventure because of significant change in their condition or medication regimen, or for whom quality use of medicines may be an issue.
Not for patients in a hospital or respite patients in RACF.

GP Initiates Service
Explain RMMR process and gain resident's consent.
Send referral to accredited pharmacist to request collaboration in medication review.
Provide input from Comprehensive Medical Assessment or relevant clinical information for RMMR and the resident's records.

Accredited Pharmacist Component
Review resident's clinical notes and interview resident. Prepare Medication Review report and send to GP.

GP and Pharmacist Post Review Discussion
Discuss: Findings and recommendations of the Pharmacist.
Medication management strategies; issues; implementation; follow up; outcomes
If no (or only minor) changes recommended a post review discussion is not mandatory.

Essential Documentation Requirements
Record resident's consent to RMMR.
Develop and/or revise Medication Management Plan which should identify medication management goals and medication regimen.
Finalise Plan after discussion with resident.
Offer copy of Plan to resident/carer, provide copy for resident's records and for nursing staff at RACF, discuss plan with nursing staff if necessary.

Claiming
All elements of the service must be completed to claim. Derived fee arrangements do not apply to RMMR.

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

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

GP MANAGEMENT PLAN (GPMP) - ITEM 721

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

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

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

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

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

*CDM services may be provided more frequently in the exceptional circumstances defined below.

Exceptional circumstances exist for a patient if there has been a significant change in the patient's clinical condition or care requirements that necessitate the performance of the service for the patient.

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

TEAM CARE ARRANGEMENT (TCA) - ITEM 723

Eligibility Criteria

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

Clinical Content

Consult with at least two collaborating providers, each of whom will provide a different kind of treatment or service to the patient, and one of whom may be another medical practitioner, when planning for the multidisciplinary care of the patient
Prepare a document that describes:
(i)Treatment and service goals for the patient.
(ii)Treatment and services that collaborating providers will provide to the patient; and
(iii)Actions to be taken by the patient
(iv)arrangements to review (i) (ii) and (iii) by a date specified in the document
Explain steps involved in TCA, possible out of pocket costs, gain consent
Discuss with patient which 2 providers the GP will collaborate with and the treatment and services the 2 providers will deliver.

Essential Documentation Requirements

Record patient's consent to TCA.
Goals, collaborating providers, treatments/services, actions to be taken by patient Set review date.
Give copies of the relevant parts of the document to the collaborating providers.
Offer a copy of the documents to the patient and the patient's carer (if appropriate and patient agrees).
Add a copy of the document to the patient's medical record.
Consult with 2 collaborating providers and obtain feedback on treatment/services they will provide to achieve patient goals.
The document must be retained for 2 years

Claiming

All elements of the service must be completed to claim. Requires personal attendance by GP with patient.
Review using item 732 at least once during the life of the plan.
Claiming a GPMP and TCA enables patients to receive 5 rebated services from allied health.

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

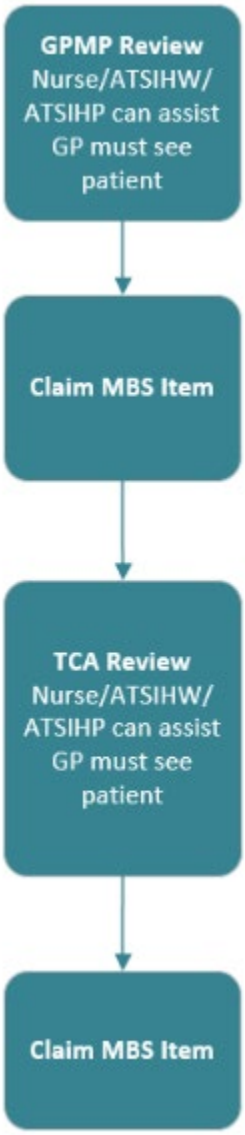
* CDM services may be provided more frequently in the exceptional circumstances defined below.

Exceptional circumstances exist for a patient if there has been a significant change in the patient's clinical condition or care requirements that necessitates the performance of the service for the patient.

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

REVIEW OF A GP MANAGEMENT PLAN (GPMP) AND/OR TEAM CARE ARRANGMENT (TCA) - ITEM 732

Review of a GP Management Plan (GPMP)



Clinical Content
Explain steps involved in the review and gain consent. Review all matters in relevant plan.

Essential Documentation Requirements Record patient's agreement to review. Make any required amendments to plan. Set new review date.
Offer copy to patient (with consent, offer to carer). Keep copy in patient file.

Claiming
All elements of the service must be completed to claim.
Item 732 should be claimed at least once over the life of the GPMP. Cannot be claimed within 3 months of a GPMP (item 721).
Item 732 can be claimed twice on same day if review of both GPMP and TCA are completed, in this case the Medicare claim should be annotated.

Review of a Team Care Arrangement (TCA)

Clinical Content
Explain steps involved in the review and gain consent.
Consult with 2 collaborating providers to review all matters in plan.

Essential Documentation Requirements
Record patient's consent to review. Make any required amendments to plan. Set new review date.
Send copy of relevant parts of amended TCA to collaborating providers. Offer copy to patient (with consent, offer to carer). Keep copy in patient file.

Claiming
All elements of the service must be completed to claim. Requires personal attendance by GP with patient.
Item 732 should be claimed at least once over the life of the TCA. Cannot be claimed within 3 months of a TCA (item 723).
Item 732 can be claimed twice on same day if review of both GPMP and TCA are completed. In this case the Medicare claim should be annotated.

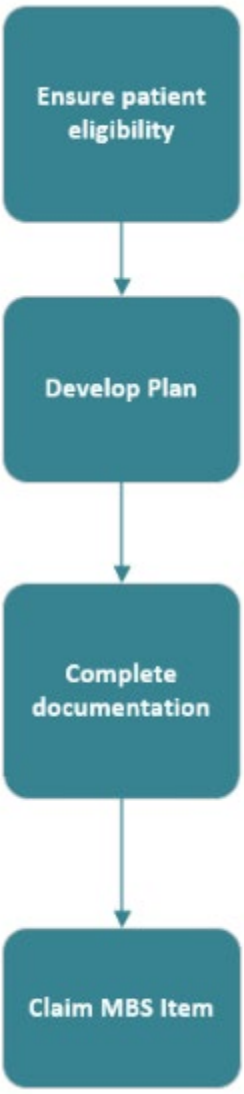
MBS Item	Name	Recommended Frequency
732	GP Management Plan and/or Team Care Arrangement	6 months (Minimum 3 months)

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

MENTAL HEALTH TREATMENT PLAN - ITEMS 2700/2701/2715/2717

2700/2701- prepared by a GP who **has not** undertaken mental health skills training. A credentialed Mental Health Nurse, Aboriginal & Torres Strait Islander Health Worker or Aboriginal & Torres Strait Islander Practitioner that has completed Mental Health training can also assist the GP.

2715/2717 - prepared by a GP who **has** undertaken mental health skills training. A credentialed Mental Health Nurse, Aboriginal & Torres Strait Islander Health Worker or Aboriginal & Torres Strait Islander Practitioner that has completed Mental Health training can also assist the GP.



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

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

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

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

MBS Item	Name	Recommended Frequency
2700 / 2701 / 2715 / 2717	Requirements of a mental health care plan - Health professionals - Services Australia	

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

REVIEW OF MENTAL HEALTH TREATMENT PLAN - ITEM 2712

Clinical Content

Explain steps involved and possible out of pocket costs. Gain patient's consent. Review patient's progress against goals outlined in the GP Mental Health Treatment Plan.
Check, reinforce and expand psychoeducation.
Plan for crisis intervention and/or relapse prevention, if appropriate and if not previously provided.
Re-administer the outcome measurement tool used when developing the GP Mental Health Treatment Plan (item 2700 /2701 /2715 /2717), except where considered clinically inappropriate.

Essential Documentation Requirements
Record patient's consent to Review.
Results of re-administered outcome measurement tool document relevant changes to GP Mental Health Treatment Plan.
Offer copy to patient (with consent, offer to carer). Keep copy in patient file.

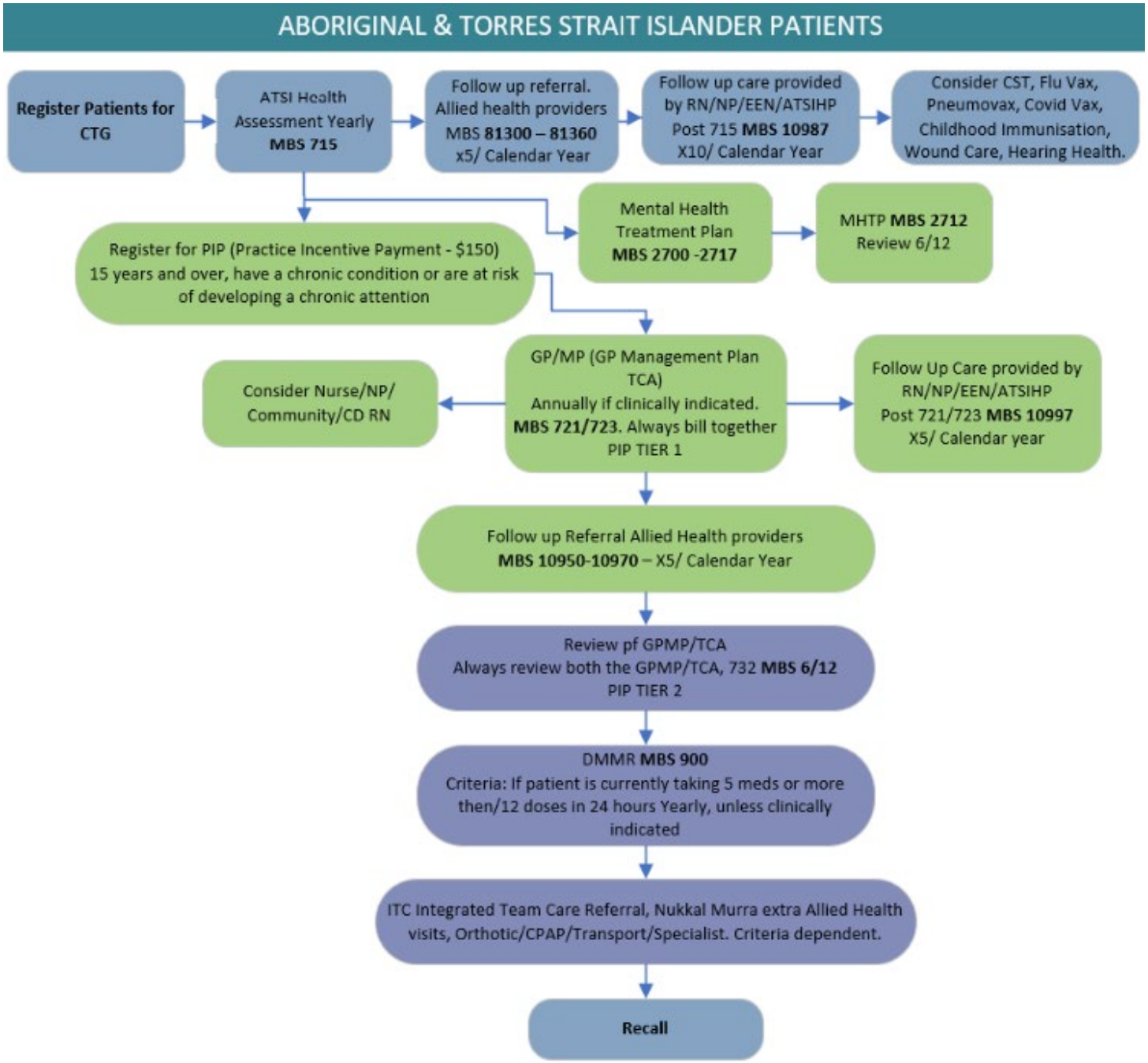
Claiming

All elements of the service must be completed to claim. Requires personal attendance by GP with patient.
Item 2712 should be claimed at least once over the life of the GP Mental Health Treatment Plan.
According to the FAQs on The Australian Government Department of Health Website (2012), it is not mandatory for the GP to see the patient to do a referral for the further four allied mental health sessions.
A review can be claimed 1–6 months after completion of the GP Mental Health Treatment Plan. If required, an additional review can be performed 3 months after the first Review.

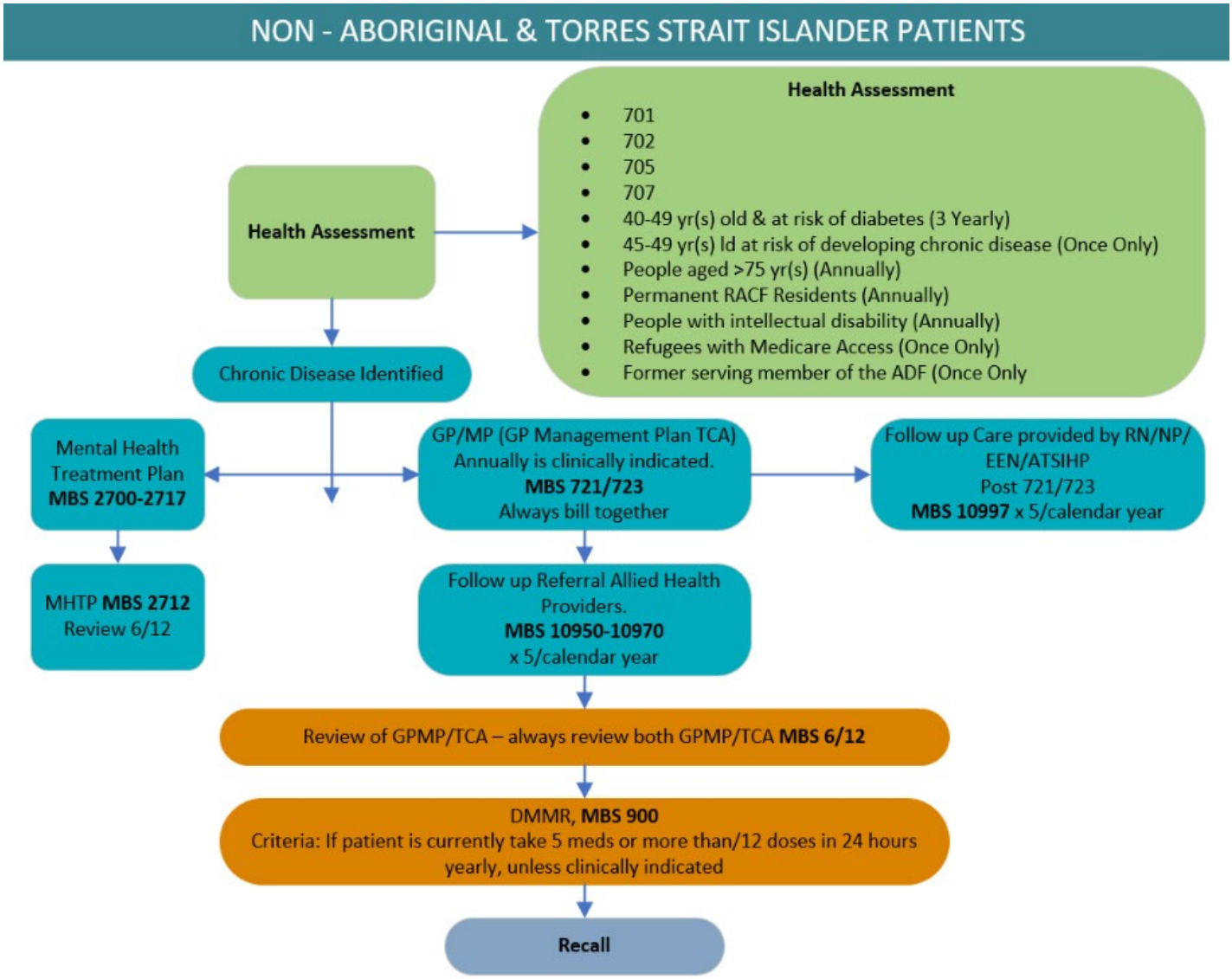
MBS Item	Name	Recommended Frequency
2712	Review of GP Mental Health Treatment Plan	1 – 6 months after GP Mental Health Treatment Plan

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

PATIENT HEALTH JOURNEY



PATIENT HEALTH JOURNEY cont.



PIP Quality Stream

INCENTIVE	ASPECT OR ACTIVITY	PAYMENT AMOUNT
Indigenous Health Incentive	**Sign on payment**. This is a once only payment. Practices agree to undertake specified activities to improve the care of their Aboriginal and Torres Strait Islander patients with a chronic disease or mental disorder.	$1,000 per practice
	Patient registration payment. This is a payment to practices for each eligible Aboriginal and/or Torres Strait Islander patient aged 15 years or over.	$150 per eligible patient per calendar year
	Outcome payment Tier 1. A payment to practices that meet the requirements of the Tier 1 Outcome payment within a 12-month assessment period.	$100 per eligible patient per 12-month assessment period
	Outcome payment Tier 2. A payment to practices for providing a target level of care for a registered patient within a 12-month assessment period.	$150 per eligible patient per 12-month assessment period
Quality Improvement Incentive	A payment to practices to undertake continuous quality improvement through the collection and review of practice data.	$5.00 per SWPE capped at $12,500 per quarter

PIP Capacity stream

INCENTIVE	ASPECT OR ACTIVITY	PAYMENT AMOUNT
After Hours Incentive	**Level 1: Participation payment** Practices must meet the requirements of Level 1. This includes having formal arrangements in place to ensure patients have access to care in the complete after-hours period.	$1 per SWPE
	Level 2: Sociable after-hours cooperative coverage Practices must meet the requirements of Level 2. This includes participating in a cooperative arrangement and other formal arrangements. This is to make sure patients have access to care in the sociable and unsociable after-hours periods.	$4 per SWPE
	Level 3: Sociable after-hours practice coverage Practices must meet the requirements of Level 3. This includes providing after hours care directly through the practice and through formal arrangements.	$5.50 per SWPE
	Level 4: Complete after-hours cooperative coverage Practices must meet the requirements of Level 4. This includes participating in a cooperative arrangement. This makes sure patients have access to care throughout the complete after-hours period.	$5.50 per SWPE
	Level 5: Complete after-hours practice coverage Practices must meet the requirements of Level 5. This includes the practice providing after hours care directly to patients throughout the complete after-hours period.	$11 per SWPE
NEW The General Practice in Aged Care Incentive *(Commenced 1 July 2024, replacing the PIP GP ACAI ceasing on 31 July 2024)*	**About:** The GPACI supports older people living in Residential Aged Care Homes (RACHs) to receive planned, quality primary care services from a regular general practice and general practitioner.	N/A
	Paid to the responsible provider.	$300 per patient, per year.
	Paid to the General Practice.	$130 per patient, per year.
	Payments are made quarterly *and are in addition to existing Medicare Benefits Scheme (MBS) and Department of Veterans' Affairs (DVA) rebates. Click here for more information.*	N/A
eHealth Incentive	Practices must meet each of the requirements to qualify for payments through this incentive	$6.50 per SWPE capped at $12,500 per practice per quarter
Teaching Payment	Payment to practices for providing teaching sessions to medical students. Practices can claim payment for up to 2 sessions per GP per day	$200 per session

PIP Rural support stream

INCENTIVE	ASPECT OR ACTIVITY	PAYMENT AMOUNT
Procedural GP Payment	**Tier 1**: Payment for a GP in a rural or remote practice who provides at least 1 procedural service in the 6 month reference period. The service must meet the definition of a procedural service.	$1,000 per procedural GP per 6-month reference period
	Tier 2: Payment for a GP in a rural or remote practice who meets both: the Tier 1 requirement provides after-hours procedural services on a regular or rostered basis. This must be 15 hours per week on average throughout the 6-month reference period.	$2,000 per procedural GP per 6-month reference period
	Tier 3: Payment for a GP in a rural or remote practice who both: meets the Tier 2 requirements. provides 25 or more eligible surgical, anaesthetic or obstetric services in the 6-month reference period.	$5,000 per procedural GP per 6-month reference period
	Tier 4: Payment for a GP in a rural or remote practice who both: meets the Tier 2 requirements delivers 10 or more babies in the 6-month reference period or meets the obstetric needs of the community.	$8,500 per procedural GP per 6-month reference period
Rural loading Incentive	Payment for a practice whose main location is outside a metropolitan area, based on the Rural, Remote and Metropolitan Area (RRMA) Classification. Once all incentive payments are added, the rural loading amount is applied.	RRMA 3 - 15% loading RRMA 4 - 20% loading RRMA 5 - 40% loading RRMA 6 - 25% loading RRMA 7 - 50% loading

PIP Enquiry Line Telephone: 1800 222 032 **Email: pip@humanservices.gov.au**

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