Australian Government
Cancer Australia

CanNet
Cancer Service Networks
National Demonstration Program
Linking regional and metropolitan cancer services for better cancer outcomes

Medicare items—

helping you deliver comprehensive cancer care

PREVENTION, SCREENING AND EARLY DIAGNOSIS

HEALTH ASSESSMENTS

At least 75 years of age annual health check: item numbers 700 & 702 (home visit) and
Annual check for Indigenous Australians 55 years of age and over: item numbers 704 & 706 (home visit)

Purpose: to assist with prevention and detection of chronic disease[1] including cancer.

Eligible population: those 75 years and over for non-Indigenous Australians and Indigenous Australians 55 years and over.

Requirements: assessment should be performed by patient's usual doctor and must include assessment of BP, PR, rhythm, medications, continence, immunisation status, physical function and falls, psychological and social functioning. Record must be kept and offered to patient with recommendations.

Limits: annual, not inpatients or aged care residents (other item numbers apply to them).

45 year old health check: item number 717

Purpose: to identify chronic diseases early, including cancer.

Eligible population: those between 45 and 49 years of age (inclusive) who are at risk[2] of developing a chronic disease.

Requirements: patient history, examination and investigations as required, overall assessment and intervention as indicated, provide advice and information to patient.

Limits: Medicare rebate payable only once- not an annual health check; not available for inpatients, GPs eligible (not specialists), expected to be performed by patient's usual doctor.

Indigenous Australians child health check: item number 708 and **adult health check: item number 710**

Purpose: to provide optimum care, early diagnosis and intervention and an opportunity for preventive health care, education and assistance in common and treatable conditions including cancer in Indigenous Australians.

Eligible population: Indigenous Australians between 15 and 54 years of age (inclusive) and Indigenous children aged <15 years.

Requirements: assessment of health and physical, psychological and social functioning.

Limits: expected to be performed by patient's usual doctor, not applicable to inpatients.

SCREENING

Cervical screening incentives: item numbers 2497, 2501, 2503, 2504, 2506, 2507, 2509, 2598, 2600, 2603, 2606, 2610, 2613, 2616 & 10995 & 10999

Purpose: to encourage PAP screening of under- or un-screened women.

Eligible population: women between 20-69 years of age inclusive, who have had intercourse, have a cervix and who have not had a PAP smear in the last 4 years.

Requirements: GPs in practices participating in the Practice Incentive Program (PIP) who have signed onto the PIP Cervical Screening Incentive.

Limits: none.

Cervical smears provided by a practice nurse: item numbers 10994 & 10998

Purpose: for cervical smear and preventive checks and cervical smear, respectively, provided by a practice nurse on behalf of a GP.

Eligible population: all women who have a cervix.

Requirements: the practice nurse must be a registered nurse or an enrolled nurse who is employed by, or whose services are otherwise retained by, a general practice. The practice nurse must be appropriately qualified and trained to take cervical smears and other preventive checks. These requirements also apply to items 10995 and 10999 which are included in the series of items listed above.

Limits: None

DISCLAIMER: Practitioners are advised that:

- before itemising an account for a MBS service, they should check the item descriptor and explanatory notes to ensure that the service has been properly rendered (i.e. that they have met all the requirements for billing for the service); and
- MBS rebates are only payable for 'clinically relevant' services (i.e. services that are generally accepted in the medical profession as being necessary for the appropriate treatment of the patients to whom they are rendered).

AFTER DIAGNOSIS, DURING AND AFTER TREATMENT

MENTAL HEALTH SUPPORT

GP Mental Health Care Plan, Review and Consultation: item numbers 2710, 2712 & 2713

Purpose: to support the early intervention, assessment and management of patients with mental disorders. These items may provide access to certain Medicare rebates for psychologists and allied mental health providers.

Eligible population: community, private in-patients (where GP is providing inpatient care).

Requirements: all of these services require the GP to obtain and record the patient's agreement for service.

A GP Mental Health Care Plan (GPMHCP) (2710) must also:

- record the patient's relevant history
- conduct a mental state examination
- assess associated risk of any co-morbidity
- make a diagnosis and/or formulation
- administer an outcome measurement tool (except where considered clinically inappropriate).

A GPMHCP Review (2712) must also:

- assess and manage the patient's progress against the plan's goals
- modify the GPMHCP, if required
- check, reinforce and expand education
- plan for crisis intervention, if required and not previously developed
- re-administering the outcome tool (except where considered clinically inappropriate).

A GP Mental Health Care Consultation (2713) must:

- record the patient's relevant history
- provide treatment/advice and/or referral for other services or treatment
- document outcomes of the consultation in the patient's medical records.

These consultations must be at least 20 minutes in duration.

Limits: a new GPMHCP (2710) should not be prepared unless clinically required, and not generally within 12 months of a previous plan. Reviews (2712) are recommended within 4-6 months of initiation of plan, a further review can occur 3 months later, if required. Most patients should not require more than 2 reviews over a 12 month period. A rebate for a GPMHCP will not be paid within 12 months for a claim of the same item.

Family group therapy by medical practitioner other than consultant psychiatrist: item numbers 170, 171 & 172

Purpose: to improve family function and communication.

Eligible population: group therapy supervised by medical practitioner other than psychiatrist.

Requirements: formal intervention with specific outcome involving groups of 2, 3 or 4 close relatives or persons with close relationship, duration not less than 1 hour.

Limits: one fee applies for each group.

MEDICATION MANAGEMENT REVIEWS

Domiciliary Medication Management Review (DMMR): item number 900 and Residential Medication Management Review (RMMR): item number 903

Purpose: targeted at patients who are likely to benefit, those at risk of medication misadventure or who have experienced adverse medication related events.

Eligible population: patients may be eligible for this item if they have difficulty managing their own medications, if their medications are complex, if there have been significant changes to their medications or if the patient has experienced adverse drug reactions.

Requirements: generally undertaken by patient's usual GP. The GP must assess whether the service is clinically necessary. The patient's or resident's informed consent must be obtained before commencement of these services.

For a DMMR, the GP must:

- refer to a community pharmacy to participate in the review
- discuss the review findings and report including suggested medication management strategies with the reviewing pharmacist
- develop a written medication management plan following a discussion with the patient
- provide a copy of the plan to the patient and to the patient's medical records.

For a RMMR, the GP must:

- collaborate with the reviewing pharmacist regarding the pharmacy component of the review
- provide input from the resident's Comprehensive Medical Assessment (CMA) or relevant clinical information
- participate in a post review discussion
- develop and/or revise the resident's Medication Management Plan (after discussing with the pharmacist and the resident)
- offer a copy of the plan to the resident and to the aged care facility
- discuss the plan with the nursing staff (if necessary).

Limits: DMMRs (900) are not available to in-patients of a hospital or residents of aged care facilities. RMMRs (903) are only available to residents of aged care facilities. Medicare benefits for DMMRs and RMMRs are not payable within 12 months of the same service, except where there has been significant change to a patient's condition or medication regimen requiring a new DMMR.

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- MBS rebates are only payable for 'clinically relevant' services (i.e. services that are generally accepted in the medical profession as being necessary for the appropriate treatment of the patients to whom they are rendered).

CASE CONFERENCES

Cancer Case Conference: item numbers 871 & 872

Purpose: to develop a cancer treatment plan in a multidisciplinary team meeting.

Eligible population: patients with cancer excluding non-melanoma skin cancer, including private inpatients.

Requirements: all treating doctors eligible but only the leading and coordinating doctor may bill item number 871. Other clinicians participating may bill item number 872. Participants must be in communication throughout the case conference.

Limits: generally 2 per year, non-treating attending clinicians and allied health providers are not remunerated.

Case Conferences (GP items): Outpatients: item numbers 740, 742, 744, 759, 762 & 765; Discharge of private inpatients: item numbers 746, 749, 757, 768, 771 & 773; Aged care residents: item numbers 734, 736, 738, 775, 778 & 779

Purpose: to improve care of patients with complex medical conditions by providing coordinated care plans.

Eligible population: patients must have at least one medical condition that has been (or is likely to be) present for at least 6 months, or that is terminal.

Requirements: these items should be provided by the patient's usual medical practitioner. The case conferencing team must consist of the medical practitioner and at least 2 other health or care providers (not counting the patient's carer), each of whom provides a different kind of ongoing care or service to the patient, and one of whom may be another medical practitioner (usually specialist or consultant). The minimum 3 team members must be present for the whole case conference. The patient or resident's informed consent must be obtained before commencement of these services.

A case conference team must:

- discuss a patient's history
- identify multidisciplinary care needs
- identify outcomes to be achieved by the team members
- identify the tasks to be undertaken by the team members to achieve these outcomes
- assess if previously identified outcomes (if any) have been achieved

A record of the case conference must be kept on the patient's medical file.

Limits: a case conference must be arranged in advance to allow for all participants to attend. A benefit is not payable until all elements of the case conference have been provided. It is expected a patient would not normally require more than 5 case conferences in a 12 month period.

Consultant physician case conference: item numbers 820–838

Case conference organised or participated in by consultant physician, and 3 additional care providers; the patient's usual GP is the only other medical practitioner who can be included amongst the 4.

Patient's prior informed consent required. Maximum of 2 may be remunerated including patient's usual GP.

CHRONIC DISEASE MANAGEMENT

Preparation and review of GP Management Plan (GPMP): item numbers 721 & 725

Purpose: to provide a structured approach to managing chronic or terminal medical conditions by the patient's usual GP.

Eligible population: patient with at least one chronic or terminal medical condition

Requirements: these items require a personal attendance of the GP with the patient. The GP must explain to the patient (and the patient's carer where applicable) the steps involved in providing the service along with any likely out-of-pocket costs to the patient for the involvement of other care providers. The GP must also ensure the patient's agreement to proceed is recorded.

A GPMP must include:

- obtaining informed patient consent
- assessing (or reviewing for item 725) and documenting patient's needs
- agreeing management goals with the patient
- identifying patient actions
- identifying the treatment/services required by the patient
- documenting each of these and a review date in a comprehensive written plan.

Limits: the recommended frequency for a GPMP (721) is 2 yearly with a minimal claiming interval of 12 months. The recommend frequency of GPMP reviews (725) is once every 6 months with a minimal claiming interval of 3 months. These items are not available to public in-patients or residents of aged care facilities except where they are private in-patients being discharged from hospital.

Coordination, development of, and review of, Team Care Arrangements (TCA): item numbers 723 & 727

Purpose: to support the GP coordination of care to patients with chronic (or terminal) medical condition(s) and complex care needs. This item, when in addition to a GPMP, may provide access to Medicare rebates for certain allied health services.

Eligible population: patients with a chronic (or terminal) medical condition AND who require ongoing care from a multidisciplinary team consisting of their GP and at least 2 other health or care providers, one of whom may be a medical specialist but not usually another GP.

Requirements: these items require a personal attendance of the GP with the patient. The GP must also explain to the patient (and the patient's carer where applicable) the steps involved in providing the service along with any likely out-of-pocket costs to the patient for the involvement of other care providers. The GP must also ensure the patient's agreement to proceed is recorded. Each of the health or care providers involved in the TCA must provide a different kind of ongoing care to the patient. These team members must also collaborate with the GP and the patient in the development and review of the TCA.

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Communication between the GP and participating care providers must be based on two-way communication, preferably oral.

A TCA must include:

- discussing with the patient which treatment/services providers should be asked to collaborate with the GP in completing the TCA
- gaining the patients agreement to share relevant information about their medical history, diagnoses, GPMP etc with the proposed providers
- contacting the proposed providers and obtaining their agreement to participate
- collaborating with the participating providers to discuss the potential treatment/services they will need to provide to achieve the management goals for the patient
- documentation of the goals, participating providers, treatments/ services agreed upon, any actions to be taken by the patient and a review date
- providing the relevant parts of the TCA to the collaborating providers and any other person involved in providing care to the patient within the TCA.

Limits: a new TCA (item 723) may be required once every 2 years, depending on the patient's needs. TCA reviews (727) are recommended once every 6 months. The minimum claiming interval for development of TCA is 12 months (3 months for review). These items are not available to public in-patients or residents of aged care facilities except where they are private in-patients being discharged from hospital.

Contribution to or review of a Multidisciplinary Care Plan: item number 729 and contribution to or review of a Multidisciplinary Care Plan for a patient who is a resident of an aged care facility: item number 731

Purpose: to support GP contribution to a multidisciplinary care plan prepared by another health care provider (i.e. other than their usual GP). Other health or care providers include (but are not limited to) allied health providers, medical specialists or home or community service providers.

Eligible population: item number 729 is available to both public and private inpatients and those in the community but not residents in an aged care facility. Item 731 is available to residents of an aged care facility only.

Requirements: the GP must explain the steps involved in providing the service to the patient (and the patient's carer where applicable) along with any likely out-of-pocket costs to the patient for the involvement of other care providers and must also ensure the patient's agreement to proceed is recorded.

Contribution must include:

- obtaining patient's agreement for GP to contribute to care plan and to share relevant information with the other care providers
- collaborating with the person preparing plan to set goals and specify the treatment/services to be provided by the GP
- recording the GP's contribution in the patient notes.

Limits: The recommended frequency of this item is once every 6 months. A rebate will not be paid within 12 months of a GPMP or TCA claimed by the same practitioner or within 3 months of a claim for same item or other CDM review or contribution items.

NOTE: This item number remunerates the GP's involvement in the development or review of a multidisciplinary care plan developed by another care provider such as an oncologist.

SURVIVORSHIP (including long term follow up) AND RECURRENT DISEASE

Health assessments, MH, GPMP, TCA, case conferences and Medication Management Reviews if applicable.

PALLIATIVE CARE

MH, GPMP, TCA, case conferences and Medication Management Reviews may be used if clinically appropriate. Palliative care item numbers can only be used for patients referred to consultant physicians or specialists in palliative care.

(Endnotes)

1. A chronic disease 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, Medicare Benefits Schedule, 1 Nov 2007, para A30.43 p62. It is at the discretion of the treating GP whether a particular cancer in any individual patient constitutes a chronic condition.
2. "At risk" a specific risk factor must be identified; may be lifestyle, biomedical or family history.

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- MBS rebates are only payable for 'clinically relevant' services (i.e. services that are generally accepted in the medical profession as being necessary for the appropriate treatment of the patients to whom they are rendered).