# Chronic Disease Management & MBS Item Numbers

## July 2022



*Wentworth Healthcare Limited (ABN 88 155 904 975) provider of the Nepean Blue Mountains PHN.* 30/07/2022

ACKNOWLEDGEMENTS:

Wentworth Healthcare acknowledges and thanks the organisations that contributed to the content used in this Desktop Guide. They include PHNs, former Divisions of General Practice and Medicare Locals, National Peak Organisations and Commonwealth Agencies.

INTRODUCTION:

This Desktop Guide is intended as a resource to assist General Practice staff to effectively coordinate care for their patients with chronic conditions. It provides comprehensive information regarding the MBS items relevant to the management of chronic diseases and other conditions commonly treated in general practice. For current and comprehensive information about each MBS item number, please refer to the Medicare Benefits Schedule at MBS Online. MBS Online is frequently updated as changes to the MBS occur.

FEEDBACK/COMMENTS:

If you have any enquiries or would like to provide feedback or comments regarding information provided in this Guide, please contact the General Practice Support Team.

P: 02 4708 8100

DISCLAIMER: whilst every effort has been made to ensure that the information included in this Desktop 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 current information.

CONTACT DETAILS:

Wentworth Healthcare
Werrington Park Corporate Centre, Level 1, Suite 1
14 Great Western Highway
Kingswood NSW 2747

P: 02 4708 8100

E: reception@nbmphn.com.au

W: www.nbmphn.com.au

# Table of Contents

# Chronic Disease Management

## Chronic Disease Overview

Our current health system is not optimally set up to effectively manage long term conditions. Increased and poorly targeted service use is resulting in variable patient outcomes and significant financial impacts across the entire health system. While not all hospital presentations for chronic or other conditions can be prevented through primary health interventions, it may be possible to prevent many.

- In 2017-18, Chronic conditions accounted for 46% of the 748000 potentially preventable hospitalisations in Australia. Of this 50% were for chronic conditions such as congestive cardiac failure, chronic obstructive pulmonary disease (COPD) and type 2 diabetes (AIHW, 2022)
- Nearly a quarter (23%) of people who visited an emergency department felt their care could have been provided by a General Practitioner.

### *Chronic Disease in the Nepean Blue Mountains (NBM) Region*

The NBM region covers almost 9179 square kilometres and aligns with the Nepean Blue Mountains Local Health District. The region encompasses 4 Local Government Areas (LGAs) and has a total population of over 380,000 people. The population is projected to grow by 17.6% by 2036 (Wentworth Healthcare Limited, 2021). By this time the region will have an additional 89 461 residents living in the area.

Chronic disease related hospitalisation rates were higher within the NBM region compared to NSW. COPD was the fourth leading cause of death, accounting for 4.9% of preventable hospitalisations in our region. An estimated 12% of the population within our region have diabetes, 61% of adults are overweight, and approximately 50% of the population do not get enough exercise. These risk factors can result in a compromised state of health and wellbeing in relation to chronic disease, especially among vulnerable population groups and mitigating these risk factors is critical to further support general health and wellbeing within the NBM region. However, 17% of the population with a chronic disease received a GP chronic management plan (2017-2018).

### *Chronic Disease Management Services*

Chronic Disease Management (CDM) services have been established to assist eligible medical practitioners (MPs) such as general practitioners (GPs) and non-vocationally recognised medical practitioners (non-VR MPs) coordinate the necessary care for patients with chronic medical conditions, thus better managing their conditions. The ‘usual’ GP co-ordinates the plan for a patient with chronic diseases and ensures that each member of the multidisciplinary team has contributed to the plan’s development or review. Where chronic conditions are defined as having been present for at least six months and include but not limited to asthma, cancer, diabetes, cardiovascular disease and kidney disease. For further information on Guidelines for Preventive Activities in General Practice (9th Edition) and Putting Prevention into Practice (Third Edition) have been developed to support evidence based preventative activities in primary care.

Please refer to Medicare Benefits Schedule (MBS) Quick Guide 2022 and Non-VR MBS Quick Guide for a list of commonly used MBS Item Numbers in the treatment and management of CDM in general practice. The General Practice MBS Calculator has been developed to provide the potential financial contribution that can be made by the practice in CDM. Click here to download an Excel version of the calculator. For further information on Chronic disease GP Management Plans and Team Care Arrangements, click here. Refer to MBS Online for current information about item numbers.

# Chronic Disease Management and Health Assessments Flowchart

Finding your way through the maze.

If your patient is of **Aboriginal** and/or **Torres Strait Islander** descent…

Do an Aboriginal and Torres Strait Islander Health Assessment **Item 715**.

Utilise **item 109787** for follow-up by PN or ATSI health worker.

If patient has a chronic or terminal illness, initiate a GPMP **item 721** and TCA **item 723** as appropriate.

If your patient has a **chronic condition** that has been or will be in place for six months, or has a **terminal illness**…

Do a GPMP item 721.
Review after 3-6 months using **item 732**.

Utilise **item 10997** for follow-up by PN or ATSI health worker is patient has a GPMP or TCA in place.

If your patient also has complex care needs necessitating the involvement of at least to other health can providers, do a TCA **item 723**.
Review after 3-6 months using **item 732**.

Your patient is eligible to access allied health.

If your patient has **diabetes**…

Commence a Diabetes Cycle of Care.

Initiate a GPMP **item 721** and TCA **item 723** as appropriate.

If your patient has type 2 diabetes and has a GPMP in place, refer for group diabetes education.

If your patient has moderate to severe **asthma**…

Commence an Asthma Cycle of Care and initiate a GPMP and TCA if necessary.

If patient has an additional chronic illness, initiate a GPMP and TCA as appropriate.

Is your patient eligible for any **health assessments**?

If your patient is over 75 years… → Do an over 75 health assessment

If your patient was a serving member of the ADF… → Do an ADF post-discharge GP health assessment.

If your patient is 45-49 years with no diagnosed chronic condition… → Do a 45-49 health check.

If your patient is 40-49 years and at 'high risk' of diabetes… → Do a type 2 diabetes risk evaluation.

If your patient has an intellectual disability... → Do an intellectual disability assessment.

If your patient resides in an RACF… → Do a comprehensive medical assessment.

If your patient is a refugee or humanitarian entrant… → Do a refugee or humanitarian entrant assessment.

If your patient has a **mental health issue**…

Prepare a GP Mental Health Treatment Plan **item 2700** (if no MH skills training) or **item 2715** (if MH skills training) and review with **item 2712**. For ongoing management **item 2713**.

If patient has an additional chronic illness, initiate a GPMP and TCA as appropriate.

Could your patient benefit from a medication **review**?

Organise a **home medication review item 900**.

**Case conferencing**

Organise and coordinate a Case Conference **item 735, 739 or 743**. Participate in a Case Conference **item 747, 750 or 758** with two or more health care providers. Consider contributing to a mutli-disciplinary care plan if requested by another health provider **item 729.**

Brief health assessment of less than 30 minutes **item 701**.

Standard health assessment lasting more than 30 minutes **item 703**.

Long health assessment lasting more than 45 minutes **item 705**.

Prolonged health assessment lasting more than 60 minutes **item 707**.

If your patient resides in an **aged care facility**…

Contribute to RACF Care Plan **item 731**. Review after 3-6 months using **item 731**.

If your patient also has complex care needs necessitating the involvement of at least two other health care professionals…

Your patient is eligible to access allied health.

Could your patient be at high risk of developing type 2 diabetes? Should your patient be referred to a **lifestyle modification program?**

1. If your patient is of Aboriginal and/or Torres Strait Islander descent and aged 15-54 years, do an ATSI Health Assessment – use **ausdrisk** tool
2. If your patient is 45-49 years with no diagnosed chronic condition, do a 45-year health check – use **ausdrisk** tool
3. If your patient is 40-49 years, use **ausdrisk** tool to determine diabetes type 2 risk. If patient is at high risk' do a diabetes type 2 risk evaluation

If your patient is found to be at 'high risk' of developing type 2 diabetes, provide advice and information such as *My Health for Life* program and/or information and strategies to achieve lifestyle and behaviour changes.



*Wentworth Healthcare Limited (ABN 88 155 904 975) provider of the Nepean Blue Mountains PHN.* 30/07/2022

# Preparation of a GP Management Plan (GPMP)

**Item 721**

Ensure patient eligibility

**Develop Plan**

Nurse/Aboriginal Health Worker or Health Practitioner may collect information

**GP must see patient**

Complete relevant activities and documentation

Claim MBS item

Eligibility Criteria

- No age restrictions for patients
- Patients with a chronic (present for or likely to persist 6 months or more) 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 2702/2710) is suggested for patients with a mental health disorder only

Clinical Content

- Explain steps involved in GPMP, possible out of pocket costs and gain patient's consent
- Assess health care needs, health problems, relevant history, and conditions
- Agree on management and patient goals with the patient
- Identify treatments and services required
- Arrangements for providing the treatments and services
- Arrangements for review using item 732 at least once over the life of the plan (12-24 months)

Essential Documentation Requirements

- Record patient's consent to GPMP
- Patients' needs and goals, patient actions and treatments/services required
- Set review date
- Offer copy to patient or carer, keep a copy in patient records

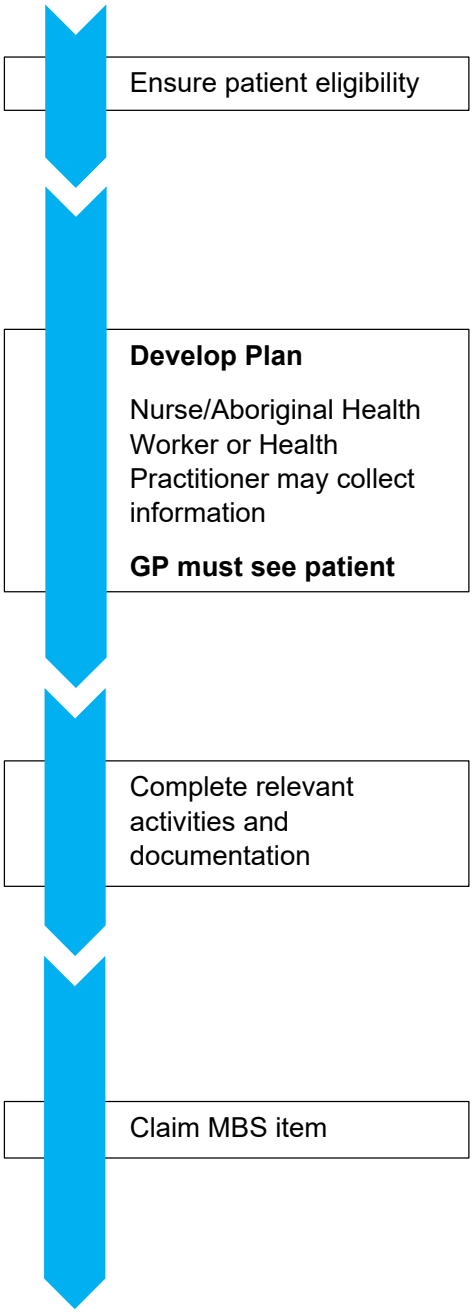
Claiming

- All elements of the service must be completed to claim
- Requires personal attendance by GP
- Review using item 732 at least once during the life of the plan (8 reviews over 24 months, more if clinically indicated)
- MBS item 10991 (bulk billing incentive) may also be claimed for eligible patients

| Item | Name | Recommended Frequency |
|---|---|---|
| 721 | GP Management Plan | Once every two years (min 12 monthly) |

# Coordination of 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 PN, and at least two other healthcare providers
- Not for patients in a hospital or patients in a Residential Aged Care Facility

Clinical Content

- Explain steps involved in TCA, possible out of pocket costs, gain and document patient's consent
- Treatment and service goals for the patient and actions to be taken by the patient
- Discuss with patient which two providers the GP will collaborate with and the treatment/services the two providers will deliver
- Gain patient's agreement on what information will be shared with other providers
- Ideally list all health and care services required by the patient
- Obtain collaborating providers agreement to participate
- Obtain feedback on treatments/services two collaborating providers will administer to achieve patient goals

Essential Documentation Requirements

- Patient's consent to TCA
- Goals, collaborating providers, treatments/services, actions to be taken by patient
- Set review date
- Send copy of relevant parts to collaborating providers
- Offer copy to patient and/or carers, keep copy in patient record

Claiming

- All elements of the service must be completed to claim
- Required 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 five rebated services from allied health during one calendar year
- NB – Indigenous patients, refer to 715 for additional TCA eligibility
- MBS item 10991 (bulk billing incentive) may also be claimed for eligible patients

| Item | Name | Recommended Frequency |
|---|---|---|
| 723 | Team Care Arrangements | Once every two years (min 12 monthly) |

# Reviewing a GPMP and/or TCA

**Item 732**

**GPMP Review**

Nurse/Aboriginal health Worker or Health Practitioner may collect information

GP must see patient

Claim MBS item

**TCA Review**

Nurse/Aboriginal Health Worker or Health Practitioner may collect information

Claim MBS item

**Reviewing a GP Management Plan (GPMP)**

Clinical Content

- Explain steps involved in the review and gain patient consent
- Review all matters in plan

Essential Documentation Requirements

- Record patient's agreement to review
- Make any required amendments to plan
- Set new review date
- Offer copy to patient and/or carers
- Keep copy in patient record

**Revieing a Team Care Arrangement (TCA)**

Clinical Content

- Explain steps involved in the review and gain consent
- Consult with two collaborating providers to review all matters in plan

Essential Documentation Requirements

- Record patient's agreement to review
- Make any required amendments to plan
- Set new review date
- Offer copy to patient and/or carers
- Keep copy in patient record
- Send copy of relevant amendments of TCA to collaborating providers

Claiming of GPMP and TCA Review

- 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 three months of a GPMP (721) except where there are exceptional circumstances arising from a significant change in the patient's clinical condition, in this case the Medicare claim should be annotated as to why the service was required earlier
- Item 732 can be claimed twice on the same day is review of both GPMP and TCA are completed. Medicare claim should be annotated "Review of GPMP" for one item number and "Review of TCA" for the other item number
- MBS item 10991 (bulk billing incentive) may also be claimed for eligible patients

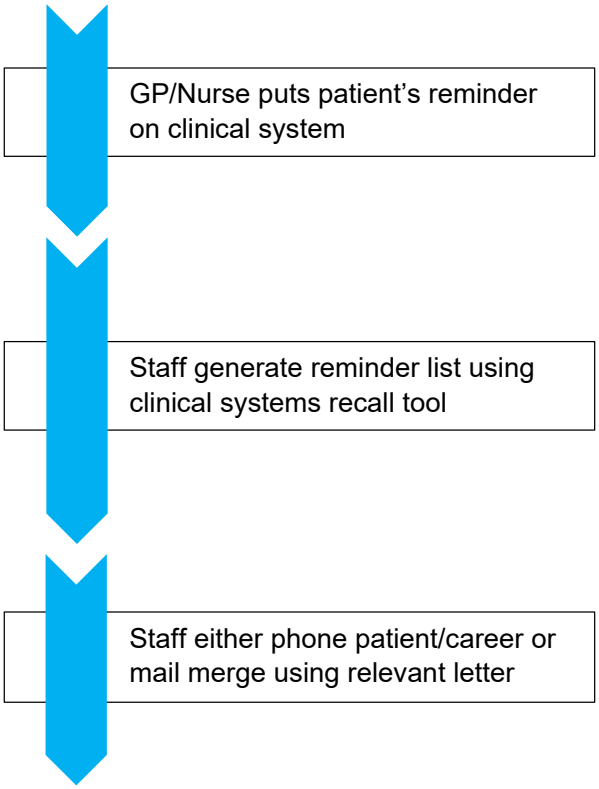
| Item | Name | Recommended Frequency |
|---|---|---|
| 732 | Review of GP Management and/or Team Care | Bi-annually (minimum three monthly) |

# Recall and Reminder Systems

Reminders are used to initiate a prevention activity, before or during the patient visit. They can be either opportunistic or proactive. Recalls are a proactive follow up to a preventative or clinical activity.

Prompts are usually computer generated through clinical information systems and designed to opportunistically draw attention during the consultation to a prevention or clinical activity needed by the patient. Using a recall system can seem complex, but there are three steps that can be taken:

- Be clear about when and how you want to use these flags.
- Explore systems used by other practices and those endorsed by information technology specialists to ensure you get the correct system.
- Identify all the people who need to be recalled and place them in a practice register. This will help to ensure that the recall process is both systematic and complete.



# Practice Nurses and Chronic Disease Management

## Workforce Incentive Program Practice Stream

The Workforce Incentive Program (WIP) provides targeted financial incentives to encourage doctors to deliver services in rural and remote areas. The WIP also provides financial incentives to support general practitioners to engage the services of nurses, Aboriginal and Torres Strait Islander Health Practitioners and Health Workers, and eligible allied health professionals.

Some areas of the NBM region are classified as rural so this stream of the WIP is available to some GPs in the region.

From early 2020, general practices participating in the Practice Nurse Incentive Program (PNIP) automatically transitioned to the WIP. An up-to-date rural classification system is used to ensure metropolitan areas are no longer able to access incentives intended for rural and remote Australia.

*WIP – Practice Stream*
Practice in all locations may be eligible for incentives to support the engagement of nurses, allied health professionals, and Aboriginal and Torres Strait Islander Health Practitioners or Health Workers. The WIP will expand eligibility for allied health to all areas of Australia and include pharmacists (non-dispensing role) and Nurse Practitioners to support increased team-based care arrangements. Practices will need to consider the needs of their community when determining which health professionals or combination of health professionals to engage.

### Patient and claiming eligibility

*Care Plan preparation*
Practice nurses as defined either as a registered or enrolled nurse may assist and deliver some services either under the supervision of or on behalf of the GP in the preparation of a GPMP (item 721) or TCA (Item 723). This includes in patient assessment, identification of patient needs and making arrangements for services. The GP must meet all regulatory requirements, personally attend the patient, review, and confirm all elements of assistance provided on their behalf before claiming the relevant item/s.

*Care Plan Monitoring*
Patients being managed under a GPMP/TCA may receive ongoing support and monitoring from practice nurses, up to five times per year, on behalf of the GP who prepared the plan. MBS nurse item 10997 applies. Item 10997 may not be claimed in the development of a GPMP and can only be claimed where your patient already has an existing GPMP, TCA or multidisciplinary care plan in place. Here, the GP is not required to see the patient or be present with the practice nurse when the chronic disease monitoring and support is undertaken. It is up to the GP to decide whether they need to see the patient, and where a consultation with the patient occurs, the GP is entitled to claim a Medicare item for the time and complexity of their personal attendance on the patient. Please refer to explanatory note MN. 12.4 for more information.

GPs and nurses should read the relevant MBS items before providing a primary care service: see MBS Online and MBS Education for Health Professionals.

### *Diabetes*

It is not necessary for a doctor to perform each step for the Diabetes Cycle of Care. For example, a doctor may assess a patient's condition, monitor, and prescribe relevant medications. An appropriately trained and skilled practice nurse, under GP supervision, can undertake checks such as blood pressure, BMI, feet examination and review the patient's diet and exercise. The nurse will then report back to the doctor who must note that the elements of the annual diabetes care have been provided.

### *Asthma*

A GP is expected to provide the majority of care for the Asthma Cycle of Care, however, under doctor's supervision, an appropriately skilled practice nurse can be utilised to measure vital signs, assess the patient's health care needs, provide information and reinforce key messages on asthma education, ensure the patient's record is up to date including medications, and undertake spirometry or peak flow testing.

### *Cervical Screening*

A practice nurse can take a cervical smear if they have undertaken appropriate training. The doctor should review the pathology results. The service can be covered by WIP funding along, or the GP can see the patient at the conclusion of the test and claim for the length of time that the GP saw the patient.

### *Health Assessments*

A suitably qualified practice nurse can assist the GP to conduct an annual health assessment for a patient over 75 years, a chronic disease 45–49-year check, a 40–49-year diabetes evaluation, or a Comprehensive Medical Assessment for a patient in Residential Aged Care. The nurse can collect information for the assessment, provide lifestyle advice and education, as well as facilitate appropriate referral pathways inclusive of a multidisciplinary team. Such assistance must be provided in accordance with accepted medical practice and under the supervision of the GP.  MBS items 701-707 apply (time-based). Item number 699 is not time based.

The MBS item 10987 can also be claimed by the practice nurse for health assessment follow up for ATSI People who have received a health assessment, including a 715 for up to 10 times per patient per calendar year. Please refer to Practice Nurse Items for more information.

### *Mental Health*

A GP Mental Health Treatment Plan can only be provided by a GP registered with Medicare Australia; a practice nurse does not take part in delivery of this service.

# Practice Nurse Activity – Item Number Income Estimator

The Practice Nurse item number calculator (reproduced in this guide) provides information regarding the financial contribution practice nurses can make when involved in providing care for patients with common chronic conditions. This calculator can be downloaded from our website.

## PRACTICE NURSE ITEM NUMBER CALCULATOR

phn NEPEAN BLUE MOUNTAINS
An Australian Government Initiative

| Item | Activity | MBS No. | No. of Services | MBS Fee | Income Generated |
|---|---|---|---|---|---|
| Health Assessmnets | Diabetes Risk (40-49 year olds) | 701 (brief) | | $62.75 | $0.00 |
| | | 703 (standard) | | $145.80 | $0.00 |
| | | 705 (long) | | $201.15 | $0.00 |
| | | 707 (prolonged) | | $284.20 | $0.00 |
| | 45 - 49 Year Old Health Check | 701 (brief) | | $62.75 | $0.00 |
| | | 703 (standard) | | $145.80 | $0.00 |
| | | 705 (long) | | $201.15 | $0.00 |
| | | 707 (prolonged) | | $284.20 | $0.00 |
| | 75 + Years | 701 (brief) | | $62.75 | $0.00 |
| | | 703 (standard) | | $145.80 | $0.00 |
| | | 705 (long) | | $201.15 | $0.00 |
| | | 707 (prolonged) | | $284.20 | $0.00 |
| | Indigneous Health Assessment | 715 | | $224.40 | $0.00 |
| | ATSI Follow Up with Nurse | 10987 | | $25.35 | $0.00 |
| | Heart Health Assessment | 699 | | $76.95 | $0.00 |
| Chronic Disese Management | GP Management Plan | 721 | | $152.50 | $0.00 |
| | Team Care Arrangement | 723 | | $120.85 | $0.00 |
| | GPMP Review | 732 | | $76.15 | $0.00 |
| | TCA Review | 732 | | $76.15 | $0.00 |
| | Nurse Contribution to GPMP/TCA | 10997 | | $12.70 | $0.00 |
| | DMMR | 900 | | $163.70 | $0.00 |
| Mental Health | GPMHP without Mental Health Skill Trainin | 2700 (20-39 min) | | $75.80 | $0.00 |
| | | 2701 (> 40 min) | | $111.60 | $0.00 |
| | GPMHP with Mental Health Skill Training | 2715 (20-39 min) | | $96.25 | $0.00 |
| | | 2717 (> 40 min) | | $141.80 | $0.00 |
| | GPMHP Review | 2712 | | $75.80 | $0.00 |
| | Mental Health Consult > 20 minutes | 2713 | | $75.80 | $0.00 |
| Eating Disorders | EDTP without Mental Health Skill Training | 90250 (20-39 min) | | $75.80 | $0.00 |
| | | 90251 (> 40 min) | | $111.60 | $0.00 |
| | EDTP with Mental Health Skill Training | 90252 (20-39 min) | | $96.25 | $0.00 |
| | | 90243 (> 40 min) | | $141.80 | $0.00 |
| | EDTP Review | 90264 | | $75.80 | $0.00 |
| Women's Health | Antenatal Attendance | 16500 | | $49.85 | $0.00 |
| | Administration of hormone implant | 14206 | | $37.65 | $0.00 |
| | Removal of hormone implant | 30062 | | $64.20 | $0.00 |
| | Insertion of IUD | 35503 | | $84.75 | $0.00 |
| | Urine pregnancy test | 73806 | | $10.15 | $0.00 |
| | Cervical Screen not done in 4 years | 2497 | | $17.90 | $0.00 |
| Other Serivces | ECG | 11707 | | $19.45 | $0.00 |
| | Spirometry - Diagnosis | 11505 | | $43.50 | $0.00 |
| | Spirometry - Monitor | 11506 | | $21.75 | $0.00 |
| | | | | Total | $0.00 |

# Cycles of Care

## Cycles of Care for Patients with Established Diabetes Mellitus

The aim of the Diabetes Cycle of Care is to enhance prevention, diagnosis, and management of people with diabetes. The GP is the coordinator of the patient care who ensures that all aspects of the Annual Cycle of Care are completed.

*Patient Register/Recall and Reminder System*
Recall system must include:

- A list of all known patients who have diabetes attending the practice, by name, contact number and file number.
- An active patient recall/reminder system, electronic or paper based.

*New MBS Pathology Item for Diagnostic HbA1c*
Medicare Benefits Schedule (MBS) pathology item 66841 was introduced on 1 November 2014:

- Quantitation of HbA1c (glycated haemoglobin) performed for the diagnosis of diabetes in asymptomatic patients at high risk.

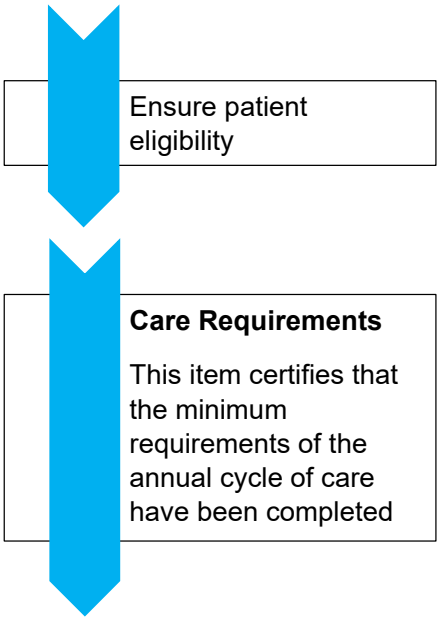
When a patient is unlikely to do an OGTT or is reluctant to fast, GPs now have the option of ordering HbA1c as a screening tool.

- If the HbA1c is within normal limits no further testing is required.
- If the HbA1c is ≥ 48 mmol/mol (6.5%) diabetes is likely.

The RACGP recommends two tests on separate occasions before a diagnosis is confirmed, however, under item 66841 each patient is entitled to only one Medicare-funded HbA1c diagnostic test in a 12-month period [Rule p12.1, 25.c applies]. Therefore, confirm the diagnosis either by ordering the second HbA1c test as 'management' of a patient with diabetes* or by ordering a Fasting Blood Glucose (FBG) or Oral Glucose Tolerance Test (OGTT).

- Path items 66551 (or 66554 if patient is pregnant) can be claimed up to 4 times in a 12-month period by the same patient.
- For diagnostic purposes this must be notated on the pathology request form.

**Note:** All visits should be billed under the normal attendance items with the exception of the visit that completes all the minimum requirements of the Diabetes Cycle of Care. These MBS specific diabetes item numbers (2517 – 2526) are to be used once all components of the diabetes annual cycle of care are completed.




Eligibility Criteria

- No age restriction for patients
- Patients with established diabetes mellitus
- For patients in the community and Residential Aged Care Facilities

Essential Clinical Documentation Requirements

- Explain Annual Cycle of Care process, gain and record patient's consent

Essential Requirements

Six Monthly

- Measure height, weight and calculate BMI, waist circumference
- Measure BP
- Foot assessment (high risk: every 1 – 3months, low risk: yearly)

Yearly

- Measure HbA1c, total cholesterol, triglycerides, and HDL cholesterol and eGFR
- Test for micro albuminuria
- Provide patient education regarding diabetes management including self-care education
- Review diet and levels of physical activity – reinforce information about appropriate dietary choices and levels of physical activity
- Check smoking status – encourage smoking cessation
- Review medication – consider Home Medicine Review

Two yearly

- Comprehensive eye examination by ophthalmologist or optometrist to detect and prevent complications – requires dilation of pupils

All elements of the Cycle of Care should be completed every 12 months. Completion item numbers below.

| Item | Name | Frequency | Rebate |
|---|---|---|---|
| 2517 | Diabetes: Level B Standard Consult | 11 – 13 monthly | + Level B |
| 2521 | Diabetes: Level C Long Consult | | + Level C |
| 2525 | Diabetes: Level D Prolonged Consult | | + Level D |

MBS Item 10991 (bulk billing incentive) may also be claimed for eligible patients.

*Patient education*

A range of Diabetes-related information for patients is available at The National Diabetes Services Scheme – About Diabetes page.

## Asthma Annual Cycle of Care

*Patient Eligibility*

Patients must have moderate to severe asthma:

- Frequency of episodes
- Frequency of use of medication
- Bronchodilator use > three times per week
- Hospital attendance following acute attack

*Completion of the Asthma Cycle of Care*

- The patient is required to attend two asthma-related consultations; one visit is opportunistic and is to be recorded, and the second visit is a planned visit for the asthma action plan to be completed.
- Consultations are attended at a minimum over a four-week period and not greater than 12 months for the cycle to be complete.

The visits must include:

- Diagnosis and assessment of severity
- Review of medication
- Written asthma action plan and education of the patient

Two Step Asthma Visit Example

**Visit 1:**

This visit is best attended as an opportunistic visit. The clinician assesses the patient's asthma severity and knowledge of their condition. Questions that are commonly asked include:

- How do you feel your asthma is currently managed?
- How often do you take your preventative or reliever medications?
- What conditions trigger your asthma symptoms?
- Do you suffer from a persistent cough?
- Do your asthma symptoms prevent you from participating in any activities?
- Do your asthma symptoms cause you to wake up at night?

The patient can be encouraged to keep a symptom diary for review at next visit. This visit is recorded in the patient's file and the patient is then invited to return for a thorough assessment and development of an Asthma Action Plan.

**Visit 2:**

The patient is booked in for a 30–40-minute visit and is advised to come to the visit having avoided any asthma-related medications on the day prior to the visit.

- A pre and post peak-flow or spirometry is attended. This is a system to both monitor lung function and to assess medication delivery technique. The patient is educated and supported in relation to medication delivery and the best techniques to maximize effectiveness of the medications.
- Review of symptom diary from visit 1.
- GP review peak-flow or spirometry results.
- Asthma Action Plan completed using the clinical software program. The action plan must be in written format and the patient must be supplied with a copy of the action plan.
- Plan is signed off by GP.

New Patient:

- Ascertain status, including history, medication, and management.

Existing Patient:

- Assess present situation, including review of medical records and consolidation/collection of information on history, medication, and management.

Asthma may be treated in General Practice using either the Asthma Cycle of Care or the GPMP. Both schemes should not be claimed in the same 12 months for the patient due to overlap in the two services. If, however, the patient has other chronic health conditions or complex care needs requiring a GPMP and TCA this can be attended in addition to the Asthma Cycle of Care. The two cannot be billed with less than three months interval between claims. Refer to MBS Online for further information.

Ensure patient eligibility

**Note**

A specialist consultation does not constitute one of the two visits – both must be with the same GP or in exceptional circumstances with another GP from the same practice.

Eligibility Criteria

- No age restrictions for patients
- Patients with moderate to severe asthma
- Available to patients in the community and in Residential Aged Care Facilitates

Essential Requirements

- At least two asthma consultations within 12 months
- One of the consultations must be for a Review
- Review must be planned during previous consultation

Clinical Content

- Explain Cycle of Care process and gain patient's consent
- Diagnosis and assessment of level of asthma related medication and devices
- Give patient written Asthma Action Plan (if the patient is unable to use a written Asthma Action Plan, discussion with the patient about an alternative method of providing an Asthma Action Plan)
- Provide patient self-management education
- Review of written or documented Asthma Action Plan

Essential Documentation Requirements

- Record patient's consent to Cycle of Care
- Document diagnosis and assessment of level of asthma control and severity
- Include documentation of the above requirements and clinical content in the patient file, including clinical content of the patient held written Asthma Action Plan

| Item | Name | Frequency | Rebate |
|---|---|---|---|
| 2546 | Asthma: Level B Standard Consult | 12 monthly | + Level B |
| 2552 | Asthma: Level C Long Consult | | + Level C |
| 2558 | Asthma: Level D Prolonged Consult | | + Level D |

MBS item 10991 (bulk billing incentive) may also be claimed for eligible patients

# Multidisciplinary Case Conferences

Patients with a chronic or terminal medication condition and complex care needs requiring care or services from their usual GP and at least two other health or care providers are eligible for a case conference service. There is no list of eligible conditions, however, the CDM items are designed for patients who require a structured approach and to enable GPs to plan and coordinate the care of patients with complex conditions requiring ongoing care from a multidisciplinary team.

Case conferences can be undertaken for patients in the community, for patients being discharge into the community from hospital and for people living in Residential Aged Care Facilitates.

*When are patients most likely to benefit from a Case Conference?*

- When there is a need to develop immediate solutions in response to a recent change in the patient's condition or circumstances, e.g., death of a carer or unexpected event such as a stroke.
- To facilitate ongoing management such as sharing of information to develop or communicate goals for patient care or define relevant provider contributions to care.

*How can a GP be involved in a Case Conference?*

Prepare and co-ordinate a case conference

- For patients living in the community
- For private patients on discharge from hospital
- For patients in a Residential Aged Care Facility; not those receiving nursing home level care

Participate in a case conference

- For patients living in the community
- For public or private patients on discharge from hospital
- For patients in a Residential Aged Care Facility; not those receiving nursing home level care

A case conference can occur face-to-face, by phone or by video conference, or through a combination of these. A minimum of three care providers (including the GP) must be in communication with each other throughout the conference. Examples of persons who may be included in a multidisciplinary care team are:

- Allied health professionals;
- Home and community service providers;
- Care organizers such as education providers, "meals on wheels" providers, personal care workers and probation officers.

| MBS item numbers for Case Conferences | GP Prepares and Co-ordinates | | | GP Participates | | |
|---|---|---|---|---|---|---|
| Community Case Conference | 15-20 mins | 20-40 mins | >40 mins | 15-20 mins | 20-40 mins | >40 mins |
| | 735 | 739 | 743 | 747 | 750 | 758 |
| Discharge Case Conference (At the invitation of the hospital) | For Private Patients | | | For Public and Private Patients | | |
| | 735 | 739 | 743 | 747 | 750 | 758 |
| RACF Case Conference | 735 | 739 | 743 | 747 | 750 | 758 |

# Cancer Screening

## Cervical Screening

Human Papillomavirus (HPV) is a common infection that can cause cervical cell changes that may lead to cervical cancer. Cervical cancer is one of the most preventable cancer types therefore, routine cervical screening is the best protection against cervical cancer. Previously, the Pap test was used to detect cell changes in the cervix. In In December 2017, this was replaced with the Cervical Screening Test (CST). CST is more effective than the Pap Test at preventing cervical cancer because it detects the HPV, whereas the Pap Test looked for cell changes in the cervix which may take a longer period to discover. The new test is only required to be completed every five years rather than every two and is expected to protect up to 30% more women (Department of Health and Aged Care, 2022).

*Patient Eligibility*

- Women aged between 25 and 74
- 'Under screened' women who have not had a cervical smear in the last four years

*Self-Collection*

Self-collection of a sample for screening is available for women between the ages of 30 and 74 years of age who are overdue for screening by two or more years (i.e., being 4 years since their last Pap Test). Self-collection should only be offered to an eligible person who refuses to have their sample collected by their requesting practitioner.

*Cervical Screening Resources*

| Resource Details | Publication Details |
|---|---|
| Various Information resources | NSW Cervical Screening Program<br>P: 131 556 |
| National Cancer Screening register | National Cervical Screening Program<br>P: 1800 627 701 |

### MBS Item Numbers for Under Screened Women

| Item | Name | Description |
|---|---|---|
| 2497 | Level A Cervical Screening | Short surgery consultation |
| 2501 | Level B Cervical Screening | < 20 min surgery consultation |
| 2503 | | < 20 min out of surgery |
| 2504 | Level C Cervical Screening | > 20 min surgery consultation |
| 2506 | | > 20 min out of surgery |
| 2507 | Level D Cervical Screening | > 40 min surgery consultation |
| 2509 | | > 40 min out of surgery |

# Health Assessments

## How to Make Health Assessments Work for Your Practice

Take a systematic approach to health care in your practice. Designate the task of setting up the health assessment process in the practice:

- Obtain a list of appropriate patients (database search) that have been seen by the GP over the last 12 months
- Ensure all patients are eligible for a Health Assessment
- Set up a process for contacting patients (phone or mail)
- Ensure adequate time is allowed for each assessment; 30-90 minutes (longer for home assessments – these require a more thorough approach)
- Identify and discuss the benefits of a Health Assessment with each patient
- Obtain patient consent
- Findings and outcomes must be discussed with the patient (and carer where appropriate)
- The GP prepares a written summary which that patient signs, including outcomes and recommendations – a copy should be offered to the patient
- Keep a copy of each assessment in patient's records
- Use a Practice Nurse to help conduct the assessments if available

If a third person is undertaking the information collection component, the GP must ensure that this person has suitable skills, experience, and qualifications.

## Health Assessment Target Groups

Medical practitioners may select one of the MBS Health Assessment items to provide a Health Assessment service to a member of any of the target groups listed. The Health Assessment item that is selected will depend on time taken to complete the Health Assessment service. This is determined by the complexity of the patient's presentation and the specific requirements that have been established for each target group eligible for Health Assessments.

This excludes the Heart Health Check item number 699, which must be at least 20 minutes.

**Type 2 Diabetes Risk Evaluation**
Provision of lifestyle modification advice and interventions for patients aged 40-49 years who score > 12 on AUSDRISK. Once every three years.
**45-49-year-old**
Once only Health Assessment for patients 45-49 years who are at risk of developing chronic disease.
**75 Years and Older**
Health Assessment for patients aged 75 years and older. Once every 12 months.
**Comprehensive Medical Assessment**
Comprehensive Medical Assessment for permanent residents of Residential Aged Care Facilitates. Available for new and existing residents. Not more than once a year.
**For Patient with an Intellectual Disability**
Health Assessment for patients with an intellectual disability. Not more than once a year.
**For Refugees and Other Humanitarian Entrants**
Once only health assessment for new refugees and other humanitarian entrants, as soon as possible after their arrival (within 12 months of arrival).

# Health Assessment Item Numbers

| Item | Name | Description/Recommended Frequency |
|---|---|---|
| 699 | Heart Health Check | ≥ 20 mins<br>a. Collection of relevant information, including taking a patient history that is aimed at identifying cardiovascular disease risk factors, including diabetes status, alcohol intake, smoking status, and blood glucose.<br>b. A physical examination, which must include recording of blood pressure and cholesterol status.<br>c. Initiating interventions and referrals to address the identified risk factors.<br>d. Implementing a management plan for appropriate treatment of identified risk factors.<br>e. Providing the patient with preventative health care advice and information, including modifiable lifestyle factors. |
| 701 | Brief Health Assessment | < 30 mins<br>a. Collection of relevant information, including taking a patient history.<br>b. A basic physical examination.<br>c. Initiating interventions and referral as indicated.<br>d. Providing the patient with preventative health care advice and information. |
| 703 | Standard Health Assessment | 30 – 45 mins<br>a. Detailed information collection, including taking a patient history.<br>b. An extensive physical examination.<br>c. Initiating interventions and referrals as indicated.<br>d. Providing a preventative health strategy for the patient. |
| 705 | Long Health Assessment | 45 – 60 mins<br>a. Comprehensive information collection, including taking a patient history.<br>b. An extensive examination of the patient's medical condition and physical function.<br>c. Providing a basic preventative health care strategy for the patient. |
| 707 | Prolonged Health Assessment | > 60 mins<br>a. Comprehensive information collection, including taking a patient history.<br>b. An extensive examination of the patient's medical condition and physical and social function.<br>c. Initiating interventions and referrals as indicated.<br>d. Providing a comprehensive preventative health care management plan for the patient. |
| 715 | Aboriginal and Torres Strait Islander Health Assessment | No designated time or complexity requirements<br>**Aboriginal and/or Torres Strait Islander Child**<br>For patients 0-14 years old. Not available to inpatients of a hospital or RACF. Not more than once every nine months.<br>**Aboriginal and/or Torres Strait Islander Adult**<br>For patients 15-54 years old. Not available to inpatients of a hospital or RACF. Not more than once every nine months.<br>**Aboriginal and/or Torres Strait Islander Older Peoples**<br>For patients 55 years and over. Not available to inpatients of a hospital or RACF. Not more than once every nine months. |

# Heart Health Assessment

**Item 699**

Perform records search to identify 'at risk' patients

Identify risk factors

**Perform Health Check**

Nurse may collect information. GP must see patient.

Claim MBS item

Eligibility Criteria

- Adults who are aged 30 years and above
- The absolute cardiovascular disease risk must be calculated as per the Australian Absolute Cardiovascular Disease Risk Calculator which can be viewed at CVD Check
- Not for patients in hospital

Risk Factors

- Lifestyle: smoking, physical inactivity, poor nutrition, alcohol use, biomedical, high cholesterol, high BP, impaired glucose metabolism or excessive weight
- Family history of chronic disease

Clinical Content

Mandatory

- Explain Health Assessment process and gain consent
- Collection of relevant information including taking a patient history that is aimed at identifying cardiovascular disease risk factors, including diabetes status, alcohol intake, smoking status, cholesterol status (if not performed within the last 12 months) and blood glucose
- A physical examination, which must include recording of blood pressure
- Initiating interventions and referrals to address the identified risk factors
- Implementing a management plan for appropriate treatment of identified risk factors
- Providing the patient with preventative health care advice and information, including modifiable lifestyle factors

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

| Item | Name | Age Range | Recommended Frequency |
|---|---|---|---|
| 699 | Heart Health Assessment | • Adults over 30 years | Annually |

You cannot bill a heart health check item for your patient if in the last 12 months have had another health assessment under Items 701 – 715.

# Health Assessment for Aboriginal and/or Torres Strait Islander People

**Item 715**

Ensure patients eligibility

**Note**

It may take several shorter sessions to complete the full Health Assessment with an Aboriginal and/or Torres Strait Islanders Patient. The Practice cannot claim the 715 until all components are completed

Complete documentation

Claim MBS item

Eligibility Criteria

- Patients 0-14 years use “child” assessment
- Patients 15-54 years use “adult” assessment
- Patients 55+ years use “older adult” assessment
- May be provided once every nine months

Clinical Content

Mandatory

- Explain Health Assessment process and gain parents’/carers consent
- Information collection - taking patient history and undertake or arrange examinations and investigations as required
- Overall assessment of patient
- Recommended appropriate interventions
- Provide advice and information
- Keep a record of the health assessment and offer a copy of the assessment with recommendations about matters covered to the patient and/or carer

Non-mandatory

- Discuss eating habits, physical activity, speech and language development, fine and gross mottos skills, behavior, and mood
- Oher examinations considered necessary by GP/Practice Nurse

Essential Documentation Requirements

- Record parent’s/carer’s consent to Health Assessment
- Record the Health Assessment and offer the parent/carer a copy
- Update parent held child record for children under 5 years of age
- Record immunisations provided

Claiming

- All elements of the service must be completed to claim
- May be completed over several sessions but do not claim 715 until all components are complete

NB: Once the patient has had a 715 Health Assessment, they are eligible for ten follow ups by the practice nurse (item number 10987) and five “at risk” allied health visits (separate/additional to the five allied health visits under TCA if the patient is diagnosed with a chronic disease)

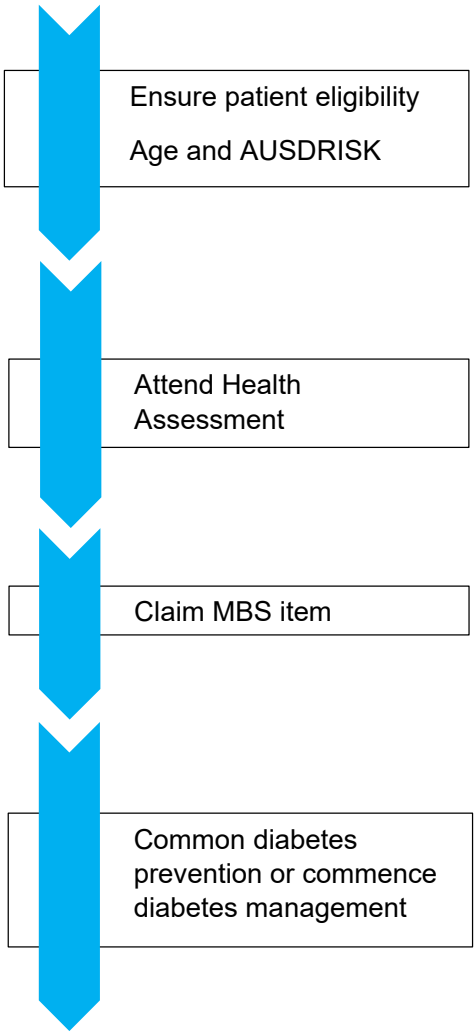
A health assessment referral form for follow-up allied health services is available on the Department of Health and Aged Care website.

| Item | Name | Age Range | Recommended Frequency |
|---|---|---|---|
| 715 | Aboriginal and/or Torres Strait Islander Health Assessment | 0-14 years<br>15-54 years<br>55+ years | Every 9 months |

# Type 2 Diabetes Risk 40 – 49 Years

**Item 701/703/705/707**

**To reduce the risk of Type 2 Diabetes**




Eligibility Criteria

- Non-Indigenous patients aged 40 – 49 years (inclusive)
- Patients must score > 12 point on Australian Type 2 Diabetes Risk Assessment Tool (AUSDRISK)
- GP must exclude diabetes via glucose tolerance test
- Document outcomes
- Determine if diabetes prevention / lifestyle modification or diabetes management is required based on the outcomes of glucose tolerance test.

| Item | Name | Age Range | Recommended Frequency |
|---|---|---|---|
| 701/703/705/707 | Health Assessment: Type 2 Diabetes Risk Evaluation | 40-49 years | Once every 3 years |
| 23 | Consulting at consultation room Level B: if referral not taken-up within 2 months by the patient – must be annotated with the original item number claimed when the original referral was written | | |

MBS item 10991 (bulk billing incentive) may also be claimed for eligible patients.

# Health Assessment for 45 – 49-Year-Olds

**Item 701/703/705/707**

Perform record search to identify 'at risk' patients

Identify risk factors

**Perform Health Check**

Nurse may collect information

GP must see patient

Claim MBS item

Eligibility Criteria

- Patients aged 45 to 49 years (inclusive)
- Must have an identified risk factor for chronic disease
- Not for patients in hospital

Risk Factors

- Lifestyle: smoking, physical inactivity, poor nutrition, alcohol use
- Biomedical: high cholesterol, high BP, excess weight, impaired glucose metabolism
- Family history of chronic disease

Clinical Content

Mandatory

- Explain Health Assessment process and gain consent
- Information collection - take patient history, examinations and investigations as clinically required
- Overall assessment of patient's health, including their readiness to make lifestyle changes
- Initiate interventions and referrals as clinically indicated
- Advice and information about Lifestyle Modification Program and strategies to achieve lifestyle and behavior changes

Non-mandatory

- Written patient information such as the Lifescripts resources are recommended

Essential Documentation Requirements

- Record parent's consent to Health Assessment
- Record the Health Assessment and offer the parent a copy

Claiming

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

| Item | Name | Age Range | Recommended Frequency |
|---|---|---|---|
| 701/703/705/707 | Health Assessment: 45–49-year-old | 45 – 49 years | Only once |

MBS item 10991 (bulk billing incentive) may also be claimed for eligible patients.

# Health Assessment for 75-Years and Older

**Item 701/703/705/707**

Establish a patient register and recall when due for assessment

**Perform Health Check**

Allow 45 – 90 minutes

Nurse may collect information

GP must see patient

Claim MBS item

Eligibility Criteria

- Patients aged 75 years and older
- Patients seen in consulting rooms and/or at home
- Not for patients in hospital or a Residential Aged Care Facility

Clinical Content

Mandatory

- Explain Health Assessment process and gain patient's/carer's consent
- Information collection - take patient history, examinations and investigations as clinically required
- Measurement of BP, pulse rate and rhythm
- Assessment of medication, continence, immunisation status for influenza, tetanus, and pneumococcus
- Assessment of physical function including activities of daily living and falls in the last three months
- Assessment of psychological function including cognition and mood
- Assessment of 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 the patient

Non-mandatory

- Consider the need for community services, social isolation, oral health and dentition, and nutrition status
- Additional matters as relevant to the patient

Claiming

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

| Item | Name | Age Range | Recommended Frequency |
|---|---|---|---|
| 701/703/705/707 | Health Assessment: 75 years and older | 75 years and older | Once every 12 months |

MBS item 10991 (bulk billing incentive) may also be claimed for eligible patients.

## Health Assessments for Government Humanitarian Program

Items 701, 703, 705 and 707 may be used to undertake a Health Assessment for refugees and other humanitarian entrants.

The purpose of this Health Assessment is to introduce new refugees and other humanitarian entrants to the Australian primary health care system as soon as possible after their arrival in Australia (within 12 months of arrival).

In addition to general requirements for Health Assessments, the assessments must include development of a management plan addressing the patient's health care needs, health problems and relevant conditions.

The Health Assessment applied to humanitarian entrants who are residents in Australia with access to Medicare services. This includes refugees, Special Humanitarian Program and Protection Program entrants.

Patients should be asked to provide proof of their visa status and date of arrival in Australia. Alternatively, medical practitioners may telephone Medicare Australia on 132 011, with the patient present, to check eligibility.

The medical practitioner and patient can use the service translator by accessing the Commonwealth Government's Translating and Interpreting Service (TIS) on 131 450.

A Health Assessment for refugees and other humanitarian entrants may only be claimed once by an eligible patient.

## Health Assessments for People with an Intellectual Disability

Items 701, 703, 705 and 707 may be used to undertake a Health Assessment for people with an intellectual disability.

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

The Health Assessment provides a structured clinical framework for medical practitioners to comprehensively assess the physical, psychological, and social function of a patient with intellectual disability and to identify any medical intervention and preventive health care required.

A Health Assessment for people with an intellectual disability may be claimed once every 12 months.

# Systematic Care Claiming Rules

For the most up to date information refer to the Medicare Benefits Schedule online at www.health.gov.au/mbsonline or phone Medicare Australia Schedule Interpretation Team on 132 150.

| | Item Number | Service | Brief Guide | Claim Period |
|---|---|---|---|---|
| Chronic Disease Management | 721 | Preparation of a General Practitioner Management Plan (GPMP) | Patients with a chronic or terminal medical condition | **2 yearly** (minimum 12 months) |
| | 723 | Coordination of a Team Care Arrangement (TCA) | Patients with a chronic disease who require ongoing care from a multidisciplinary team | **2 yearly** (minimum 12 months) |
| | 732 | Review of GPMP | Systematic review of the patient's progress against GPMP goals | **6 monthly** (minimum 3 months) |
| | | Review of TCA | Systematic team-based review of the patient's progress against TCA goals | |
| | 729 | Contribution to care plan or to review the care plan being prepared by the other provider | Not available to patients of RACF | **6 monthly** (minimum 3 months) |
| | 731 | Contribution to care plan or to review the care plan for patient of RACF | Plan prepared by such a facility | **6 monthly** (minimum 3 months) |
| | 139 | Assessment, diagnosis and development of a treatment and management plan for a disability | Children aged under 13 years with an eligible disability | **Once only** |
| Medication reviews | 900 | Domiciliary Medication Management Review (DMMR) for patient living in the community setting | Assessment, referral to a community pharmacy | **12 months** except in circumstances with significant change |
| | 903 | Residential Medication Management Review (RMMR) | For new or existing residents of Residential Aged Care Facilities | **12 months** except in circumstances with significant change |
| Practice Nurse | 10987 | Monitoring and support for a person who has had a 715-health assessment | 715 Health Assessment for ATSI people | Maximum 10 per patient per year |
| | 10997 | Monitoring and support for a person with a chronic disease | Patient must have a GPMP, TCA or multidisciplinary care plan in place | Maximum of 5 times per patient per calendar year |

**Restrictions of Co-claiming of Chronic Disease and General Consultation Items**

Co-claiming of GP consultation items 3, 4, 23, 24, 36, 37, 44, 47, 52, 54, 57, 58, 59, 60, 63, 65, 597, 598, 599, 600, 5000, 5003, 5020, 5023, 5040, 5043, 5060, 5063, 5200, 5203, 5207, 5208, 5220, 5223, 5227, and 5228 with chronic disease management items 721, 723, or 732 is not permitted for the same patient on the same day.

Note: CDM services can also be provided more frequently in circumstances where there has been a significant change in the patient's clinical condition or care circumstances that require a new GPMP/TCA or review service. You must mark the Medicare claim as "exception circumstances" or "clinically indicated".

# Individual Allied Health Services Under Medicare

*Summary*

- A Medicare rebate is available for a maximum of five services per patient each calendar year. Additional services are not possible under any circumstances.
- If a provider accepts the Medicare benefit as full payment for the services, there will be no out-of-pocket cost. If not, the patient will have to pay the difference between the fee charged and the Medicare rebate.
- Patients must have a GP Management Plan and Team Care Arrangement prepared by their GP or be residents of a Residential Aged Care Facility who are managed under a multidisciplinary care plan.
- Referrals to allied health providers must be from GPs.
- Allied health providers must report back to the referring GP.

*Eligible Patients*

Community-based patients may be eligible if they have a chronic (or terminal) medical condition, and their GP has provided the following Chronic Disease Management (CDM) services:

- A GP Management Plan (GPMP) **item 721**
- Team Care Arrangements (TCA) **item 723**

Residents of a Residential Aged Care Facility may be eligible if their GP has contributed to a multidisciplinary care plan prepared for them by the aged care facility or to a review of the multidisciplinary care plan (item 731).

| Item | Name | Recommended Frequency |
|---|---|---|
| 10950 | Aboriginal Health Worker Services | Five allied health services per calendar year. Can be five sessions with one provider or a combination (e.g., three dietician and two diabetes education sessions). Referral for allied health services under Medicare form for each provider. Allied health provider must be Medicare registered. |
| 10951 | Diabetes Educator Services | |
| 10952 | Audiologist Services | |
| 10953 | Exercise Physiologist | |
| 10954 | Dietician 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 Services | • Better access to metal health care items: ten sessions<br>• GPMP and TCA for chronic medical conditions: five sessions |
| 10968 | Psychologist Services | |

# Residential Aged Care Facilities

## Health Assessment Provided as a Comprehensive Medical Assessment for Residents of Residential Aged Care Facilities

Items 701, 703, 705 and 707 may be used to undertake a Comprehensive Medical Assessment (CMA) of a resident of a Residential Aged Care Facility.

This requires an assessment of the resident's health and physical and psychological functioning, and must include:

- Making a written summary of the CMA.
- Developing a list of diagnoses and medical problems based on the medical history and examination.
- Providing a copy of the summary to the Residential Aged Care Facility.
- Offering the resident a copy of the summary.

A Residential Aged Care Facility is a facility in which residential care services, as defined in the Aged Care Act 1997, are provided. This includes facilities that were formerly known as Nursing Homes and Hostels. A person is a resident of a Residential Aged Care Facility if they have been admitted as a permanent resident of that facility.

This Health Assessment is available to new residents on admission. It is recommended that new residents should receive the Health Assessment as soon as possible after admission, preferably within six weeks following admission into a Residential Aged Care Facility.

A Health Assessment for the purpose of a CMA of a resident of a Residential Aged Care Facility may be claimed for an eligible patient:

- On admission to a Residential Aged Care Facility, provided that a CMA has not already been provided in another Residential Aged Care Facility within the previous 12 months.
- At 12-month intervals thereafter.

*Can a GP Charge for a Consultation as well as the CMA?*
Medical practitioners should not conduct a separate consultation for any other health-related issue in conjunction with a Health Assessment unless it is clinically necessary (i.e., the patient has an acute problem that needs to be managed separately from the assessment).

The only exceptions are:

- The CMA, where, if this Health Assessment is undertaken during the course of a consultation for another purpose, the Health Assessment item and the relevant item for the other consultation may both be claimed.
- Use of a specific form to record the results of the CMA is not mandatory. A Health Assessment provided as a CMA may be claimed annually to an eligible patient.

# Commonly Used Item Numbers

**Comprehensive Medical Assessment**
Item 701/703/705/707

A full systems review of a permanent resident in a Residential Aged Care Facility (RACF)

**Activities:**
Time based, see MBS for complexity of care requirements for each item.

CMA requires assessment of the resident's health and physical and psychological function and must include:

- Obtain and record resident's consent.
- Information collection, including taking patient history and undertaking or arranging examinations and investigations as required.
- Making an overall assessment of the patient.
- Recommending appropriate interventions.
- Providing advice and information to the patient.
- Keeping a record of the Health Assessment and offering the patient a written report about the Health Assessment, with recommendations about matters covered by the Health Assessment.
- Providing a written summary of the outcomes of the Health Assessment for the resident's records and to inform the provision of care for the resident by the RACF and assist in the provision of Medical Management Review services for the resident.

**GP Contribution or Review of a Multidisciplinary Care Plan Prepared by a RACF**
Item 731

For patients in RACFs with a chronic or terminal condition and complex care needs requiring ongoing care from a team including the GP and at least two other health or care providers. Involves GP contributing to, or reviewing, a Multidisciplinary Care Plan prepared by the RACF, at the request of the facility. The plan must describe, at least, treatment and services to be provided to the patient by the collaborating providers. Item number 731 enables Commonwealth funded patients who are classified as low care residents to receive five rebated allied health services per calendar year. The need for allied health services must be identified in the Care Plan

**Activities:**

- Obtain and record the resident's consent.
- Prepare part of the plan or amendments to the plan and add a copy to the patient's medical records.
- Give advice to a person (e.g., nursing staff in RACF) who prepares or reviews the plan and record in writing, on the patient's medical records, any advice provided.

**GP Multidisciplinary Case Conference**
Item 735-758

For patients in RACFs or the community or on discharge from hospital, with a chronic or terminal condition and complex care needs requiring ongoing care from a multidisciplinary case conference team including the GP and at least two other health or care providers. A carer can be included as a formal member of the team but does not count towards the minimum of three providers.

**Activities:**
Time based items 735-743 require:

- Obtain and record resident's consent.
- Recording meeting details including date, start and end time, location, participants names, all matters discussed and identified by the team.
- Discuss outcomes with patient and carer and offer a summary of the conference to them and team members.
- Keep record in the patient's medical file.

Time based items 747-758 participation required:

- Above activities excluding discussion of outcomes with patient/career and offering summary to patient/carer and team members.

**Residential Medication Management Review (RMMR)**
Item 903

For permanent residents (new or existing) of RACFs. A RMMR is a review of medications, in collaboration with pharmacist, for patients at risk of medication related misadventure or for whom quality use of medicines may be an issue.

**Activities:**

- Obtain and record resident's consent.
- Collaborate with reviewing pharmacist. Provide input from the resident's CMA or relevant clinical information for RMMR and resident's records.
- Participate in post-review discussion with pharmacist (unless exceptions apply) regarding the findings, medication management strategies, issues, implementation, follow up and outcomes.
- Develop and/or revise Medication Management Plan and finalise plan after discussion with resident.
- Offer copy of Medication Management Plan to resident/carer, provide copy for resident's records and for nursing staff of RACF, discuss plan with nursing staff is necessary.

# Arrangements for GP RACF Services

## New Items for Doctor's RACF Services

On 1 March 2019, the Government introduced new MBS items for professional services provided by a general practitioner (GP) or medical practitioner at a RACF. The new items include a call-out fee to cover doctors' costs of travel to a RACF (MBS items 90001 and 90002), and new (standard level A to D) attendance items.

The new items simplify claims for RACF services and replace the derived fee payment model.

## Call-Out Fee

The call-out items apply to a doctor's initial attendance at a RACF and are billable only for the first patient seen on a RACF visit. Once a call-out item is billed, doctors may then bill an applicable attendance item for each of the RACF patients they see. The fees for the call-out items are $58.15 for GPs.

| Item number | Fee |
|---|---|
| 90001 | $58.15 |
| 90020 | $18.20 |
| 90035 | $39.75 |
| 90043 | $76.95 |
| 90051 | $113.30 |

## Billing

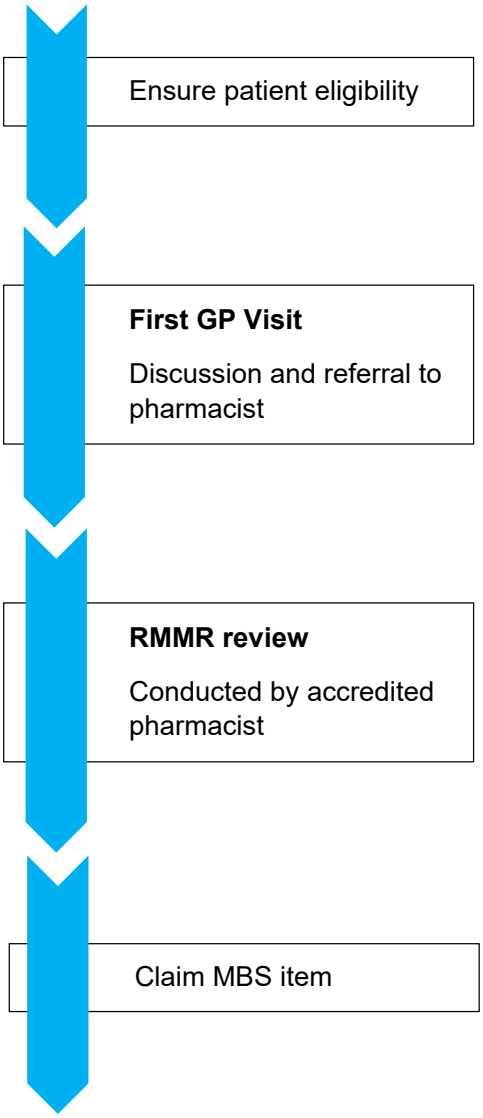
The RACF items are only for Medicare-eligible GP and other medical practitioners providing primary care services in RACFs. Doctors employed by RACFs cannot claim the items, nor can specialists, consultant physicians, nurses and other allied health professionals.

*Item Restrictions*

In general, the call-out fee is intended as a one-off payment to help reimburse travel expenses, but if a doctor must return to a RACF, on the same day and the attendances are not a continuation of an earlier episode of treatment, another call-out fee would apply per subsequent RACF visit.

# Residential Medication Management Review (RMMR)

**Item 903**




Eligibility Criteria

- New residents on admission into a RACF
- Existing residents on an 'as required' basis every 12-months or if there is a significant change in medical condition or medication regimen
- Not for respite patients in a RACF (eligible for Domiciliary Medicines Review when they are living in the community setting)

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 regime
- Finalise plan after discussion with resident
- Offer copy of plan to resident/carer
- Provide copy for resident's records, discuss plan with nursing staff if necessary

Claiming

- All elements of the service must be completed to claim
- Derived fee arrangement does not apply to RMMRs

| Item | Name | Recommended Frequency |
|---|---|---|
| 903 | Residential Medication Management Review | As required (payable once in a 12-month period – unless the medical practitioner believes there has been a significant change to a patient's condition or medicine regimen) |

# Prescribing/Home Medicines Review

## Domiciliary Medication Management Review (DMMR)

Targeted at patients living in the community who are likely to benefit from a review and may be at risk of medication misadventure because of risk factors such as:

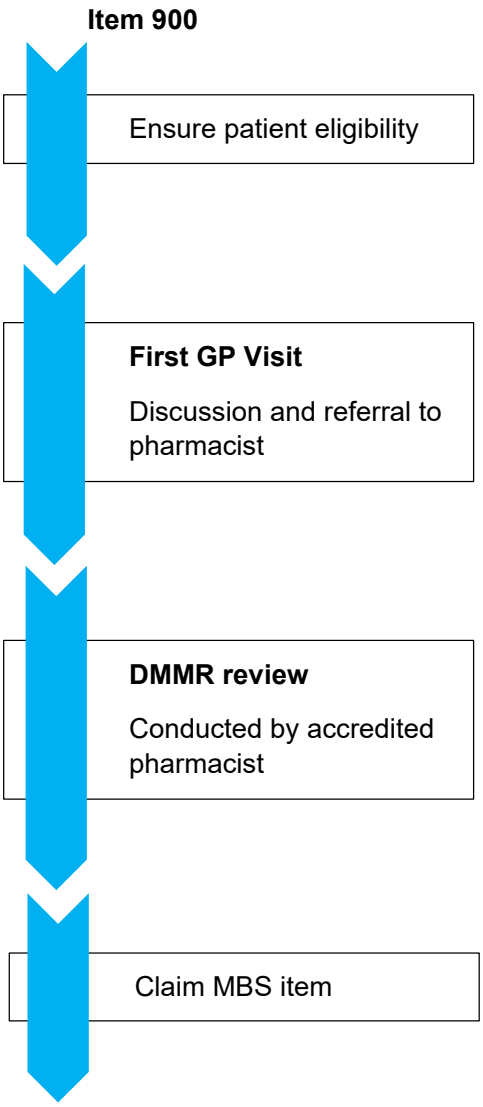
- Co-morbidities
- Age or social circumstances
- Characteristics of their medicines
- Complexity of their medication regime
- Lack of skills or knowledge to use medicines to their best effect

Examples of risk factors include:

- Currently taking five or more medications
- Taking more than 12 doses of medication per day
- Medications with a narrow therapeutic index or medications requiring therapeutic monitoring
- Significant changes to medication treatment in the last three months
- Suspended non-compliance
- Difficulty managing medication dues to literacy difficulties, cognitive difficulties, or physical difficulties
- Recent discharge from a facility/hospital (in the last four weeks)

In conducting a DMMR, a medical practitioner must:

- Assess a patients medication management need
- Following that assessment, refer the patient to a community pharmacy or an accredited pharmacist for DMMR
- With the patient's consent, provide relevant clinical information required for the review
- Discuss with the reviewing pharmacist the results of that review, including suggested medication management strategies
- Develop a written medication management plan following discussion with the patient




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 Residential Aged Care Facility

GP Initiates Service

- Explain purpose, possible outcomes, process, information sharing with pharmacist
- Gain and record patient's consent to DMMR
- Inform patient of need to return for second visit
- Complete DMMR referral and send to a pharmacy or an accredited pharmacist

DMMR Interview

- Pharmacist holds review in patient's home unless prior approval is sought by the pharmacist
- 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 Visit

- Develop summary of findings as part of draft Medication Management Plan
- Discuss draft plan with patient and offer copy of complete plan
- Send copy of completed, agreed plan to pharmacist

Claiming

- All elements of the service must be completed to claim
- Patient must be seen by the GP at the time of claiming

| Item | Name | Recommended Frequency |
|---|---|---|
| 900 | Domiciliary Medication Management Review | Once every 12 months (unless the medical practitioner believes there has been a significant change to a patient's condition or medicine regimen) |
| CP42 | Medication Review of a DVA Patient | Once every six months GP is required to ring Veterans Affairs Pharmaceutical Advisory Centre (VAPAC) 1800 552 580 for Authority Prescriptions for 6 months of DVA service and discuss suitability with pharmacist or an accredited pharmacist |

# Mental Health

## MBS Better Access Initiative

The Better Access initiative aims to improve outcomes for people with a clinically diagnosed mental disorder through evidence-based treatment. Under this initiative, Medicare rebates are available to patients for selected mental health services provided by eligible general practitioners (GPs), psychiatrists, psychologists (clinical and registered) and social workers and occupational therapists.

*What Medicare Services can be Provided Under the Better Access Initiative?*
Medicare rebates are available for up to ten individual* and ten group allied mental health services per calendar year to patients with an assessed mental disorder who are referred by:

- A GP managing the patient under a GP Mental Health Treatment Plan
- Under a referred psychiatrist's assessment and management plan
- A psychiatrist or paediatrician

*From 9 October 2020 until 31 December 2022, 10 additional individual psychological therapy sessions, previously available only to people whose movement was restricted by a state or territory public health order, are now available each calendar year to all eligible patients under the existing Better Access to psychiatrists, psychologists, and general practitioners through the MBS (Better Access) initiative. Full change descriptor can be found here.

### Short Term Psychological Therapies

*Description of Services*
There are three categories of services available for short term psychological therapies.

- **Short term psychological therapies** provided to people who have mild to moderate mental illness, or are at risk of suicide or self-harm
- **Group therapy programs** for people with mild to moderate mental illness who would benefit from group therapy. Available groups include: Perinatal depression, Dialectical Behavioral Therapy for young people and adults and Hoarding Disorder treatment.
- **Short term psychological therapies** for people from a Chinese background, including culturally appropriate services in English, Cantonese, Mandarin and Shanghainese.

# Mental Health Item Numbers

| Item | Name | Description/Recommended Frequency |
|---|---|---|
| 2700 | GP Mental Health Treatment Plan (prepared by a GP who has not undertaken Mental Health Skills Training) | Assessment of patient taking between 20-39 minutes. Not more than once yearly |
| 2701 | | Assessment of patient taking more than 40 minutes. Not more than once yearly |
| 2715 | GP Mental Health Treatment Plan (prepared by GP who has undertaken Mental Health Skills Training) | Assessment of patient taking between 20-39 minutes. Not more than once yearly |
| 2717 | | Assessment of patient taking more than 40 minutes. Not more than once yearly |
| 2712 | Review of GP Mental Health Treatment Plan | Plan should be reviewed every one – six months |
| 2713 | GP Mental Health Consultation | Consult > 20 minutes for the ongoing management of a patient with a mental disorder. No restrictions on the number of these consultations per year |
| 2721 | GP focused Psychological Strategies (provision of focused psychological strategies by an appropriately trained and registered GP working in an accredited practice) | 30-40 minutes |
| 2723 | | Out of surgery consultation. 30 – 40 minutes |
| 2725 | | > 40 minutes |
| 2727 | | Out of surgery consultation. > 40 minutes |

# Preparation of a Mental Health Treatment Plan

**Items 2700, 2701, 2715 and 2717**

Preparation of a GP Mental Health Treatment Plan involves both assessing the patient and preparing the GP Mental Health Treatment Plan document.

### *What must be Included in the Assessment?*

Assessment of a patient for the GP Mental Health Treatment Plan must include:

- Recording the patient's agreement for the GP Mental Health Treatment 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
- Administering an outcome measurement tool, except where it is considered clinically inappropriate

A formulation is important for the development of a GP Mental Health Treatment Plan and includes an assessment of the biological, psychological, and social factors predisposing, precipitating and/or protecting against a mental health problem.

Where the patient has a carer, the GP may find it useful to have the carer present for the assessment or components thereof (subject to patient agreement). The assessment can be part of the same consultation in which the GP Mental Health Treatment Plan is developed, or they can be undertaken in different visits. Where separate visits are undertaken for the purpose of assessing the patient and developing the GP Mental Health Treatment Plan, they are part of the GP Mental Health Treatment Plan service and are included in items 2700, 2701. 2715, or 2717. A benefit is not claimable, and an account should not be rendered until all components of the relevant item have been provided (see Associated Note 0.56 for more details).

### *What must a GP Mental Health Treatment Plan Include?*

The development of a mental health plan must include:

- Discussion of 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 psychoeducation
- 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
- Documenting this in the patient's GP Mental Health Treatment Plan
- Offering a copy of the written GP Mental Health Treatment Plan to the patient and/or carer (with patient's agreement)

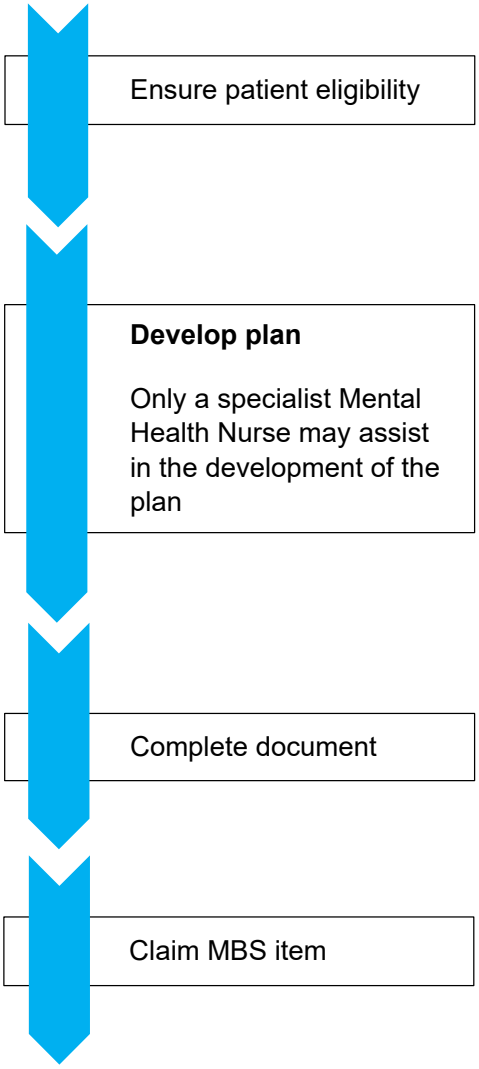
A GP Mental Health Treatment Plan sample template for the Better Access Program can be accessed here.

### *Can a Practice Nurse Assist with the Plan?*

All consultations conducted as part of the GP Mental Health Care items must be rendered by the GP. A specialist mental health nurse, other allied health practitioner or Aboriginal Health Worker with appropriate mental health qualifications and training may provide general assistance to GPs in provision of mental health care where the GP considers that they have skills appropriate to the assistance required.

**Item 2700/2701/2715/2717/2712**

2700/2701 prepared by a GP who has not undertaken Mental Health Skills Training
2715/2717 prepared by a GP who has undertaken Mental Health Skills Training




Eligibility Criteria

- No age restrictions for patient
- Patients with a mental disorder, excluding dementia, delirium, tobacco use disorder and mental retardation
- Not for patients in a hospital or a Residential Aged Care Facility

Clinical Content

- Explain steps involved, possible out of pocket costs and 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 psychological education
- 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 make arrangements for these

Essential Documentation Requirements

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

Claiming

- All elements of the service must be completed to claim
- Review using 2712 at least once during the life of the plan
- Requires personal attendance by GP with patient
- Claiming a 2700/2701/2712/2717 enables patients to receive up to ten rebated individual and up to ten group psychology services per calendar year

| Item | Name | Recommended Frequency |
|---|---|---|
| 2700/2701/2015/2017 | GP Mental Health Treatment Plan | Not more than once yearly |

# Review of a Mental Health Treatment Plan

**Item 2712**

The review is the key component for assessing and managing the patient's progress once a GP Mental Health Treatment Plan has been prepared, along with ongoing management through the GP Mental Health Consultation item and/or standard consultation items. A patient's GP Mental Health Treatment Plan should be reviewed at least once.

### *What must the Review Include?*

The review stage must include:

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

**Note:** This review is a formal review point only and it is expected that in most cases there will be other consultations between the patient and the GP as part of the ongoing management.

### *When should a Review of the GP Mental Health Care Plan be Done?*

The initial review should take place a minimum of four weeks and a maximum of six months after the completion of a GP Mental Health Treatment Plan. If required, an additional review three months after the first review is allowed within a 12-month period.

# GP Mental Health Care Consultation

**Item 2713**

### *When can I use the GP Mental Health Care Consultation Item?*

The GP Mental Health Care Consultation item applies to surgery consultations, which are of at least 20 minutes duration and where the primary treating problem is related to a mental disorder.

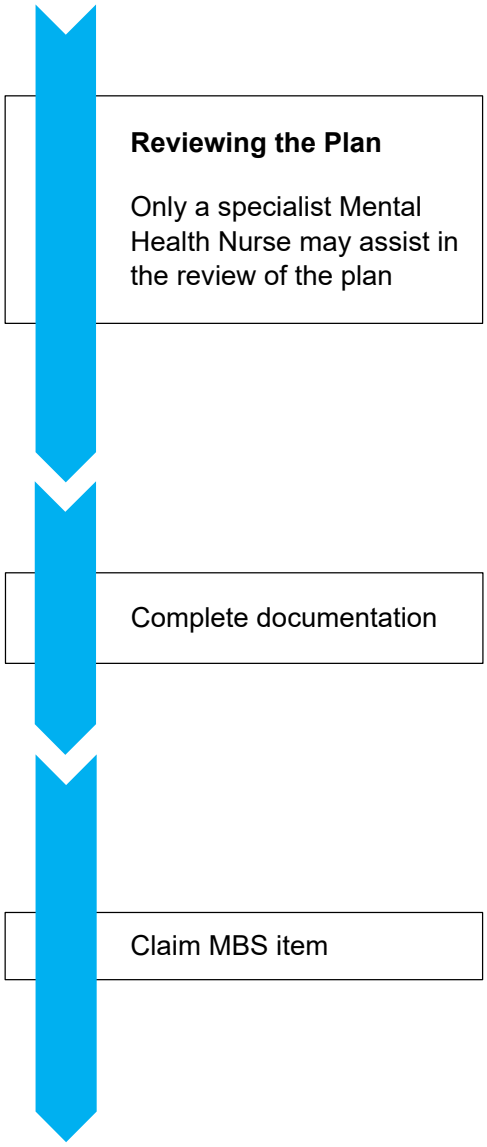
This item is for the ongoing management of patients with a mental disorder, including patients being managed under a GP Mental Health Treatment Plan, however, it can be used whether or not a patient has a Mental Health Treatment Plan. This item should not be used for the patient assessment or preparation of a GP Mental Health Treatment Plan. There are no restrictions on how often this item can be used.

### *What must a GP Mental Health Care Consultation Include?*

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

A patient may be referred from a GP Mental Health Care Consultation for other treatment and services as per normal GP referral arrangements. This does not include referral for Medicare rebate-able services by focused psychological services, clinical psychology, or other allied mental health services, unless the patient is being managed by the GP under a GP Mental Health Treatment Plan or under a referred psychiatrist assessment and management plan (item 291).

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




Clinical Content

- Explain steps involved, possible out of pocket costs and gain patient's consent
- Review patient's progress against goals outlines in the GP Mental Health Treatment Plan
- Check, reinforce and expand psychological education
- Plan for crisis intervention and/or relapse prevention is appropriate and if not previously provided
- Re-administered the outcome measurement tool used when developing the GP Mental Health Treatment Plan, 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
- Claiming a 2712 enables patients to receive a second set of six individual or six group psychology services
- Item 2712 should be claimed at least once over the life of the GP Mental Health Treatment Plan
- A review can be claimed one to six months after completion of the GP Mental Health Treatment Plan if required and additional review can be performed three months after the first review

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

# Checklist for GP Mental Health Treatment Plan

| | |
|---|---|
| **Assessment**<br>(As part of a GP Mental Health Treatment Plan) | • Patient's agreement for the GP Mental Health Treatment Plan service<br>• Relevant History<br>• Mental state examination<br>• Assess risk and co-morbidity<br>• A diagnosis and/or formulation<br>• Administer outcome measurement tool (unless clinically inappropriate) |
| **Plan** | • Discussion of the assessment with the patient, including the mental health formulation and/or diagnosis<br>• Identifying and discussing referral and treatment options with the patient<br>• Agreeing on goals with the patient<br>• Provision of psychoeducation<br>• Crisis intervention and/or relapse prevention plan if appropriate<br>• Referrals, treatment, appropriate support services, review, and follow-up<br>• Documenting results in the patient's GP Mental Health Treatment Plan<br>• Offer a copy of the plan to the patient |
| **Review** | • Recording the patient's agreement for this service<br>• Review patient's progress against the goals outlined in the GP Mental Health Treatment Plan<br>• Modify GP Mental Health Treatment Plan if required<br>• Check, reinforce and expand education<br>• Crisis intervention and/or relapse prevention plan if appropriate and if not previously provided<br>• Re-administration of the outcome measurement tool (unless clinically inappropriate)<br>**The Review is conducted one month to six months from when the GP Mental Health Treatment Plan was prepared** |
| **Consultation** | • Taking relevant history and identifying the patient's presenting problem(s) (if not previously documented)<br>• Providing treatment, advice and/or referral for other services of treatment<br>• Documenting the outcomes of the consultation in the patient's medical records and other relevant mental health plan (where applicable) |

| **Mental State Examination** | |
|---|---|
| **Appearance and General Behaviour** | **Mood** (Depressed/Labile) |
| **Thinking** (Content/Rate/Disturbances) | **Affect** (Flat/Blunted) |
| **Perception** (Hallucinations etc.) | **Appetite** (Disturbed eating patterns) |
| **Cognition** (Level of consciousness/Delirium/Intelligence) | **Sleep** (Initial insomnia/Early morning wakening) |
| **Attention/Concentration** | **Motivation/Energy** |
| **Memory** (Short and long term) | **Judgement** (Ability to make rational decisions) |
| **Insight** (Capacity to organise and understand problem, symptom, or illness) | **Anxiety Symptoms** (Physical and emotional |
| **Orientation** (Time/Place/Person) | **Speech** (Volume/Rate/Content) |

# Veterans' Care

## Coordinated Veterans' Care Program (CVC)

*About the CVC Program*

The Department of Veterans' Affairs (DVA) new Coordinated Veterans' Care Program commenced on 1 May 2011. The CVC Program:

- Uses a proactive approach to improve the management of participant's chronic diseases and quality of care
- Involves a care team of a general practitioner plus a nurse coordinator who work with the participant (and their carer if applicable) to manage their ongoing care
- Provides new payments to GPs for initial and ongoing care

*Eligibility*

The program is aimed at veterans who are at risk of unplanned admission to the hospital and hold either:

- A Veteran Gold Card and have a chronic health condition
- A Veteran White Card and have a DVA-accepted mental health condition

A DVA-accepted mental health condition means DVA has accepted it as being related to a veteran's military service.

GPs can enrol participants in the program if they:

- Pass an eligibility assessment
- Give their informed consent to be involved in the program

*Payments for GPs*

By participating in the program, GPs can claim the following payments through existing payment arrangements with Medicare Australia:

- Initial assessment and program enrolment (UP01 or UP02)
- Quarterly Care Payments for ongoing care (UP03 or UP04)

Guide for General Practice

The DVA has developed a guide to help with the implementation of the CVC. It can be downloaded here. The CVC Program items are DVA only items and do not appear in the MBS Schedule.

*UP01 Initial Payment – LMO/GP with Practice Nurse Coordinator*

| Item Description | Business Rules |
|---|---|
| The payment is to an LMO/GP, with a Practice Nurse coordinator, for enrolling a person in the CVC Program and having done all things necessary for the enrolment as described in the guide for General Practice or notes for CVC Program Providers and summarised as follows:<br>• The LMO/GP has made any required changes to the practice before enrolling the participant in the Program<br>• The participant has been assessed by the LMO/GP as meeting the eligibility criteria for participation in the Program<br>• The LMO/GP has explained the Program and the person has provided informed consent to being enrolled in the Program and to the sharing of health and medical information | This item will be claimed on enrolment of a participant in the CVC Program.<br><br>Only one claim of either UP01 or UP02 will be paid per participant regardless of change in LMO/GP or in Practice Nurse arrangements. Where a person ceases to be a participant and later re-enters the Program, the initial incentive payment (UP01 or UP02) will not be payable. |

| | |
|---|---|
| • A care coordinator employed by the general practice has been appointed<br>• A comprehensive needs assessment of the participant has been carried out by the care coordinator or the LMO/GP<br>• A care plan (GPMP) has been prepared and agreed with the participant and a patient friendly copy provided to the participant and any carer/family as agreed | The date of service is the date of enrolment in the Program which is the date that all steps necessary for enrolment in the Program have been completed. |

# Contact Details for Key Organisations

**Asthma**
National Asthma Council
W: nationalasthma.org.au
T: 03 8699 0476 / 1800 032 495

**Best Practice**
W: bpsoftware.net
T: (07) 4155 8888

**Cancer Screening**
W: cancerscreening.gov.au**Diabetes**
Diabetes Australia NSW
W: diabetesnsw.com.au
T: 1300 342 238

**Immunisation**
Australian Immunisation Register (AIR) Immunisation Information
T: 1800 653 809

**My Health Record**
W: myhealthrecord.gov.au
T: 1800 723 471

**Medical Director**
W: medicaldirector.com
T: 1300 300 161

**National Cervical Screening Program**

W: https://www.health.gov.au/initiatives-and-programs/national-cervical-screening-program

**NBMPHN Health Pathways**
W: nbm.communityhealthpathways.org

**NSW Cervical Screening Program**

W: https://www.cancer.nsw.gov.au/prevention-and-screening/screening-and-early-detection/cervical-screening

**Practice Incentive Program (PIP)**

W: https://www.servicesaustralia.gov.au/practice-incentives-program
T: 1800 222 032

**Quality Use of Medicines**
NPS MedicineWise
W: nps.org.au
T: (02) 8217 8700

**Services Australia**
W: servicesaustralia.gov.au
T: 132 150