Chronic Disease Management & MBS Item Numbers

September 2021

Wentworth Healthcare Limited (ABN 88 155 904 975) provider of the Nepean Blue Mountains PHN. 08/09/2021

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.

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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.

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Contents

Contents ... 3
Chronic Disease Management ... 5
Chronic Disease Overview ... 5
Chronic Disease in the NBM Region ... 5
Commonly Used MBS Item Numbers ... 5
Health Assessments and Health Checks ... 6
Chronic Disease Management ... 6
Medication and Management of Cycles of Care ... 7
Mental Health ... 7
Practice Nurse Activity – Item Number Income Estimator ... 8
Preparation of a GP Management Plan (GPMP) ... 9
Coordination of Team Care Arrangement (TCA) ... 10
Reviewing a GPMP and/or TCA ... 11
Recall and Reminder Systems ... 12
Practice Nurses and Chronic Disease Management ... 13
Cycles of Care ... 15
Diabetes Annual Cycle of Care ... 15
Asthma Annual Cycle of Care ... 17
Multidisciplinary Case Conferences ... 20
Health Assessments ... 21
How to Make Health Assessments Work for Your Practice ... 21
Health Assessment Target Groups ... 21
Health Assessment Item Numbers ... 22
Hearth Health Assessment ... 23
Health Assessment for Aboriginal and Torres Strait Islander People ... 24
Type 2 Diabetes Risk 40 – 49 Years ... 25
Health Assessment for 45 – 49-Year-Olds ... 26
Health Assessment for 75-Years and Older ... 27
Health Assessments for Government Humanitarian Program ... 28
Health Assessments for People with an Intellectual Disability ... 28
Health Assessments and Chronic Disease Management Flowchart ... 29
Systematic Care Claiming Rules ... 30
Individual Allied Health Services Under Medicare ... 31
Residential Aged Care Facilities ... 32
Health Assessment Provided as a Comprehensive Medical Assessment for Residents of Residential Aged Care Facilities ... 32
Commonly Used Item Numbers ... 33

Arrangements for GP RACF Services ... 34
New Items for Doctor's RACF Services ... 34
Call-Out Fee ... 34
Billing ... 34
Residential Medication Management Review (RMMR) ... 35
Prescribing/Home Medicines Review ... 36
Domiciliary Medication Management Review (DMMR) ... 36
Incentive Programs ... 38
Practice Incentive Program and Service Incentive Payments ... 38
Payments Summary ... 38
PIP Payment Calculator ... 43
Cancer Screening ... 44
Cervical Screening ... 44
MBS Item Numbers for Under Screened Women ... 44
Mental Health ... 45
MBS Better Access Initiative ... 45
Short Term Psychological Therapies ... 45
Mental Health Item Numbers ... 46
Preparation of a Mental Health Treatment Plan ... 47
Review of a Mental Health Treatment Plan ... 49
GP Mental Health Care Consultation ... 49
Checklist for GP Mental Health Treatment Plan ... 51
Procedural Items ... 52
Procedural Item Numbers ... 52
Dislocations ... 52
Fractures ... 52
Obstetrics ... 52
Operations ... 53
Pathology of Diagnostic Tests ... 54
Procedures ... 54
Skin Lesions, Excisions, Biopsies and Wounds ... 54
Veterans' Care ... 56

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 2013-14, 48% (285 000) of potentially avoidable hospitalisations were for chronic conditions; and
- 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 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 377 189 (2019). The population is projected to grow by 24% by 2036. By this time the region will have an additional 89 461residents living in the area.

Chronic disease related hospitalisation rates were higher within the NBM region compared to NSW. COPD was the leading cause of potentially avoidable hospitalisations in 2011/12. An estimated 21.6% of people within the region are smokers, 59% 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.

Commonly Used MBS Item Numbers

The following item numbers are commonly used in the treatment and management of chronic conditions in general practice.

Item	Name	Description/Recommended Frequency
3	Level A	Short (see MBS for complexity of care requirements)
23	Level B	< 20 mins (see MBS for complexity of care requirements)
36	Level C	> 20 mins (see MBS for complexity of care requirements)
44	Level D	> 40 mins (see MBS for complexity of care requirements)
10991	Bulk Billing item	DVA, under 16s and Commonwealth Concession Card holders. Can be claimed concurrently for eligible patients. Confirm with Medicare as to Regional coding

Health Assessments and Health Checks

Item	Name	Description/Recommended Frequency
701	Brief Health Assessment	< 30 mins (see MBS for complexity of care requirements)
703	Standard Health Assessment	30 – 45 mins (see MBS for complexity of care requirements)
705	Long Health Assessment	45 – 60 mins (see MBS for complexity of care requirements)
707	Prolonged Health Assessment	> 60 mins (see MBS for complexity of care requirements)
715	Aboriginal and Torres Strait Islander Health Assessment	Every 9 months (see MBS for care requirements)
699	Heart Health Check	> 20 mins (see MBS for care requirements)

Chronic Disease Management

Item	Name	Description/Recommended Frequency
721	GP Management Plan (GPMP)	Management plan for patients with a chronic or terminal condition – not more than once yearly
723	Team Care Arrangement (TCA)	Management plan for patients with a chronic or terminal condition who require ongoing care from a team including the GP and at least two other health care providers. Enables referral for five rebated allied health services – not more than once yearly
732	Review of GPMP and/or TCA	Recommended six monthly, must be performed at least once over the life of the plan
729	GP contribution to, or review of, Multidisciplinary Care Plan	Contribution to, or review of, a multidisciplinary care plan provided by another provider. For patients with a chronic or terminal condition and complex needs requiring ongoing care from a team including the GP and at least two other health care providers. Not more than once every three months.
731	GP contribution to Care Plan by RACF	GP contribution to, or review of, a multidisciplinary care plan prepared by RACF, at the request of the facility. For patients with a chronic or terminal condition and complex needs requiring ongoing care from a team including the GP and at least two other health care providers. Not more than once every three months.

Restriction 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, 4, 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.

Medication and Management of Cycles of Care

Item	Name	Description/Recommended Frequency
900	Domiciliary Medication Management Review (DMMR)	Review of medications in collaboration with a pharmacist for patients as risk of medication related misadventure. Once every 12 months
903	Residential Medication Management Review (RMMR)	For permanent residents of Residential Aged Care Facilitates who are at the risk of medication misadventure. Performed in collaboration with the resident's pharmacist. Not more than once yearly.
2521	Diabetes Annual Cycle of Care Level C	Used in place of usual attendance item when complete diabetes Annual Cycle of Care. Once eery 11-13 months.
2552	Asthma Cycle of Care Level C	Used in place of usual attendance item when completing the Asthma Cycle of Care for patients with moderate to severe asthma. Not more than once yearly.
11505	Spirometry	a) Involves a permanently recorded tracing, performed before and after inhalation of a bronchodilator; and b) Is performed to confirm diagnosis of: i. Asthma; or ii. Chronic obstructive pulmonary disease (COPD); or iii. Another cause of airflow limitation
11506	Spirometry	Measurement of respiratory function involving a permanently recorded tracing performed before and after inhalation of bronchodilator.

Mental Health

Item	Name	Description/Recommended Frequency
2700	GP Mental Health Treatment Plan (GPMHP)	Prepared by GP who has **not** undertaken Mental Health Skills Training. Assessment of patient taking between 20-39 minutes. Not more than once yearly.
2701	GP Mental Health Treatment Plan (GPMHP)	Prepared by GP who has **not** undertaken Mental Health Skills Training. Assessment of patient taking more than 40 minutes. Not more than once yearly.
2715	GP Mental Health Treatment Plan (GPMHP)	Prepared by a HP who has undertaken Mental Health Skills Training. Assessment of patient taking between 20-39 minutes. Not more than once yearly.
2717	GP Mental Health Treatment Plan (GPMHP)	Prepared by GP who has undertaken Mental Health Skills Training. Assessment of patient taking more than 40 minutes. Not more than once yearly.
2712	Review of GPMHP	Plan should be reviewed after 1-6 months
2713	Mental Health Consultation	Consult > 20 mins, for the ongoing management of a patient with mental disorder. No restriction on the number of these consultations per year.

Practice Nurse Activity – Item Number Income Estimator

The table below is a snapshot of the Practice Nurse Item Number Calculator Tool that assists with identifying activities frequently undertaken to provide care for patients with or at risk of chronic disease. It shows the potential financial contribution that can be made by practice nurses towards claiming these item numbers. Click here to download an Excel version of the calculator.

Item	Activity	MBS No.	No. of Services	MBS Fee	Income Generated
Health Assessmnets	Diabetes Risk (40-49 year olds)	701 (brief)		$61.20	$0.00
		703 (standard)		$142.20	$0.00
		705 (long)		$196.25	$0.00
		707 (prolonged)		$277.20	$0.00
	45 - 49 Year Old Health Check	701 (brief)		$61.20	$0.00
		703 (standard)		$142.20	$0.00
		705 (long)		$196.25	$0.00
		707 (prolonged)		$277.20	$0.00
	75 + Years	701 (brief)		$61.20	$0.00
		703 (standard)		$142.20	$0.00
		705 (long)		$196.25	$0.00
		707 (prolonged)		$277.20	$0.00
	Indigneous Health Assessment	715		$218.90	$0.00
	ATSI Follow Up with Nurse	10987		$24.75	$0.00
	Heart Health Assessment	699		$75.05	$0.00
Chronic Disese Management	GP Management Plan	721		$148.74	$0.00
	Team Care Arrangement	723		$117.90	$0.00
	GPMP Review	732		$74.30	$0.00
	TCA Review	732		$74.30	$0.00
	Nurse Contribution to GPMP/TCA	10997		$12.40	$0.00
	DMMR	900		$159.65	$0.00
Mental Health	GPMHP without Mental Health Skill Traini	2700 (20-39 min)		$73.95	$0.00
		2701 (> 40 min)		$108.85	$0.00
	GPMHP with Mental Health Skill Training	2715 (20-39 min)		$93.90	$0.00
		2717 (> 40 min)		$138.30	$0.00
	GPMHP Review	2712		$73.95	$0.00
	Mental Health Consult > 20 minutes	2713		$73.95	$0.00
Eating Disorders	EDTP without Mental Health Skill Training	90250 (20-39 min)		$73.95	$0.00
		90251 (> 40 min)		$108.85	$0.00
	EDTP with Mental Health Skill Training	90252 (20-39 min)		$93.90	$0.00
		90243 (> 40 min)		$138.30	$0.00
	EDTP Review	90264		$73.95	$0.00
Women's Health	Antenatal Attendance	16500		$48.60	$0.00
	Administration of hormone implant	14206		$36.70	$0.00
	Removal of hormone implant	30062		$62.65	$0.00
	Insertion of IUD	35503		$55.20	$0.00
	Urine pregnancy test	73806		$10.15	$0.00
	Cervical Screen not done in 4 years	2497		$17.45	$0.00
Other Serivces	ECG	11707		$19.00	$0.00
	Spirometry - Diagnosis	11505		$42.40	$0.00
	Spirometry - Monitor	11506		$21.20	$0.00
				Total	**$0.00**

Preparation of a GP Management Plan (GPMP)

The Chronic Disease Management (CDM) Medicare items are for General Practitioners (GPs) to manage the health care of people with chronic or terminal medical conditions. This includes those requiring multidisciplinary, team-based care from a GP and at least two other health care providers. Click here for more information.

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 is clinically indicated)
- MBS item 10991 (bulk billing incentive) may also be claimed for eligible patients

Item	Name	Recommended Frequency
721	GP Management Plan	Two yearly (min 12 monthly)

Coordination of Team Care Arrangement (TCA)

Item 723

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 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	Two yearly (min 12 monthly)

Practice Nurse Monitoring and Support

Patients with either a GPMP or a TCA can also receive monitoring and support services from a practice nurse or Aboriginal and Torres Strait Islander health practitioner on behalf of the GP (MBS item 10997) to a maximum of 5 services per patient in a calendar year.

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

GP must see patient

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

Claiming of CPMP 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

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

Claiming

- 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

Item	Name	Recommended Frequency
732	Review of GP Management and/or Team Care	Six monthly (minimum three monthly)

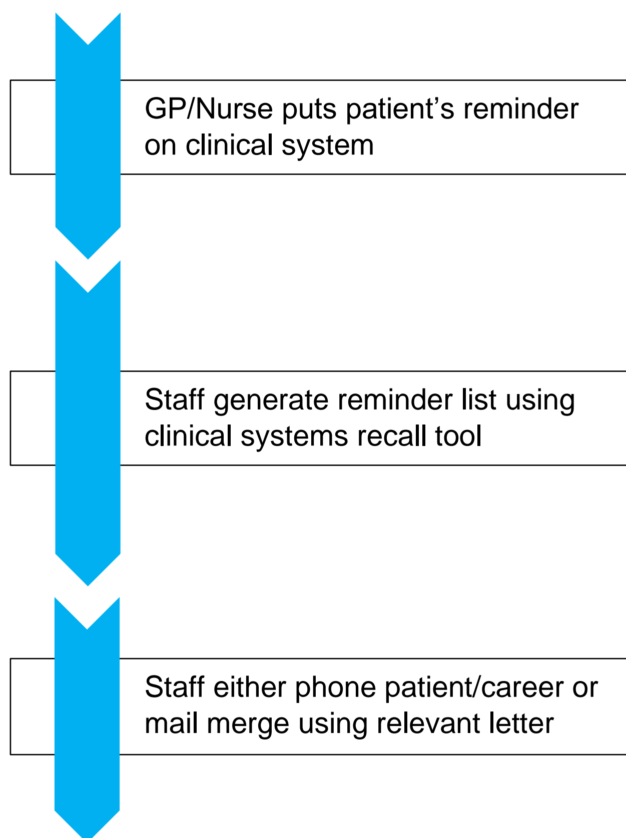
MBS item 10991 (bulk billing incentive) may also be claimed for eligible patients

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

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 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.

Diabetes

It is not necessary for a doctor to perform each step for the Diabetes Annual 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. The doctor may claim only for the time in which he/she saw the patient, not the time the nurse takes to undertake checks.

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 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. The doctor must be satisfied that each of the requirements has been completed and only claim for the duration of time in which they saw the patient.

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. SIP item numbers still exist for complete cycles of care but will not trigger the payment to the GP. The new PIP QI incorporates the SIP payments.

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.

Health Assessments

A 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. MBS items 701-707 apply (time-based). Item number 699 is not time based.

Care Plan Preparation

A nurse may assist a GP in preparing or reviewing a GP Management Plan (GPMP) or Team Care Arrangement (TCA). The 'usual' GP co-ordinated the plan for a patient with chronic diseases and ensure that each member of the multidisciplinary team has contributed to the plan's development or review. The nurse can collect history, identify needs, goals, and the actions, and make arrangements with services. The GP must review the plan with the patient before claiming the relevant item/s. Items 721, 723 and 732 apply.

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.

GPs and nurses should read the relevant MBS items before providing a primary care service: see MBS online and MBS Primary Care.

> Note: The Practice Nurse item number income estimator (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.

Cycles of Care

Diabetes Annual Cycle of Care

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: these MBS specific diabetes item numbers are to be used once all components of the diabetes annual cycle of care are completed.

Ensure patient eligibility

Eligibility Criteria

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

Care Requirements

This item certifies that the minimum requirements of the annual cycle of care have been completed

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
- Measure BP
- Examine feet

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: https://www.ndss.com.au/about-diabetes/

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.

Utilising a Practice Nurse for the Asthma Cycle of Care

A Practice Nurse can be used to assist the GPs with the completion of the Asthma Cycle of care. A nurse can provide patient education, record peak-flow or spirometry results, take a detailed patient and medication history, and review device techniques.

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 bill 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 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. The minimum 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	30-40 mins	>40 mins	15-20 mins	30-40 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

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 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. b. A physical examination, which must include recording of blood pressure and cholesterol status. c. Initiating interventions and referrals to address the identified risk factors. d. Implementing a management plan for appropriate treatment of identified risk factors. e. Providing the patient with preventative health care advice and information, including modifiable lifestyle factors.
701	Brief Health Assessment	< 30 mins a. Collection of relevant information, including taking a patient history. b. A basic physical examination. c. Initiating interventions and referral as indicated. d. Providing the patient with preventative health care advice and information.
703	Standard Health Assessment	30 – 45 mins a. Detailed information collection, including taking a patient history. b. An extensive physical examination. c. Initiating interventions and referrals as indicated. d. Providing a preventative health strategy for the patient.
705	Long Health Assessment	45 – 60 mins a. Comprehensive information collection, including taking a patient history. b. An extensive examination of the patient's medical condition and physical function. c. Providing a basic preventative health care strategy for the patient.
707	Prolonged Health Assessment	> 60 mins a. Comprehensive information collection, including taking a patient history. b. An extensive examination of the patient's medical condition and physical and social function. c. Initiating interventions and referrals as indicated. 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 **Aboriginal and Torres Strait Islander Child** For patients 0-14 years old. Not available to inpatients of a hospital or RACF. Not more than once every nine months. **Aboriginal and Torres Strait Islander Adult** For patients 15-54 years old. Not available to inpatients of a hospital or RACF. Not more than once every nine months. **Aboriginal and Torres Strait Islander Older Peoples** For patients 55 years and over. Not available to inpatients of a hospital or RACF. Not more than once every nine months.

Hearth 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

- Aboriginal and/or Torres Strait Islander persons who are aged 30 years and above
- Adults aged 45 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 cvdcheck.org.au/calculator/
- 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	• Aboriginal and Torres Strait Islander adults over 30 • Adults over 45 years	Annually

Health Assessment for Aboriginal and 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 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)

Use “Referral form for follow-up allied health services under Medicare for People of Aboriginal or Torres Strait Islander descent”

Item	Name	Age Range	Recommended Frequency
715	Aboriginal & Torres Strait Islander Health Assessment	0-14 years 15-54 years 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

Ensure patient eligibility

Age and AUSDRISK

Attend Health Assessment

Claim MBS item

Common diabetes prevention or commence diabetes management

Eligibility Criteria

- Non-Aboriginal and Torres Strait Islander 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 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 Australian 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) 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

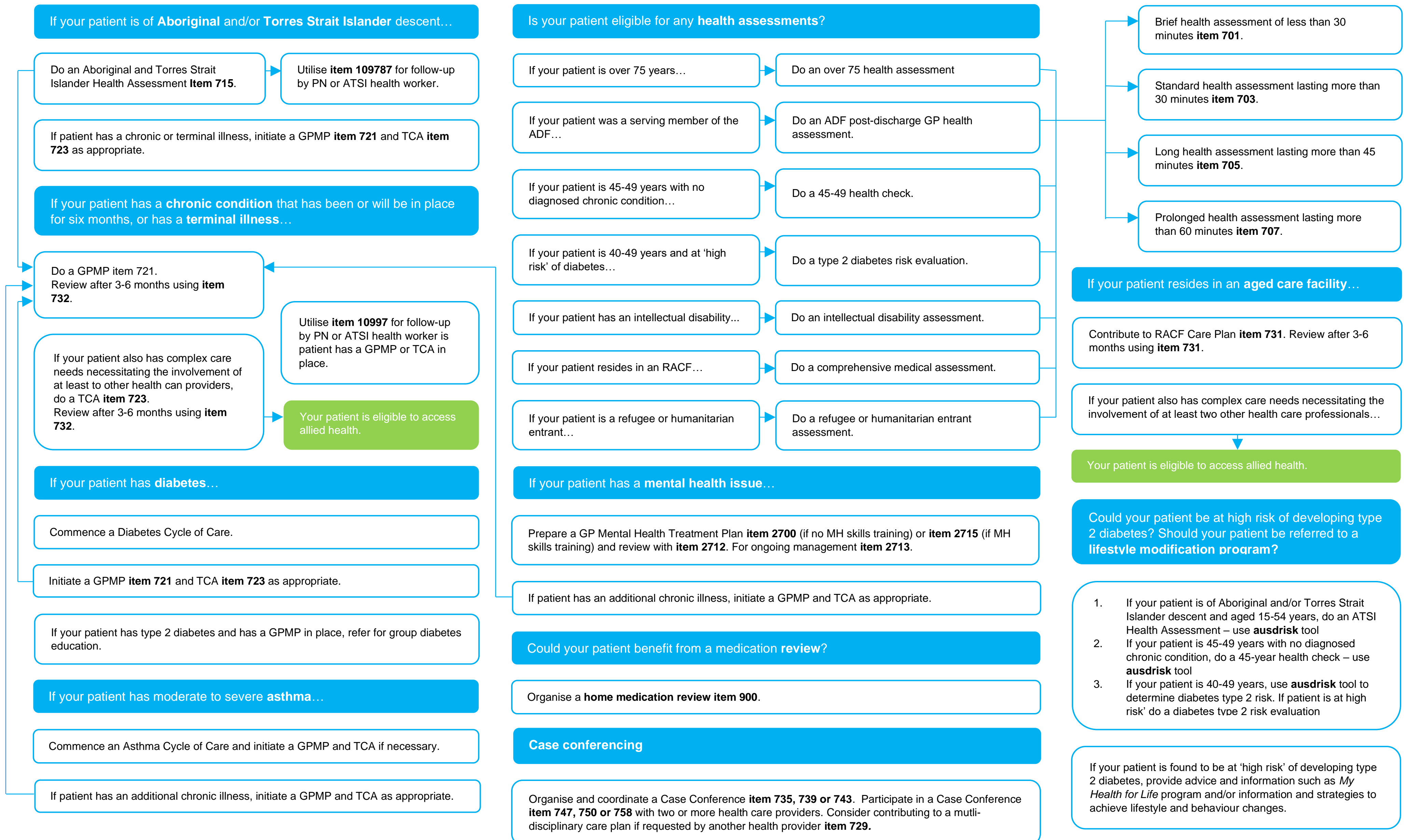
Items 701, 703, 705 and 707 may be used to undertake a Health Assessment for people with an intellectual disability.

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.

Health Assessments and Chronic Disease Management Flowchart



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 gals	**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 RACG	**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 of 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 or 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 e 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).

<table>
<tr><th>Item</th><th>Name</th><th>Recommended Frequency</th></tr>
<tr><td>10950</td><td>Aboriginal Health Worker Services</td><td rowspan="11">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.</td></tr>
<tr><td>10951</td><td>Diabetes Educator Services</td></tr>
<tr><td>10952</td><td>Audiologist Services</td></tr>
<tr><td>10953</td><td>Exercise Physiologist</td></tr>
<tr><td>10954</td><td>Dietician Services</td></tr>
<tr><td>10958</td><td>Occupational therapist Services</td></tr>
<tr><td>10960</td><td>Physiotherapist Services</td></tr>
<tr><td>10962</td><td>Podiatrist Services</td></tr>
<tr><td>10964</td><td>Chiropractor Services</td></tr>
<tr><td>10966</td><td>Osteopath Services</td></tr>
<tr><td>10970</td><td>Speech Pathologist Services</td></tr>
<tr><td>10956</td><td>Mental Health Worker Services</td><td rowspan="2">• Better access to metal health care items: ten sessions
• GPMP and TCA for chronic medical conditions: five sessions</td></tr>
<tr><td>10968</td><td>Psychologist Services</td></tr>
</table>

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 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 comprehensive medical assessment.
- Developing a list of diagnoses and medical problems based on the medical history and examination.
- Providing a copy of the summary to the residential aged care facility.
- Offering the resident a copy of the summary.

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 comprehensive medical assessment of a resident of a residential aged care facility may be claimed by an eligible patient:

- On admission to a residential aged care facility, provided that a comprehensive medical assessment 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 comprehensive medical assessment, where, if this Health Assessment is undertaken during the course of a consultation for another purpose, the Health Assessment item and the relevant item for the other consultation may both be claimed.
- Use of a specific form to record the results of the CMA is not mandatory. A Health Assessment provided as a Comprehensive Medical Assessment (CMA) may be claimed annually to an eligible patient.

Commonly Used Item Numbers

Comprehensive Medical Assessment	GP Contribution or Review of a Multidisciplinary Care Plan Prepared by a RACF
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 CMA and offering the patient a written report about the Health Assessment, with recommendations about matters covered by the Health Assessment CMA. • Providing a written summary of the outcomes of the Health Assessment CMA 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.	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 organise, and coordinate 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** 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 of resident's records and for nursing staff or 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 $55 for GPs and $20 for other medical practitioners.

Item number	Fee
90001	$55
90020	$17.20
90035	$37.60
90043	$72.80
90051	$107.15

Billing

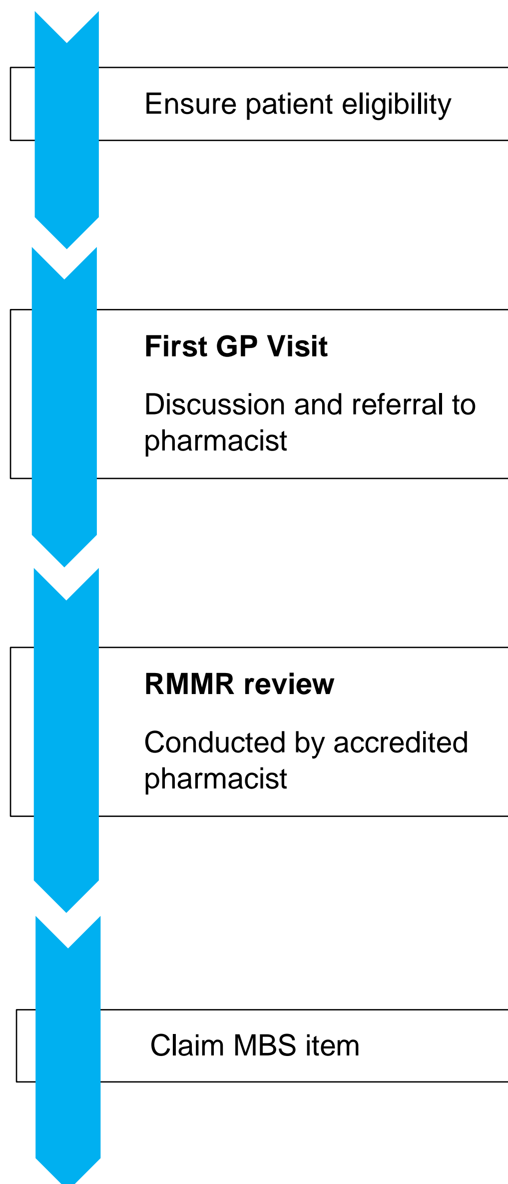
The RACF items are only for Medicare-eligible GP and other medical practitioners providing primary care services in RACFs. Doctors employed by RACFs cannot claim the items, nor can specialists, consultant physicians, nurses and other allied health professionals.

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

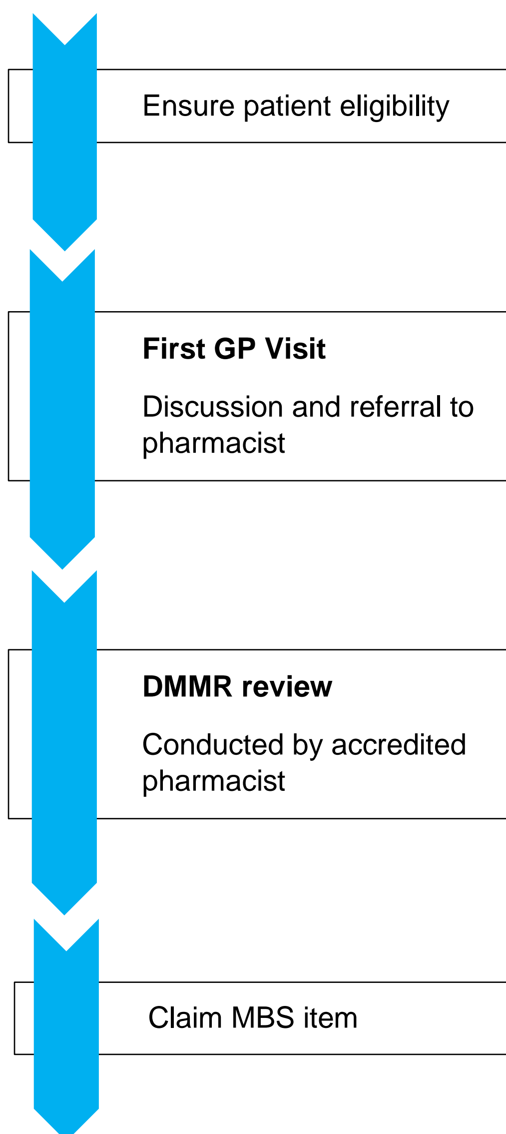
Examples of risk factors include:

- 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

Item 900



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 DAA service and discuss suitability with pharmacist or an accredited pharmacist

Incentive Programs

Practice Incentive Program and Service Incentive Payments

Payments Summary

Item	Activity	PIP ($ per SWPE)	Notes (PIP Enquiry Line 1800 222 032) https://www.servicesaustralia.gov.au/
eHealth	**Requirement 1:** Integrating Healthcare Identifiers into Electronic Practice Records. **Requirement 2:** Secure messaging capability. **Requirement 3:** Data records and clinical coding. **Requirement 4:** Electronic transfer prescriptions. **Requirement 5:** My Health Record system.	$6.50 per SWPE, per annum Capped at $12 500 per quarter	To qualify, practices must meet each of the requirements: **Requirement 1:** • Apply for a Health Care Provider Identifier-Organization (HPI-O) • Ensure each GP within the practice has a Healthcare Provider Identifier – Individual (HPI-I) • Use a compliant clinical software system to access, retrieve and store verified individual Healthcare Identifiers (IHI) for patients **Requirement 2:** • Apply for a NASH PKI Certificate • Have a standards-compliant secure messaging capability and use it where feasible • Work with your secure messaging vendor to ensure it is installed and configured correctly • Have a written policy to encourage its use **Requirement 3:** • Be working towards recording the majority of diagnoses electronically using a medical vocabulary that can be mapped against a nationally recognised disease classification or terminology system • Provide written policy to this effect to all GPs **Requirement 4:** • Use a software system that is able to send an electronic prescription to a Prescription Exchange Service (PES) • The majority of prescriptions are sent to a PES **Requirement 5:** • Use compliant software to access the My Health Record system and create and post Shared Health Summaries (SHS) and Event Summaries • Apply to participate in the My Health Record system upon obtaining a HPI-O • Upload SHS for a minimum of 0.5% of the practice's SWPE count of patients per PIP payment quarter Please refer to the ePIP incentive guidelines released by Medicare Australia

Quality Improvement	The PIP QI incentive rewards practices for participating in continuous quality improvement activities in partnership with their local PHN	Maximum payment of $12 500 per quarter, based on $5.00 per SWPE	To be eligible to receive PIP QI payment, general practices must: • Be eligible for the PIP • Register for the PIP QI Incentive (via PRODA) from 01/08/19 • Electronically submit the de-identified PIP Eligible Data Set to their local PHN quarterly via agreed Data Extraction Tool • Undertake continuous quality improvement activities in partnership with their local PHN **Commenced in August 2019.** Further information here.
Teaching	Aims to encourage general practices to provide teaching sessions to undergraduate and graduate medical students preparing for entry into the Australian Medical profession	$100.00 per session	Practices can access a maximum of $100.00 for each three-hour teaching session provided to medical students. Each practice can claim a maximum of two sessions per GP, per day.
Age Care Access	**Tier 1:** GP completes the Qualifying Service Level (QSL) 1 – 60 MBS services in RACF claimed in a financial year.	$1500	MBS items that count towards QSLs include attendances in RACF, contributions to multidisciplinary care plans and Residential Medication Management Requires. GPs need to provide the service using their PIP linked Medicare provider number. GPs do not need to apply to participate in the Incentive. Medicare will request bank details from GPs eligible to receive payments once they have reached the QSL.
	Tier 2: GP completes the Qualifying Service Level 2 – 140 MBS services in RACF claimed in a financial year.	$3500	
Indigenous Health	Provision of better health care for Indigenous patients, including best practice management of chronic disease. Sign-on payment.	$1000	One-off payment only. Practice must be registered for PIP. The practice must: • Seek consent to register their Aboriginal and/or Torres Strait Islander (ATSI) patients (regardless of age) who have, or are at risk of, chronic disease, with Medicare and the practice for chronic disease management in a calendar year • Establish a mechanism to ensure their ATSI patients aged 15 years and over with chronic disease, are followed up e.g., recall/reminder system to ensure they return for ongoing care • Undertake cultural awareness training within 12 months of joining incentive • Annotate PBS prescriptions for eligible ATSI patients for the PBS Co-payment

<table>
<tr>
<td rowspan="3"></td>
<td>Annual patient registration payments</td>
<td>$250.00 per registered ATSI patient, per calendar year</td>
<td>

Practice registers their eligible ATSI patients with Medicare for the PIP Indigenous Health Incentive or PBS Co-payment measure
Practice must actively plan and manage care of their ATSI patients with chronic disease for a calendar year
Payment made to practice for each ATSI patient who:

Is aged 15 years or over and has chronic disease
Has had (or has been offered) the 715 ATSI Health Assessment
Has provided informed consent to be registered for the PIP Indigenous Health Incentive

The patient’s registration period commences from the day they provide consent to participate in the incentive, and will end on 31 December that year
Practices are required to obtain consent to re-register patients each year

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<td>Tier 1 (Outcomes Payment):
Chronic Disease Management</td>
<td>$200.00 per registered patient per calendar year</td>
<td>Payment made to practices that (in a calendar year):

Develop a 721 GPMP or 723 TCA for the patient and undertake at least one 732 Review of GPMP or TCA
Undertake two 732 Reviews of GPMP or TCA
Complete 731 contribute to, or review, a care plan for a patient in a RACF, on two occasions

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<tr>
<td>Tier 2 (Outcomes Payment):
Total Patient Care</td>
<td>$150.00 per registered patient per calendar year</td>
<td>

Payment made to practices that provide the majority (i.e., the highest number) of MBS services for the patient (with minimum of 5 MBS services) in a calendar year. This may include MBS services provided for Tier 1.

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<tr>
<td>COVID-19 Vaccine</td>
<td>Patients to receive both a first and second dose assessment at the same practice</td>
<td>$10.00 per patient</td>
<td>For the payment to be made, the following criteria must be satisfied:

Practice staff must have completed COVID-19 vaccination training for the safe management and administration of COVID-19 vaccines
Be the first PIP eligible practice to process a first and a second-dose assessment service to the same patient at the same practice
Assessment services must have been successfully processed
Vaccine dose must occur within the timeframes approved by the Therapeutic Goods Administration (TGA) and consistent with advice provided by the Australian Technical Advisory Group on Immunisation (ATAGI)

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After Hours Incentive

The After-Hours Incentive aims to support general practice to provide their patients with appropriate access to after hours care.

After hours periods:
For PIP the complete after-hours period is:

- Outside 8am to 6pm weekdays
- Outside 8am to 12 noon on Saturdays
- All day on Sundays and public holidays

The complete after-hours period is broken into:

- Sociable after-hours period: 6pm to 11pm weeknights
- Unsociable after-hours periods: 11pm to 8am weekdays, hours outside of 8am and 12 noon Saturdays, and all-day Sundays and public holidays

Core Eligibility Requirements
To be eligible for the PIP After-Hours incentive, practice must meet the following core eligibility requirements:

1. Be registered for the PIP and meet the requirements for the payment level claimed for the entire quarter before the payment month
2. Provide after-hours care for patients in accordance with the RACGP Standards for general practices
3. Clearly communicate after hours arrangements to patients, including information available within the practice, on the practice website or through a telephone answering machine

Guidelines and requirements for the new PIP After-Hours Incentive are available at the Services Australia website.

Payment level		**Description**
Level 1 Participation	$1 per SWPE	Practices must have formal arrangements in place to ensure that practice patients have access to care in the complete after-hours period.
Level 2 Sociable after-hours cooperative coverage	$4 per SWPE	Practices must participate in cooperative arrangement with other general practices that provide after-hours care to practice patients in the sociable after-hours period and ensure formal arrangements are in place to cover the unsociable after-hours period.
Level 3 Sociable after-hours practice coverage	$5.50 per SWPE	Practice must provide after-hours care to practice patients directly through the practice in the sociable after-hours period and ensure formal arrangements are in place to cover the unsociable after-hours period.
Level 4 Complete after-hours cooperative coverage	$5.50 per SWPE	Practice must participate in a cooperative arrangement with other general practices that provides after-hours care to practice patients for the complete after-hours period.
Level 5 Complete after-hours practice coverage	$11 per SWPE	Practice must provide afterhours care to practice patients in the complete after-hours period.

Procedural GP			
	To encourage GPs in rural and remote areas to maintain local access to surgical, anaesthetic, and obstetric services. **Procedural Services:** • Obstetric delivery • General anesthetic • Major regional blocks • Abdominal surgery • Gynecological surgery requiring general anesthetic • endoscopy **Core Eligibility Criteria** • Have at least one procedural GP registered with the PIP for the entire reference period • Meet the activity requirements for claiming the relevant payment tier • Be in a rural, remote of metropolitan area (MMM 3-7) • Ensure the GP providing the services has a level of professional indemnity insurance that indicates they are covered to perform procedural services Guidelines and requirements are available here.		
	Payment Level		**Description**
	Tier 1	$1000 per GP per 6 months	A GP must provide at least one procedural service in the six-month period
	Tier 2	$2000 per GP per 6 months	A GP must: • Meet the Tier 1 requirements • Provide after-hours procedural services on a regular rostered basis (15 hours per week on average)
	Tier 3	$5000 per GP per 6 months	A GP must: • Meet the Tier 2 requirements • Provide 25 or more eligible surgical, anesthetic or obstetric services in the six-month period
	Tier 4	$8500 per GP per 6 months	A GP must: • Meet the tire 2 requirements • Deliver 10 or more babies in the 6-month period

PIP Payment Calculator

The table below is a snapshot of the Practice Incentive Program Income Estimator that assists with identifying potential income generated by participating in the relevant practice incentive programs. Click here to download an Excel version of the calculator. Contact your General Practice Support Officer for support.

Practice Situation	
FTE GP	
SWPE	
Total active Patients	
Modified Monash Model	
Remote Area (RA) Classification	

Please enter relevant information in the blue boxes

Click here to seach for MMM and RA classification

PIP Forms and Guidelines

		Payments per FTE GP	Annual Payment to Practice	Once off Payment to Practice
After Hours Incentive				
Level 1 Participation $1 per SWPE Formal arrangements in place to ensure pratcie patients can access care in the complete after hours period. Services do not have to be supplied by the practice. **Level 2 Sociable After Hours Cooperative Coverage** $4 per SWPE Participate in a cooperative assangements that provides after hours care to practice patients in the sociable after hours period and ensure formal arrangments are in place to cover the unsociable after hours period. **Level 3 Socialable After Hours Practice Coverage** $5.50 per SWPE Provide after hours cause to practice patients directly through the practice in sociable after hours and ensure formal arrangements are inplace to cover the unsociable after hours period. **Level 4 Complete After Hours Cooperative Coverage** $5.50 per SWPE Participate in a cooperative arrangement thatprovides after hours care to practice patients for the complete after hours period. **Level 5 Complete After Hours Practice Coverage** $11 per SWPE Provide after hours care to practice patients in the complete after hours period.		-	$ -	-
e-Health Incentive				
Practices must meet all of the following criteria: **Requirement 1** - Integrating Healthcare Identifiers into Electronic Practice Records **Requirement 2** - Secure Messaging Capability **Requirement 3** - Data Records and Clinical Coding **Requirement 4** - Electronic Transfer of Prescriptions **Requirement 5** - My Health Records System (upload health summaiers for a minimum of 0.5% of the SWPE per quarter)	**Total Amount Annually**	-	$ -	-
General Practitioner Aged Care Access				
Tier 1 Payment of $1500 Provide at least 60 eligible MBS services in RACF in this financial year **Tier 2** Payment of $3500 Provide at least 140 eligible MBS services in RACF in this financial year		$ -	-	-
Indigenous Health Incentive				
Sign-on Payment		-	-	$ -
Estimated number of Indigenous Patients 15 years olf and above with Cronic Diseases	**Patient Registration Payment**	-	$ -	-
	Outcomes Payment Tier 1	-	$ -	-
	Outcomes Payment Tier 2	-	$ -	-
Procedural General Practitioner Payment				
Number of Procedural GPs in the practice (First 6 Month Payment Period / Second 6 Month Payment Period)				
Tier 1 A GP in a rural or remote pratcie provides any service in the six month reference period that meets the definition of a procedural service. **Tier 2** A GP meets the Tier 1 requirement and provides after hours procedural services on a regular or rostered bases throuhgout the six month reference period.	**First 6 Months Payment Period**	-	$ -	-
Tier 3 A GP meets the Tier 2 requiremets and provides surgical and/or anaeshetic and/or obstertric services totalling 25 or more eligible procedures in the six month reference period. **Tier 4** A GP meets the Tier 3 requiremens and delivers 10 or more babies in the six month reference period or meets the obstertric needs of the community	**Second 6 Month Payment Period**	-	$ -	-
Quality Improvement Incentive				
Practices must meet all of the following criteria: **Requirement 1** - Submits data to the PHN **Requirement 2** - Continually makes quality improvements	**Total Amount Annually**	-	$ -	-
Teaching Payment				
Number of Teaching Sessions per Week	**Total Amount Annually**	-	#DIV/0!	-
Rural Loading Incentive				
	Total Amount Annually	-	$ -	-
		TOTAL PAYMENT per FTE GP	**TOTAL ANNUAL PAYMENT TO PRACTCIE**	**TOTAL ONCE OFF PAYMENT TO PRACTICE**
		$ -	#DIV/0!	$ -
			GRAND TOTAL	
			#DIV/0!	

Cancer Screening

Cervical Screening

In December 2017, the Cervical Screening Test replaced the Pap test in Australia. Cervical cancer is one of the most preventable cancer types. Routine cervical screening is the best protection against cervical cancer. The Cervical Screening Test is expected to protect up to 30% more women.

The Cervical Screening Test is more effective than the Pap test at preventing cervical cancer because it detects the human papillomavirus (HPV), whereas the Pap test looked for cell changes in the cervix which may take a longer period to discover. HPV is a common infection that can cause cervical cell changes that may lead to cervical cancer. The new test is only required to be completed every five years rather than every two.

Patient Eligibility

- Women between 24 years and 9 months and less than 74 years
- '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 only 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 131 556 or https://www.cancerinstitute.org.au/cervical-screening-nsw
National Cancer Screening register	https://www.ncsr.gov.au/ P: 1800 627 701

MBS Item Numbers for Under Screened Women

Item	Name	Description
2496	Level A Cervical Screening	Short surgery consultation
2501	Level B Cervical Screening	< 20 min surgery consultation
2503	Level B Cervical Screening	< 20 min out of surgery
2504	Level C Cervical Screening	> 20 min surgery consultation
2506	Level C Cervical Screening	> 20 min out of surgery
2507	Level D Cervical Screening	> 40 min surgery consultation
2509	Level D Cervical Screening	> 40 min out of surgery

Mental Health

MBS Better Access Initiative

The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (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 general practitioners (GPs), psychiatrists, psychologists (clinical and registered) and eligible 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 30 June 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 age 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. This is, for separate visits that are undertaken to assess the patient and develop the plan, no MBS item would be claimed for the first visit and item 2700, 2701, 2715 or 2717 would be claimed for the second visit (see A.40.9 to A.40.17 of the Explanatory Notes of the Nov 2009 MBS Book).

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)

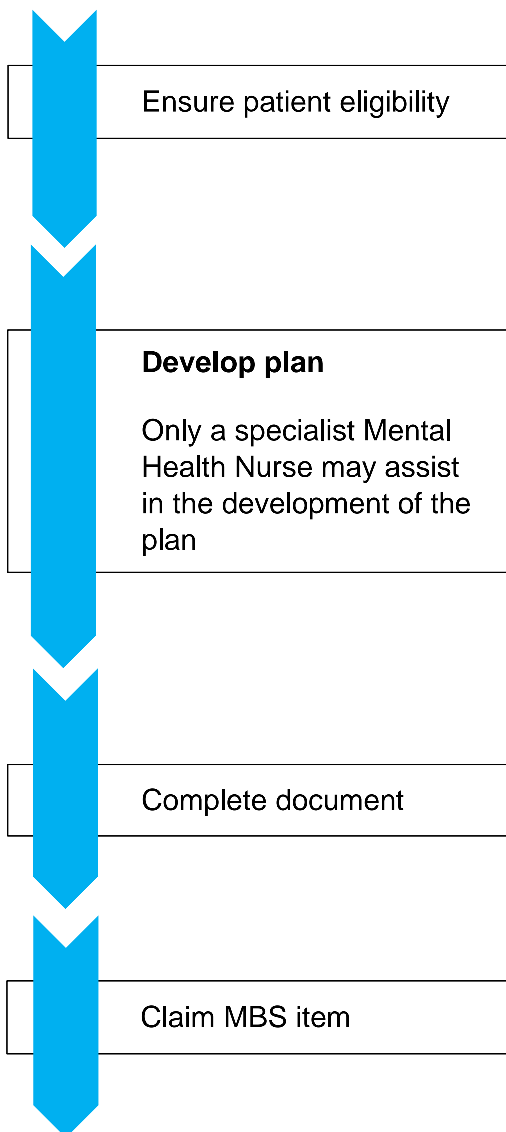
A GP Mental Health Treatment Plan sample template for the Better Access Program can be accessed here.

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 requires 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 outlines 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

Reviewing the Plan

Only a specialist Mental Health Nurse may assist in the review of the plan

- Explain steps involves, 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

Complete documentation

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

Claim MBS item

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-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

Clinical Content

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 (As part of a GP Mental Health Treatment Plan)	• Patient's agreement for the GP Mental Health Treatment Plan service • Relevant History • Mental state examination • Assess risk and co-morbidity • A diagnosis and/or formulation • Administer outcome measurement tool (unless clinically inappropriate)
Plan	• 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 • Agreeing goals with the patient • Provision of psychoeducation • Crisis intervention and/or relapse prevention plan if appropriate • Referrals, treatment, appropriate support services, review, and follow-up • Documenting results in the patient's GP Mental Health Treatment Plan • Offer a copy of the plan to the patient
Review	• Recording the patient's agreement for this service • Review patient's progress against the goals outlined in the GP Mental Health Treatment Plan • Modify GP Mental Health Treatment Plan if required • Check, reinforce and expand education • Crisis intervention and/or relapse prevention plan if appropriate and if not previously provided • Re-administration of the outcome measurement tool (unless clinically inappropriate) **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) • Providing treatment, advice and/or referral for other services of treatment • 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)

Procedural Items

Procedural Item Numbers

Dislocations

Item	Service or Procedure
47018	ELBOW, treatment of dislocation of, by closed reduction
47036	INTERPHARLANGEAL JOINT, treatment of dislocation of, by closed reduction
47000	MANDIBLE, treatment of dislocation of, by closed reduction
47042	METACARPOPHALANGEAL JOINT, treatment of dislocation of, by closed reduction
47057	PATELLA, treatment of, by closed reduction
47024	RADIOULNAR JOINT, DISTAL or PROXIMAL, treatment of dislocation of, by closed reduction, not being a service associated with fracture or dislocation in the same region
47015	SHOULDER, treatment of dislocation of, not requiring general anaesthesia
47069	TOE, treatment of dislocation of, by closed reduction

Fractures

Item	Service or Procedure
47354	CARPAL SCAPHOID, treatment of fracture of, not being a service to which item 47357 applies
27348	CAPUS (excluding scaphoid), treatment of fracture of, not being a service to which item 47351 applies
47462	CALVICLE, treatment of fracture or, not being a service to which 47465 applies
47516	FEMUR, treatment of fracture of, by closed reduction or traction
47576	FIBULA, treatment of fracture of
47444	HUMERUS, shaft of, treatment of fracture of, not being a service to which item 47447 or 47450 applies
47633	METATARSAL, one of, treatment of fracture of
47636	METATARSAL, one of, treatment of fracture of, by closed reduction
47579	PATELLA, treatment of fracture of, not being a service to which item 47582 or 47585 applies
47663	PHALANX OF GREAT TOE, treatment of facture of, by closed reduction
47546	TIBIA, plateau of treatment of medial or lateral fracture of, by closed reduction
47543	TIBIA, plateau of, treatment of medial or lateral fracture of, not being a service to which item 47546 or 47549 applies
47561	TIBITA, shaft of, treatment of, by cast immobilisation, bot being a service to which item 47564, 47567, 47570 or 47573 applies
47564	TIBIA, shaft of, treatment of fracture of, by closed reduction, with or without treatment of fibular fracture

Obstetrics

Item	Service or Procedure
16500	ANTENATAL ATTENDANCE
16407	POSTNATAL ATTENDANCE by a GP or obstetrician

Operations

Item	Service or Procedure
30219	HAEMATOMA, FURUNCLE, SMALL ABSCESS OR SIMILAR LESION not requiring admission to a hospital – INCISION WITH DRAINAGE OF (excluding after-care)
51300	Assistance at any operation identified by the word 'assist' for which the fee does not exceed $558.30 or at a series or combination of operations identified by the word 'assist' where the fee does not exceed $558.30
51306	Assistance at the delivery involving Caesarean section
30071	DIAGNOSTIC BIOPSY OF SKIN OR MUCOUS MEMBRANE, as an independent procedure, where the biopsy specimen is sent for pathological examination
41500	EAR, foreign body (other than ventilating tube) in, removal of, other than by simply syringing
41659	NOSE, removal of foreign body in, other than by simple probing
30064	SUBCUTANEOUS FOREIGN BODY, removal of, requiring incision and exploration, including closure of wound if performed, as an independent procedure
30216	HAEMATOMA, aspiration of
47915	INGROWING NAIL OF TOE, wedge resection for, including removal of segment of nail, ungula fold and portion of the nail bed
42575	TARSAL CYST, extirpation of
46513	DIGITAL NAIL OF FINGER OR THUMB, removal of, not being a service to which item 46516 applies
47904	DIGITAL NAIL OF TOE, removal of, not being a service to which item 47906 applies
30195	BENIGN NEOPLASM OF SKIN, other than viral verrucae (common warts) seborrheic keratosis, cysts and skin tags, treatment by electrosurgical destruction, simple curettage or shave excision, or laser photocoagulation, not being a service to which item 30196, 30197, 30202, 30203 or 30205 applies (one or more lesions)
32147	PERIANAL THROMBOSIS, incision of
30186	PALMAR OR PLANTAR WARTS (less than ten), definitive removal of, excluding ablative methods alone, not being a service to which item 30185 or 30187 applies
30099	SINUS, excision of, involving superficial tissue only
45400	FREE GRAFTING (split skin) of a granulating area, small
45200	SINGLE STAGE LOCAL FLAP, where indicated to repair one defect, simple and small, excluding flap for male pattern baldness and excluding H-flap or double advancement flap not in association with any of items 31356 or 31376
30213	TELANGIECTASES OR STARBURST VESSELS on the head or neck where lesions are visible from four metres, diathermy or sclerosant injection of, including associated consultation – limited to a maximum of six sessions (including any session to which items 14100 to 14118 and 30213 apply) in any 12-month period – for a session of at least 20 minutes duration

Pathology of Diagnostic Tests

Item	Service or Procedure
13839	ARTERIAL PUNCTURE and collection of blood for diagnostic purposes
11707	TWELVE-LEAD ELECTROCARDIOGRAPHY, trace only
73806	Pregnancy test by one or more immunochemical methods
12000	SKIN SENSITIVITY TESTING for allergens, using one to 20 allergens, other than a service associated with a service to which item 12012, 12017, 12021, 12022 or 12024 applies
11505	MEASUREMENT OF RESPIRATORY FUNCTION involving a permanently recorded tracing performed before and after inhalation of bronchodilator – each occasion at which one or more such tests are performed. Performed to confirm diagnosis or asthma, COPD, or another cause of airflow limitation
11506	MEASUREMENT OF RESPIRATORY FUNCTION involving a permanently recorded tracing performed before and after inhalation of bronchodilator – each occasion at which one or more such tests are performed

Procedures

Item	Service or Procedure
30003	LOCALISED BURNS, dressing of, (not involving grafting) each attendance at which the procedure is performed, including any associated consultation
14206	HORMONE OR LIVING TISSUE IMPLANTATION by cannula
14203	HORMONE OF LIVING TISSUE IMPLANTATION, by direct implantation involving incision and suture
30628	HYDROCELE, tapping of
35503	INTRAUTERINE CONTRACEPTIVE DEVICE, introduction of, not being a service associated with a service to which another item in this group applies (other than a service mentioned in item 30062)
32072	SIGMOIDOSCOPIC EXAMINATION (with rigid sigmoid scope), with or without biopsy
30207	SKIN LESIONS, multiple injections with hydrocortisone or similar preparations

Skin Lesions, Excisions, Biopsies and Wounds

Item	Service or Procedure	Size of Lesion
Benign skin lesions (other than common warts and seborrheic keratosis) for diagnostic purposes		
31357	Nose, eyelid, eyebrow, lip, ear, digit, genitalia, or a contiguous areas	<6mm
31360		6mm +
31362	Face, neck, scalp, nipple-areola, distal lower/upper limb	<14mm
31364		14mm +
31366		<15mm
31368	Body, other than above	15-30mm
31370		>30mm
Malignant skin lesions (malignancy confirmed from the excised specimen or previous biopsy)		
31356	Nose, eyelid, eyebrow, lip, ear, digit, genitalia, or a contiguous areas	<6mm
31358		6mm +
31361	Face, neck, scalp, nipple-areola, distal lower/upper limb	<14mm
31363		14mm +
31365		<15mm
31367	Body, other than above	15-30mm
31369		>30mm

Malignant melanoma, appendageal carcinoma, connective tissue tumour of skin or merkel cell carcinoma of skin (malignancy confirmed from the excised specimen or previous biopsy)		
31371	Nose, eyelid, eyebrow, lip, ear, digit, genitalia, or a contiguous areas	6mm +
31372	Face, neck, scalp, nipple-areola, distal lower/upper limb	<14mm
31373		14mm +
31374		<15mm
31375	Body, other than above	15-30mm
31376		>30mm
Tumour, cyst, ulcer, scar, removal and suture (^other than common warts and seborrheic keratosis)		
31206		<10mm
31211	Mucous membrane	10-20mm
31216		>20mm
31220	4 to 10 lesions – skin^	
31221	4 to 10 lesions – mucous membrane^	Each <10mm
31225	>10 lesions – skin or mucous membrane^	
Biopsy for diagnostic purposes		
30071	Biopsy of skin	
30072	Biopsy of mucous membrane	
Skin wounds and other		
30026	Wound, superficial, other than on face or neck	
30029	Wound, deep, other than on face or neck	<7cm
30032	Wound, superficial, face or neck	
30035	Wound, deep, face or neck	
30038	Wound, superficial, other than on face or neck	
30042	Wound, deep, other than on face or neck	>7cm
30045	Wound, superficial, face or neck	
30023	Repair of soft tissue wound – deep, including debridement and suture	
30052	Full thickness laceration of ear, eyelid, nose, or lip	
30111	Removal of large burse, including olecranon, calcaneum or patella	

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, war widows, war widowers and dependants who are Gold Care holders and are as risk of being admitted or readmitted to hospital.

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 Incentive Payment for enrolling a participant in the program
- Quarterly Care Payments for ongoing care

Guide for General Practice

The DVA has developed a guide to help with the implementation of the Coordinated Veterans' Program. 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: • The LMO/GP has made any required changes to the practice before enrolling the participant in the Program • The participant has been assessed by the LMO/GP as meeting the eligibility criteria for participation in the Program • 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 • A care coordinator employed by the general practice has been appointed • A comprehensive needs assessment of the participant has been carried out by the care coordinator or the LMO/GP • 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	This item will be claimed on enrolment of a participant in the CVC Program. 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. 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.

NSW Workers Compensation Regulation Rates

From 1 January 2016

AMA Codes must be used for all consultations and medical services.

Note: From 1 September 2015, Insurance and Care NSW (iCare) is the organisation responsible for workers compensation insurance.

Item	Name	Description/Recommended Frequency
AA010	Level A Consultation	The rate for consultation fee applies for services provided on or after 1 January 2016. GST should not be charged on the consultation fee. For further information on the criteria for Level A, B, C and D consultation services please consult the AMA List of Medical Services and Fees (1 November 2015). Out-of-hours fees are only payable for emergency attendance and emergency treatment of a worker at the time when the practice is not usually open
AA020	Level B Consultation	
AA030	Level C Consultation	
AA040	Level D Consultation	
WC0001	Certificate of Capacity	One certification fee may be charged for the initial certificate only. No fee is payable for subsequent certificates. To order certificates of capacity call SIRA on 13 10 50.
WC0002	Maximum hourly rate payable to GP	This fee is to remunerate for any time spent by the medical practitioner, in addition to the usual medical management, to assist the worker to recover at or return to work. These rates may cover, for example, discussions with employers, case conferences (see definition below), visits to worksites, time spent reviewing injury management to return to work plans and providing additional reports requested from treating doctors (where is was preapproved by the insurer). These should be billed to reflect the time taken (to the nearest five minutes) to deliver the service.
	Case Conference	Case conference means a face-to-face meeting, video conference or teleconference with any or all of the following parties: workplace rehabilitation provider, employer, insurer or other treatment provider(s) delivering services to the worker. Discussion must seek to clarify the worker's capacity for work, barriers to return to work, and strategies to overcome these barriers via an open forum to ensure parties are aligned with respect to expectations and direction of the injured worker's recovery at work or return to suitable employment. If the discussion is with the worker, it must involve a third party to be considered a case conference. Discussions between the worker's nominated treating doctor and other treating practitioners (e.g., allied health practitioners, medical specialists/surgeons) relating to treatment are considered a normal interaction between referring doctor and practitioner. This will not be charged as a case conference
WC0004	Other Medical Items	The cost of all bandages and dressings etc.
PHS001	Pharmaceutical Services	Payment for pharmaceutical services
WC0005	Medical Records	Fee for providing copies of medical records (including treating general practitioner, specialist or consulting surgeon notes and reports). If the clinical records are provided electronically, a flat fee applies.

Note: these item numbers to be used for Motor Vehicle Accident consultations

After-Hours Services Item Numbers

<table>
<tr><th colspan="3">Attendance Period</th><th colspan="2">Item Number</th><th>Brief Guide</th></tr>
<tr><td colspan="3">Urgent attendance – after hours</td><td colspan="2" rowspan="2">585 (GP)
588 (Non-VR GP, rural area)
591 (Non-VR GP, metropolitan area)
594 (additional patients at one location)</td><td rowspan="9">• These items can only be used for the first patient, if more than one patient is seen on the one occasion, standard (non-urgent) after hours items apply
• The urgent after-hours items can only be used where the patient has a medical condition that requires urgent assessment which could not be delayed until the next in-hours period
• For consultations at the health center it is necessary for the practitioner to return to, and especially open the consulting rooms for the attendance</td></tr>
<tr><td>Mon-Fri
7-8am
6-11pm</td><td>Sat
7-8am
12noon-11pm</td><td>Sun & Pub Holidays
7am-11pm</td></tr>
<tr><td colspan="3">Urgent attendance – unsociable hours</td><td colspan="2" rowspan="2">599 (GP)
600 (Non-VR GP)</td></tr>
<tr><td>Mon-Fri
11pm-7am</td><td>Sat
11pm-7am</td><td>Sun & Pub Holidays
11pm-7am</td></tr>
<tr><td colspan="3">Non urgent after hours at consulting room</td><td colspan="2" rowspan="2">GP
5000 (Level A)
5020 (Level B < 20 mins)
5040 (Level C > 20 mins)
5060 (Level D > 40 mins)

Non-VR GP
5200 (Level A)
5203 (Level B < 20 mins)
5207 (Level C > 20 mins)
5208 (Level D > 40 mins)</td></tr>
<tr><td>Mon-Fri
Before 8am
After 8pm</td><td>Sat
Before 8am
After 1pm</td><td>Sun & Pub Holidays
All day</td></tr>
<tr><td colspan="3">Non-urgent after hours at place other than consulting rooms</td><td>Home</td><td>RACFs</td></tr>
<tr><td>Mon-Fri
Before 8am
After 8pm</td><td>Sat
Before 8am
After 1pm</td><td>Sun & Pub Holidays
All day</td><td>GP
5003
5023
5042
5063

Non-VR GP
5220
5223
5227
5228</td><td>GP
5010
5028
5049
5067

Non-VR GP
5260
5263
5265
5267</td></tr>
</table>

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

NSW Pap Test Infoline
T: 1800 671 693

NSW Cervical Screening Program
W: canacer.nsw.gov.au/cervical-screening-nsw

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

Practice Incentive Program (PIP)
T: 1800 222 032

Diabetes
Diabetes Australia NSW
W: diabetesnsw.com.au
T: 1300 342 238

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

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

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

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

NBMPHN Health Pathways
W: nbm.communityhealthpathways.org