

Frequently used Desktop Guide to MBS Item Numbers

For Primary Health Care Services

November 2023

Western Queensland PHN acknowledges the traditional owners of the country on which we work and live and recognises their continuing connection to land, waters and community.



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WESTERN QUEENSLAND
An Australian Government Initiative

Desktop Guide to MBS Item Numbers

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Desktop Guide to MBS Item Numbers

This guide outlines the most used MBS Item Numbers in Primary Care and aims to assist with the correct utilisation when claiming MBS Item Numbers. Each item number in this guide contains a link which provides item number criteria and fact sheets. Also included is an outline of Practice Incentive Payments and useful flow charts.

MBS ONLINE

[Search for Item Number](#)

[Latest Fact Sheets](#)

[Latest MBS Item Updates \(XML Files\)](#)

[MBS News and Information](#)

PROFESSION DEVELOPMENT

[MBS Education for Health Professionals](#)

To discuss further, or for more information contact your WQPHN Coordinator or admin@wqphn.com.au.

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This desktop guide was created in line with the latest MBS Online information. Whilst every effort has been made to ensure that the information included in this 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 latest information.

Desktop Guide to MBS Item Numbers

FREQUENTLY USED DESKTOP GUIDE TO ITEM NUMBERS

COMMONLY USED ITEM NUMBERS			
ITEM	NAME	BENEFIT	DESCRIPTION / RECOMMENDED FREQUENCY
3	Level A	\$18.95	Short - see MBS for complexity of care requirements
23	Level B	41.20	< 20 min - see MBS for complexity of care requirements
36	Level C	\$81.10	≥ 20 min - see MBS for complexity of care requirements
44	Level D	\$118.00	≥ 40 min - see MBS for complexity of care requirements
10990	Bulk Billing Item	\$8.10	For patients U16 years or a concessional beneficiary For services provided in a practice location of MMM1
10991	Bulk Billing Item	\$12.24	U16s and CC Card holders. Used in conjunction with items in the GMS Table of the MBS. Can be claimed concurrently for eligible patients Region specific MMM2.
11505	Spirometry (Diagnosis)	\$45.30	To confirm diagnosis of Asthma, COPD or another cause of airflow limitation – once in a 12 months period
11506	Spirometry Monitoring	\$22.65	Measurement of spirometry before and after inhalation of bronchodilator to confirm diagnosis of Asthma, COPD other causes.
11309	Audiometry	\$21.75	Audiogram, air conduction
11707	ECG	\$17.25	12 lead electrocardiography, tracing only by medical practitioner
73806	Pregnancy test	\$8.65	Pregnancy test by one or more immunochemical methods
16500	Antenatal attendance	\$44.15	Antenatal attendance
14206	Implant (Implanon)	\$33.35	Hormone or living tissue implant (implanon) by cannula
30062	Implant (Implanon) removal	\$56.85	Removal of Etonogestrel subcutaneous implant (eg. implanon)

BULK BILLING ITEMS: MM7 – MM1

75858	Bulk Billing Item	\$13.25	For patients U16 years or a concessional beneficiary for services provided in a practice location of MMM7. Practice location is associated with provider number & can be also used for services away from the practice. (EG home or Aged Care Facility visit)
75857	Bulk Billing Item	\$12.45	For patients U16 years or a concessional beneficiary for services provided in a practice location of MMM6. Practice location is associated with provider number & can be also used for services away from the practice. (EG home or Aged Care Facility visit)
75856	Bulk Billing Item	\$11.80	For patients U16 years or a concessional beneficiary for services provided in a practice location of MMM5
75855	Bulk Billing Item	\$11.05	For patients U16 years or a concessional beneficiary for services provided in a practice location of MMM3 or MMM4
10991	Bulk Billing Item	\$10.45	For patients U16 years or a concessional beneficiary for services provided in a practice location of MMM2 (MyMedicare registered)
10990	Bulk Billing Item	\$6.90	For patients U16 years or a concessional beneficiary For services provided in a practice location of MMM1 (MyMedicare registered)

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NEW Bulk Billing Items

ITEM	NAME	\$ Benefit	DESCRIPTION / RECOMMENDED FREQUENCY
75870	Bulk Billing Item MMM1	\$20.65	For patients U16 years or a concessional beneficiary for services provided where not admitted to hospital and service is bulk-billed. This item can be claimed with face-to-face level B, C, D and E general attendance items, and level B telehealth and telephone general attendance items. <i>*This is a general overview, please click on the link to assess eligibility.</i>
75871	Bulk Billing Item MMM2	\$31.40	For patients U16 years or a concessional beneficiary for services provided where not admitted to hospital and service is bulk-billed. This item can be claimed with face-to-face level B, C, D and E general attendance items, and level B telehealth and telephone general attendance items. <i>*This is a general overview, please click on the link to assess eligibility.</i>
75872	Bulk Billing Item MMM2, 3, 4, 5, 6 & 7	\$31.40	For patients U16 years or a concessional beneficiary for services provided where not admitted to hospital and service is bulk-billed. <i>*This is a general overview, please click on the link to assess eligibility.</i>
75873	Bulk Billing Item MMM3 & 4	\$33.35	For patients U16 years or a concessional beneficiary for services provided where not admitted to hospital and service is bulk-billed. This item can be claimed with face-to-face level B, C, D and E general attendance items, and level B telehealth and telephone general attendance items. <i>*This is a general overview, please click on the link to assess eligibility.</i>
75874	Bulk Billing Item MMM5	\$35.45	For patients U16 years or a concessional beneficiary for services provided where not admitted to hospital and service is bulk-billed. This item can be claimed with face to face level B, C, D and E general attendance items, and level B telehealth and telephone general attendance items. <i>*This is a general overview, please click on the link to assess eligibility.</i>
75875	Bulk Billing Item MMM6	\$37.4	For patients U16 years or a concessional beneficiary for services provided where not admitted to hospital and service is bulk-billed. This item can be claimed with face to face level B, C, D and E general attendance items, and level B telehealth and telephone general attendance items. <i>*This is a general overview, please click on the link to assess eligibility.</i>
75876	Bulk Billing Item MMM7	\$39.70	For patients U16 years or a concessional beneficiary for services provided where not admitted to hospital and service is bulk-billed. This item can be claimed with face to face level B, C, D and E general attendance items, and level B telehealth and telephone general attendance items. <i>*This is a general overview, please click on the link to assess eligibility.</i>
75880	Bulk Billing Item MMM1 MyMedicare	\$20.65	MyMedicare service is provided to MyMedicare enrolled patient. For patients U16 years or a concessional beneficiary for services provided where not admitted to hospital and service is bulk-billed. This item can be claimed with level C, D, and E telehealth general attendance items, and level C and D telephone general attendance items, where the patient is registered with MyMedicare. <i>*This is a general overview, please click on the link to assess eligibility.</i>
75881	Bulk Billing Item MMM2 MyMedicare	\$31.40	MyMedicare service is provided to MyMedicare enrolled patient. For patients U16 years or a concessional beneficiary for services provided where not admitted to hospital and service is bulk billed. This item can be claimed with level C, D, and E telehealth general attendance items, and level C and D telephone general attendance items, where the patient is registered with MyMedicare. <i>*This is a general overview, please click on the link to assess eligibility.</i>
75882	Bulk Billing Item MMM3 & 4 MyMedicare	\$33.35	MyMedicare service is provided to MyMedicare enrolled patient. For patients U16 years or a concessional beneficiary for services provided where not admitted to hospital and service is bulk billed. This item can be claimed with level C, D, and E telehealth general attendance items, and level C and D telephone general attendance items, where the patient is registered with MyMedicare. <i>*This is a general overview, please click on the link to assess eligibility.</i>
75883	Bulk Billing Item MMM5 MyMedicare	\$35.45	MyMedicare service is provided. For patients U16 years or a concessional beneficiary for services provided where not admitted to hospital and service is bulk-billed. This item can be claimed with level C, D, and E telehealth general attendance items, and level C and D telephone general attendance items,

Desktop Guide to MBS Item Numbers

			where the patient is registered with MyMedicare. <i>*This is a general overview, please click on the link to assess eligibility.</i>
75884	Bulk Billing Item MMM6 MyMedicare	\$37.40	MyMedicare service is provided, if:(a) the attendance service is provided to a patient:(i) who is enrolled in MyMedicare at the general practice through which the attendance service is provided; and(ii) who is under the age of 16 or who is a concessional beneficiary; and(b) the patient is not an admitted patient of a hospital; and(c) the attendance service is bulk-billed. This item can be claimed with level C, D, and E telehealth general attendance items, and level C and D telephone general attendance items, where the patient is registered with MyMedicare. <i>*This is a general overview, please click on the link to assess eligibility.</i>
75885	Bulk Billing Item MMM7 MyMedicare	\$39.70	Professional attendance at which a MyMedicare service is provided, practice location in a Modified Monash 7 area ; other than an attendance service associated with a service to which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75870, 75871, 75872, 75873, 75874, 75875, 75876, 75880, 75881, 75882, 75883 or 75884. This item can be claimed with level C, D, and E telehealth general attendance items, and level C and D telephone general attendance items, where the patient is registered with MyMedicare. <i>*This is a general overview, please click on the link to assess eligibility.</i>

VIDEO CONSULTATIONS AND TELEHEALTH SERVICES

ITEM	NAME	\$ Benefit	DESCRIPTION / RECOMMENDED FREQUENCY
91790	Short Consultation video conference only	\$18.85	Telehealth attendance by a general practitioner requiring a short patient history and limited management. Must have an established clinical relationship with patient
91800	Consultation video conference only	\$41.40	Telehealth attendance by general practitioner lasting less than 20 mins. Must have an established clinical relationship with patient
91801	Consultation video consultation only	\$80.10	Telehealth attendance by general practitioner lasting longer than 20 mins. Must have an established clinical relationship with patient
91890	Short Consultation Telephone	\$18.95	Phone attendance by a general practitioner lasting less than 6 minutes requiring a short patient history and if required limited management. Must have an established clinical relationship
91891	Consultation Telephone ≥ 6 minutes	\$41.40	Phone attendance lasting at least 6 minutes and includes any of the following that are clinically relevant: short patient history, investigations, implementing a management plan and appropriate preventative health
92004	Health Assessment for Aboriginal and or Torres Strait Islander people via videoconference	\$233.65	92004 is the videoconference equivalent of existing face to face item 715
92024	Preparation of GP Management Plan via videoconference	\$158.80	92024 is the videoconference equivalent of existing face to face item 721
92025	Coordination of Team Care Arrangement via videoconference	\$125.85	92025 is the videoconference equivalent of existing face to face item 721
92026	Care Plan via videoconference	\$77.50	Contribution to a Care Plan or to a review of Care Plan prepared by another provider or a review prepared by another provider. 92026 is the videoconference equivalent of existing face to face item 729
92027	Care Plan for RACF patient via videoconference	\$77.50	Contribution to a Care Plan or to a review of Care plan for a patient being discharge from hospital or in a residential aged care facility. Service must be performed by pts usual GP. 92026 is the videoconference equivalent of existing face to face item 731
92028	Review or coordinate a review of GPMP or TCA via videoconference	\$79.30	Attendance by the GP to review or coordinate a review of GPMP or TCA Must be performed by the patient's usual GP
92142	Management Plan for patient with a disability <13 yrs via videoconference	\$148.05	Assessment, diagnosis and preparation of treatment and management plan, applicable only once.92142 is the equivalent existing face to face item 139
93700	Smoking Cessation <20 minutes via telephone	\$41.40	Consultation for nicotine & smoking cessation, care & advice by a general practitioner at consulting room < 20 minutes
93690	Smoking Cessation <20 minutes via videoconference	\$41.40	Consultation for nicotine & smoking cessation, care and advice by a general practitioner at consulting rooms < 20 minutes
93703	Smoking Cessation ≥20 minutes via telephone	\$80.10	Consultation for nicotine & smoking cessation, care and advice by a general practitioner at consulting rooms ≥ 20 minutes

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93693	Smoking Cessation ≥ 20 minutes via videoconference	\$80.10	Consultation for nicotine & smoking cessation, care and advice by a general practitioner at consulting rooms ≥ 20 minutes
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VIDEO CONSULTATIONS AND TELEHEALTH SERVICES Continued

92136	Non-directive pregnancy support >20mins via videoconference	\$83.90	92136 is the videoconference equivalent of existing face to face item 4001 GP required to meet credentialing requirements for this item
92138	Non-directive pregnancy support >20mins via telephone	\$83.90	92138 is the telehealth equivalent of existing face to face item 4001 GP required to meet credentialing requirements for this item
92731	Professional attendance < 5 minutes for sexual or reproductive health check via telephone	\$18.85	Consultation for the provision of services related to blood borne virus, sexual or reproductive health by a GP less than 5 minutes. Note assisted reproductive technology & antenatal care are outside these items
92715	Consultation < 5 minutes for sexual or reproductive health check via videoconference	\$18.85	Consultation for the provision of services related to blood borne virus, sexual or reproductive health by a GP less than 5 minutes. Note assisted reproductive technology & antenatal care are outside these items
92734	Consultation 5 -20 minutes for sexual or reproductive health check via telephone	\$41.40	Consultation for the provision of services related to blood borne virus, sexual or reproductive health by a GP between 5 -20 minutes. Note assisted reproductive technology & antenatal care are outside these items
92718	Consultation 5 -20 minutes for sexual or reproductive health check via videoconference	\$41.40	Consultation for the provision of services related to blood borne virus, sexual or reproductive health by a GP between 5 – 20 minutes. Note assisted reproductive technology & antenatal care are outside these items
92737	Consultation 21-40 minutes for sexual or reproductive health check via telephone	\$80.10	Consultation for the provision of services related to blood borne virus, sexual or reproductive health by a GP between 20-40 minutes. Note assisted reproductive technology & antenatal care are outside these items
92721	Consultation 21-40 minutes for sexual or reproductive health check via videoconference	\$80.10	Consultation for the provision of services related to blood borne virus, sexual or reproductive health by a GP between 20-40 minutes. Note assisted reproductive technology & antenatal care are outside these items
92740	Consultation ≥ 40 minutes for sexual or reproductive health check via telephone	\$118.00	Consultation for the provision of services related to blood borne virus, sexual or reproductive health by a GP for at least 40 minutes. Note assisted reproductive technology & antenatal care are outside these items
92724	Consultation ≥ 40 minutes for sexual or reproductive health check via videoconference	\$118.00	Consultation for the provision of services related to blood borne virus, sexual or reproductive health by a GP for at least 40 minutes. Note assisted reproductive technology & antenatal care are outside these items
14206	Implant (implanon)	\$33.35	Hormone or living tissue implant (implanon) by cannula
30062	Implant (Implanon) removal	\$56.85	Removal of Etonogestrel subcutaneous implant (e.g. Implanon)

Desktop Guide to MBS Item Numbers

NEW VIDEO CONSULTATIONS AND TELEHEALTH SERVICES

Bulk billing incentives for eligible patients from 1 November 2023 – Modified Monash 1 (Metropolitan Area) (Refer to criteria on page 14)

Applicable BBI item	10990	75870	75880 (MyMedicare enrolled patients only)
Standard hours consultations			
In consulting rooms	3	23, 36, 44, 123	
Out of consulting rooms	4	24, 37, 47, 124	
Residential aged care facility	90020	90035, 90043, 90051, 90054	
Telehealth			
Video	91790 (all) 91801, 91802, 91920 if not MyMedicare enrolled	91800	91801, 91802, 91920
Phone	91890	91891	91900, 91910
After hours consultations			
In consulting rooms	5000	5020, 5040, 5060, 5071	
Out of consulting rooms	5003 ⁴	5023 ⁵ , 5043 ⁵ , 5063 ⁵ , 5076 ⁵	
Residential aged care facility	5010 ⁴	5028 ⁵ , 5049 ⁵ , 5067 ⁵ , 5077 ⁵	
Other	All other “unreferred services” ⁶ , including but not limited to: chronic disease management items, Better Access mental health items, health assessments, minor procedures etc		

Desktop Guide to MBS Item Numbers

Bulk billing incentives for eligible patients from 1 November 2023 – Modified Monash 2 (Regional Centre) (Refer to criteria on page 14)

Applicable BBI item	10991	75871	75881 (MyMedicare enrolled patients only)
Standard hours consultations			
In consulting rooms	3	23, 36, 44, 123	
Out of consulting rooms	4	24, 37, 47, 124	
Residential aged care facility	90020	90035, 90043, 90051, 90054	
Telehealth			
Video	91790 (all) 91801, 91802, 91920 if not MyMedicare enrolled	91800	91801, 91802, 91920
Phone	91890	91891	91900, 91910
After hours consultations			
In consulting rooms	5000	5020, 5040, 5060, 5071	
Out of consulting rooms	5003	5023, 5043, 5063, 5076	
Residential Aged Care Facility	5010	5028, 5049, 5067, 5077	
Other	All other “unreferred services” ⁴ , including but not limited to: chronic disease management items, Better Access mental health items, health assessments, minor procedures etc		



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Bulk billing incentives for eligible patients from 1 November 2023 – Modified Monash 3 and 4 (Medium and Large Rural Towns) (Refer to criteria on page 14)

Applicable BBI item	75855	75873	75882 (MyMedicare enrolled patients only)
Standard hours consultations			
In consulting rooms	3	23, 36, 44, 123	
Out of consulting rooms	4	24, 37, 47, 124	
Residential aged care facility	90020	90035, 90043, 90051, 90054	
Telehealth			
Video	91790 (all) 91801, 91802, 91920 if not MyMedicare enrolled	91800	91801, 91802, 91920
Phone	91890	91891	91900, 91910
After hours consultations			
In consulting rooms	5000	5020, 5040, 5060, 5071	
Out of consulting rooms	5003	5023, 5043, 5063, 5076	
Residential aged care facility	5010	5028, 5049, 5067, 5077	
Other	All other “unreferred services” ⁴ , including but not limited to: chronic disease management items, Better Access mental health items, health assessments, minor procedures etc		

Desktop Guide to MBS Item Numbers

Bulk billing incentives for eligible patients from 1 November 2023 – Modified Monash 5 (Small Rural Towns) (Refer to criteria on page 14)

Applicable BBI item	75856	75874	75883 (MyMedicare enrolled patients only)
Standard hours consultations			
In consulting rooms	3	23, 36, 44, 123	
Out of consulting rooms	4	24, 37, 47, 124	
Residential aged care facility	90020	90035, 90043, 90051, 90054	
Telehealth			
Video	91790 (all) 91801, 91802, 91920 if not MyMedicare enrolled	91800	91801, 91802, 91920
Phone	91890	91891	91900, 91910
After hours consultations			
In consulting rooms	5000	5020, 5040, 5060, 5071	
Out of consulting rooms	5003	5023, 5043, 5063, 5076	
Residential aged care facility	5010	5028, 5049, 5067, 5077	
Other	All other “unreferred services” ⁴ , including but not limited to: chronic disease management items, Better Access mental health items, health assessments, minor procedures etc		



Desktop Guide to MBS Item Numbers

Bulk billing incentives for eligible patients from 1 November 2023 – Modified Monash 6 (Remote Communities) (Refer to criteria on page 14)

Applicable BBI item	75857	75875	75884 (MyMedicare enrolled patients only)
Standard hours consultations			
In consulting rooms	3	23, 36, 44, 123	
Out of consulting rooms	4	24, 37, 47, 124	
Residential aged care facility	90020	90035, 90043, 90051, 90054	
Telehealth			
Video	91790 (all) 91801, 91802, 91920 if not MyMedicare enrolled	91800	91801, 91802, 91920
Phone	91890	91891	91900, 91910
After hours consultations			
In consulting rooms	5000	5020, 5040, 5060, 5071	
Out of consulting rooms	5003	5023, 5043, 5063, 5076	
Residential aged care facility	5010	5028, 5049, 5067, 5077	
Other	All other “unreferred services” ⁴ , including but not limited to: chronic disease management items, Better Access mental health items, health assessments, minor procedures etc		

Desktop Guide to MBS Item Numbers

Bulk billing incentives for eligible patients from 1 November 2023 – Modified Monash 7 (Very Remote Communities) (Refer to criteria on page 14)

Applicable BBI item	75858	75876	75885 (MyMedicare enrolled patients only)
Standard hours consultations			
In consulting rooms	3	23, 36, 44, 123	
Out of consulting rooms	4	24, 37, 47, 124	
Residential aged care facility	90020	90035, 90043, 90051, 90054	
Telehealth			
Video	91790 (all) 91801, 91802, 91920 if not MyMedicare enrolled	91800	91801, 91802, 91920
Phone	91890	91891	91900, 91910
After hours consultations			
In consulting rooms	5000	5020, 5040, 5060, 5071	
Out of consulting rooms	5003	5023, 5043, 5063, 5076	
Residential aged care facility	5010	5028, 5049, 5067, 5077	
Other	All other “unreferred services” ⁴ , including but not limited to: chronic disease management items, Better Access mental health items, health assessments, minor procedures etc		

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- ¹ Includes all medical practitioners eligible to claim MBS GP items ie fellows of the RACGP or ACRRM, medical practitioners undertaking a training placement approved by the RACGP or ACRRM or a training placement under the Remote Vocational Training Scheme, practitioners listed on the Vocational Register of General Practitioners, a medical practitioner who has successfully completed the requirements of the MedicarePlus for Other Medical Practitioners Program or is providing services under that program, or a medical practitioner providing services in accordance with the Other Medical Practitioners Extension Program
- ² Bulk billing incentives can be claimed you bulk bill a child under 16 or a Commonwealth Concession Card holder www.servicesaustralia.gov.au/concession-and-health-care-cards
- ³ Practice located in Modified Monash area www.health.gov.au/resources/apps-and-tools/health-workforce-locator/app
- ⁴ If service is provided in an MM 2 – 7 area by a GP whose practice is located in an MM 1 area, then BBI item number 10992 is claimed
- ⁵ If service is provided in an MM 2 – 7 area by a GP whose practice is located in an MM 1 area, then BBI item number 75872 is claimed
- ⁶ Bulk billing incentives cannot be claimed for the provision of COVID vaccine support services

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- ¹ Includes all medical practitioners eligible to claim MBS GP items ie fellows of the RACGP or ACRRM, medical practitioners undertaking a training placement approved by the RACGP or ACRRM or a training placement under the Remote Vocational Training Scheme, practitioners listed on the Vocational Register of General Practitioners, a medical practitioner who has successfully completed the requirements of the MedicarePlus for Other Medical Practitioners Program or is providing services under that program, or a medical practitioner providing services in accordance with the Other Medical Practitioners Extension Program
- ² Bulk billing incentives can be claimed you bulk bill a child under 16 or a Commonwealth Concession Card holder www.servicesaustralia.gov.au/concession-and-health-care-cards
- ³ Practice located in Modified Monash area www.health.gov.au/resources/apps-and-tools/health-workforce-locator/app
- ⁴ Bulk billing incentives cannot be claimed for the provision of COVID vaccine support services

Desktop Guide to MBS Item Numbers

CHRONIC DISEASE MANAGEMENT

CHRONIC DISEASE MANAGEMENT			
ITEM	NAME	\$ Benefit	DESCRIPTION / RECOMMENDED FREQUENCY
721	GP Management Plan (GPMP)	\$119.10	Management plan for patients with a chronic or terminal condition. Not more than once yearly unless clinically required, e.g. patient unable to meet the goals set due to chronic condition or hospital stay. GP needs to indicate in the clinical notes on the Medicare Bulk Bill form prior to billing the service.
723	Team Care Arrangement (TCA)	\$94.40	Management plan 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. Enables referral for 5 rebated allied health services. Not more than once yearly unless clinically required, e.g. patient unable to meet the goals set due to chronic condition or hospital stay. GP needs to indicate in the clinical notes on the Medicare Bulk Bill form prior to billing the service.
732	Review of GP Management Plan and/or Team Care Arrangement	\$59.50	The recommended frequency is every 6 months. Minimum claiming period is 3 months. If a GPMP and TCA are both reviewed on the same date item 732 can be claimed twice on the same day
729	GP Contribution to, or Review of, Multidisciplinary Care Plan	\$77.50	Contribution by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), to a multidisciplinary care plan prepared by another provider or a review of a multidisciplinary care plan prepared by another provider (other than a service associated with a service to which any of items 735 to 758 apply). Not more than once every 3 months.
731	GP Contribution to, or Review of, Multidisciplinary Care Plan prepared by RACF	\$77.50	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 (other than a service associated with a service to which items 735 to 758 apply).

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

HEALTH ASSESSMENTS

HEALTH ASSESSMENTS			
ITEM	NAME	\$ Benefit	DESCRIPTION / RECOMMENDED FREQUENCY
699	Heart Health Assessment	\$80.10	30 + years Lasting at least 20 minutes – see MBS for complexity of care req.*
701	Brief Health Assessment	\$65.30	Brief health assessment, lasting not more than 30 minutes
703	Standard Health Assessment	\$151.80	>30 - 45 minutes - see MBS for complexity of care requirements
705	Long Health Assessment	\$209.45	>45 - <60 minutes - see MBS for complexity of care requirements
707	Prolonged Health Assessment	\$295.90	> 60 minutes - see MBS for complexity of care requirements
715	Aboriginal and Torres Strait Islander Health Assessment	\$233.65	Not timed – Frequency 9-12 months

MEDICATION MANAGEMENT

MEDICATION MANAGEMENT			
ITEM	NAME	\$	DESCRIPTION / RECOMMENDED FREQUENCY
900	Domiciliary Medication Management Review (DMMR)	\$170.45	Intended to maximize an individual patient's benefit from their medication regimen, and prevent medication-related problems through a team approach, Once every 12 months except if there has been a significant change in the patient's condition or medication regimen requiring a new DMMR
903	Residential Medication Management Review (RMMR)	\$116.70	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

PRACTICE NURSE/ABORIGINAL & TORRES STRAIT ISLANDER HEALTH PRACTITIONERS (ATSIHP)* ITEM NUMBERS AS OF NOVEMBER, 2015

PRACTICE NURSE/ABORIGINAL & TORRES STRAIT ISLANDER HEALTH PRACTITIONERS (ATSIHP)* ITEM NUMBERS AS OF NOVEMBER, 2015			
ITEM	NAME	\$	DESCRIPTION / RECOMMENDED FREQUENCY
10987	Follow Up Health Services for Indigenous people	\$26.40	Follow-up services provided by Practice Nurse or Aboriginal and Torres Strait Islander Health Practitioner for an Indigenous person who has received a Health Assessment (715), not an admitted patient of a hospital. Maximum of 10 services per patient, per calendar year.
10988	Immunisation	\$13.20	Immunisation provided to a person on behalf of the medical practitioner by an Aboriginal and Torres Strait Islander Health Practitioner. Claimed once per patient visit even if multiple vaccines given
10989	Wound Treatment	\$13.20	Treatment of wound (other than normal after care) provided by an Aboriginal and Torres Strait Islander Health Practitioner if the treatment is provided on behalf of, and under supervision of, a medical practitioner and the person is not admitted to hospital
10997	Chronic Disease Management	\$13.20	Monitoring and support for patients being managed under a GPMP or TCA. Not more than 5, per patient, per calendar year

**From 1 July 2023, restrictions preventing First Nations people claiming a heart health assessment service within 12 months of an Aboriginal and Torres Strait Islander Peoples health assessment service will be removed.*

**A practice nurse means a registered or enrolled nurse or nurse practitioner who is employed by, or whose services are otherwise retained by a general practice on behalf of and under supervision of Medical Practitioner*

An Aboriginal and Torres Strait Islander health practitioner means a person who has been registered as an Aboriginal and Torres Strait Islander health practitioner by the Aboriginal and Torres Strait Islander Health Practice Board of Australia and meets the Board's registration standards. The Aboriginal and Torres Strait Islander health practitioner must be employed or retained by a general practice, or by an Aboriginal & Torres Strait Health Service that has an exemption to claim Medicare benefits under subsection 19(2) of the Health Insurance Act 1973.

Desktop Guide to MBS Item Numbers

MENTAL HEALTH NUMBERS

MENTAL HEALTH ITEM NUMBERS			
ITEM	NAME	\$	DESCRIPTION / RECOMMENDED FREQUENCY
2700	GP Mental Health Treatment Plan	\$59.25	>20mins -<40mins – Professional attendance by a general practitioner (including a general practitioner who has not undertaken mental health skills training) of at least 20 minutes but less than 40 minutes in duration for the preparation of a GP *
2701	GP Mental Health Treatment Plan	\$87.15	>20mins -<40mins – Professional attendance by a general practitioner (including a general practitioner who has not undertaken mental health skills training) of at least 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient *
2715	GP Mental Health Treatment Plan	\$75.15	>20mins -<40mins Professional attendance by a general practitioner (including a general practitioner who has undertaken mental health skills training) of at least 20 minutes but less than 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient *
2717	GP Mental Health Treatment Plan	\$110.75	>20mins -<40mins - Professional attendance by a general practitioner (including a general practitioner who has undertaken mental health skills training) of at least 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient.
2712	Review of GP Mental Health Treatment Plan	\$59.25	Professional attendance by a general practitioner to review a GP mental health treatment plan which he or she, or an associated general practitioner has prepared, or to review a Psychiatrist Assessment and Management Plan.
2713	Mental Health Consultation	\$78.95	Consult >20mins -<40mins Professional attendance by a general practitioner in relation to a mental disorder and of at least 20 minutes in duration, involving taking relevant history and identifying the presenting problem (to the extent not previously recorded), providing treatment and advice and, if appropriate, referral for other services or treatments, and documenting the outcomes of the consultation
2721	GP Focused Psychological Strategies	\$102.10	>30mins -<40mins Professional attendance at consulting rooms by a general practitioner, for providing focussed psychological strategies for assessed mental disorders by a general practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 30 minutes, but less than 40 minutes.

*Many patients will not require a new plan after their initial plan has been prepared. A new plan should not be prepared unless clinically indicated, and generally not within 12 months of a previous plan. Ongoing management can be provided through the GP Mental Health Treatment Consultation and standard consultation items, as required, and reviews of progress through the GP Mental Health Treatment Plan Review item. A rebate for preparation of a GP Mental Health Treatment Plan will not be paid within 12 months of a previous claim for the patient for the same or another Mental Health Treatment Plan item or within three months following a claim for a GP Mental Health Treatment Review (item 2712 or former item 2719), other than in exceptional circumstances.

+The recommended frequency for the review service, allowing for variation in patients' needs, is:

- an initial review, which should occur between four weeks to six months after the completion of a GP Mental Health Treatment Plan; and
 - if required, a further review can occur three months after the first review.
- In general, most patients should not require more than two reviews in a 12-month period, with ongoing management through the GP Mental Health Treatment Consultation and standard consultation items, as required.

ALLIED HEALTH SERVICES FOR CHRONIC CONDITIONS REQUIRING TEAM CARE

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) or have had a Review of a GPMP & TCA item 732 and completed a referral containing all components of form which can be found [HERE](#). 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 & Torres Strait Health Workers (ATSIHW) or Aboriginal & Torres Strait Islander Health Practitioner (ATSIHP) Services	ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH SERVICE Aboriginal or Torres Strait Islander health service provided to a person by an eligible Aboriginal health worker or eligible Aboriginal and Torres Strait Islander health practitioner \$68.55
10951	Diabetes Educator Services	Aboriginal & Torres Strait Health Workers (ATSIHW) or Aboriginal & Torres Strait Islander Health Practitioner (ATSIHP) Services and Allied Health Providers must have a Medicare Provider number. Maximum of five services (including any services to which items 10950 to 10970, 93000, 93013, 93501 to 93513 and 93524 to 93538 apply) in a calendar year.
10952	Audiologist Services	
10953	Exercise Physiologist Services	
10954	Dietitian Services	
10958	Occupational Therapist Services	
10960	Physiotherapist Services	Can be 5 sessions with one provider or a combination, e.g., 3 dietitians' and 2 diabetes educators' 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. Allied health professionals must report back to the referring GP after first and last visit.
10962	Podiatrist Services	
10964	Chiropractor Services	
10966	Osteopath Services	
10970	Speech Pathologist Services	
10956	Mental Health Worker	For mental health conditions use Better Access Mental Health Care items - 10 sessions For chronic physical conditions use GPMP and TCA - 5 sessions >20mins per calendar year Better access and GPMP can be used for the same patient where eligible.
10968	Psychologist	For mental health conditions, use Better Access Mental Health Care items – 10 sessions For chronic physical conditions, use GPMP and TCA – 5 sessions per calendar year Better Access and GPMP can be used for the same patient, where eligible.

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

Desktop Guide to MBS Item Numbers

FOLLOW-UP ALLIED HEALTH SERVICES FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES WHO HAVE HAD A HEALTH ASSESSMENT

ASSESSMENT AND PROVISION OF SERVICES

A person who is of Aboriginal or Torres Strait Islander descent may be referred by their GP for follow-up allied health services under items 81300 to 81360 **when the GP has undertaken a health assessment (Items 701, 703, 705, 707 or 715) and identified a need for follow-up allied health services.**

These items provide an alternative pathway for Aboriginal or Torres Strait Islander peoples to access allied health services. If a patient meets the eligibility criteria for individual allied health services under the Chronic Disease Management items (10950 to 10970) and for follow-up allied health services, they can access both sets of services and are eligible for up to ten allied health services under Medicare per calendar year.

ITEM	NAME	DESCRIPTION / RECOMMENDED FREQUENCY
81300	Aboriginal & Torres Strait Health Worker or Aboriginal & Torres Strait Islander Health Practitioner Services	<p>Aboriginal & Torres Strait Health Workers, or Aboriginal & Torres Strait Islander Health Practitioners and Allied Health Providers must have a current Medicare Provider number for each location in which they practice. \$58.30</p> <p>Maximum of 5 allied health services per patient each calendar year (in addition to the 5 services eligible from TCA 10950- 10970).</p> <p>Services must be of at least 20min duration and medical notes need to reflect same</p> <p>GP refers to allied health professional using a 'Referral form for follow-up allied health services under Medicare for People of Aboriginal or Torres Strait Islander descent' or a referral form containing all components. One for each provider.</p> <p>Allied health professionals must report back to the referring GP after the first and last services. This also includes health professionals using the same clinical software, an internal process of feedback must be in place for the GP to review the medical notes and enter if any further action is required e.g., recall patient, as they did not attend service or further action not required, recall patient for health assessment in 9-12months</p>
81305	Diabetes Education	
81310	Audiology	
81315	Exercise Physiology	
81320	Dietetics	
81325	Mental Health	
81330	Occupational Therapy	
81335	Physiotherapy	
81340	Podiatry	
81345	Chiropractic	
81350	Osteopathy	
81355	Psychology	
81360	Speech Pathology	

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

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) and completed a referral containing all components of form.		
For more information Click HERE		
ITEM	NAME	DESCRIPTION / RECOMMENDED FREQUENCY
81100	Assessment for Group Services by Diabetes Educator	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 A report is required to be provided to the referring GP that identifies if the patient would benefit from Group Services, before the group services are provided to the patient. \$74.80
81110	Assessment for Group Services by Exercise Physiologist	
81120	Assessment for Group Services by Dietitian	
81105	Diabetes Education Group Services	8 group per calendar year, can be 8 sessions with one provider or a combination e.g. 3 diabetes education, 3 dietitians and 2 exercise physiology sessions. Medicare Allied Health Group Services for Type 2 Diabetes Referral Form. Ensure all participants sign the Medicare Assignment of Benefits form after the group sessions. A report back to the referring GP is required at the completion of the group services and all providers who provided Group Services must contribute to this report. \$18.65

GP MULTIDISCIPLINARY CARE CONFERENCES

Item Number	NAME	DESCRIPTION / RECOMMENDED FREQUENCY
735	Organise and coordinate a case conference	>15 -<20 minutes. GP organises and coordinates case conference with at least 2 other members, each of whom provide a different kind of care or service to the patient and is not a family carer of the patient, and 1 of whom may be another medical practitioner in RACF or community, or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs \$77.85
739	Organise and coordinate a case conference	>20 - <40 minutes. GP organises and coordinates case conference in RACF or community, or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs. \$133.10
743	Organise and coordinate a case conference	> 40 minutes. GP organises and coordinates case conference in RACF or community, or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs. \$221.90
747	Participate in a case conference	>15 - <20 minutes. GP participates in a case conference in RACF or community or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs. \$57.20
750	Participate in a case conference	>30 - <40 minutes. GP participates in a case conference in RACF or community or on discharge. For patients with a chronic or terminal condition complex, and multidisciplinary care needs. \$98.00
758	Participate in a case conference	> 40 minutes. GP participates in a case conference in RACF or community or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs. \$163.10

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

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HEALTH ASSESSMENT TARGET GROUPS

Pages 15 to 22 will provide a more comprehensive overview of each target group and the health assessment criteria, clinical content, essential documentation and claiming requirements. The table below provides an overview of the Health Assessment target groups and frequency of assessments.

TARGET GROUP	FREQUENCY
Patient aged 30 years and over can have a Heart Health Assessment lasting at least 20 minutes (item 699)	Once Annually
People aged 45- 49 years (inclusive) who are at risk of developing a chronic disease. Pts may also receive a type 2 diabetes risk evaluation if they are at high risk of developing type 2 diabetes and meet the relevant eligibility criteria.	Once only
People aged 40-49 years (inclusive) or 15-54 years (inclusive) for Aboriginal and Torres Strait Islander people with a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool (AUSDRISK)	Once every 3 years only
People aged 75 years and older.	Provided annually
Comprehensive medical assessment for permanent residents of a Residential Aged Care Facility (new and existing)	Provided annually
People who have an intellectual disability	Provided annually
This health assessment is for refugees and other humanitarian entrants who arrive in Australia with complex and unusual medical conditions resulting from their area of origin or previous living conditions. This assessment is separate from, and in addition to, a medical assessment specifically for the grant of a Refugee or Humanitarian visa.	Voluntary, one-off service and must be provided within twelve months of the person's arrival in Australia or grant of visa
Health Assessment for patients that have identified as Aboriginal &/or Torres Strait Islander	Once every 9-12 Months
Former serving members of the Australian Defence Force including former members of permanent and reserve forces	Once only

Further Information

- https://www1.health.gov.au/internet/main/publishing.nsf/Content/mha_resource_kit
- A health assessment should generally be undertaken by the patient's 'usual doctor', that is, the medical practitioner (or medical practitioner in the same practice) who has provided the majority of services to the patient in the past 12 months, and/or is likely to provide the majority of services in the following 12 months. Should a medical practitioner other than the patient's 'usual doctor' or practice nurse undertake the health assessment, a copy of the health assessment record should be forwarded to the patient's 'usual doctor' or practice, subject to the agreement of the patient or their parent/guardian.
- Items 701,703,705 &707 may be used to undertake a health assessment. Item 699 used for Heart Health Assessment
- Item 10990 or 10991 (bulk billing incentives) can be claimed in conjunction with any health assessment, provided the conditions of item 10990 and 10991 are satisfied.
- Medical practitioners should establish a register of patients who require annual health assessments and remind these patients when their next health assessment is due. If an assessment identifies that a patient has a chronic medical condition and complex care needs, it may be appropriate for the GP to involve other health professionals in the patient's care using the MBS Chronic Disease Management items.

HEALTH ASSESSMENT ITEM NUMBERS

ITEM	NAME	DESCRIPTION / RECOMMENDED FREQUENCY
701	Brief Health Assessment <30mins	Professional attendance by a general practitioner to perform: Collection of relevant information, including taking a patient history and A basic physical examination and Initiating interventions and referrals as indicated and Providing the patient with preventive health care advice and information.
703	Standard Health Assessment 30 - 44 minutes	Professional attendance by a general practitioner to perform: Detailed information collection, including taking a patient history and An extensive physical examination and Initiating interventions and referrals as indicated and Providing a preventive health care strategy for the patient.
705	Long Health Assessment 45 - 59 minutes	Professional attendance by a general practitioner to perform: Comprehensive information collection, including taking a patient history and An extensive examination of the patient's medical condition and physical function and Initiating interventions and referrals as indicated; and Providing a basic preventive health care management plan for the patient.
707	Prolonged Health Assessment Lasting at least 60 minutes	Professional attendance by a general practitioner to perform: Comprehensive information collection, including taking a patient history and Extensive examination of the patient's medical condition, and physical, psychological, and social function and Initiating interventions and referrals as indicated and Providing a comprehensive preventive health care management plan for the patient.
715	Aboriginal and Torres Strait Islander Peoples Health Assessment No designated time / complexity requirements	Professional attendance by a general practitioner at consulting rooms or in another place other than a hospital or residential aged care facility to perform: For children aged 0 - 14 years old. Adults between 15- 54 years of age Older people over 55 years Must include the following: Information collection, including taking a patient history and undertaking examinations and investigations as required Making an overall assessment of the patient; Recommending appropriate interventions; Providing advice and information to the patient; and Keeping a record of the health assessment, and offering the patient, and/or patient's carer, a written report about the health assessment with recommendations about matters covered by the health assessment; and Offering the patient's carer (if any, and if the general practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report relevant to the carer

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

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RESIDENTIAL AGED CARE FACILITY ITEM NUMBERS

ITEM	NAME	DESCRIPTION / RECOMMENDED FREQUENCY
731	GP Contribution or review of a Multidisciplinary Care Plan	Contribution by a General Practitioner to: <ul style="list-style-type: none"> a multidisciplinary care plan for a patient in a residential aged care facility, prepared by that facility, or to a review of such a plan prepared by such a facility; or a multidisciplinary care plan prepared for a patient by another provider before the patient is discharged from a hospital, or to a review of such a plan prepared by another provider
701-707	Health Assessment	Comprehensive medical assessment for permanent residents of a Residential Aged Care Facility (new and existing)
<ul style="list-style-type: none"> Health assessments are not available to people who are in-patients of a hospital or care recipients in a residential aged care facility (with the exception of a comprehensive medical assessment provided to a permanent resident of a residential aged care facility). Before a health assessment is commenced, the patient (and/or the patient's parent(s), carer or representative, as appropriate) must be given an explanation of the health assessment process and its likely benefits. The patient must be asked whether they consent to the health assessment being performed. In cases where the patient is not capable of giving consent, consent must be given by the patient's parent(s), carer or representative. Consent to the health assessment must be noted in the patient's records. A health assessment may only be claimed by a general practitioner. <p>A health assessment must include the following elements:</p> <ol style="list-style-type: none"> information collection, including taking a patient history and undertaking or arranging examinations and investigations as required; making an overall assessment of the patient; recommending appropriate interventions; providing advice and information to the patient; keeping a record of the health assessment, and offering the patient a written report about the health assessment, with recommendations about matters covered by the health assessment; and offering the patient's carer (if any, and if the general practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report relevant to the carer. 		
903	Residential Medication Management Reviews	Available new residents on admission and existing permanent residents on a "as required" basis to people who are likely to benefit from such a review. This includes residents for whom quality use of medicines may be an issue or residents who are at risk of medication misadventure because of a significant change in their condition or medication regimen.

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

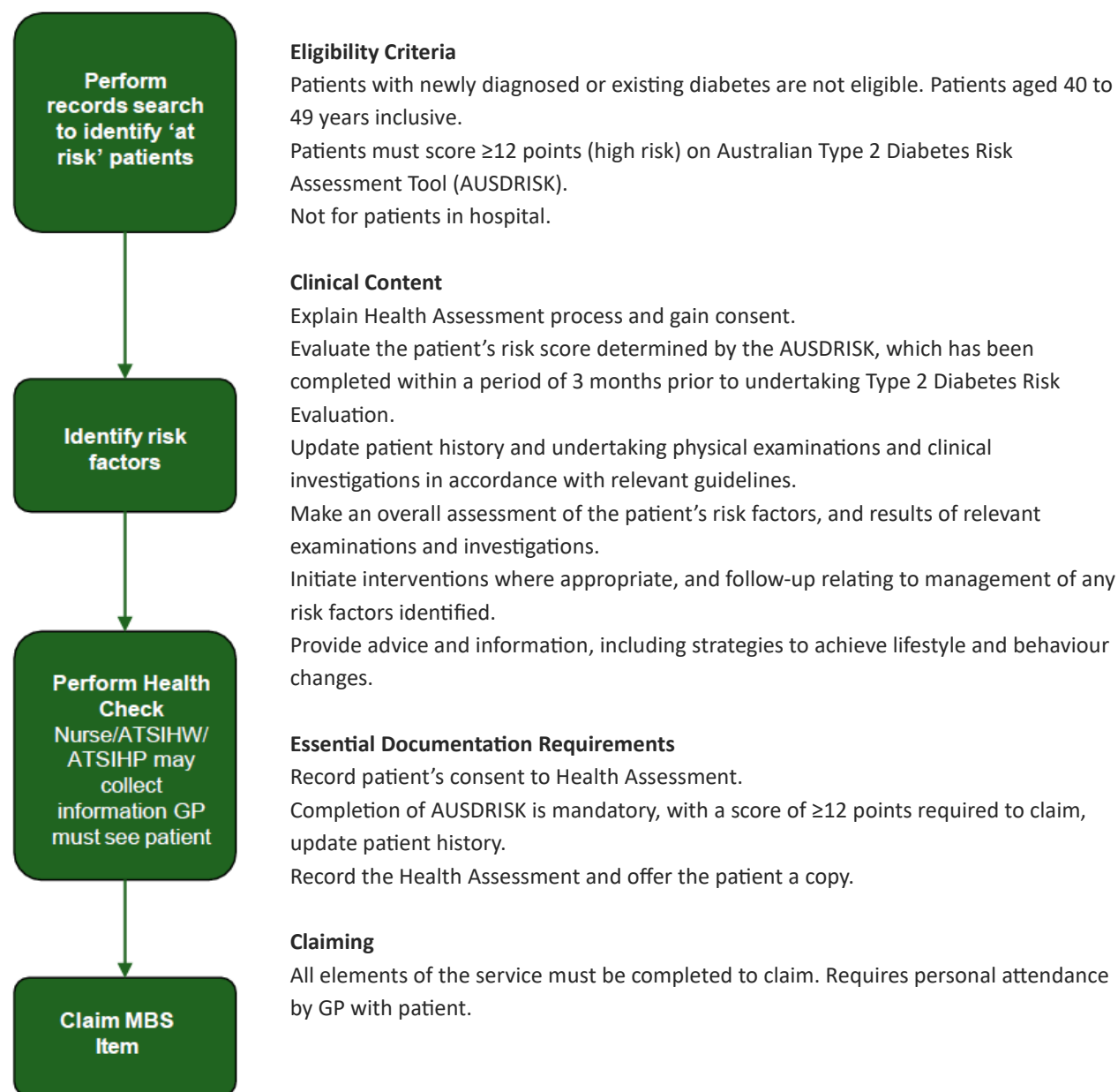
RESIDENTIAL AGED CARE FACILITY ITEM NUMBERS Continued

ITEM	NAME	DESCRIPTION / RECOMMENDED FREQUENCY
735	Organise and coordinate a case conference	15 – 19 minutes GP to organise and coordinate, or participate in, multidisciplinary case conferences for patients in the community or patients being discharged into the community from hospital or people living in residential aged care facilities
739	Organise and coordinate a case conference	20 - 39 minutes. GP to organise and coordinate, or participate in, multidisciplinary case conferences for patients in the community or patients being discharged into the community from hospital or people living in residential aged care facilities
743	Organise and coordinate a case conference	At least 40 minutes. GP to organise and coordinate, or participate in, multidisciplinary case conferences for patients in the community or patients being discharged into the community from hospital or people living in residential aged care facilities
747	Participate in a case conference	15 - 19 minutes. Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to participate in: a community case conference or a multidisciplinary case conference in a residential aged care facility or a multidisciplinary discharge case conference;
750	Participate in a case conference	30 - 40 minutes. GP participates in a case conference in RACF or 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 or community or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs
<ul style="list-style-type: none"> Items 735-758 are for patients who have at least one medical condition that has been (or likely to be) present for at least 6 months, is terminal and require ongoing care from a multidisciplinary case conference team who includes a medical practitioner and at least two other members, each providing a different kind of care and is not a family carer of the patient Should generally be undertaken by the patient's usual general practitioner that has provided the majority of services to the patient over the previous 12 months and/or will be providing the majority of services to the patient over the coming 12 months. May include allied health professionals such as, but not limited to: Aboriginal health care workers; asthma educators; audiologists; dental therapists; dentists; diabetes educators; dietitians; mental health workers; occupational therapists; optometrists; orthoptists; orthotists or prosthetists; pharmacists; physiotherapists; podiatrists; psychologists; registered nurses; social workers; speech pathologists. A team may also include home and community service providers, or care organisers, such as: education providers; "meals on wheels" providers; personal care workers (workers who are paid to provide care services); probation officers. The patient's informal or family carer may be included as a formal member of the team in addition to the minimum of three health or care providers. The patient and the informal or family carer do not count towards the minimum of three. Organisation and coordination of a multidisciplinary discharge case conference (items 735, 739 and 743) may be provided for private in-patients being discharged into the community from hospital. 		

For a comprehensive explanation of each MBS Item number please refer to the Medicare Benefits Schedule online at [MBS Online - MBS Online](#)

Desktop Guide to MBS Item Numbers

TYPE 2 DIABETES RISK EVALUATION – HEALTH ASSESSMENT - ITEMS [701 / 703 / 705 / 707](#)

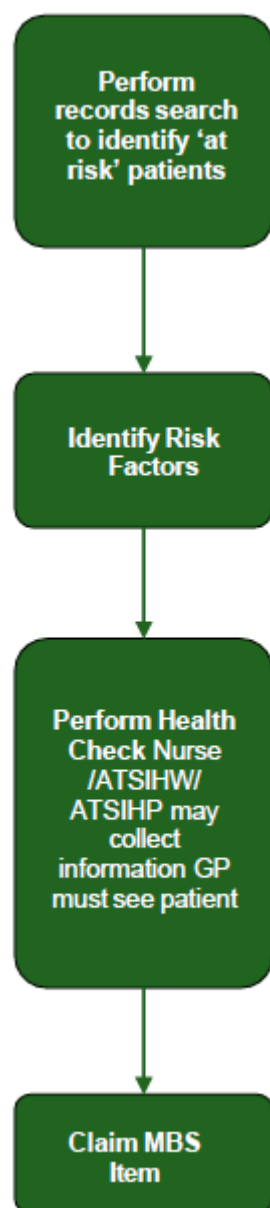


MBS item	Name	Age Range	Recommended Frequency
701 / 703 / 705 / 707	Health Assessment – Type 2 Diabetes Risk Evaluation.	40 - 49 years	Once every 3 years

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

[Click Here for Department of Health and Aged Care Fact Sheet](#)

45 - 49-YEAR-OLD HEALTH ASSESSMENT - ITEMS [701 / 703 / 705 / 707](#)



Eligibility Criteria

Patients aged 45 to 49 years inclusive

Must have an identified risk factor for chronic disease Not for patients in a 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; Excess weight

Family history of chronic disease

Clinical Content Mandatory

Explain Health Assessment process and gain consent

Information collection – takes patient history; undertake examinations and investigations as clinically required

Overall assessment of the patient's health, including their readiness to make lifestyle changes

Initiate interventions and referrals as clinically indicated

Advice and information about lifestyle modification programs and strategies to achieve lifestyle and behaviour changes

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

<i>MBS item</i>	<i>Name</i>	<i>Age Range</i>	<i>Recommended Frequency</i>
701 / 703 / 705 / 707	Health Assessment – 45 - 49	45 - 49 years	Once only

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

[Click Here for Department of Health and Aged Care Fact Sheet](#)

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75 YEARS AND OLDER – HEALTH ASSESSMENT - ITEMS [701 / 703 / 705 / 707](#)

Establish a patient register and recall when due for assessment

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 patient Recommend appropriate interventions Provide advice and information

Discuss outcomes of the assessment and any recommendations with patient

Perform Health Assessment
Allow 45 – 90 minutes.
Nurse/ATSIHW/ ATSIHP may collect information. GP must see patient

Complete Documentation

Non-Mandatory

Consider: Need for community services; Social isolation; Oral health and dentition; and Nutrition status

Additional matters as relevant to the patient

Claim MBS Item

Essential Documentation Requirements

Record patient's/carers 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 +.	75 years and older	Provided Annually

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

[Click Here for Department of Health and Aged Care Fact Sheet](#)

ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH ASSESSMENT - [ITEM 715](#)

**GP performs Health Assessment 715
Nurse/ATSIHW/
ATSIHP may collect
information. GP must
see patient**

**Claim MBS
Item 715**

**If Allied Health
Service is required**

**Allied Health
Service
Must be of a least
20 minutes
duration Service
must be performed
personally by
Allied Health
Professional**

**Allied Health
must provide
report to GP**

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

Eligibility Criteria

Aboriginal and Torres Strait Islander children who are less than 15 years old
An Aboriginal or Torres Strait Islander person who is aged between 15 years and 54 years
Aboriginal and Torres Strait Islander older people who are aged 55 years and over

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 recommending any appropriate intervention provide advice and information

Recording the health assessment.

Offering the patient, a written report with recommendations about matters cover 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

Essential Documentation Requirements

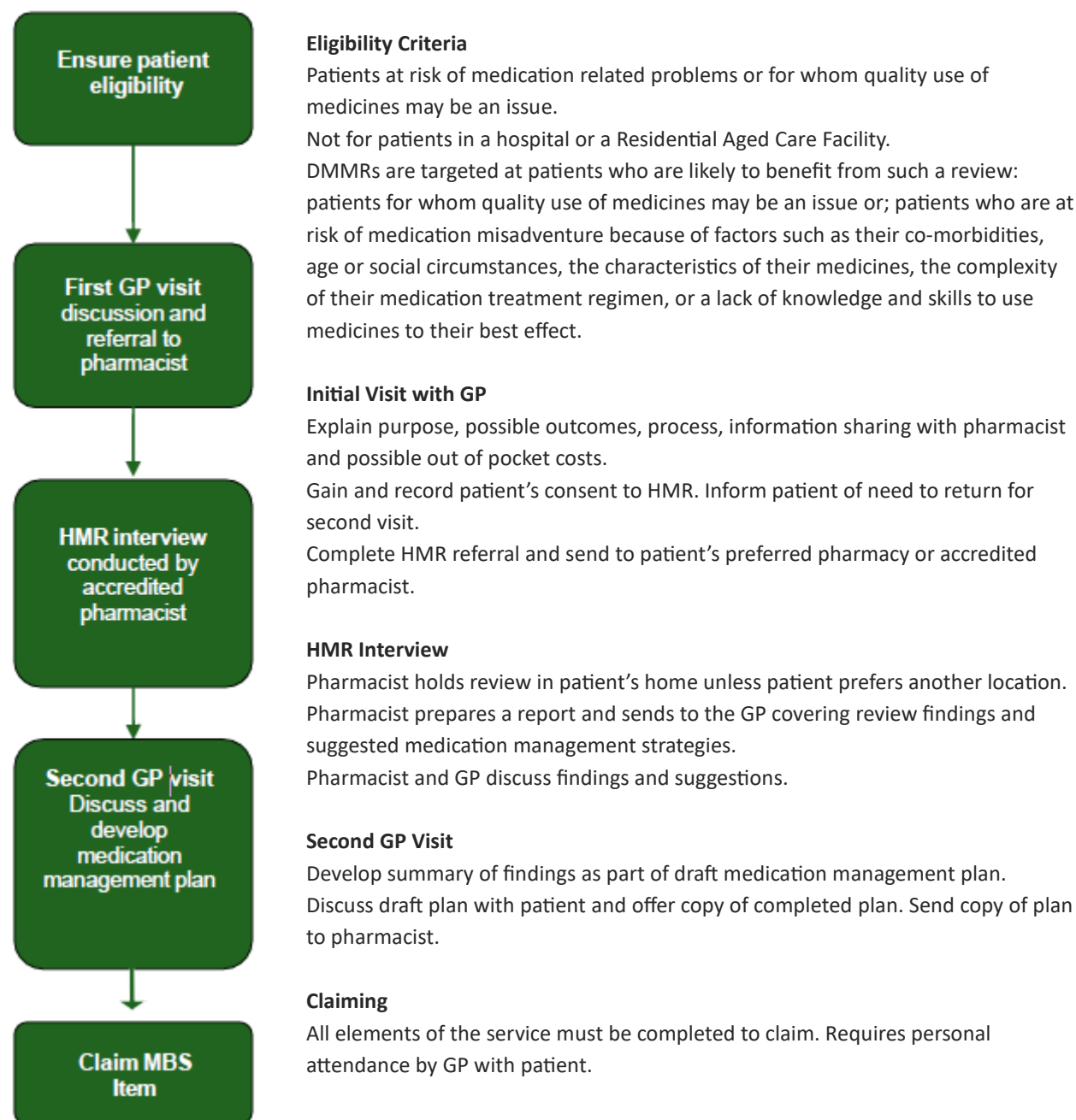
If referred to an Allied Health Professional, they must provide a written report to the GP after the first and last service (more often if clinically required)

<i>MBS item</i>	<i>Name</i>	<i>Age Range</i>	<i>Recommended Frequency</i>
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	Service provided by practice nurse or registered Aboriginal health worker	All Ages	Max 10 services per year

Desktop Guide to MBS Item Numbers

HOME MEDICINES REVIEW (HMR) - [ITEM 900](#)

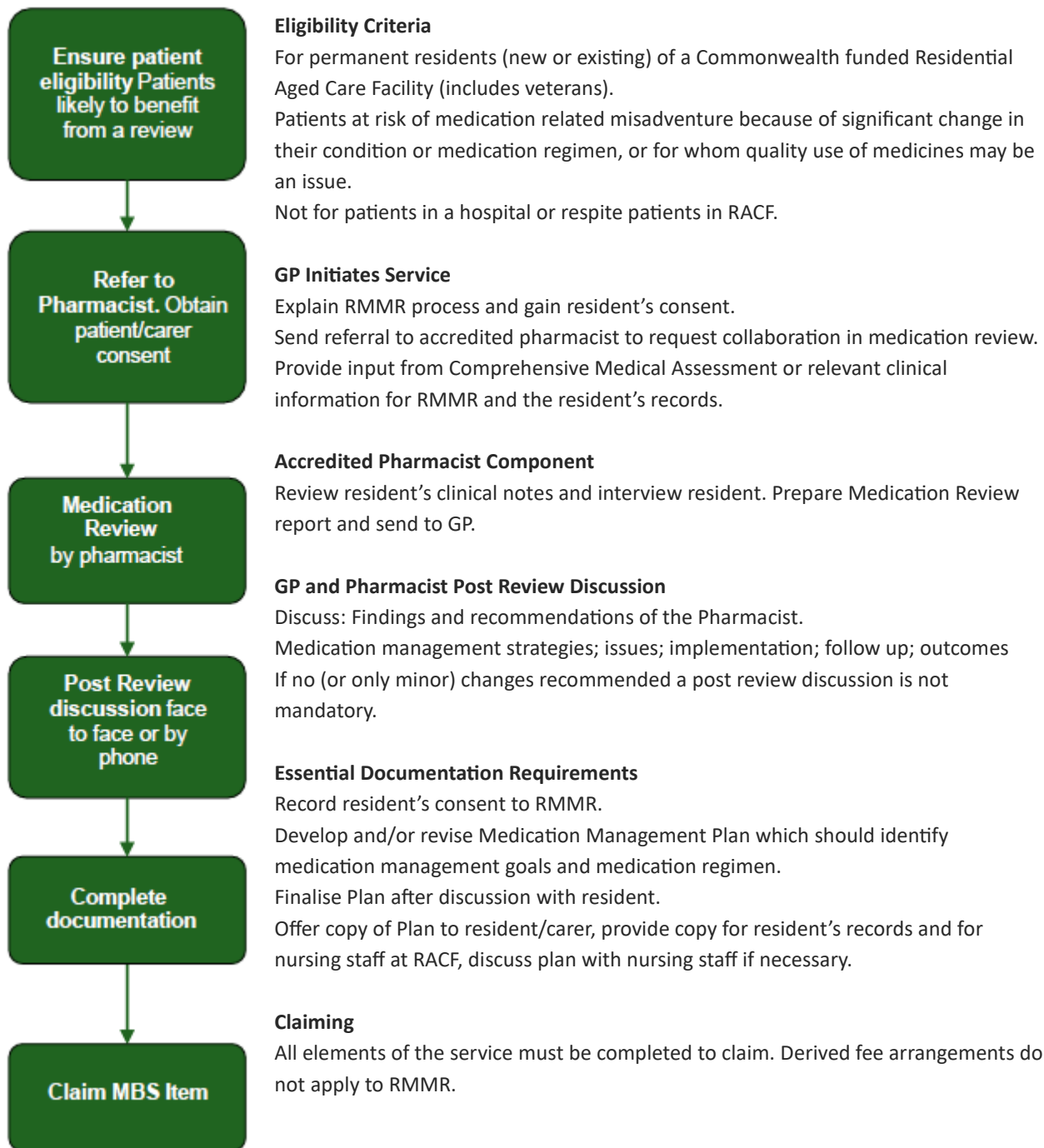
Also known as Domiciliary Medication Management Review (DMMR)



MBS Item	Name	Recommended Frequency
900	Home Medicines Review	Once every 12 months

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

RESIDENTIAL MEDICATION MANAGEMENT REVIEW (RMMR) - [ITEM 903](#)

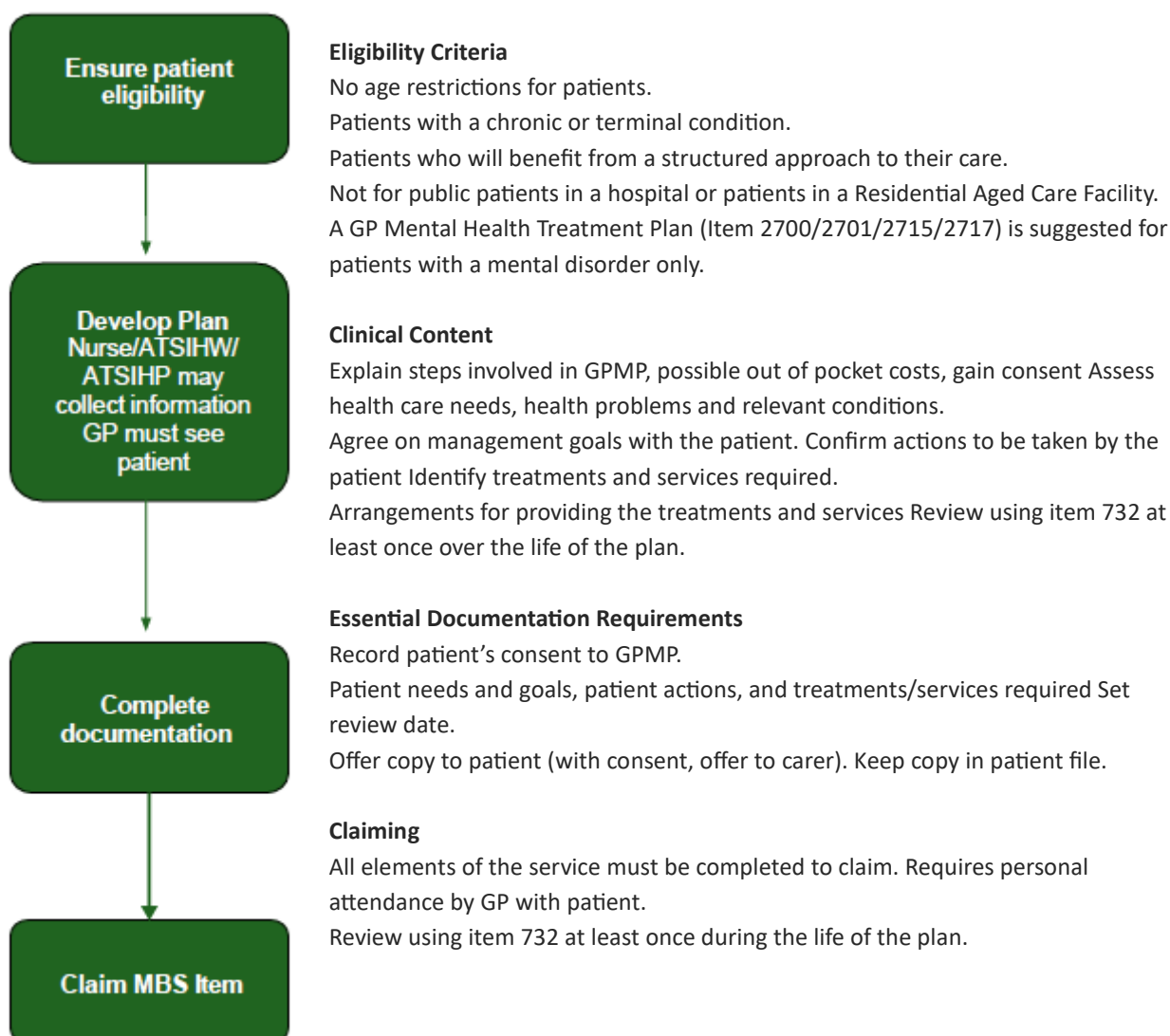


<i>MBS item</i>	<i>Name</i>	<i>Recommended Frequency</i>
903	Residential Medication Management Review	As required (Minimum 12 monthly)

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GP MANAGEMENT PLAN (GPMP) – [ITEM 721](#)



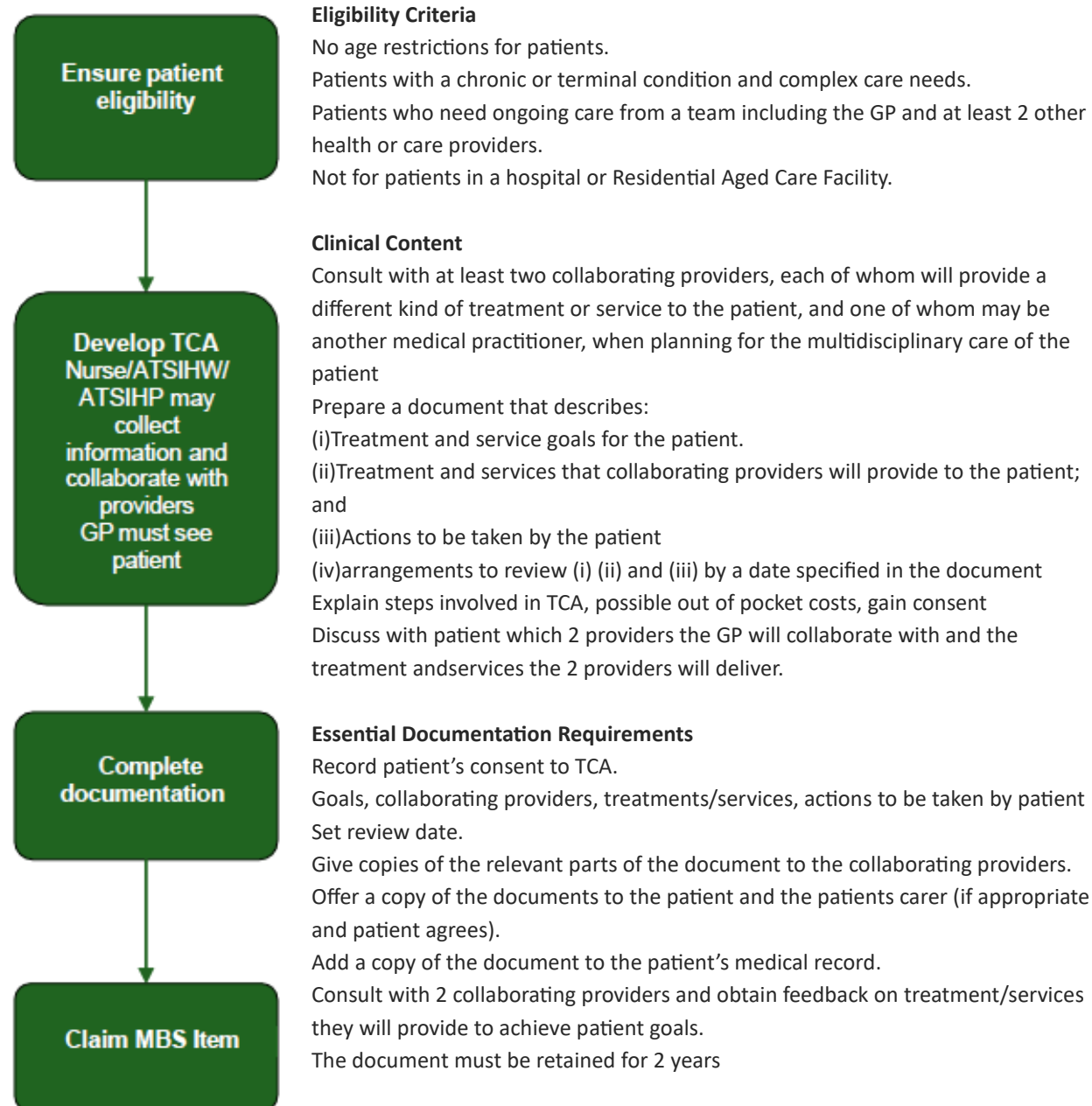
<i>MBS item</i>	<i>Name</i>	<i>Recommended Frequency</i>
721	GP Management Plan	2 yearly (Minimum 12 monthly) *

*CDM services may be provided more frequently in the exceptional circumstances defined below.

Exceptional circumstances exist for a patient if there has been a significant change in the patient's clinical condition or care requirements that necessitate the performance of the service for the patient.

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TEAM CARE ARRANGEMENT (TCA) – [ITEM 723](#)



Claiming

All elements of the service must be completed to claim. Requires 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 5 rebated services from allied health.

MBS item	Name	Recommended Frequency
723	Team Care Arrangement	2 yearly (Minimum 12 monthly) *

* CDM services may be provided more frequently in the exceptional circumstances defined below.

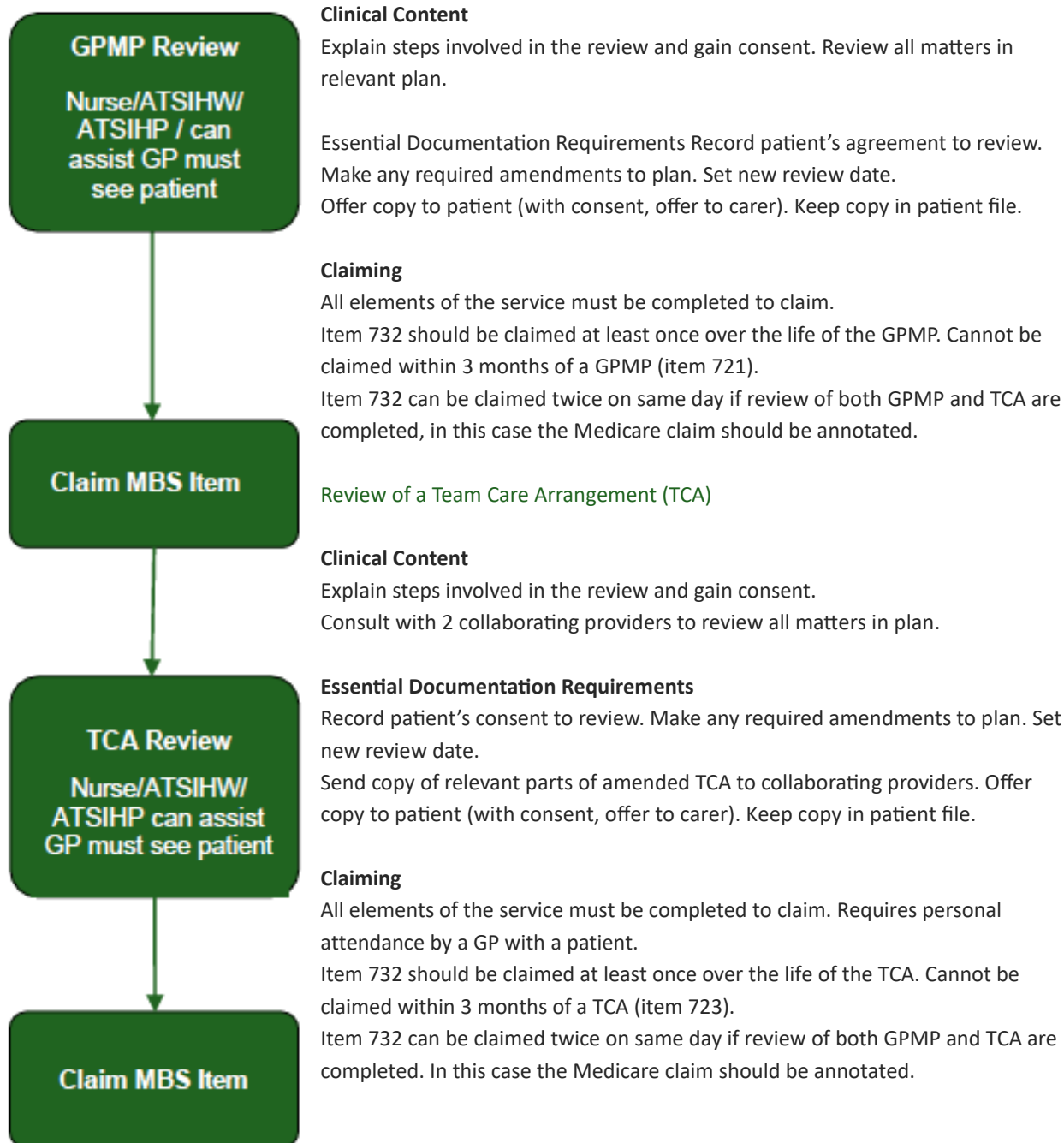
Exceptional circumstances exist for a patient if there has been a significant change in the patient's clinical condition or care requirements that necessitates the performance of the service for the patient.

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REVIEW OF A GP MANAGEMENT PLAN (GPMP) AND/OR TEAM CARE ARRANGEMENT (TCA) ITEM 732

Review of a GP Management Plan (GPMP)



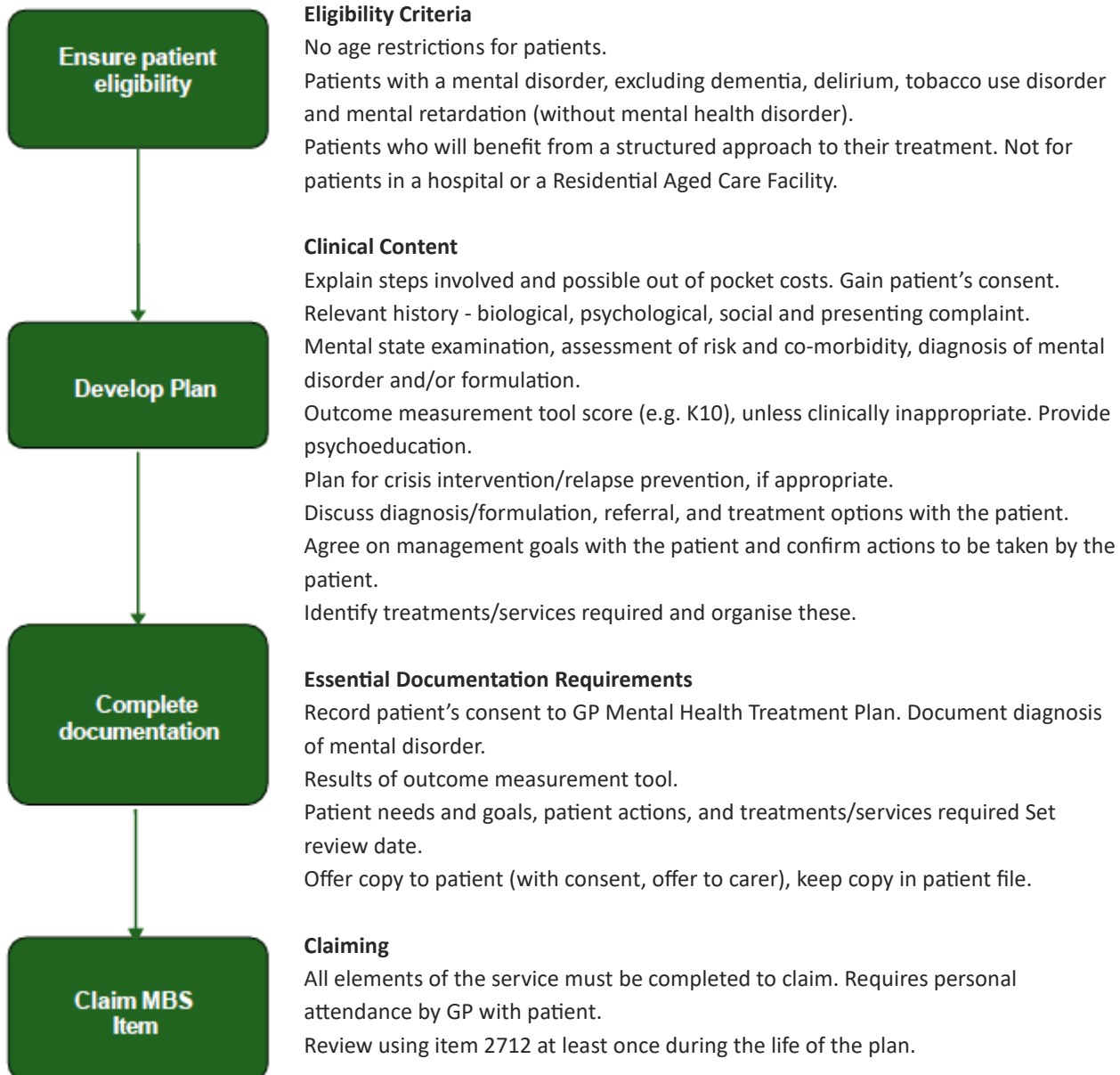
MBS Item	Name	Recommended Frequency
<u>732</u>	GP Management Plan and/or Team Care Arrangement	6 months (Minimum 3 months)

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MENTAL HEALTH TREATMENT PLAN – [ITEMS 2700/2701/2715/2717](#)

2700/2701- prepared by a GP who **has not** undertaken mental health skills training. A credentialed Mental Health Nurse, Aboriginal & Torres Strait Islander Health Worker or Aboriginal & Torres Strait Islander Practitioner that has completed Mental Health training can also assist the GP.

2715/2717 - prepared by a GP who **has** undertaken mental health skills training. A credentialed Mental Health Nurse, Aboriginal & Torres Strait Islander Health Worker or Aboriginal & Torres Strait Islander Practitioner that has completed Mental Health training can also assist the GP.

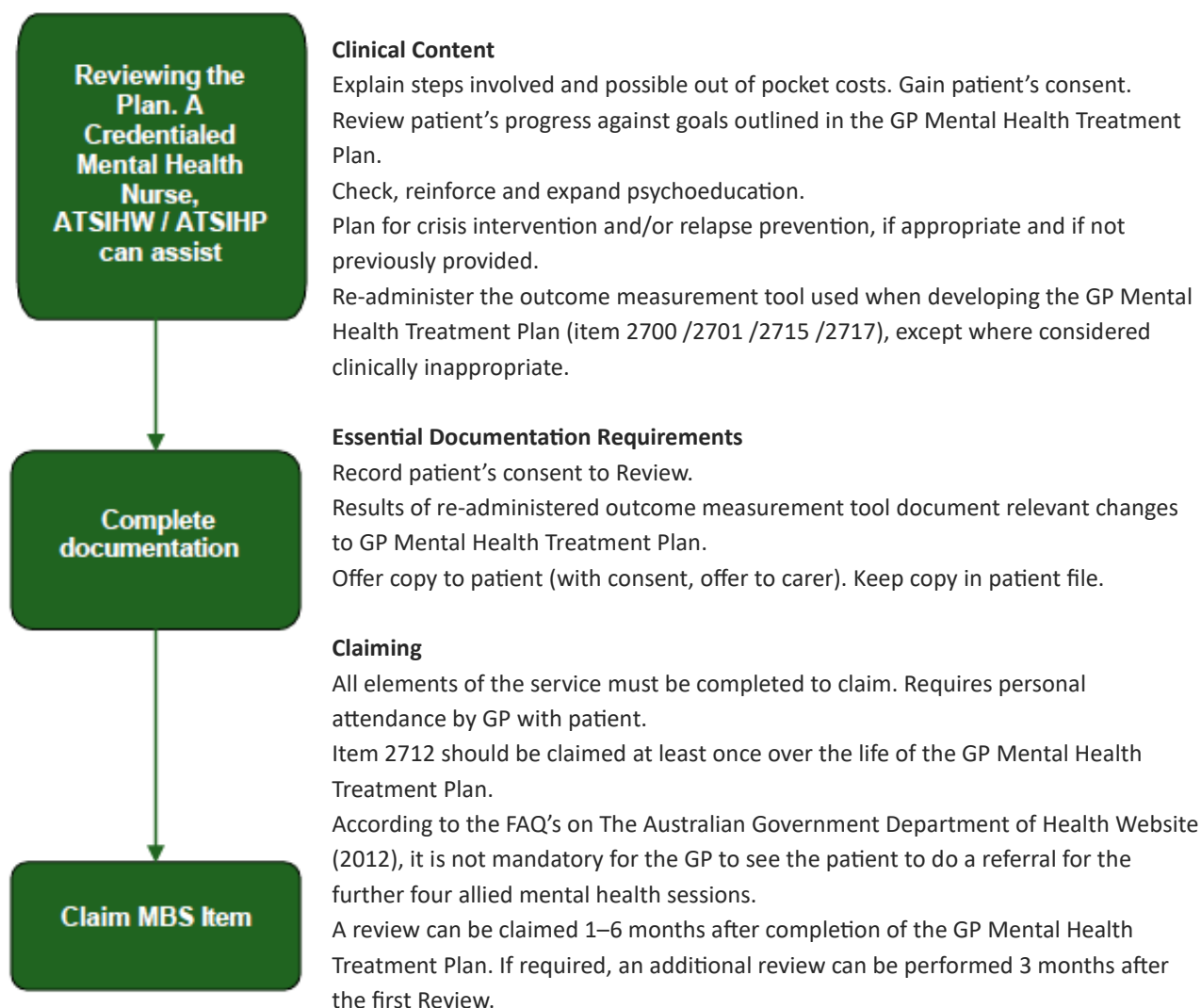


MBS item	Name	Recommended Frequency
2700,2701,2715,2717	GP Mental Health Treatment Plan: FACT SHEETS	Not more than once a year except in exceptional circumstances

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

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REVIEW OF MENTAL HEALTH TREATMENT PLAN – [ITEM 2712](#)



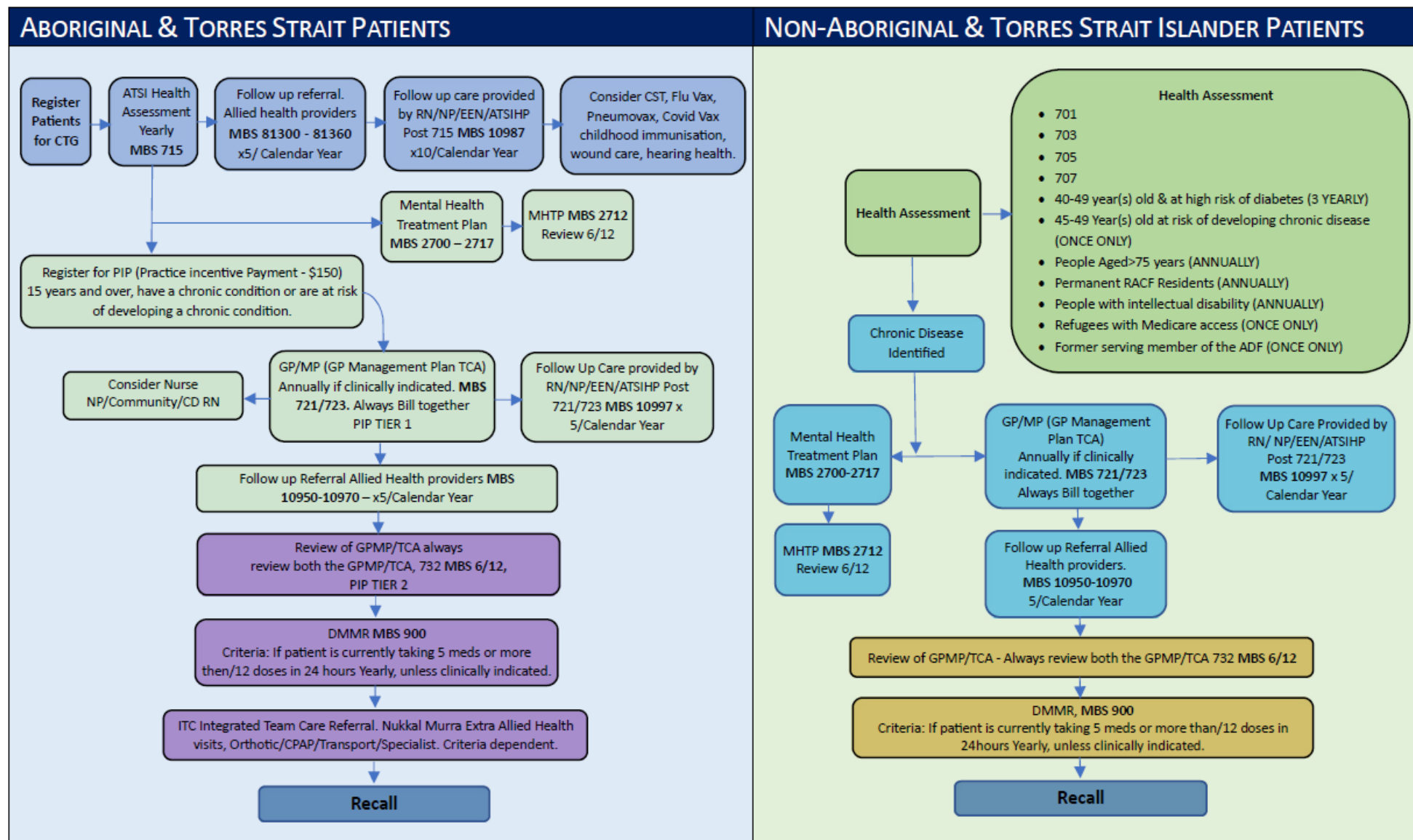
<i>MBS item</i>	<i>Name</i>	<i>Recommended Frequency</i>
2712	Review of GP Mental Health Treatment Plan	1 – 6 months after GP Mental Health Treatment Plan

For a comprehensive explanation of each MBS Item number please refer to the Medicare Benefits Schedule online at

www.health.gov.au/mbsonline

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PATIENT HEALTH JOURNEY



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PRACTICE INCENTIVE PAYMENTS AND SERVICE INCENTIVE PAYMENTS SUMMARY

PIP Quality stream

Incentive	Aspect or Activity	Payment amount
Indigenous Health Incentive	Sign on payment. This is a once only payment. Practices agree to undertake specified activities to improve the care of their Aboriginal and Torres Strait Islander patients with a chronic disease or mental disorder.	\$1,000 per practice
	Patient registration payment. This is a payment to practices for each eligible Aboriginal and/or Torres Strait Islander patient aged 15 years or over.	\$150 per eligible patient per calendar year
	Outcome payment Tier 1. A payment to practices that meet the requirements of the Tier 1 Outcome payment within a 12-month assessment period.	\$100 per eligible patient per 12-month assessment period
	Outcome payment Tier 2. A payment to practices for providing a target level of care for a registered patient within a 12-month assessment period.	\$150 per eligible patient per 12-month assessment period
Quality Improvement Incentive	A payment to practices to undertake continuous quality improvement through the collection and review of practice data.	\$5.00 per SWPE capped at \$12,500 per quarter

PIP Capacity stream

Incentive	Aspect or Activity	Payment amount
After Hours Incentive	Level 1: Participation payment Practices must meet the requirements of Level 1. This includes having formal arrangements in place to ensure patients have access to care in the complete after-hours period.	\$1 per SWPE
	Level 2: Sociable after-hours cooperative coverage Practices must meet the requirements of Level 2. This includes participating in a cooperative arrangement and other formal arrangements. This is to make sure patients have access to care in the sociable and unsociable after-hours periods.	\$4 per SWPE
	Level 3: Sociable after hours practice coverage Practices must meet the requirements of Level 3. This includes providing after hours care directly through the practice and through formal arrangements.	\$5.50 per SWPE
	Level 4: Complete after hours cooperative coverage Practices must meet the requirements of Level 4. This includes participating in a cooperative arrangement. This makes sure patients have access to care throughout the complete after hours period.	\$5.50 per SWPE
	Level 5: Complete after hours practice coverage Practices must meet the requirements of Level 5. This includes the practice providing after hours care directly to patients throughout the complete after hours period.	\$11 per SWPE

Incentive	Aspect or Activity	Payment amount
Aged Care Access Incentive	Tier 1a: payment to GPs for providing at least 60 eligible Medicare Benefits Schedule services in residential aged care facilities in the financial year	\$2,000 per financial year
	Tier 1b: payment to GPs for providing at least 100 eligible Medicare Benefits Schedule services in residential aged care facilities in the financial year	\$2,500 per financial year
	Tier 2a: payment to GPs for providing at least 140 eligible Medicare Benefits Schedule services in residential aged care facilities in the financial year	\$2,500 per financial year
	Tier 2b: payment to GPs for providing at least 180 eligible Medicare Benefits Schedule services in residential aged care facilities in the financial year	\$3,000 per financial year
eHealth Incentive	Practices must meet each of the requirements to qualify for payments through this incentive	\$6.50 per SWPE capped at \$12,500 per practice per quarter
Teaching Payment	Payment to practices for providing teaching sessions to medical students. Practices can claim payment for up to 2 sessions per GP per day	\$200 per session

PIP Rural support stream

Incentive	Aspect or activity	Payment amount
Procedural GP Payment	Tier 1: Payment for a GP in a rural or remote practice who provides at least 1 procedural service in the 6 month reference period. The service must meet the definition of a procedural service.	\$1,000 per procedural GP per 6 month reference period
	Tier 2: Payment for a GP in a rural or remote practice who meets both: the Tier 1 requirement provides after-hours procedural services on a regular or rostered basis. This must be 15 hours per week on average throughout the 6-month reference period.	\$2,000 per procedural GP per 6 month reference period
	Tier 3: Payment for a GP in a rural or remote practice who both: meets the Tier 2 requirements. provides 25 or more eligible surgical, anaesthetic or obstetric services in the 6-month reference period.	\$5,000 per procedural GP per 6 month reference period
	Tier 4: Payment for a GP in a rural or remote practice who both: meets the Tier 2 requirements. delivers 10 or more babies in the 6-month reference period or meets the obstetric needs of the community.	\$8,500 per procedural GP per 6 month reference period
Rural loading Incentive	Payment for a practice whose main location is outside a metropolitan area, based on the Rural, Remote and Metropolitan Area (RRMA) Classification. Once all incentive payments are added, the rural loading amount is applied.	RRMA 3- 15% loading RRMA 4- 20% loading RRMA 5- 40% loading RRMA 6- 25% loading RRMA 7- 50% loading

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PIP Enquiry Line Telephone: 1800 222 032
Email: pip@humanservices.gov.au

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