

# General Information for Standard MBS Items

working to improve the  
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families and individuals in  
south gippsland...

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*The assistance of the Townsville Division of General Practice Ltd for providing this document is appreciated and acknowledged.*



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This manual was originally prepared by SA Divisions of General Practice in conjunction with the Mid North Division of Rural Medicine and the Murray-Mallee Division of General Practice, with funding from the Department of Health and Ageing.

It has been modified by Townsville Division of General Practice and adapted by General Practice Alliance South Gippsland for use by general practitioners in South Gippsland.

Updated April 2011.

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

# General Information for Standard Items

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

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

# Cervical Screening

- GPs working in PIP practice that have signed on for the cervical screening incentive will receive a service incentive payment (SIP-Cervical) for **screening women between 20-69 years who have not had a cervical smear within the last 4 years** (considered high risk).
- Upon completion of a cervical smear for women meeting the above criteria, GPs claim the appropriate item number below to receive payment for consult plus SIP payment of \$35.00.

Item Numbers	Level B	Level C	Level D
	2501	2504	2507

**SIP Payment = \$35.00**

- This SIP Payment is also claimable where the cervical smear is undertaken by a Practice Nurse on behalf of the GP under Items 10995 and 10999. (See pages 34 and 35)

# Pregnancy Support Counselling

Professional attendance for the purpose of providing non-directive pregnancy support counselling to a woman who is concerned about a current pregnancy or a pregnancy that occurred in the preceding 12 months, by a medical practitioner registered with Medicare Australia as meeting the credentialling requirements for provision of this service, and lasting at least 20 minutes. The service may be used to address any pregnancy related issues for which non-directive counselling is appropriate.

This service may not be provided by a medical practitioner who has a direct pecuniary interest in a health service that has as its primary purpose the provision of services for pregnancy termination.

To a maximum of 3 non-directive pregnancy support counselling services per patient, per pregnancy from any of the following items - [4001](#), [81000](#), [81005](#) and [81010](#) (see *Explanatory note M.8*).

## Transitional Hours - Items 603 and 696

Two new Medicare items were introduced on 1 November 2008 to give doctors access to higher rebates for providing urgent out-of-surgery attendances to their patients out of normal working hours but before the start of the time period known as 'after hours'.

The items may be provided during the newly-created MBS 'transitional hours' timezone. Transitional hours are between 6pm and 8pm on weekdays and between midday and 1pm on Saturdays.

The items are only for use where the patient has a medical condition requiring urgent out-of-surgery medical treatment within the transitional hours period and treatment cannot be delayed till the next in-hours period.

GPs may provide item 603, General Practitioner Urgent Attendances – Transitional Hours, for a 1 November 2008 benefit of \$83.50 (100% Medicare).

Other medical practitioners may provide item 696, Other Non-Referred Urgent Attendances – Transitional Hours, for a 1 November 2008 benefit of \$67.00 (100% Medicare).

The new items allow for bookings to be taken between 4-8pm for services provided between 6-8pm on weekdays, and between 10am-1pm for services provided between midday and 1pm Saturdays.

The table below provides examples of how the new item may be claimed.

Time booking taken	Time of attendance	Relevant item	Reason
5pm (weekday)	6.30pm	603 or 696	Booking taken within 4-6pm booking period; service provided within transitional hours
6.30pm (weekday)	7.30pm	603 or 696	Booking taken outside of 4-6pm booking period but within transitional hours; service provided within transitional hours
5.30pm (weekday)	9pm	Relevant non-urgent, out-of-surgery after hours item (A22 or A23 group)	Booking taken within 4-6pm booking period; service provided after end of transitional hours
12.15pm (Saturday)	12.30pm	603 or 696	Booking taken outside of 10am-midday booking period but within transitional hours; service provided within transitional hours
11.45am (Saturday)	1.30pm	Relevant non-urgent, out-of-surgery after hours item (A22 or A23 group)	Booking taken within 10am-midday booking period; service provided after end of transitional hours

For the second or more patients seen on the same occasion during transitional hours, the relevant in-hours out-of-surgery item should be itemised.

<b>Item Number</b>	<b>603</b>
<b>Item Number</b>	<b>696</b>

# Diabetes 12 month cycle of care

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

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

Item Numbers	Level B 2517	Level C 2521	Level D 2525
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## SIP Payment = \$40.00

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

**Note:** Payment to Practice, not paid to individual GP provider numbers.

# Asthma Cycle of Care

*For patients with moderate to severe asthma.*

**Patients must receive the following treatment:**

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

Item Numbers	Level B	Level C	Level D
	2546	2552	2558

**SIP Payment = \$100.00**

# Spirometry

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

Item Number

11506

# Focused Psychological Strategies (FPS)

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

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

The GP must be providing the service from a registered PIP or accredited practice. More information about registration and training programs can be obtained from your local Division of General Practice.

# GP Mental Health Care Consultation

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

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

A GP Mental Health Care Consultation must include:

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

**Item Number**

**2713**

# GP Mental Health Care Plans

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

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

An assessment of a patient must include:

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

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

- Discussing the assessment with the patient, including the mental health formulation and/or diagnosis;
- Identifying and discussing referral and treatment options with the patient, including appropriate support services;
- Agreeing goals with the patient – what should be achieved by the treatment – and any actions the patient will take;
- Provision of psycho-education;
- A plan for crisis intervention and/or for relapse prevention, if appropriate at this stage;
- Making arrangements for required referrals, treatment, appropriate support services, review and follow-up; and
- Documenting this (results of assessment, patient needs, goals and actions, referrals and required treatment/services, and review date) in the patient's GP Mental Health Care Plan.

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

**Item Number**

**2710**

*Inquiries concerning matters of interpretation of Schedule items should be directed to Medicare Australia on (03) 9605 7964.*

# Review of GP Mental Health Care Plan

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

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

The review must include:

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

**Item Number**

**2712**

# Home Medicines Review

## Guide for Patient Selection

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

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

## Item Number

900

**Note:** Can be claimed by GP only, or see below to include Practice Staff.

### Process:

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

### Other Points to consider:

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

## Process for claim Home Medicine Review (item 900) utilising Practice Nurse/Staff

The Home Medicines Review is one the Medicare items that can utilise the skills of the Practice staff.

**Practice staff use clinical software program to identify suitable patients;**

- those on multiple medications
- suspected medication occurrences of concern
- when doing GPMP, Team Care Arrangement, Health Assessments
- those recently discharged from hospital

When the Patient attends the surgery the HMR referral process can be shared

**The GP**

- explains and initiates HMR
- generates HMR referral for Community Pharmacy

**Practice staff**

- records date of referral, patient name and Pharmacy
- bills item number appropriate for that consultation
- monitors for confirmation of referral receipt from Pharmacy

The Patient is contacted by the Pharmacy to arrange the home visit and interview

**Pharmacist**

- conducts home visit
- sends report to GP
- discusses findings with GP

**Practice staff**

- monitors for receipt of pharmacists report
- documents and files report
- recalls patient

The Patient returns to the surgery for the second consultation to discuss the HMR report

**The GP**

- discusses the HMR report with the patient
- prepares medication management plan
- sends copy to Pharmacy
- offers copy to Patient

**Practice staff**

- bills item 900
- bills item 10990 if applicable

# Residential Medication Management Review

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

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

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

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

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

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

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

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

**Item Number**

**903**

# Aboriginal & Torres Strait Islander Health Check

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

## ***Health Check must include:***

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

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

- Item can be claimed once every 18 months.

Item Number

710

# Comprehensive Medical Assessments – Residents of Aged Care Facilities

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

Item Number

712

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

# Health Assessments

Is an **assessment of the patient's health and physical, psychological and social function** and whether preventive health care and education should be offered.

- not for in-patients of hospital, day hospital or aged care residents.

**It should include:**

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

**Additional components may include:**

Multi-system review, fitness to drive, hearing, vision, oral health, diet and nutritional status, smoking, foot care, sleep, need for community services, home safety, cardiovascular risk factors and alcohol use.

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

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

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

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

# Health Assessment for People with an Intellectual Disability

## Eligibility

Patient is a person with an intellectual disability.

Name	Item Number
Annual health assessment for a person with an intellectual disability, provided in a consulting room	<b>718</b>
Annual health assessment for a person with an intellectual disability, provided outside consulting room, hospitals and residential aged care facilities	<b>719</b>

# Refugee and Other Humanitarian Entrants (R&OHE) Health Check

## Eligibility

Patient is a refugee or other humanitarian entrant who has arrived in Australia in the last 12 months.

Name	Item Number
Refugee and other humanitarian entrants health check provided in a consulting room	<b>714</b>
Refugee and other humanitarian entrants health check provided outside consulting rooms, hospitals and resident aged care facilities	<b>716</b>

# 45 Year Old Health Check

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

Factors to consider may include but are not limited to:

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

## **Health Check must include:**

- Patient must consent to health check and this must be noted in the patient's chart;
  - Taking patient's history (or updating an existing one);
  - Examination (tailored to the patient's individual needs and risk factors);
  - Investigations as clinically indicated ;
  - Overall assessment of the patient;
  - Interventions e.g. referrals as indicated;
  - Provide advice and information to the patient.
- 
- Practice Nurses, Aboriginal Health Workers and other health professionals may assist the GP in performing the health check, in accordance with accepted medical practice and under the supervision of the GP.
  - Item can only be claimed once for any eligible patient.

# Type 2 Diabetes Risk Evaluation

Attendance by a medical practitioner (including a general practitioner but not including a specialist or consultant physician) **AT A PLACE OTHER THAN A HOSPITAL** to undertake a type 2 diabetes risk evaluation for a patient who is 40 to 49 years of age (inclusive) with a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool - not being a type 2 diabetes risk evaluation of a patient in respect of whom, in the preceding 3 years, a payment has been made under this item or item 717.

The purpose of this item is to support general practitioners (GPs) to address the health needs of patients 40 to 49 years of age who are at 'high risk' of developing type 2 diabetes. The 'high risk' score will be determined following the patient's completion of the Australian Type 2 Diabetes Risk Assessment Tool. The aim of this item is to review the factors underlying the 'high risk' score identified by the Australian Type 2 Diabetes Risk Assessment Tool to instigate early interventions, such as lifestyle modification programs, to assist with the prevention of type 2 diabetes.

## Eligible Population

The Type 2 Diabetes Risk Evaluation is targeted at people aged 40 to 49 years (inclusive) who are at high risk of developing type 2 diabetes.

## Assessing a 'high risk' score and conducting a Type 2 Diabetes Risk Evaluation

The Type 2 Diabetes Risk Evaluation is a review of the factors underlying the 'high risk' score identified by the Australian Type 2 Diabetes Risk Assessment Tool.

Clinical factors that the GP should consider include:

- lifestyle, such as smoking, physical inactivity and poor nutrition;
- biomedical risk factors, such as high blood pressure, impaired glucose metabolism and excess weight;
- any relevant recent diagnostic test results; and
- family history.

As part of a regular consultation (billed under the appropriate attendance item) a GP may suspect that a patient may have, or be at risk of developing diabetes. The GP may consequently order diagnostic tests to exclude the presence of type 2 diabetes. If diabetes is diagnosed, the GP may determine that a chronic disease management item is clinically relevant. If diabetes is not diagnosed, the GP may advise the patient to complete the Australian Type 2 Diabetes Risk Assessment Tool.

If the GP determines that the patient is not likely to have already developed diabetes, but the Australian Type 2 Diabetes Risk Assessment Tool indicates that the patient is at 'high risk', the GP may choose to undertake a Type 2 Diabetes Risk Evaluation during the same attendance (billed under item 713). If the preceding consultation was not exclusively related to diabetes risk assessment, and was a clinically relevant service (see *General Explanatory Note 1.2*), the appropriate attendance item may also be claimed.

## Medicare Eligibility

A Medicare rebate is payable for the Type 2 Diabetes Risk Evaluation only once every three years for any eligible patient, or where more than three years has elapsed since item 717 has been claimed by that patient. If a GP is unsure whether a patient has already received this service, they may call Medicare Australia, with the patient present, on 132 011. The item does not apply to patients admitted to a hospital or day-hospital facility.

## Eligible practitioners

The Type 2 Diabetes Risk Evaluation should generally be undertaken by the patient's 'usual doctor', that is, a medical practitioner, or a medical practitioner in the 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. A medical practitioner includes a general

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practitioner but not a specialist or consultant physician. In these notes, the term "GP" is used as a generic reference to a medical practitioner able to claim this item.

### **Components of the Type 2 Diabetes Risk Evaluation**

The risk evaluation must include:

- evaluation of a 'high risk' score determined by the Australian Type 2 Diabetes Risk Assessment Tool, which has been completed by the patient within a period of 3 months prior to undertaking the Type 2 Diabetes Risk Evaluation service;
- updating a patient history and undertaking examinations and investigations in accordance with relevant guidelines (see below);
- making an overall assessment of the patient's risk factors, relevant examinations and the results of any investigations.
- initiating interventions where appropriate, including referrals and follow-up relating to the management of any risk factors identified; and
- providing advice and information (such as *Lifescrpts* resources) to the patient including strategies to achieve lifestyle and behaviour changes where appropriate.

The Australian Type 2 Diabetes Risk Assessment Tool can be obtained from [www.health.gov.au/epc](http://www.health.gov.au/epc).

The completion of the Australian Type 2 Diabetes Risk Assessment Tool is mandatory for patient access to the Type 2 Diabetes Risk Evaluation item. The tool can be completed either by the patient or with the assistance of a health professional or practice staff. Patients with a 'high' score result are eligible to attend a Type 2 Diabetes Risk Evaluation by their GP, and subsequent referral to the lifestyle modification programs if appropriate.

### **Lifestyle Modification Program**

Eligible patients who have attended a diabetes risk evaluation with their GP, under this item, may be referred to a subsidised lifestyle modification program as one of a number of possible intervention strategies in addition to what may be available locally.

Where a service for an eligible patient has previously been billed under item 717, but within the specified three year period the risk of diabetes as measured by the Australian Type 2 Diabetes Risk Assessment Tool increases to 'high', the patient's GP may use his/her clinical judgement in a subsequent consultation to refer the patient to the lifestyle modification programs if it would provide health benefits.

Relevant resources on lifestyle modification are available at [www.healthinsite.gov.au](http://www.healthinsite.gov.au), including for patients who may not wish to attend or are unable to participate in a formal lifestyle modification program.

### **Role of the GP**

The GP is responsible for the conduct of the Type 2 Diabetes Risk Evaluation provided to the patient. The GP is expected to take a primary role in the following activities:

- Reviewing and analysing the information collected (including the risk factors underlying the 'high risk' score identified by the Australian Type 2 Diabetes Risk Assessment Tool);
- Making an overall assessment of the risk factors that contributed to the "high" risk score of the patient and their readiness to make lifestyle changes to address these identified risk factors;
- Undertaking and arranging relevant investigations;
- Making relevant referrals, including to lifestyle modification programs, and identifying appropriate follow-up; and
- Providing information and advice to the patient, for example, to undertake lifestyle modifications, and/or the use of Lifescrpt resources. Access to subsidised lifestyle modification programs will require the provision of a formal referral letter including the provider number of the referring GP.

### **Role of other health professionals**

Practice nurses, Aboriginal Health Workers and other health professionals may assist GPs in performing the Type 2 Diabetes Risk Evaluation, in accordance with accepted medical practice

*Inquiries concerning matters of interpretation of Schedule items should be directed to Medicare Australia on (03) 9605 7964.*

and under the supervision of the GP.

This may include activities which:

- identify eligible patients through examination of patient records, patient information systems, and risk assessment tools used within the practice;
- collect information such as measuring height and weight (body mass index), waist circumference and blood pressure;
- provide patients with information about recommended interventions, and actions the patient should take (at the direction of the GP) to encourage good health.

### **Relationship with other GP consultation items**

This diabetes risk evaluation item 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).

Indigenous Australians are able to access the Aboriginal and Torres Strait Adult Health Check (MBS item 710) and a Type 2 Diabetes Risk Evaluation item if they meet the patient eligibility requirements. GPs are encouraged to use item 710 where appropriate because it covers a broad range of health issues including diabetes. Under item 710, GPs can refer patients with a high risk of developing type 2 diabetes to a subsidised lifestyle modification program. It is expected that item 710 covering ages 15-54 years, would negate the need for patients to have a separate Type 2 Diabetes Risk Evaluation. Patients eligible for item 710 are able to access the Type 2 Diabetes Risk Evaluation item 713 if they are in between health checks and if it has become clinically relevant for a Type 2 Diabetes Risk Evaluation to be conducted.

People aged 45 - 49 years (inclusive) are able to access the once only 45 year old health check (MBS item 717) if they are at risk of developing a chronic disease. Based on this consultation, if they have a high risk of type 2 diabetes, the GP is able to refer a person to a subsidised lifestyle modification program, along with other possible strategies to improve the health status of the patient.

A person who has previously accessed an item 717 consultation, can only become eligible for a Type 2 Diabetes Risk Evaluation when three years have elapsed. A previous Item 713 Type 2 Diabetes Risk Evaluation does not preclude an eligible person from accessing Item 717 in relation to the risk of developing other chronic illnesses.

For patients with an existing chronic condition, the Chronic Disease Management (CDM) items (721-731) provide a suite of items for the management and review of chronic conditions. Patients with a care plan for a non-diabetes condition are able to access the Type 2 Diabetes Risk Evaluation item if they meet the patient eligibility requirements.

### **Guidelines**

In considering and addressing risk factors, GPs are encouraged to utilise relevant guidelines and resources, such as:

- The RACGP publications: "*SNAP - a population health guide to behavioural risk factors in general practice*"; "*Putting Prevention into Practice*" (the Green Book); and "*Guidelines for Preventive Activities in General Practice*" (the Red Book).
- The National Health and Medical Research Council's approved guidelines *National Evidence Based Guidelines for the Management of Type 2 Diabetes Mellitus - Primary Prevention of Type 2 Diabetes*.

**Item Number**

**713**

# Healthy Kids Check

Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) **AT CONSULTING ROOMS** to undertake a health check for a patient who is receiving or has received their four year old immunisation.

Not being an attendance on a patient in respect of whom a payment has already been made under this item or item 711. Benefits are payable on one occasion only for each eligible patient.

## Item Number

709

Service provided by a practice nurse or registered Aboriginal Health Worker being the provision of a health check for a patient who is receiving or has received their four year old immunisation, if :

- (a) the service is provided on behalf of, and under the supervision of, a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), and
- (b) the person is not an admitted patient of a hospital.

Not being an attendance on a patient in respect of whom a payment has already been made under this item or item 709. Benefits are payable on one occasion only for each eligible patient.

## Item Number

711

# Case Conference

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

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

A case conferencing team includes:

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

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

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

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

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

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

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

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

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

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

# GP Management Plan Team Care Arrangements

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

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

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

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

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

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

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

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

### Further information

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

# GP Management Plan

## GP Management Plan

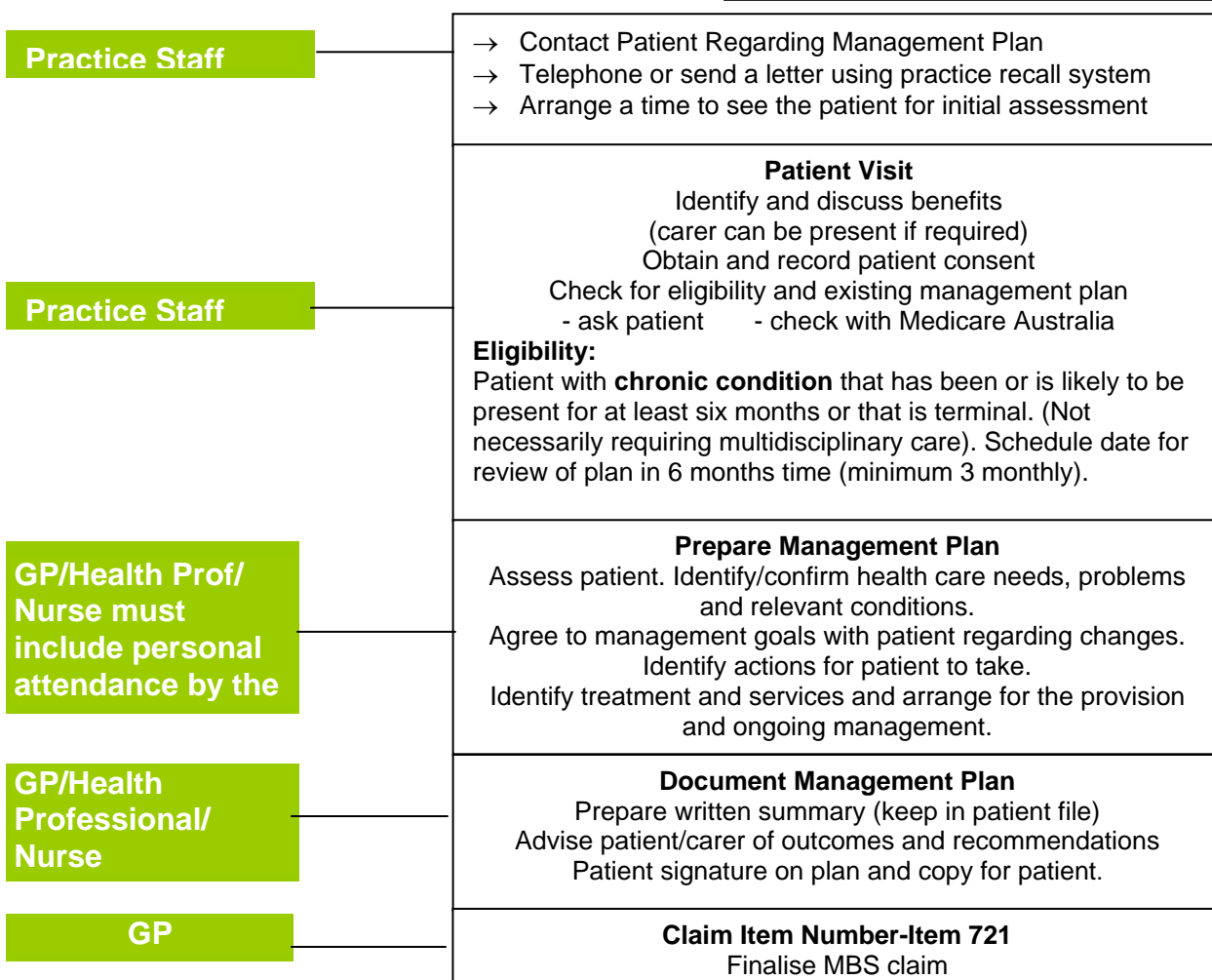
**Patient with chronic or terminal condition that has or is likely to be present for at least six months or that is terminal (not necessarily requiring multidisciplinary care)**

### Preparation Item 721

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

### Review Item 725

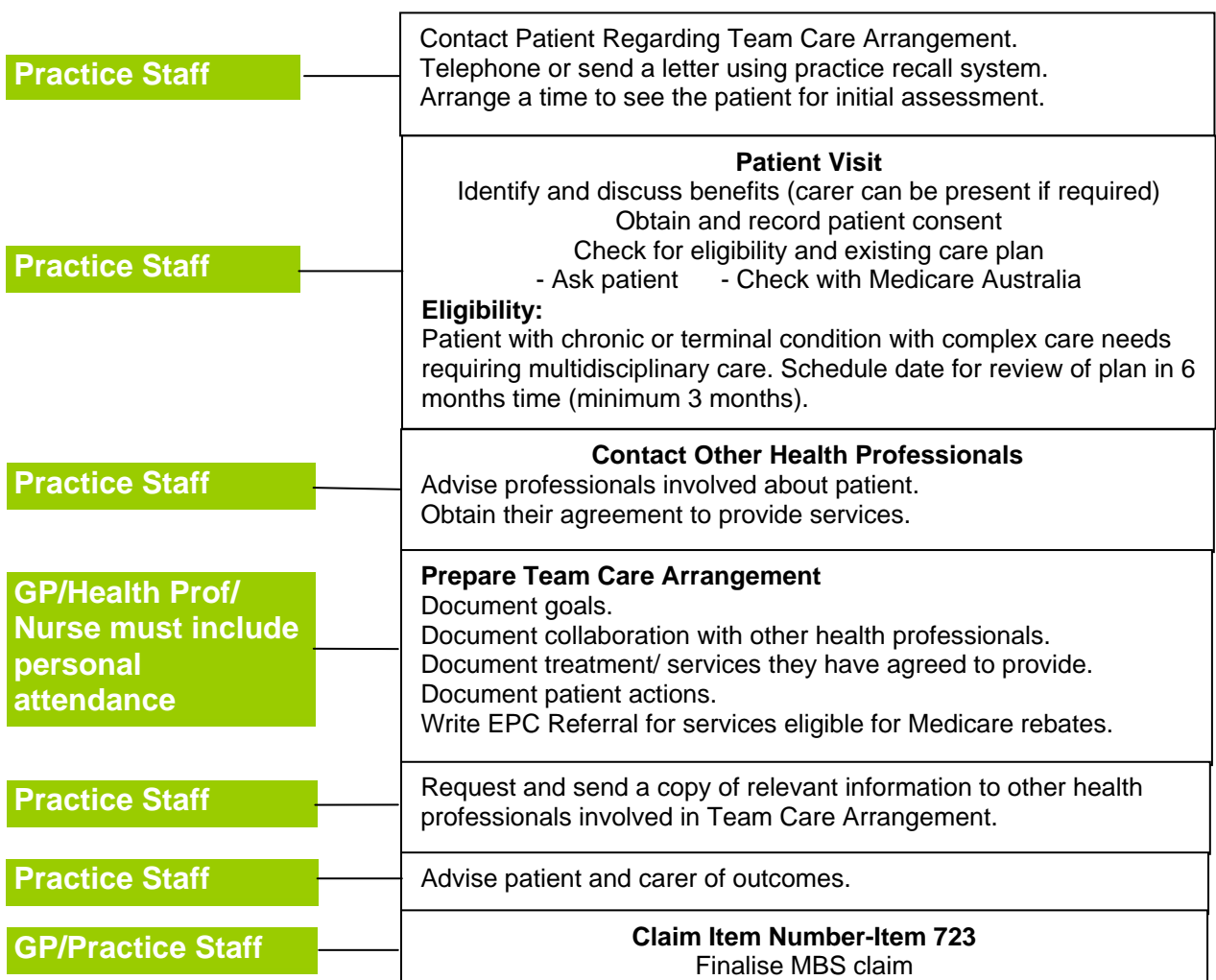
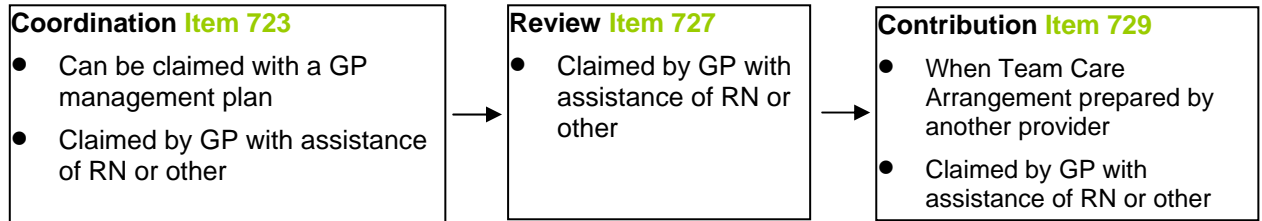
- Claimed by GP with assistance of RN or other
- Recommended every 6 months (minimum 3 monthly) or when clinically required



# Team Care Arrangements

## Team Care Arrangement

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



### Preparation of a GP Management Plan (Item 721)

*Must include:*

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

### Coordinating the development of Team Care Arrangements (Item 723)

*Steps must include:*

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

### **GP Management Plan and Team Care Arrangement:**

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

### **Review of a GP Management Plan (Item 725)**

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

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

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

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

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

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

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

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

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

## Allied Health Services for Chronic or Complex Conditions

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

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

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

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

### Overview:

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

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

*Inquiries concerning matters of interpretation of Schedule items should be directed to Medicare Australia on (03) 9605 7964.*

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

# Dental Care for Chronic or Complex Conditions

More detailed information is available in the *Medicare Benefits Schedule (MBS) Book* and the *MBS Dental Services* book.

## Summary:

- **New Medicare dental items (items 85011-87777)** commence on 1 November 2007. These items cover services by dentists, dental specialists and dental prosthetists.
- The patient must be referred by their GP for dental services.
- Eligible patients can receive up to \$4,250 in Medicare benefits (including Extended Medicare Safety Net benefits where applicable) for dental services over two consecutive calendar years.
- Eligible patients are those with a chronic medical condition and complex care needs being managed by their GP under a GP Management Plan and Team Care Arrangements, or a multidisciplinary care plan for residents of aged care facilities.
- The patient's oral health must also be impacting on, or likely to impact on, their general health.
- Dental practitioners may set their own fees. In some cases, patients may have out-of-pocket costs.
- The new items replace the Enhanced Primary Care (EPC) dental items 10975, 10976 and 10977.

## Eligible patients

To be eligible, a person must have a chronic medical condition and complex care needs (ie be managed by a GP under the following care plans). The patient's oral health must also be impacting on, or likely to impact on, their general health.

Whether the patient is eligible for referral for dental services is a clinical judgment for the GP, taking into account the patient's condition and care needs.

The care planning requirements are the same as those under the EPC allied health items, and the existing EPC dental items, ie the patient must have received the following services from a GP within the previous two years:

- GP Management Plan (item 721 or a review under item 725) **and** Team Care Arrangements (item 723 or a review under item 727); or
- for residents of an aged care facility, their GP must have contributed to or reviewed a multidisciplinary care plan prepared for the resident by the facility (item 731).

Further information on these chronic disease management items is set out in the MBS Book at note A.30.

**If these GP care planning items have not been claimed and paid by Medicare Australia or the patient has used their \$4,250 allocation, no Medicare benefits for dental services can be paid to the patient. The care plans cannot be done retrospectively, ie after the dental services have been provided to the patient.**

### **Types of dental services covered**

A comprehensive range of services are covered by the dental items, including dental assessments, preventative services, restorative services such as fillings, crowns, bridges and implants, extractions and other oral surgery (other than hospital services), orthodontic services and dentures.

The items can only be used where the primary objective of the treatment is to improve oral health or function. The items cannot be claimed for treatment that is predominantly for the improvement of the appearance of the patient (eg cosmetic). Services where the primary aim is to improve the health or function of the patient, but which also comprise a cosmetic component, may be claimed.

The items are not available to admitted hospital patients (ie the items apply to out-of-hospital dental services only). The items also do not generally apply to services that are provided by Commonwealth or State funded dental services.

### **Eligible dental practitioners**

The dental items can be used by dentists, dental specialists and dental prosthetists registered with Medicare Australia. GPs are encouraged to establish links with local dental practitioners and check whether they will accept referrals under the new Medicare dental items.

### **Medicare benefits payable**

Eligible patients can receive up to \$4,250 in Medicare benefits (including Extended Medicare Safety Net benefits where applicable) for dental services *over two consecutive calendar years* under items 85011 to 87777.

The two-year period is counted from the calendar year of the patient's first eligible dental service. For example, if the patient's first dental service is on 15 November 2007, the applicable two-year period will be the 2007 and 2008 calendar years.

Patients, GPs and dental practitioners will be able to call Medicare Australia to check how much the patient has already received in Medicare benefits for dental services over the relevant period. GPs may call the Provider Enquiry Line on 132 150. Patients may call the Patient Enquiry Line on 132 011.

### **Referrals by a GP to a dental practitioner**

In most cases, the GP will refer the patient to an eligible *dentist* in the first instance.

GPs may refer a patient directly to a dental prosthetist where the patient has no natural teeth and requires dental prosthetic services only (ie full dentures), or requires repairs or maintenance to full or partial dentures.

GPs cannot refer patients directly to a dental specialist. A dentist will refer the patient onto a dental specialist, another dentist or a dental prosthetist, where required.

### **Referral form**

GPs must use the *Referral Form for Dental Services under Medicare* issued by the Department of Health and Ageing, or a form that substantially complies with this referral form. This referral form replaces the Department's EPC referral form used for dental items 10975-10977. The form can be downloaded from [www.health.gov.au/epc](http://www.health.gov.au/epc) or obtained by calling the Department on (02) 6289 4297.

### **New referrals**

The GP referral remains valid for two consecutive calendar years from the date of the patient's first dental service (eg if the first dental service is on 15 November 2007, the GP referral is valid to 31 December 2008). Where further dental services are required to treat new or existing oral health problems at the end of a patient's two calendar year period, the patient will need to obtain a new referral from their GP.

### **Informing patients about the cost of dental services**

When referring patients for dental services, GPs should inform patients that the dental services may not be bulk billed. Dental practitioners are free to bulk bill or set their own fees for services. In some instances, patients may incur out-of-pocket costs not covered by Medicare.

To assist patients in understanding the cost of dental treatment, dental practitioners are required to provide a written quote or cost estimate to the patient prior to commencing a course of treatment.

### **Reporting by the dental practitioner to the GP**

Dental practitioners must provide a copy or summary of the patient's treatment plan to the referring GP at the commencement of the course of treatment.

### **Cessation of EPC dental items 10975-10977**

The EPC dental items 10975-10977 will remain in place until 31 December 2007 to enable patients to complete treatment they have already commenced under these items (if they wish). Existing patients can also receive dental services under the new dental items from 1 November 2007, as long as they have a new referral from their GP.

# Immunisation provided by a practice nurse

Immunisation provided to a person by a practice nurse: if

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

Item Number

10993

## Pap Smear Service provided by a practice nurse

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

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

Item 10998 only applies where:

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

Item 10999 applies where:

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

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See Also SIP Payment Information on Page 2.

## Pap Smear Service and Preventive Checks provided by a practice nurse

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

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

Item 10994 only applies where:

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

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

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

And may also include:

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

Item 10995 applies where:

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

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See Also SIP Payment Information on Page 2.

## Service provided to a person with a chronic disease by a practice nurse

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

- the service is provided on behalf of and under the supervision of a medical practitioner; and
- the person is not an admitted patient of a hospital; and
- the person has a GP Management Plan, Team Care Arrangements or Multidisciplinary Care Plan in place; and
- the service is consistent with the GP Management Plan, Team Care Arrangements or Multidisciplinary Care Plan

to a maximum of 5 services per patient in a calendar year.

Item 10997 may be used to provide:

- checks on clinical progress;
- monitoring medication compliance;
- self management advice, and;
- collection of information to support GP reviews of Care Plans.

The services provided by the practice nurse or Aboriginal Health Worker should be consistent with the scope of the GP Management Plan, Team Care Arrangements, or Multidisciplinary Care Plan.

Item 10997 may only be accessed by a patient with a GP Management Plan, Team Care Arrangements or Multidisciplinary Care Plan (items 721, 723, 725, 727, 729, 731).

**Item Number**

**10997**

## Wound management services provided by a practice nurse

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

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

**Item Number**

**10996**

# Medicare Plus – Bulk Billing Children and Concessional Patients

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

## GPs working in Rural and Remote Locations (RRMA 3-7)

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

**Item 64991**— to be used where a medical practitioner provides an unreferral diagnostic imaging service under the MBS.

**Item 74991**— to be used where a medical practitioner provides an unreferral pathology service under the MBS.

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

## Incentives

Region	MBS Item Number
Rural/remote	10991
	64991
	74991

# Eligible MBS items

Eligible services are those provided to aged care residents in Commonwealth-funded RACFs and Multipurpose Services.

MBS items that count towards QSLs include attendances in RACFs, Comprehensive Medical Assessments, contributions to Care Plans, Case Conferences, and Residential Medication Management Reviews.

Further enquiries about the GP Incentive can be directed to the PIP enquiry line on 1800 222 032.