



**Wentworth
Healthcare**

Blue Mountains | Hawkesbury | Lithgow | Penrith

Desktop Guide:
**Frequently
used MBS Item
Numbers**
For General Practice
Services

March
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Revised
Edition

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NEPEAN
BLUE MOUNTAINS

An Australian Government Initiative

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Frequently used MBS Item Numbers

For a comprehensive explanation of each MBS Item Number, please refer to [MBS Online](#).

Commonly Used Item Numbers			
Item	Name	\$	Description/Recommended Frequency
3	Level A	\$17.75	Brief < 5 minutes
23	Level B	\$38.75	Standard 5-24 minutes
36	Level C	\$75.05	Long 25-44 minutes
44	Level D	\$110.50	Prolonged > 45 minutes
10990	Bulk Billing item	\$7.60	DVA, under 16's and Commonwealth Concession Card holders. Can be claimed concurrently for eligible patients.
10991	Bulk Billing item	\$11.50	Rural and remote
11505	Spirometry	\$42.40	Measurement of spirometry, that: (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; Each occasion at which 3 or more recordings are made. Applicable only once in any 12 month period.
11506	Spirometry	\$21.20	Measurement of spirometry, that: (a) involves a permanently recorded tracing, performed before and after inhalation of a bronchodilator; and (b) is performed to: (i) confirm diagnosis of chronic obstructive pulmonary disease (COPD); or (ii) assess acute exacerbations of asthma; or (iii) monitor asthma and COPD; or (iv) assess other causes of obstructive lung disease or the presence of restrictive lung disease; Each occasion at which recordings are made.
11707	ECG Trace only	\$19.00	Twelve-Lead Electrocardiography, tracing only
Residential Aged Care Facility – GP Call Out Fee and Consults			
90001	Single site call out fee	\$56.75	A flag fall service to which item 90020, 90035, 90043 or 90051 applies. For the initial attendance at one residential aged care facility on one occasion, applicable to a maximum of one patient attended on.
90020	Brief	\$17.75	< 5 minutes
90035	Standard	\$38.75	< 20 minutes
90043	Long	\$75.05	≥ 20 minutes
90051	Prolonged	\$110.50	≥ 40 minutes

Chronic Disease Management			
Item	Name	\$	Description/Recommended Frequency
721	GP Management Plan (GPMP)	\$148.75	Management plan for patients with chronic or terminal condition. Not more than once yearly.
723	Team Care Arrangement (TCA)	\$117.90	Management plan for patients with chronic or terminal condition and complex needs requiring ongoing care from a team including the GP and at least 2 other health or care providers. Enables referral for 5 rebated allied health services. Not more than once yearly.
732	Review of GPMP and/or TCA	\$74.30	Recommended 6 monthly. Must be performed at least once over the life of the plan.
729	GP Contribution to, or Review of, Multidisciplinary Care Plan	\$72.60	Contribution to, or review of, a multidisciplinary care plan prepared by another provider (e.g. community, home, allied health providers, or specialists), for patients with a chronic or terminal condition and complex needs that requires ongoing care from a team including the GP and at least 2 other health or care providers. Not more than once every 3 months.
731	GP Contribution to, or Review of, Multidisciplinary Care Plan prepared by RACF	\$72.60	GP contribution to, or review of, a multidisciplinary care plan prepared by RACF, at the request of the facility, for patients with a chronic or terminal condition and complex needs requiring ongoing care from a team including the GP and at least 2 other health or care providers. Not more than once every 3 months.

Health Assessments			
Item	Name	\$	Description/Recommended Frequency
699	Heart Health Assessment	\$75.05	Lasting at least 20 minutes
701	Brief Health Assessment	\$61.20	Lasting no more than 30 minutes
703	Standard Health Assessment	\$142.20	> 30 - 44 minutes
705	Long Health Assessment	\$196.25	> 45 - < 60 minutes
707	Prolonged Health Assessment	\$277.20	> 60 minutes
715	Aboriginal and Torres Strait Islander Health Assessment	\$218.90	See MBS for requirements

Practice Nurse Item Numbers			
10987	Follow Up Health Services for Indigenous people	\$24.75	Follow up services for an Indigenous person who has received a Health Assessment. Not an admitted patient of a hospital. Maximum of 10 services per patient per calendar year.
10997	Chronic Disease Management	\$12.40	Monitoring and support for patients being managed under a GPMP or TCA. Not more than 5 per patient per year.

Medication Management			
Item	Name	\$	Description/Recommended Frequency
900	Domiciliary Medication Management Review (DMMR)	\$159.65	Review of medications in collaboration with a pharmacist for patients at risk of medication related misadventure. Once every 12 months.
903	Residential Medication Management Review (RMMR)	\$109.30	For permanent residents of Residential Aged Care Facilities who are at risk of medication related misadventure. Performed in collaboration with the resident's pharmacist. Once every 12 months.

Mental Health Item Numbers			
Item	Name	\$	Description/Recommended Frequency
2700	GP Mental Health Treatment Plan	\$73.95	Min 20 minutes. Prepared by GP who has not undertaken Mental Health Skills Training. Assessment of patient and preparation of a care plan with option to refer for rebated psychological services. Not more than once yearly.
2701	GP Mental Health Treatment Plan	\$108.85	Min 40 minutes. Prepared by GP who has not undertaken Mental Health Skills Training. Assessment of patient and preparation of a care plan with option to refer for rebated psychological services. Not more than once yearly.
2712	Review of GP Mental Health Treatment Plan	\$73.95	Plan should be reviewed between 1 – 6 months and no more than 2 per year.
2713	Mental Health Consultation	\$73.95	Consult ≥ 20 minutes, for the ongoing management of a patient with mental disorder. No restriction on the number of these consultations per year.
2715	GP Mental Health Treatment Plan	\$93.90	Min 20 minutes. Prepared by GP who has undertaken Mental Health Skills Training. Assessment of patient and preparation of a care plan with option to refer for rebated psychological services. Not more than once yearly.
2717	GP Mental Health Treatment Plan	\$138.30	Min 40 minutes. Prepared by GP who has undertaken Mental Health Skills Training. Assessment of patient and preparation of a care plan with option to refer for rebated psychological services. Not more than once yearly.
2721	GP Focussed Psychological Strategies	\$95.65	30-40 minutes. Provision of focussed psychological strategies by an appropriately trained and registered GP working in an accredited practice.
2725	GP Focussed Psychological Strategies	\$136.85	> 40 minutes. Provision of focussed psychological strategies by an appropriately trained and registered GP working in an accredited practice.

Allied Health Services

Allied Health Services for Chronic Conditions Requiring Team Care

GP must have completed a GP Management Plan (721) and Team Care Arrangement (723) or contributed to a Multidisciplinary Care Plan in a Residential Aged Care Facility (731).

Patient must have a chronic or terminal medical condition and complex care needs requiring care from a multidisciplinary team consisting of their GP and at least two other health or care providers.

Item	Name	Description/Recommended Frequency
10950	Aboriginal Health Worker Services	<ul style="list-style-type: none"> Allied Health Provider must be Medicare registered Maximum of 5 allied health services per patient per each calendar year Can be 5 sessions with one provider or a combination e.g. 3 dietitian and 2 diabetes education sessions GP refers to allied health professional using 'Referral Form for Chronic Disease Allied Health (Individual) Services under Medicare' or a referral form containing all components. One for each provider Services must be at least 20 minutes duration and provided to an individual not a group Allied health professionals must report back to the referring GP after first and last visit
10951	Diabetes Educator Services	
10952	Audiologist Services	
10953	Exercise Physiologist Services	
10954	Dietitian Services	
10958	Occupational Therapist Services	
10960	Physiotherapist Services	
10962	Podiatrist Services	
10964	Chiropractor Services	
10966	Osteopath Services	
10970	Speech Pathologist Services	
10956	Mental Health Worker Services	<ul style="list-style-type: none"> For mental health conditions, use Better Access Mental Health Care items – 10 sessions For chronic physical conditions, use GPMP and TCA – 5 sessions Better access and GPMP can be used for the same patient where eligible
10968	Psychologist Services	

Allied Health Group Services for Patients with Type 2 Diabetes

Assessment and Provision of Group Services

GP must have completed a GP Management Plan (721), or reviewed an existing GPMP (732), or contributed to, or reviewed a Multidisciplinary Care Plan in a Residential Aged Care Facility (731).

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

Item	Name	Description/Recommended Frequency
81100	Assessment for Group Services by Diabetes Educator	<ul style="list-style-type: none"> One assessment session only by either Diabetes Educator, Exercise Physiologist or Dietitian per calendar year Medicare Allied Health Group Services for Type 2 Diabetes Referral Form
81110	Assessment for Group Services by Exercise Physiologist	
81120	Assessment for Group Services by Dietitian	
81105	Diabetes Education Group Services	<ul style="list-style-type: none"> 8 group services per calendar year, can be 8 sessions with one provider or a combination e.g. 3 diabetes education, 3 dietitian and 2 exercise physiology sessions Medicare Allied Health Group Services for Type 2 Diabetes Referral Form

After-Hours Services

Attendance Period			Item Number	MBS Payment	Brief Guide
Urgent attendance – after hours			585 (GP) ¹ 588 (Non-VR GP, rural area) ² 591 (Non-VR GP, metropolitan area) 594 (additional patients at one location) ³	\$133.90 \$133.90 \$92.80 \$43.25	<ul style="list-style-type: none"> 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 centre it is necessary for the practitioner to return to, and specially open the consulting rooms for the attendance
Mon – Fri 7 – 8am or 6 – 11pm	Sat 7 – 8am or 12noon – 11pm	Sun & Pub Holidays 7am – 11pm			
Urgent attendance – unsociable hours			599 (GP) ¹ 600 (Non-VR GP)	\$157.80 \$126.10	
Mon – Fri 11pm – 7am	Sat 11 pm – 7am	Sun & Pub Holidays 11 pm – 7am			
Non-urgent after hours at a place other than consulting rooms			Home	RACFS	
Mon – Fri Before 8am or after 6pm	Sat Before 8am or after 12pm	Sun & Pub Holidays All day	<u>GP:</u> 5003 5023 5043 5063 <u>Non-VR GP:</u> 5220 5223 5227 5228	<u>GP:</u> 5010 5028 5049 5067 <u>Non-VR GP:</u> 5260 5263 5265 5267	
			*The above MBS Payments are for the 1 st patient only. Please refer to MBS Online for multiple patient fee schedules.		
Non-urgent after hours at consulting rooms			GP 5000 (Level A) 5020 (Level B < 20 min) 5040 (Level C > 20 min) 5060 (Level D > 40 min)		
Mon – Fri Before 8am or after 8pm	Sat Before 8am or after 1pm	Sun & Pub Holidays All day	<u>Non-VR GP</u> 5200 (Level A) 5203 (Level B < 20 min) 5207 (Level C > 20 min) 5208 (Level D > 40 min)	Refer to MBS online for further information	

¹ 585 and 599 available to medical practitioners who are vocationally registered or vocationally recognised or practitioners who are AHOMPS program participants employed with full time general practice.

² 588 is available to non-vocationally recognised medical practitioners in areas MMM 3 to MMM 7. For our region this includes the following: **MMM Area 3:** Blackheath, Medlow Bath, Medlow Bath, Mt Victoria; **MMM Area 4:** Lithgow, Hartley, Bowenfels, Rydal, Marrangaroo; **MMM Area 5:** Portland, Wallerawang, Bilpin, Mt Irvin, Colo, Colo Heights.

³ Professional attendance by a medical practitioner—each additional patient at an attendance that qualifies for item 585, 588 or 591 in relation to the first patient.

GP Multidisciplinary Case Conferences

Item	Name	Description/Recommended Frequency
735	Organise and coordinate a case conference	15 – 20 minutes. GP organises and coordinates case conference in RACF, community, or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs.
739	Organise and coordinate a case conference	20 – 40 minutes. GP organises and coordinates case conference in RACF, community, or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs.
743	Organise and coordinate a case conference	> 40 minutes. GP organises and coordinates case conference in RACF, community, or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs.
747	Participate in a case conference	15 – 20 minutes. GP participates in a case conference in RACF, community, or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs.
750	Participate in a case conference	30 – 40 minutes. GP participates in a case conference in RACF, community, or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs.
758	Participate in a case conference	> 40 minutes. GP participates in a case conference in RACF, community, or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs.

Health Assessments

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


Item	Name	Description/Recommended Frequency
699	Heart Health Assessment	<p>>20 Minutes</p> <ol style="list-style-type: none"> 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
701	Brief Health Assessment	<p>< 30 Minutes</p> <ol style="list-style-type: none"> Collection of relevant information, including taking a patient history A basic physical examination Initiating interventions and referrals as indicated Providing the patient with preventive health care advice and information <p>Incorporating:</p> <ul style="list-style-type: none"> Health Assessment – 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 3 years Health Assessment – 45 – 49 Year Old Once only health assessment for patients 45 – 49 years who are at risk of developing a chronic disease Health Assessment – 75 Years and Older Health assessment for patients aged 75 years and older. Once every 12 months Health Assessment – Comprehensive Medical Assessment Comprehensive Medical Assessment for permanent residents of Residential Aged Care Facilities. Available for new and existing residents. Not more than once yearly Health Assessment for patient with an Intellectual Disability

		<p>Health assessment for patient with Intellectual Disability. Not more than once yearly</p> <ul style="list-style-type: none"> • Health Assessment 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 their arrival). <p>A desktop guide – Caring for Refugee Patients in General Practice is available on the RACGP website www.racgp.org.au</p>
703	Standard Health Assessment	<p>30 – 44 minutes</p> <ol style="list-style-type: none"> Detailed information collection, including taking patient history An extensive physical examination Initiating interventions and referrals as indicated Providing a preventative health care strategy for the patient
705	Long Health Assessment	<p>45 – 59 Minutes</p> <ol style="list-style-type: none"> Comprehensive information collection, including taking a patient history An extensive examination of the patient’s medical condition and physical function Initiating interventions and referrals and indicated Providing a basic preventive health care management plan for the patient <p>Incorporating the Health Assessment categories listed in 701.</p>
707	Prolonged Health Assessment	<p>> 60 minutes</p> <ol style="list-style-type: none"> Comprehensive information collection, including taking a patient history An extensive examination of the patient’s medical condition, and physical, psychological and social function Initiating interventions and referrals as indicated Providing a comprehensive preventive health care management plan for the patient <p>Incorporating the Health Assessment categories listed in 701.</p>
715	Aboriginal and Torres Strait Islander Health Assessment	<p>No designated time or complexity requirements</p> <p>Incorporating:</p> <ul style="list-style-type: none"> • ATSI Child Health Assessment

		<p>Health Assessment for ATSI patients 0 – 14 years old. Not available to inpatients of hospitals or RACF. Not more than once every 9 months</p> <ul style="list-style-type: none"> • ATSI Adult Health Assessment Health Assessment for ATSI patients 15 – 54 years old. Not available to inpatients of hospitals or RACF. Not more than once every 9 months • ATSI Health Assessment for an Older Person Health Assessment for ATSI patients 55 years and over. Not available to inpatients of hospitals or RACF. Not more than once every 9 months
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Systematic Care Claiming Rules

Legend MBS Item Numbers

	No claiming restrictions		
721	GP Management Plan (GPMP)	2713	GP Mental Health Consultation
723	Team Care Arrangement (TCA)	2700 / 2701	GP Mental Health Treatment Plan
732	Review of GPMP and/or TCA	2715 / 2717	GP Mental Health Treatment Plan
900	Home Medication Review	2712	Review of GP Mental Health Treatment Plan

Recommended Months until Next Claim for Service

*721	24		6					
*723		24	6					
**732	6	6	6					
900				12				
2700 / 2701					12	3		
§2712					3	3	3	
2713								
2715 / 2717							12	
MBS Item Numbers	*721	*723	**732	900	2700 / 2701	§2712	2715 / 2717	2713

Additional Claiming Rules

***721 & 733** Recommended claiming period 24 months, minimum claiming period 12 months

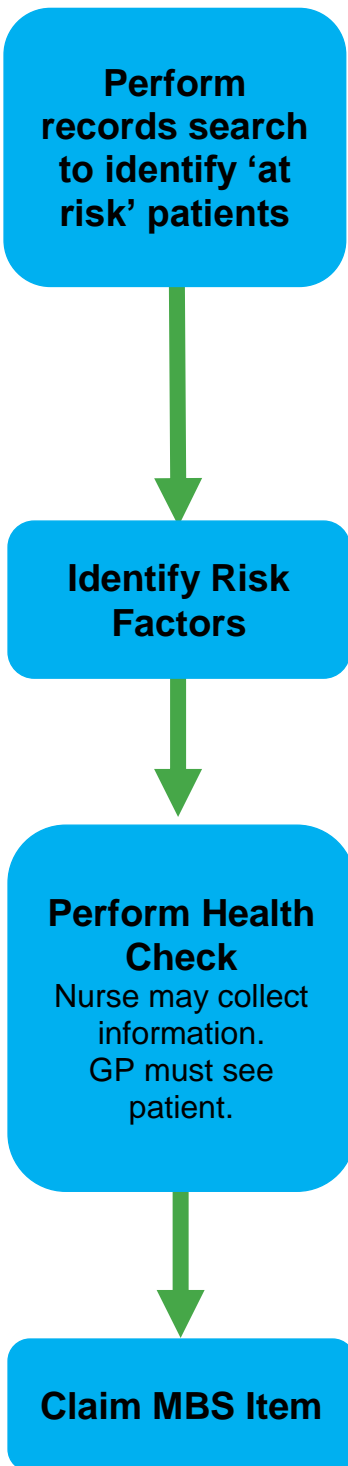
****732** Recommended claiming period 6 months, minimum claiming period 3 months. Can be claimed twice on the same day if review of both GPMP and TCA are completed, in this case the patient invoice and Medicare claim should be annotated.

§2712 Review recommended 1 month – 6 months after 2700, 2701, 2715, 2717 with not more than 2 reviews in a 12 month period.

Notes Where a service is provided earlier than minimum claiming periods the patient invoice and Medicare claim should be annotated. For example; clinically indicated/required, hospital discharge, exceptional circumstances significant change.

Standard consultations, health assessments, care plans and medication reviews should not be claimed on the same day. If provided on the same day the patient invoice and Medicare claim should be annotated, for example; clinically indicated/required, separate service.

Type 2 Diabetes Risk Evaluation – Health Assessment - Items 701, 703, 705 & 707



Eligibility Criteria

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

Clinical Content

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

Essential Documentation Requirements

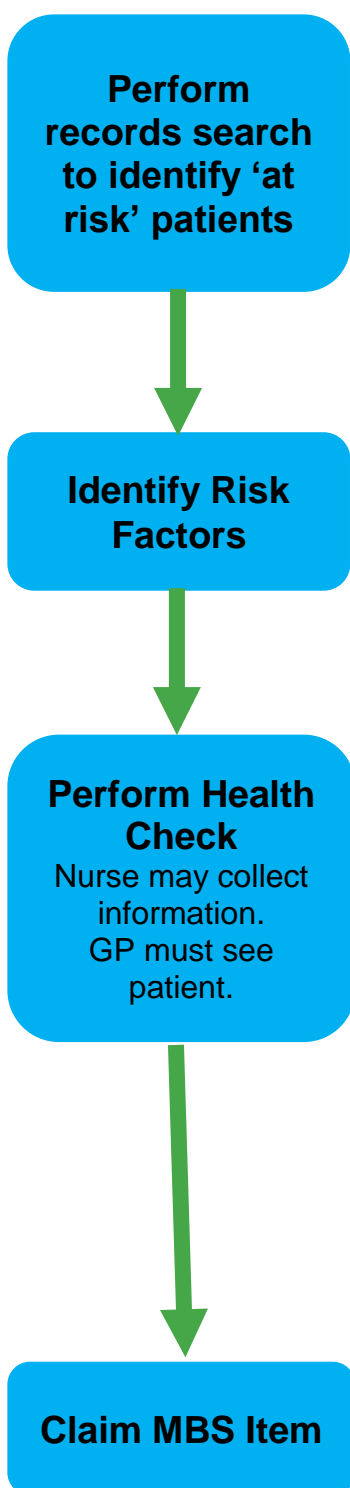
- Record patient’s consent to Health Assessment
- Completion of AUSDRISK is mandatory, with score of ≥ 12 points required to claim; update patient history
- Record the Health Assessment and offer the patient a copy

Claiming

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

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

Heart Health Assessment – Item 699



Eligibility Criteria

- Aboriginal 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 viewed at <http://www.cvdcheck.org.au/calculator/>
- Not for patients in hospital

Risk Factors

Include, but are not limited to:

- Lifestyle: Smoking, physical inactivity, poor nutrition, alcohol use, biomedical, high cholesterol, high BP, impaired glucose metabolism, 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

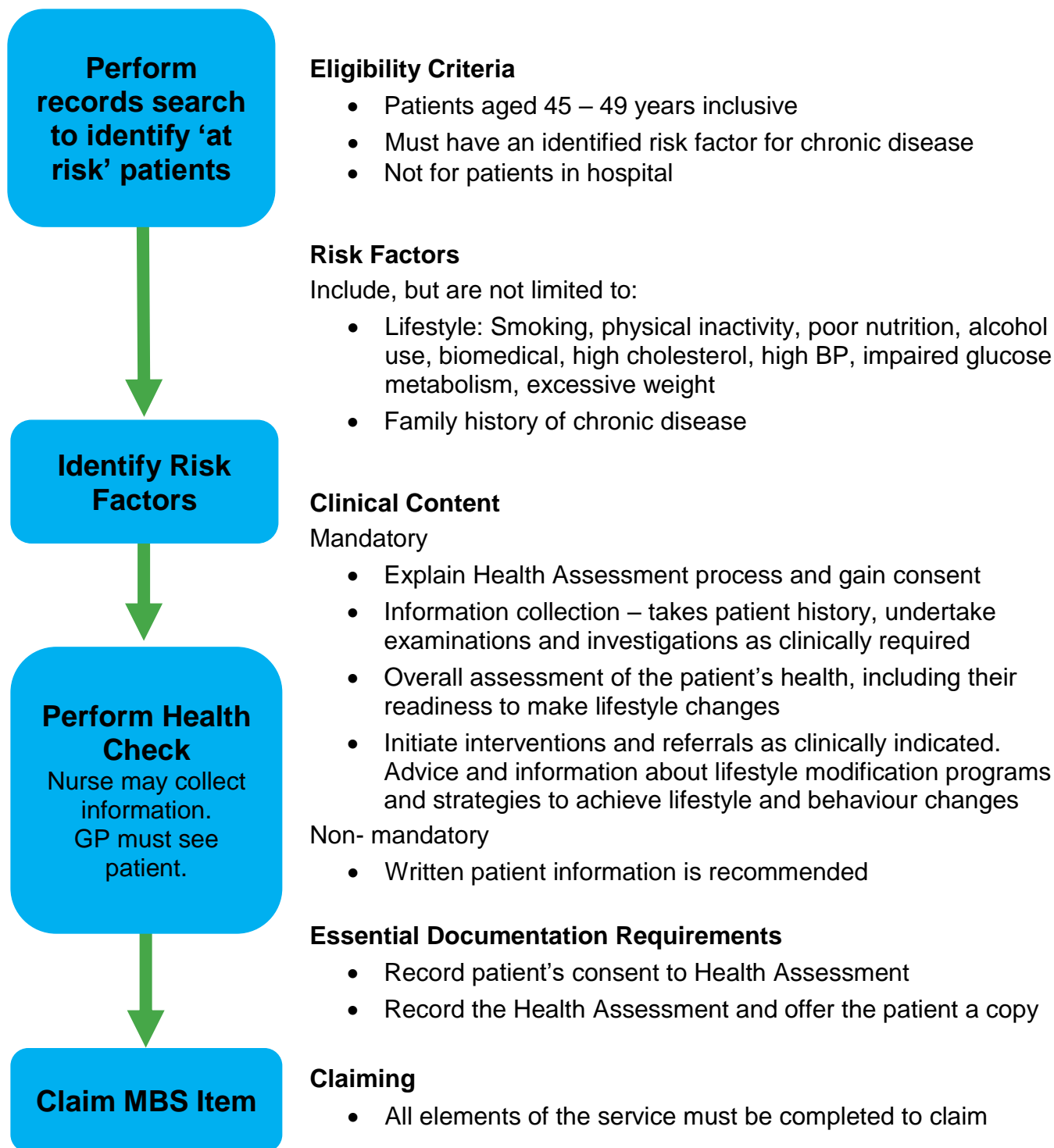
- Record patient's consent to Health Assessment
- Record the Health Assessment and offer the patient a copy

Claiming

- All elements of the service must be completed to claim

MBS Item	Name	Age Range	Recommended Frequency
699	Heart Health Assessment	<ul style="list-style-type: none"> • Aboriginal and Torres Strait Islander over 30 years • Adults over 45 years 	Annually

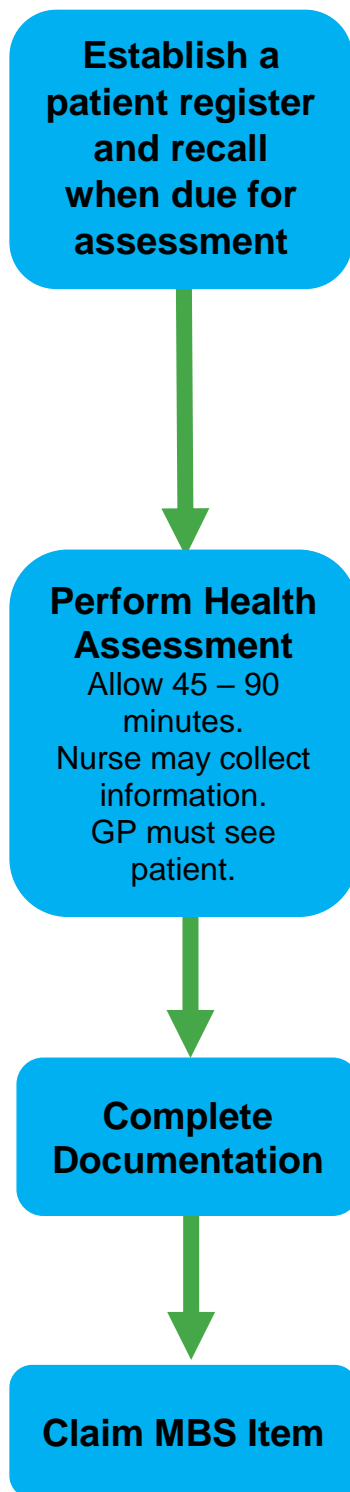
45 – 49 Year Old – Health Assessment - Items 701, 703, 705 & 707



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

75 Years and Older – Health Assessment - Items 701, 703, 705 & 707

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



Eligibility Criteria

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

Clinical Content

Mandatory

- Explain Health Assessment process and gain patient's/carer's consent
- Information collection – takes patient history, undertake examinations and investigations as clinically required
- Measurement of: BP, pulse rate and rhythm
- Assessment of: medication; continence; immunisation status for influenza, tetanus and pneumococcus; physical function including activities of daily living and falls in the last 3 months; psychological function including cognition and mood; and social function including availability and adequacy of paid and unpaid help and the patient's carer responsibilities
- Overall assessment of the patient
- Recommend appropriate interventions
- Provide advice and information
- Discuss outcomes of the assessment and any recommendations with patient

Non-mandatory

- Consider: need for community services; social isolation; oral health and dentition; nutritional status
- Additional matters as relevant to patient

Essential Documentation Requirements

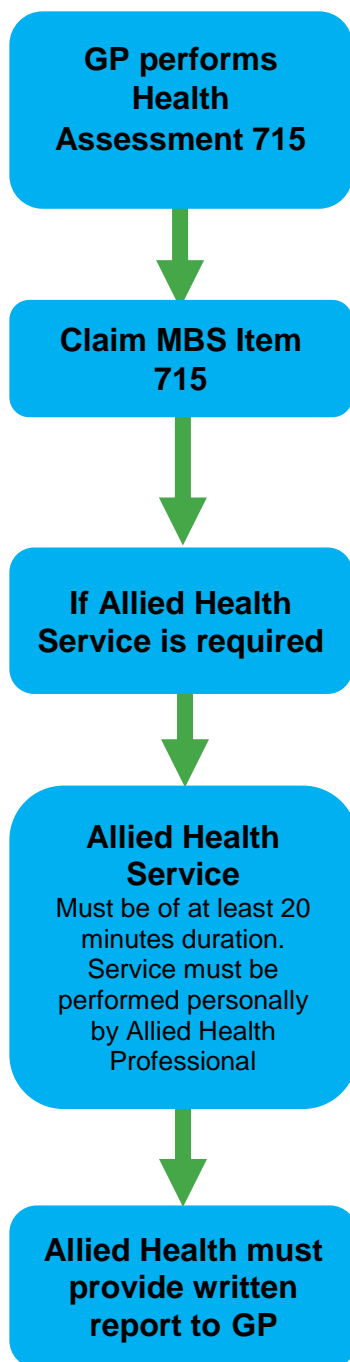
- Record patient's/carer's consent to Health Assessment
- Record the Health Assessment and offer the patient a copy (with consent, offer to carer)

Claiming

- All elements of the service must be completed to claim

MBS Item	Name	Age Range	Recommended Frequency
701/703/705/707	Health Assessment – 75 Years and Older	75 years and older	Once every 12 months

Aboriginal and Torres Strait Islander - Health Assessment - Item 715



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

Items 81300 to 81360 – Allied Health Service

Eligibility Criteria

- Items 81300 to 81360 with the exception of 81305 (which does not require a health assessment) are in addition to items 10950 to 10970 and provide an alternative to the referral pathway to access Allied Health Services
- Items available to individual patients only, not a group service
- This patient is not an admitted patient of a hospital
- Eligible patients may access Medicare rebates for up to 5 allied health services in a calendar year. Allied Health Professionals may set their own fees. Charges in excess of the Medicare benefit for these items are the responsibility of the patient

Essential Documentation Requirements

Allied Health Professionals must provide a written report to the GP after the first and last service (more often if clinically required)

Mandatory

Health Assessment includes physical, psychological and social wellbeing. It also assesses what preventative health care, education and other assistance that should be offered to improve the patient's health and wellbeing. It must include:

- Information collection of patient history and undertaking examinations and investigations as required;
- Overall assessment of the patient;
- Recommending appropriate interventions;
- Providing advice and information to the patient;
- Recording the health assessment; and
- Offering the patient a written report with recommendations about matters covered by the health assessment

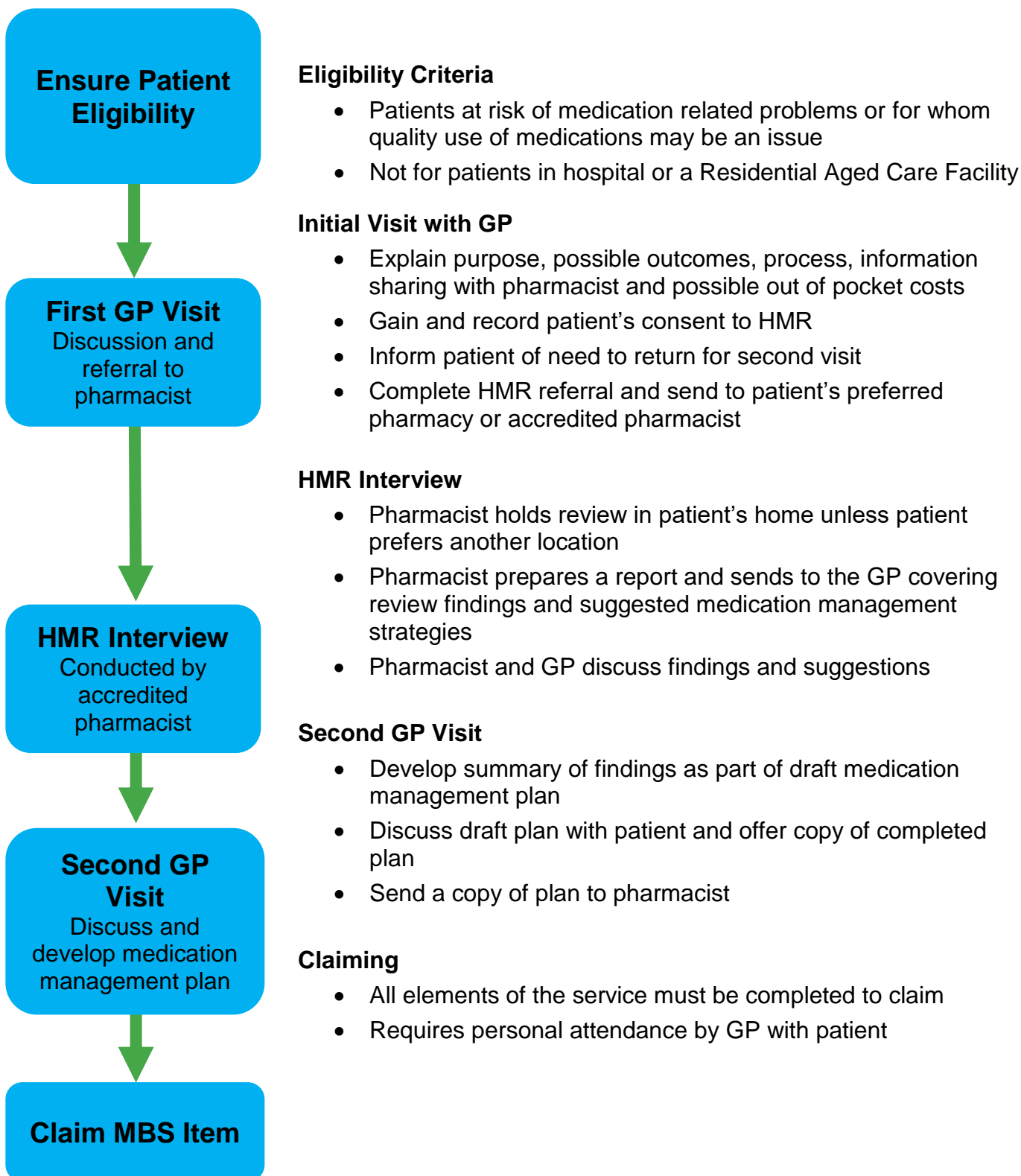
Optional

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

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

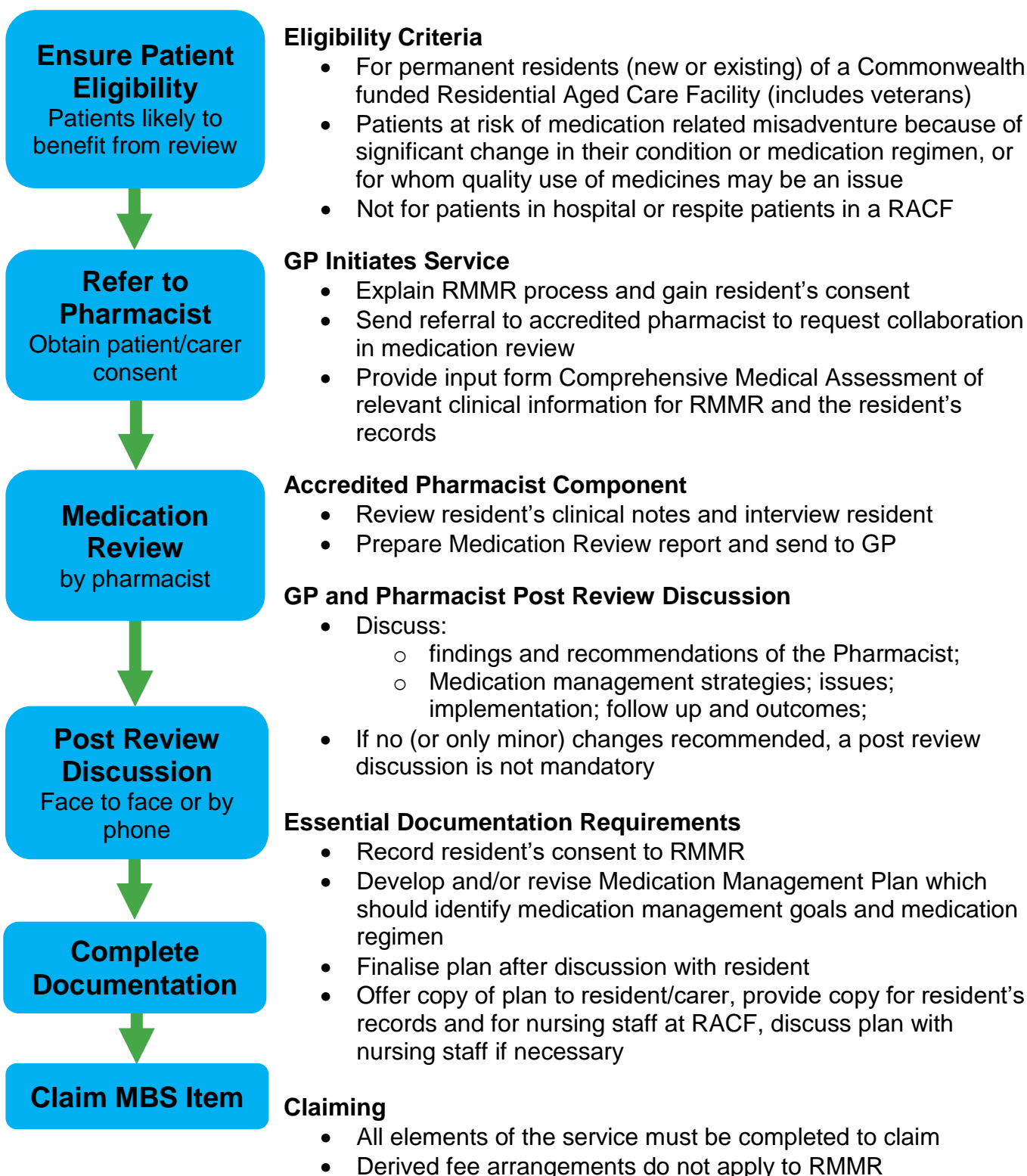
Domiciliary Medication Management Review (DMMR) - Item 900

Also known as Home Medicines Review (HMR)



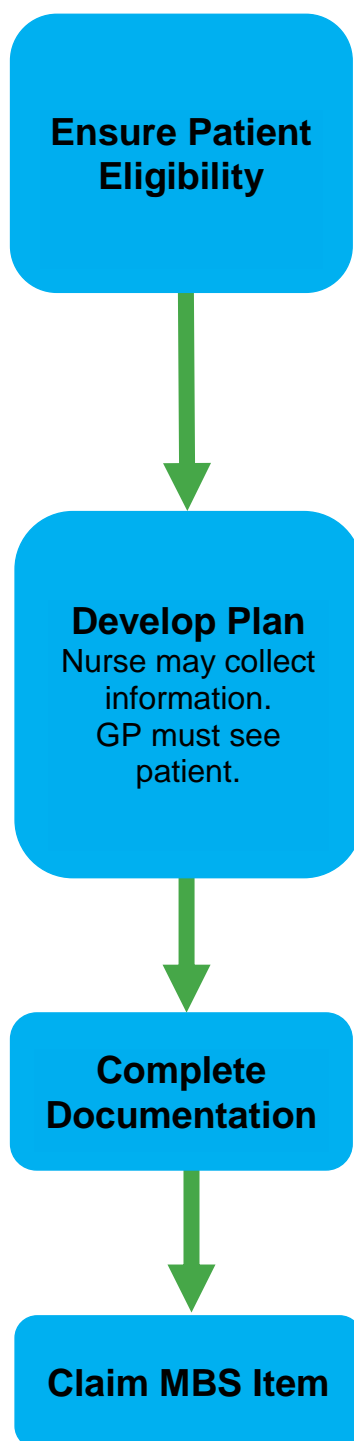
<i>MBS Item</i>	<i>Name</i>	<i>Recommended Frequency</i>
900	Domiciliary Medication Management Review	Once every 12 months

Residential Medication Management Review (RMMR) - Item 903



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

GP Management Plan (GPMP) – Item 721



Eligibility Criteria

- No age restrictions for patients
- Patients with a chronic or terminal condition
- Patients who will benefit from a structured approach to their care
- Not for public patients in a hospital or patients in a Residential Aged Care Facility

Clinical Content

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

Essential Documentation Requirements

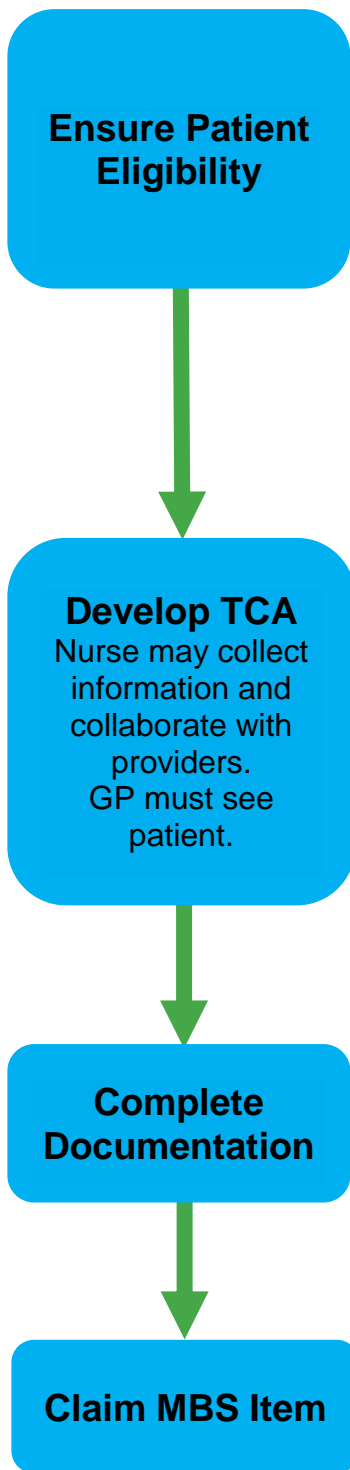
- Record patient's consent to GPMP
- Patient needs and goals, patient actions, and treatment/services required
- Set review date
- Offer the patient a copy (with consent, offer to carer), keep copy in patient file

Claiming

- All elements of the service must be completed to claim
- Requires that there has been personal attendance by GP to assess and gain consent
- Review using item 732 at least once during life of the plan

MBS Item	Name	Recommended Frequency
721	GP Management Plan	2 Yearly (minimum 12 monthly)

Team Care Arrangement (TCA) – Item 723



Eligibility Criteria

- No age restrictions for patients
- Patients with a chronic or terminal condition and complex care needs
- Patients who need ongoing care from a team including the GP and at least 2 other health and care providers
- Not for public 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 consent
- Treatment and service goals for the patient
- Discuss with patient which 2 providers the GP will collaborate with and the treatment and services the 2 providers will deliver
- Actions to be taken by the patient
- 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 potential collaborating providers’ agreement to participate
- Consult with the 2 collaborating providers and obtain feedback on treatment/services they will provide to achieve patient goals

Essential Documentation Requirements

- Record patient’s consent to TCA
- Goals, collaborating providers, treatment/services, actions to be taken by patient
- Set review date
- Send copy of relevant parts to collaborating providers
- Offer the patient a copy (with consent, offer to carer), keep copy in patient file

Claiming

- All elements of the service must be completed to claim.
- Requires that there has been personal attendance by GP to assess and gain consent
- Review using item 732 at least once during life of the plan
- Claiming a GPMP and TCA enables patients to receive 5 elaborated services from allied health

MBS Item	Name	Recommended Frequency
723	Team Care Arrangement	2 Yearly (minimum 12 monthly)

Reviewing a GP Management Plan (GPMP) and/or Team Care Arrangement (TCA) – Item 732

Reviewing a GP Management Plan

Clinical Content

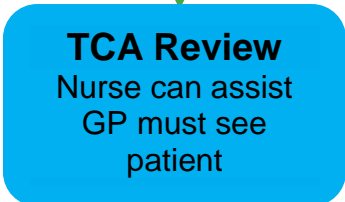
- Explain steps involved in the review and gain consent
- Review all matters in relevant plan

Essential Documentation Requirements

- Record patient’s agreement to review
- Make any required amendments to plan
- Set a new review date
- Offer copy to patient (with consent, offer to carer), keep copy in patient file

Claiming

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



Reviewing a Team Care Arrangement (TCA)

Clinical Content

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

Essential Documentation Requirements

- Record patient’s agreement to review
- Make any required amendments to plan
- Set a new review date
- Send copy of relevant parts of amended TCA to collaborating providers
- Offer copy to patient (with consent, offer to carer), keep copy in patient file

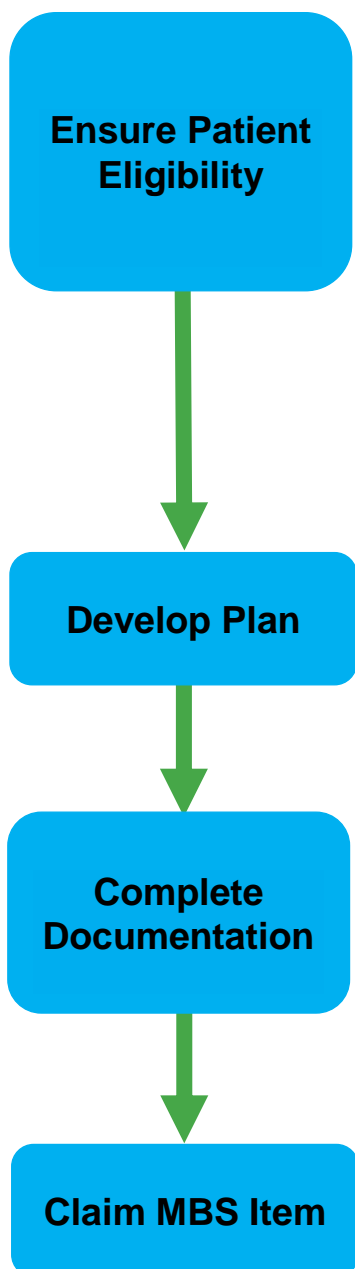
Claiming

- All elements of the service must be completed to claim
- Requires that there has been personal attendance by GP to assess and gain consent
- Item 732 should be claimed at least once over the life of the TCA
- Cannot be claimed within 3 months of a TCA (item 723)
- Item 732 can be claimed twice on same day if review of both GPMP and TCA are completed, in this case, the Medicare claim should be annotated

MBS Item	Name	Recommended Frequency
732	Review of GP Management Plan and/or Team Care Arrangement	6 monthly (minimum 3 monthly)

Mental Health Treatment Plan – Items 2700, 2701, 2715 and 2717

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 patients
- Patients with a mental disorder, excluding dementia, delirium, tobacco use disorder and mental retardation (without mental health disorder)
- Patients who will benefit from structured approach to their treatment
- Not for patients in a hospital or patients in a Residential Aged Care Facility

Clinical Content

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

Essential Documentation Requirements

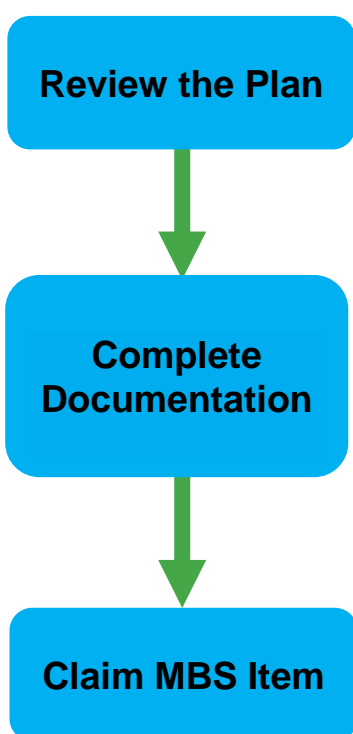
- Record patient’s consent to GP Mental Health Treatment Plan
- Document diagnosis of mental disorder
- Results of outcome measurement tool
- Patient’s needs and goals, patient actions and treatments/services required
- Set review date
- Offer the patient a copy (with consent, offer to carer), keep copy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

Claiming

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

MBS Item	Name	Recommended Frequency
2700, 2701, 2715, 2717	Mental Health Treatment Plan	No more than once yearly

Review of the Mental Health Treatment Plan – Item 2712



Clinical Content

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

Essential Documentation Requirements

- Record patient’s consent to Review
- Results of re-administered outcome measurement tool
- Document relevant changes to GP Mental Health Treatment Plan
- Offer the patient a copy (with consent, offer to carer), keep copy in patient file

Claiming

- All elements of the service must be completed to claim.
- Requires personal attendance by GP with patient
- Item 2712 should be claimed at least once over the life of the GP Mental Health Treatment Plan
- Claiming 2712 enables patients to receive 4 further rebated individual and group psychology services
- A review can be claimed 1-6 months after completion of the GP Mental Health Treatment Plan
- If required, an additional review can be performed 3 months after the first Review

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

Practice Incentive Payment Summary

Item	Activity	Item Number & Type of Consultation	PIP (\$ per SWPE)	Notes (PIP Enquiry Line 1800 222 032) http://www.humanservices.gov.au
My Health Record	<p>Requirement 1: Integrating Healthcare Identifiers into Electronic Practice Records.</p> <p>Requirement 2: Secure messaging capability.</p> <p>Requirement 3: Data records and clinical coding.</p> <p>Requirement 4: Electronic transfer prescriptions.</p> <p>Requirement 5: My Health Record system.</p>		<p>\$6.50 per SWPE, per annum</p> <p>Capped at \$12,500 per quarter</p>	<p>To qualify, practices must meet each of the requirements:</p> <p>Requirement 1:</p> <ul style="list-style-type: none"> • Apply for a Health Care Provider Identifier-Organisation (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 <p>Requirement 2:</p> <ul style="list-style-type: none"> • 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 <p>Requirement 3:</p> <ul style="list-style-type: none"> • 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 <p>Requirement 4:</p> <ul style="list-style-type: none"> • Use a software system that is able to send an electronic prescription to a Prescription Exchange Service (PES) • The majority of prescriptions are sent electronically to a (PES) <p>Requirement 5:</p> <ul style="list-style-type: none"> • 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 Shared Health Summaries for a minimum of 0.5 % of the practice’s SWPE count of patients per PIP payment quarter

Item	Activity	Item Number & Type of Consultation	PIP (\$ per SWPE)	Notes (PIP Enquiry Line 1800 222 032) http://www.humanservices.gov.au
My Health Record Continued				Please refer to the ePIP Incentive guidelines released by Medicare Australia https://www.humanservices.gov.au/health-professionals/services/medicare/practice-incentives-program
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 SWPE	<p>To be eligible to receive PIP QI payment general practices must:</p> <ul style="list-style-type: none"> • 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. <p>Commences on 1 August 2019</p> <p>For further information: https://www.health.gov.au/internet/main/publishing.nsf/Content/PIP-QI_Incentive_guidance</p>
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.

Item	Activity	Item Number & Type of Consultation	PIP (\$ per SWPE)	Notes (PIP Enquiry Line 1800 222 032) http://www.humanservices.gov.au
Aged Care Access	Tier 1: GP completes the Qualifying Service Level (QSL) 1 – 60 MBS services in RACF claimed in a financial year.			MBS items that count towards QSLs include attendances in RACF, contributions to multidisciplinary care plans and Residential Medication Management Reviews. 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 (QSL) 2 – 140 MBS services in RACF claimed in a financial year.			
Indigenous Health	Provision of better health care for Indigenous patients, including best practice management of chronic disease. Sign-on payment.		\$1,000	One-off payment only. Practice must be registered for PIP – Practice: <ul style="list-style-type: none"> • Seeks 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 • Establishes 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 • Undertakes cultural awareness training within 12 months of joining incentive • Annotates PBS prescriptions for eligible ATSI patients for the PBS Co-payment

Item	Activity	Item Number & Type of Consultation	PIP (\$ per SWPE)	Notes (PIP Enquiry Line 1800 222 032) http://www.humanservices.gov.au
Indigenous Health	Annual patient registration payments.		\$250.00 per registered ATSI patient, per calendar year	<ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> Is aged 15 years or over & 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
	Tier 1: Outcomes payment: Chronic Disease Management.		\$100.00 per registered patient per calendar year	Payment made to practices that (in a calendar year): <ul style="list-style-type: none"> Develop a 721 GP Management Plan or 723 Team Care Arrangement for the patient and undertake at least one 732 Review of the GPMP or TCA; or Undertake two 732 Reviews of GPMP or TCA; or Complete 731 contribute to, or review, a care plan for a patient in a RACF, on two occasions
	Tier 2: Outcomes payment: Total Patient Care.		\$150.00 per registered patient per calendar year	<ul style="list-style-type: none"> 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 the MBS services provided for Tier 1.
Practice Nurse	Practice employs or retains the services of a Registered Nurse, Enrolled Nurse or Aboriginal Health Worker.		Capped at \$125,000 per annum	<ul style="list-style-type: none"> This incentive aims to broaden the range of services a nurse can provide. Payments are based on practice SWPE and nurse hours. Refer to http://www.humanservices.gov.au/health-professionals/services/practice-nurse-incentive-programme/ for complete PNIP guidelines

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

After hours periods:

For PIP the complete after hours period is:

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

The complete after hours period is broken into:

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

Core Eligibility Requirements

To be eligible for the PIP After Hours Incentive, practices 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 Department of Human Services website. Please visit <http://www.humanservices.gov.au/health-professionals/services/practice-incentives-programme/pip-after-hours-incentive> or contact the PIP Enquiry Line on 1800 222 032.

Payment level and amount	Description
<u>Level 1 Participation</u> \$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 (hours outside of 8 am to 6pm weeknights; hours outside of 8am to 12 pm Saturdays; and all day Sundays and public holidays).
<u>Level 2 Sociable after hours cooperative coverage</u> \$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 (6pm to 11 pm weeknights) and ensure formal arrangements are in place to cover the unsociable after hours period (11pm to 8am weekdays, hours outside of 8 am to 12 pm Saturdays and all day Sundays and public holidays).
<u>Level 3 Sociable after hours practice coverage</u> \$5.50 per SWPE	Practices must provide after hours care to practice patients directly through the practice in the sociable after hours period (6pm to 11pm weeknights); and ensure formal arrangements are in place to cover the unsociable after hours period (11pm to 8am weekdays, hours outside of 8am and 12pm Saturdays and all day Sundays and public holidays).
<u>Level 4 Complete after hours cooperative coverage</u> \$5.50 per SWPE	Practices must participate in a cooperative arrangement with other general practices that provides after hours care to practice patients for the complete after hours period (hours outside of 8 am to 6pm weeknights; hours outside of 8am to 12 pm Saturdays; and all day Sundays and public holidays).
<u>Level 5 Complete after hours practice coverage</u> \$11 per SWPE	To be eligible for the Level 5 Complete After Hours Practice Coverage Payment, practices must provide after hours care to practice patients in the complete after hours period (hours outside of 8 am to 6 pm weeknights; hours outside of 8 am to 12 pm Saturdays; and all day Sundays and public holidays).

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