phn
WESTERN QUEENSLAND

An Australian Government Initiative

FREQUENTLY USED DESKTOP GUIDE TO MBS ITEM NUMBERS

for Primary Health Care Services

12 July 2021

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Western Queensland PCC Ltd (ABN 86 604 686 660), trading as Western Queensland PHN gratefully acknowledges the financial and other support from the Australian Government Department of Health

FREQUENTLY USED DESKTOP GUIDE TO ITEM NUMBERS

COMMONLY USED ITEM NUMBERS			
ITEM	**NAME**	**$**	**DESCRIPTION / RECOMMENDED FREQUENCY**
3	Level A	$17.90	Short - see MBS for complexity of care requirements
23	Level B	$39.10	< 20 min - see MBS for complexity of care requirements
36	Level C	$75.75	≥ 20 min - see MBS for complexity of care requirements
44	Level D	$111.50	≥ 40 min - see MBS for complexity of care requirements
10990	Bulk Billing Item	$7.65	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 to 7
10991	Bulk Billing Item	$11.60	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 to 7.
11505	Spirometry	$42.80	To confirm diagnosis of Asthma, COPD or another cause of airflow limitation – once in a 12 months period
11506	Spirometry	$21.40	Measurement of respiratory function before and after inhalation of bronchodilator
11309	Audiometry	$27.35	Audiogram, air conduction
11707	ECG	$19.15	12 lead electrocardiography, tracing only
73806	Pregnancy test	$10.15	Pregnancy test by one or more immunochemical methods
16500	Antenatal attendance	$49.05	Antenatal attendance
14206	Implant (implanon)	$37.05	Hormone or living tissue implant (implanon) by cannula
30062	Implant (implanon) removal	$63.20	Removal of implant (implanon)

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

CHRONIC DISEASE MANAGEMENT			
ITEM	**NAME**	**$**	**DESCRIPTION / RECOMMENDED FREQUENCY**
721	GP Management Plan (GPMP)	$150.10	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)	$118.95	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	$74.95	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	$73.25	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	$73.25	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.

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HEALTH ASSESSMENTS			
ITEM	**NAME**	**$**	**DESCRIPTION / RECOMMENDED FREQUENCY**
699	Heart Health Assessment	$75.75	Lasting at least 20 minutes – see MBS for complexity of care requirements
701	Brief Health Assessment	$61.75	Lasting not more than 30 minutes
703	Standard Health Assessment	$143.50	>30 - 45 minutes - see MBS for complexity of care requirements
705	Long Health Assessment	$198.00	>45 - <60 minutes - see MBS for complexity of care requirements
707	Prolonged Health Assessment	$279.70	> 60 minutes - see MBS for complexity of care requirements
715	Aboriginal and Torres Strait Islander Health Assessment	$220.85	Not timed – Frequency 9-12 months

MEDICATION MANAGEMENT			
ITEM	**NAME**	**$**	**DESCRIPTION / RECOMMENDED FREQUENCY**
900	Domiciliary Medication Management Review (DMMR)	$161.10	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)	$110.30	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

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	$24.95	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	$12.50	Monitoring and support for patients being managed under a GPMP or TCA. Not more than 5, per patient, per calendar year

*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.

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www.health.gov.au/mbsonline

MENTAL HEALTH ITEM NUMBERS			
ITEM	**NAME**	**$**	**DESCRIPTION / RECOMMENDED FREQUENCY**
2700	GP Mental Health Treatment Plan	$74.60	>20mins -<40mins – Prepared by GP who has **not** undertaken Mental Health Skills training. Assessment of patient and preparation of a GP Mental Health Treatment Plan with option to refer for rebated psychological services. Only when clinically required *
2701	GP Mental Health Treatment Plan	$109.85	>20mins -<40mins – Prepared by GP who has **not** undertaken Mental Health Skills training. Assessment of patient and preparation of a GP Mental Health Treatment Plan with option to refer for rebated psychological services. Only when clinically required *
2715	GP Mental Health Treatment Plan	$94.75	>20mins -<40minsPrepared by GP who **has** undertaken Mental Health Skills training. Assessment of patient and preparation of a GP Mental Health Treatment Plan with option to refer for rebated psychological services. Only when clinically required *
2717	GP Mental Health Treatment Plan	$139.55	>20mins -<40mins - Prepared by GP who **has** undertaken Mental Health Skills training. Assessment of patient and preparation of a GP Mental Health Treatment Plan with option to refer for rebated psychological services. Only when clinically required *
2712	Review of GP Mental Health Treatment Plan	$74.60	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. +
2713	Mental Health Consultation	$74.60	Consult >20mins -<40mins for the ongoing management of a patient with mental disorder. No restriction on the number of these consultations per year.
2721	GP Focused Psychological Strategies	$96.50	>30mins -<40mins Provision of focused psychological strategies by an appropriately trained and registered GP working in an accredited practice.
2729	GP Focused Psychological Strategies	$96.50	Telehealth attendance 30mins -<40mins. Provision of focused psychological strategies by an appropriately trained and registered GP working in an accredited practice.
2725	GP Focused Psychological Strategies	$138.10	> 40 minutes. Provision of focused psychological strategies by an appropriately trained and registered GP working in an accredited practice
2731	GP Focused Psychological Strategies	$138.10	Telehealth attendance > 40 minutes. Provision of focused psychological strategies by an appropriately trained and registered GP working in an accredited practice.

*Many patients will not require a new plan after their initial plan has been prepared. A new plan should not be prepared unless clinically required, 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
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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 (www.health.gov.au/mbsprimarycareitems)* **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 & Torres Strait Health Workers (ATSIHW) or Aboriginal & Torres Strait Islander Health Practitioner (ATSIHP) Services and Allied Health Providers must have a Medicare Provider number. $64.80 Maximum of 5 allied health services ATSIHW/P. per patient each calendar year. 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. Services must be of at least 20min 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	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

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	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. $64.80 Maximum of 5 allied health services per patient each calendar year (in addition to the 5 services eligible from TCA 10950-10970). Services must be of at least 20min duration and medical notes need to reflect same 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. 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
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 (www.health.gov.au/mbsprimarycareitems)

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. $83.10
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. $20.70

AFTER-HOURS SERVICES

ATTENDANCE PERIOD			ITEM NO	MBS PAYMENT	BRIEF GUIDE
Urgent attendance – after hours			5 8 5	$135.10	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 treatment, which could not be delayed until the next in-hours period For consultations at the practice, it is necessary for the practitioner to return to, and especially open the consulting rooms for the attendance * look up MBS online ready reckoner http://www9.health.gov.au/mbs/ready_reckoner.cfm?item_num=5023 The fee for these items is 5020 or 5040 plus $ divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5020 plus $2.10 per patient * look up MBS online ready reckoner http://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&qt=ItemID&q=5049
Mon-Fri 7am-8am or 6pm-11pm	**Sat** 7am-8am or 12noon-11pm	**Sun & Pub Holidays** 7am-11pm			
Urgent attendance – unsociable hours			5 9 9	$159.20	
Mon-Fri 11pm- 7am	**Sat** 11pm-7am	**Sun & Pub Holidays** 11pm-7am			
Non-urgent after hours at a place other than consulting rooms			5023 (1 patient) 5043 (1 patient) 5028 (1 patient) 5028 (2 patients) 5028 (3 patients) 5049 (1 patients) 5049 (2 patients) 5049 (3 patients)	$78.05 $114.40 $99.60 $75.30 $67.20 $136.00 $111.70 $103.60	
Mon-Fri Before 8am or after 6pm	**Sat** Before 8am or After 12pm	**Sun & Pub Holidays** All day			
Non-urgent after hours at consulting rooms			5000 (Level A) 5020 (Level B <20min) 5040 (Level C >20min) 5060 (Level D >40min)	$30.15 $51.00 $87.40 $122.55	
Mon-Fri Before 8am or After 8pm	**Sat** Before 8am or After 1pm	**Sun & Pub Holidays** All day			

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 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. $73.55
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. $125.85
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. $209.80
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. $54.05
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. $92.60
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. $154.20

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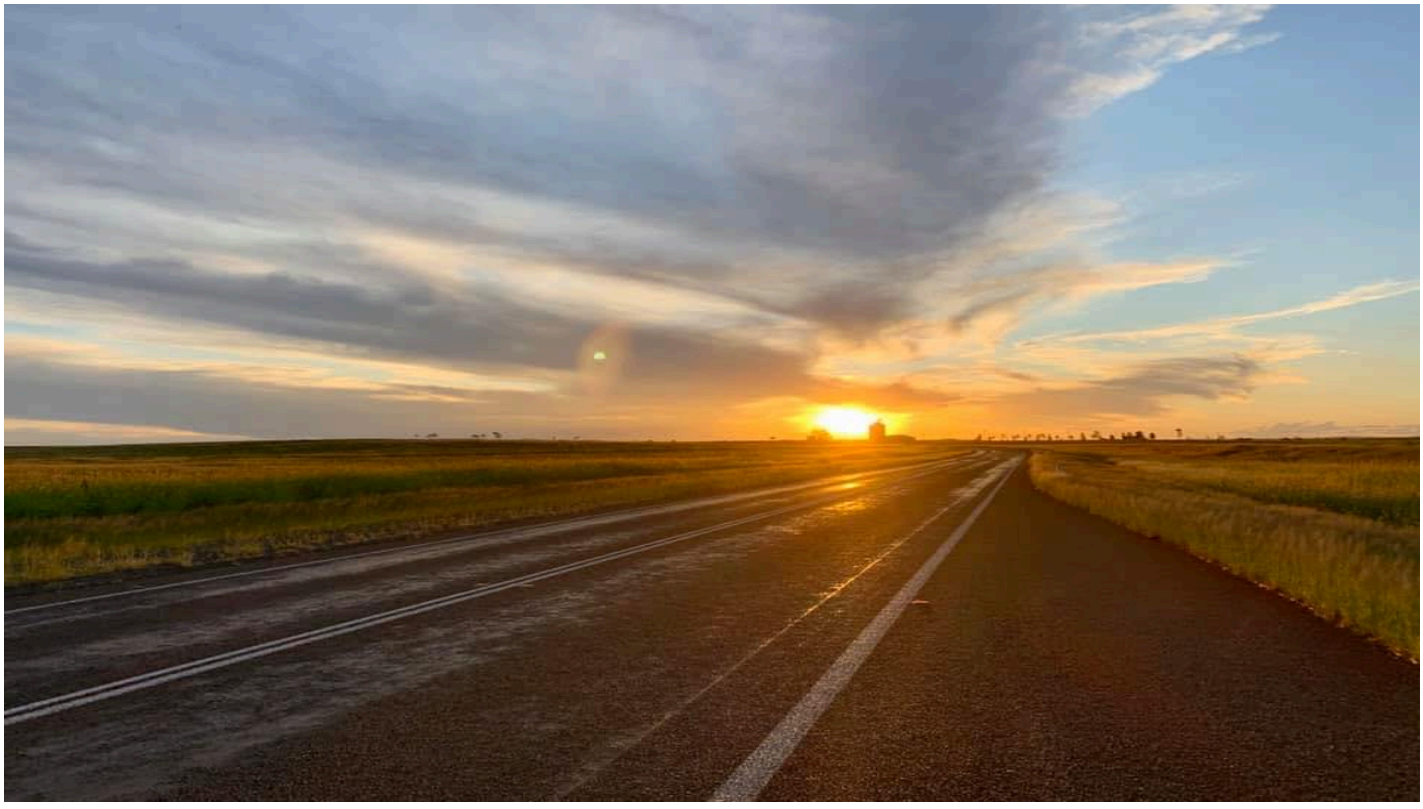

HEALTH ASSESSMENTS

There are 8 Health Assessment target groups:

Health Assessment – Heart Health
Aimed at identifying cardiovascular disease risk factors, **including** diabetes status, alcohol intake, smoking status and blood glucose. Once in 12 months period. Cannot be claimed if had another HA service (701,703,705,707,715) in previous 12 months

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 Years Old

Health assessment for patients 45-49 years who are at risk of developing a chronic disease Once only

Health Assessment - 75 Years and Older

Health assessment for patients aged 75 years and older. Once every 12 months

Health Assessment – Aboriginal & Torres Strait Islander
Health Assessment for patients that have identified as Aboriginal & Torres Strait Islander. Once every 9 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

Health assessment for patient with an Intellectual Disability. Not more than once yearly

Health Assessment for Refugees and other Humanitarian Entrants

Health assessment for new refugees and other humanitarian entrants, as soon as possible after their arrival (within 12 months of arrival). Once only to eligible patient

A desktop guide - Caring for Refugee Patients in General Practice is available on the RACGP website www.racgp.org.au

Health Assessment for former serving members of the Australian Defence Force (ADF).

Health assessment for former serving members of the ADF, including former members of permanent and reserve forces. Once only to eligible patient

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

There are four time-based Health Assessment item numbers which may be used for any of the target groups:

ITEM	NAME	DESCRIPTION / RECOMMENDED FREQUENCY
701	Brief Health Assessment **<30mins**	a) Collection of relevant information, including taking a patient history b) A basic physical examination c) Initiating interventions and referrals as indicated; and d) Providing the patient with preventive health care advice and information.
703	Standard Health Assessment **30 - 44 minutes**	a) Detailed information collection, including taking a patient history b) An extensive physical examination c) Initiating interventions and referrals as indicated; and d) Providing a preventive health care strategy for the patient.
705	Long Health Assessment **45 - 59 minutes**	a) Comprehensive information collection, including taking a patient history b) An extensive examination of the patient's medical condition and physical function c) Initiating interventions and referrals as indicated; and d) Providing a basic preventive health care management plan for the patient.
707	Prolonged Health Assessment **> 60 minutes**	a) Comprehensive information collection, including taking a patient history b) An extensive examination of the patient's medical condition, and physical, psychological, and social function. c) Initiating interventions and referrals as indicated; and d) Providing a comprehensive preventive health care management plan for the patient.
715	Aboriginal and Torres Strait Islander Health Assessment No designated time / complexity requirements	**Aboriginal and Torres Strait Islander Child Health Assessment** Health Assessment for Aboriginal and Torres Strait Islander patients 0 - 14 years old. Not available to in-patients of a hospital or RACF. Not more than once every 9 months **Aboriginal and Torres Strait Islander Adult Health Assessment** Health Assessment for Aboriginal and Torres Strait Islander patients aged 15 – 54 years old. Not available to in-patients of a hospital or RACF. Not more than once every 9 months **Aboriginal and Torres Strait Islander Health Assessment for an Older Person** Health Assessment for Aboriginal and Torres Strait Islander patients aged 55 years and over. Not available to in-patients of a hospital or RACF. Not more than once every 9 months. Refer to page 18 for further details

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RESIDENTIAL AGED CARE FACILITY ITEM NUMBERS

ITEM	NAME	DESCRIPTION / RECOMMENDED FREQUENCY
701	Brief Health Assessment	< 30 minutes - see MBS for complexity of care requirements Incorporating: **Health Assessment - Comprehensive Medical Assessment** Comprehensive Medical Assessment (CMA) for permanent residents of Residential Aged Care Facilities. Available for new and existing residents. Not more than once yearly
703	Standard Health Assessment	30 - 44 minutes - see MBS for complexity of care requirements. Incorporating: **Health Assessment - CMA**
705	Long Health Assessment	45 - 60 minutes - see MBS for complexity of care requirements. Incorporating: **Health Assessment - CMA**
707	Prolonged Health Assessment	> 60 minutes - see MBS for complexity of care requirements. Incorporating: **Health Assessment - CMA**

CMA Activities:

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

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

- Obtain and record resident's consent
- Information collection, including taking patient history and undertaking or arranging examinations and investigations as required
- Making an overall assessment of the patient
- Recommending appropriate interventions
- Providing advice and information to the patient
- Keeping a record of the Health Assessment - CMA, and offering the patient a written report about the health assessment, with recommendations about matters covered by the Health Assessment - CMA

Providing a written summary of the outcomes of the Health Assessment - CMA for the resident's records and to inform the provision of care for the resident by the RACF, and assist in the provision of Medication Management Review services for the resident

731	GP Contribution to, or Review of, Multidisciplinary Care Plan prepared by RACF	GP contribution to, or review of, a multidisciplinary care plan prepared by RACF, at the request of the facility, for patients with a chronic or terminal condition and complex needs requiring ongoing care from a team including the GP and at least 2 other health or care providers. Not more than once every 3 months

Activities:

- Obtain and record resident's consent
- Prepare part of the plan or amendments to the plan and add a copy to the patient's medical records; or

Give advice to a person (e.g. Nursing staff in RACF) who prepares or reviews the plan and record in writing, on the patient's medical records, any advice provided.

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www.health.gov.au/mbsonline

RESIDENTIAL AGED CARE FACILITY ITEM NUMBERS Cont'd

ITEM	NAME	DESCRIPTION / RECOMMENDED FREQUENCY
735	Organise and coordinate a case conference	15 – 19 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
739	Organise and coordinate a case conference	20 - 39 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
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
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
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

Activities:

Time based items 735 - 743 Organise and Coordinate requires:

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

Telehealth - Residential MBS Time Based Items 2125, 2138, 2179 & 2220

Professional attendance by a general practitioner at a residential aged care facility that requires the provision of clinical support to a patient who is:

a) a care recipient receiving care in a residential aged care service (other than a professional attendance at a self-contained unit); or

b) at consulting rooms situated within such a complex where the patient is a resident of the aged careservice (excluding accommodation in a self-contained unit)

Time Based Items 2125, 2138, 2179 & 2220

Residential Medication Management Review (RMMR) Item 903

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

Activities:

Obtain and record resident's consent

- Collaborate with reviewing pharmacist
- Provide input from the resident's CMA or relevant clinical information for RMMR and resident's records
- Participate in post–review discussion with pharmacist (unless exceptions apply) regarding the findings, medication management strategies, issues, implementation, follow up andoutcomes
- Develop and/or revise Medication Management Plan and finalise plan after discussion with resident

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

SYSTEMATIC CARE CLAIMING RULES

Legend MBS Item Numbers

	No claiming restrictions	**2517**	Diabetes Annual Cycle of Care SIP
721	GP Management Plan (GPMP)	**2546**	Asthma Cycle of Care SIP
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
		2713	GP Mental Health Consultation

MONTHS UNTIL NEXT CLAIM FOR SERVICE

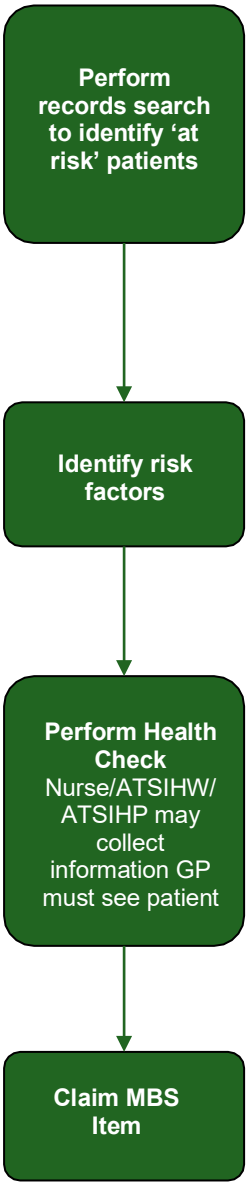
***721**	24		6			12				
***723**		24	6							
****732**	6	6	6		3	3				
900				12						
†2517			3		11-13					
††2546	12		3			12				
2700/2701							12	3		
§2712							3	3	3	
2713										
2715/2717									12	
MBS Item Numbers	***721**	***723**	****732**	**900**	**†2517**	**††2546**	**2700/ 2701**	**§2712**	**2715/ 2717**	**2713**

Additional Claiming Rules

***721 & 723**	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.
† 2517	Recommended not to be claimed within 3 months of Review Item 732, as services overlap.
††2546	Recommended not to be claimed within 12 months of claiming Item 721 alone, as services significantly overlap. Can be claimed on the same day if both 721 and 723 are completed, as the patient has multidisciplinary care needs. Recommended not to be claimed within 3 months of Review Item 732, as services overlap.
§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.

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

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 to 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 risk score determined by the AUSDRISK, which has been completed within a period of 3 months prior to undertaking Type 2 Diabetes Risk Evaluation.
Update patient history and undertaking 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, including strategies to achieve lifestyle and behavior changes.

Essential Documentation Requirements

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

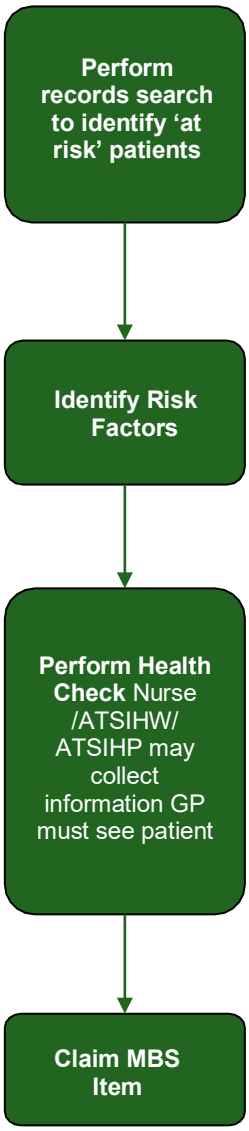
Claiming

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

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

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 behavior 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

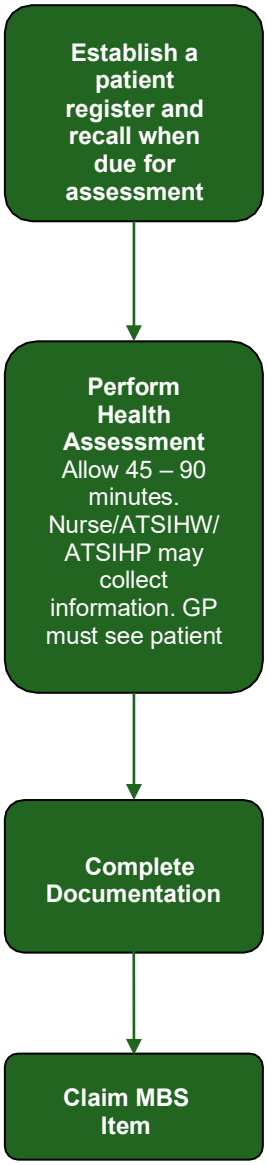
Claiming

All elements of the service must be completed to claim

MBS item	*Name*	*Age Range*	*Recommended Frequency*
701 / 703 / 705 / 707	Health Assessment – 45 - 49 Year Old	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

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 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; and Nutrition status
Additional matters as relevant to the 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)

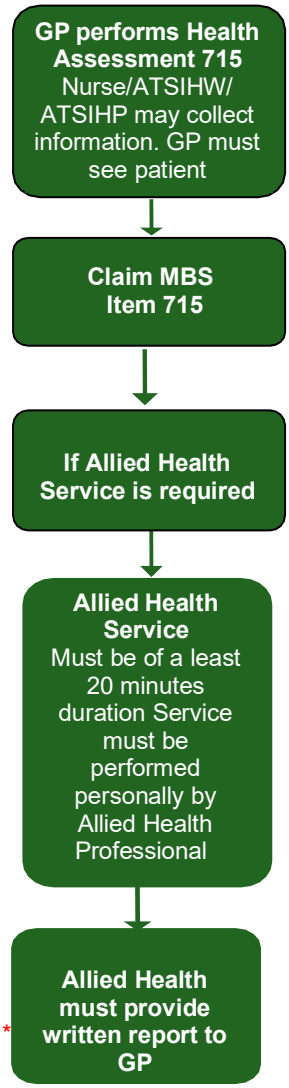
Claiming

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

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

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

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)

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 *refer to page 7
10987	Service provided by practice nurse or registered Aboriginal health worker	All Ages	Max 10 services per year

HOME MEDICINES REVIEW (HMR) - ITEM 900

Also known as Domiciliary Medication Management Review (DMMR)

Eligibility Criteria

Patients at risk of medication related problems or for whom quality use of medicines may be an issue.
Not for patients in a hospital or a Residential Aged Care Facility.
DMMRs are targeted at patients who are likely to benefit from such a review: patients for whom quality use of medicines may be an issue or; patients who are at risk of medication misadventure because of factors such as their co-morbidities, age or social circumstances, the characteristics of their medicines, the complexity of their medication treatment regimen, or a lack of knowledge and skills to use medicines to their best effect.

Initial Visit with GP

Explain purpose, possible outcomes, process, information sharing with pharmacist and possible out of pocket costs.
Gain and record patient's consent to HMR.
Inform patient of need to return for second visit.
Complete HMR referral and send to patient's preferred pharmacy or accredited pharmacist.

HMR Interview

Pharmacist holds review in patient's home unless patient prefers another location.
Pharmacist prepares a report and sends to the GP covering review findings and suggested medication management strategies.
Pharmacist and GP discuss findings and suggestions.

Second GP Visit

Develop summary of findings as part of draft medication management plan.
Discuss draft plan with patient and offer copy of completed plan.
Send copy of plan to pharmacist.

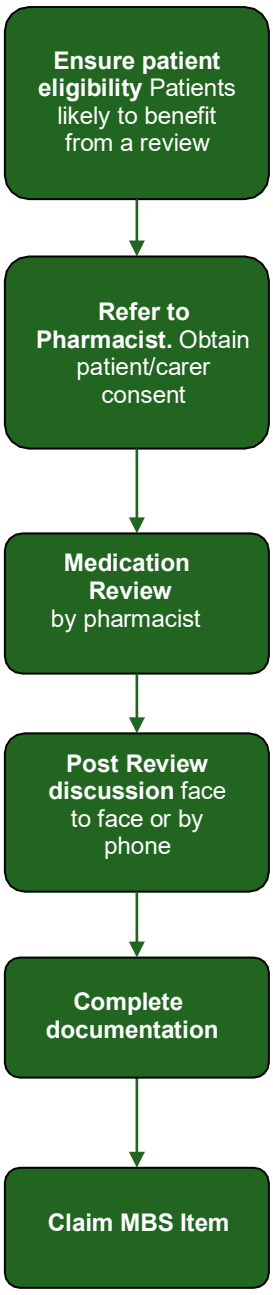
Claiming

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

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



Eligibility Criteria

For permanent residents (new or existing) of a Commonwealth funded Residential Aged Care Facility (includes veterans).
Patients at risk of medication related misadventure because of significant change in their condition or medication regimen, or for whom quality use of medicines may be an issue.
Not for patients in a hospital or respite patients in RACF.

GP Initiates Service

Explain RMMR process and gain resident's consent.
Send referral to accredited pharmacist to request collaboration in medication review.
Provide input from Comprehensive Medical Assessment or relevant clinical information for RMMR and the resident's records.

Accredited Pharmacist Component

Review resident's clinical notes and interview resident.
Prepare Medication Review report and send to GP.

GP and Pharmacist Post Review Discussion

Discuss: Findings and recommendations of the Pharmacist.
Medication management strategies; issues; implementation; follow up; outcomes
If no (or only minor) changes recommended a post review discussion is not mandatory.

Essential Documentation Requirements

Record resident's consent to RMMR.
Develop and/or revise Medication Management Plan which should identify medication management goals and medication regimen.
Finalise Plan after discussion with resident.
Offer copy of Plan to resident/carer, provide copy for resident's records and for nursing staff at RACF, discuss plan with nursing staff if necessary.

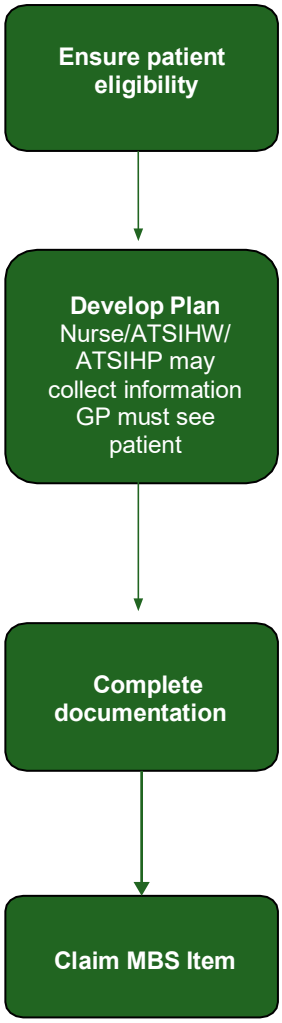
Claiming

All elements of the service must be completed to claim.
Derived fee arrangements do not apply to RMMR.

MBS item	*Name*	*Recommended Frequency*
903	Residential Medication Management Review	As required (Minimum 12 monthly)

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

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.
A GP Mental Health Treatment Plan (Item 2700/2701/2715/2717) is suggested for patients with a mental disorder only.

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 treatments/services required Set 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.
Requires personal attendance by GP with patient.
Review using item 732 at least once during the life of the plan.

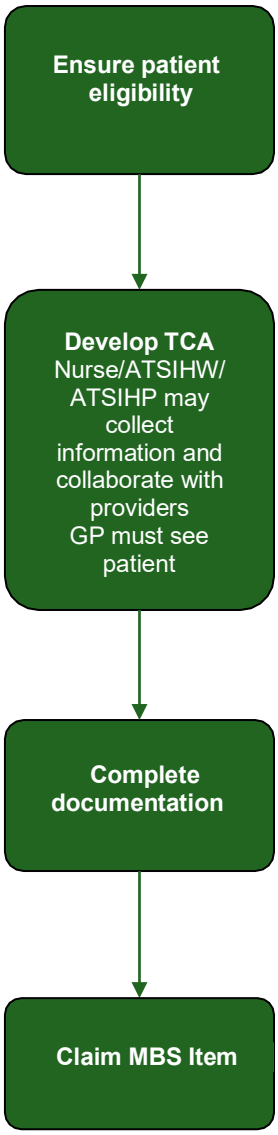
MBS item	*Name*	*Recommended Frequency*
721	GP Management Plan	2 yearly (Minimum 12 monthly) *

***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 necessitates the performance of the service for the patient.

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

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 or care providers.
Not for patients in a hospital or Residential Aged Care Facility.

Clinical Content

Consult with at least two collaborating providers, each of whom will provide a different kind of treatment or service to the patient, and one of whom may be another medical practitioner, when planning for the multidisciplinary care of the patient
Prepare a document that describes:
(i) Treatment and service goals for the patient.
(ii) Treatment and services that collaborating providers will provide to the patient; and
(iii) Actions to be taken by the patient
(iv) arrangements to review (i) (ii) and (iii) by a date specified in the document
Explain steps involved in TCA, possible out of pocket costs, gain consent
Discuss with patient which 2 providers the GP will collaborate with and the treatment and services the 2 providers will deliver.

Essential Documentation Requirements

Record patient's consent to TCA.
Goals, collaborating providers, treatments/services, actions to be taken by patient
Set review date.
Give copies of the relevant parts of the document to the collaborating providers.
Offer a copy of the documents to the patient and the patients carer (if appropriate and patient agrees).
Add a copy of the document to the patient's medical record.
Consult with 2 collaborating providers and obtain feedback on treatment/services they will provide to achieve patient goals.
The document must be retained for 2 years

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) *

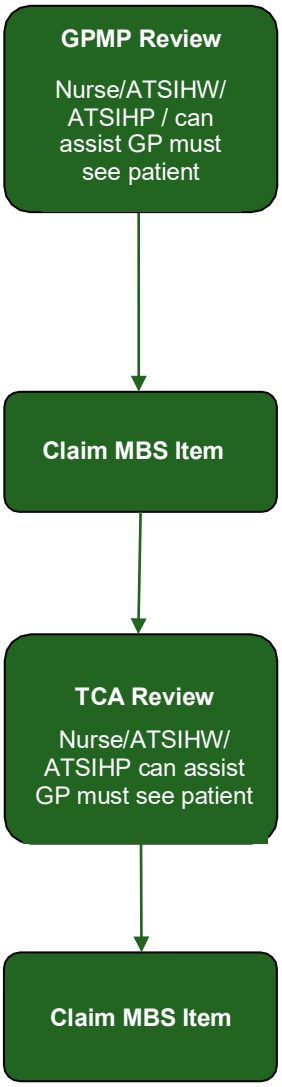
*** CDM services may be provided more frequently in the exceptional circumstances defined below.**

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.

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

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

Reviewing a GP Management Plan (GPMP)



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 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 GPMP. 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 consent to review.
Make any required amendments to plan.
Set 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 personal attendance by GP with patient.
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.

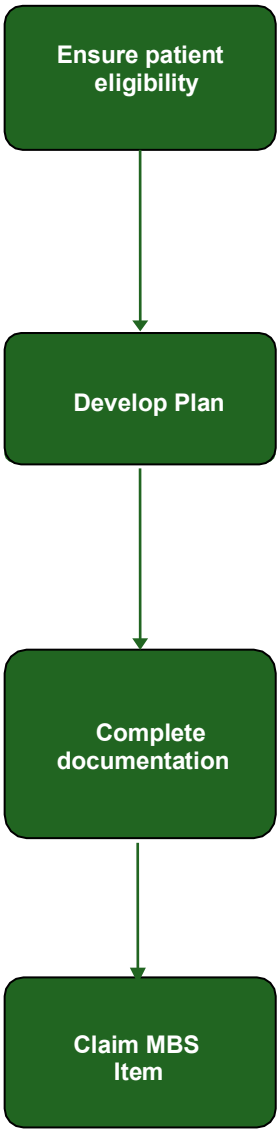
MBS Item	*Name*	*Recommended Frequency*
732	GP Management Plan and/or Team Care Arrangement	6 months (Minimum 3 months)

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

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.



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 a structured approach to their treatment. Not for patients in a hospital or a Residential Aged Care Facility.

Clinical Content

Explain steps involved and 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 psychoeducation.
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 organise 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 needs and goals, patient actions, and treatments/services required
Set review date.
Offer copy to patient (with consent, offer to carer), keep copy in patient file.

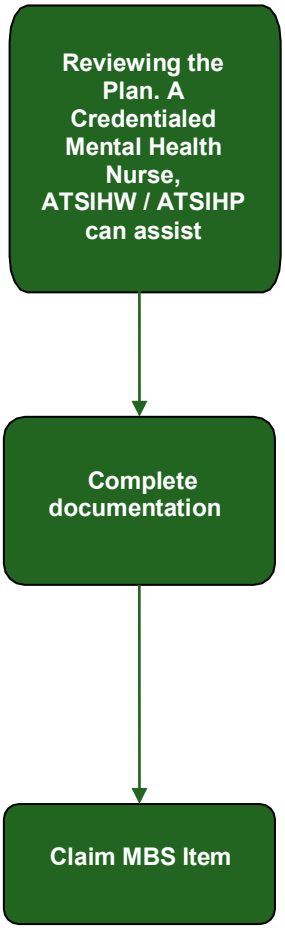
Claiming

All elements of the service must be completed to claim.
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	GP Mental Health Treatment Plan	Not more than once yearly, other than 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

REVIEW OF THE MENTAL HEALTH TREATMENT PLAN – ITEM 2712



Clinical Content

Explain steps involved and 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 psychoeducation.
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 copy to patient (with consent, offer to carer). Keep copy in patient file.

Claiming

All elements of the service must be completed to claim. Requires personal attendance by GP with patient.
Item 2712 should be claimed at least once over the life of the GP Mental Health Treatment Plan.
According to the FAQ's on The Australian Government Department of Health Website (2012), it is not mandatory for the GP to see the patient to do a referral for the further four allied mental health sessions.
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

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

DIABETES CYCLE OF CARE

Care Requirements

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

Eligibility Criteria

No age restrictions for patients.
Patients with established Diabetes Mellitus.
For patients in the community and in Residential Aged Care Facilities.

Essential Clinical and Documentation Requirements

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

6 Monthly

Measure height, weight and calculate BMI.
Measure BP.
Examine feet.

Yearly

Measure HbA1c, eGFR, total cholesterol, triglycerides, and HDL cholesterol test for microalbuminuria.
Provide patient education regarding diabetes management including self- care education.
Review diet and levels of physical activity. Reinforce information about appropriate dietary choices and levels of physical activity.
Check smoking status and encourage smoking cessation (if relevant).
Review medication.

2 Yearly

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

MBS item				
Name	***Frequency***	***In surgery***	***Out of surgery***	***Consult Time***
Diabetes - Standard Consult. (Level B)	11-13 monthly	2517	2518	< 20 mins
Diabetes - Long Consult. (Level C)	11-13 monthly	2521	2522	> 20 mins
Diabetes - Prolonged Consult. (Level D)	11-13 monthly	2525	2526	> 40 mins

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

ASTHMA CYCLE OF CARE

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

Eligibility Criteria

No age restrictions for patients.
Patients with moderate to severe asthma.
For patients in the community and in Residential Aged Care Facilities.

Essential Requirements

At least 2 asthma consultations within 12 months.
One of the consultations must be for a Review.
Review must be planned during previous consultation.

Clinical Content

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

Essential Documentation Requirements

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

Claiming

Available to GPs in accredited practices
All elements of the service must be completed to claim.
Only paid once every 12 months.

MBS item				
Name	***Frequency***	***In surgery***	***Out of surgery***	***Rebate***
Asthma - Standard Consult. (Level B)	12 monthly	2546	2547	+ Level B
Asthma - Long Consult. (Level C)	12 monthly	2552	2553	+ Level C
Asthma - Prolonged Consult. (Level D)	12 monthly	2558	2559	+ Level D

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

PRACTICE INCENTIVE PAYMENTS AND SERVICE INCENTIVE PAYMENTS SUMMARY

ITEM	ACTIVITY	PIP ($ PER SWPE)	NOTES	PIP ENQUIRY LINE: 1800 222 032
eHEALTH (effective May 2016)	To qualify practices must meet each of the 5 requirements	$6.50 per SWPE, per annum Capped at $12,500 per quarter 1 GP annual return (1,000 pts) $6,500	**1:** Integrating Healthcare Identifiers into Electronic Practice Records **2:** Secure messaging capability **3:** Data records and clinical coding **4:** Electronic transfer of prescriptions **5:** My Health Record system	
AFTER HOURS	Level 1-5	No limit 1 GP annual return (1,000 patients) $5,500	Quarterly L1= $1, L5 =$11	
TEACHING (effective May 2018)	Aims to encourage general practices to provide teaching sessions to undergraduate and graduate medical students preparing for entry into the Australian Medical profession.	$200.00 per 3hr session 4 weeks = $8,000	Practices can access a maximum of $200 for each three-hour teaching session provided to any number of medical students. Each practice can claim a maximum of two sessions per GP daily Must submit teaching payment claim form. A rural loading will be added based on the remoteness of the practice.	
QUALITY IMPROVEMENT INCENTIVE (effective Aug 2019)	Payment to practices to undertake continuous quality improvement through a collection and review of practice data	$5 per SWPE capped at $12,500 per quarter 1 GP annual return (1,000 patients) $5,000	Each PHN have these guidelines Provide PIP Eligible Data Set to PHN 10 Improvement Measures, Data Governance Framework, Quality improvement activities, Eligibility for a PIP QI Incentive payment	
COVID-19	**Automatic**	$10 per SWPW	Automatic eligibility 500 patients = $5,000	
RURAL LOADING	**RRMA 3-7**	RRMA 3 $5,775	15% to 20% load no limit quarterly	

For further information on the Practice Incentive Program (PIP) see full guidelines and up to date information -see Services Australia Website
https://www.servicesaustralia.gov.au/organisations/health-professionals/services/medicare/practice-incentives-program/what-are-individual-incentives

Acknowledgement and thanks to Queensland Aboriginal and Islander Health Council (QAIHC) and various Primary Health Networks –12 July 2021

ITEM	ACTIVITY	PIP	SIP	NOTES	PIP ENQUIRY LINE: 1800 222 032
AGED CARE ACCESS (effective July 2021)	Provision of primary care services for patients in Residential Aged Care Facilities (RACFs).			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. Eligible GPs can get 4 payments totaling $10,000 for the financial year, in addition to the consultation fee. https://www.servicesaustralia.gov.au/organisations/health-professionals/services/medicare/practice-incentives-program/what-are-individual-incentives/general-practitioner-aged-care-access	
	Tier 1a: GP completes the Qualifying Service Level (QSL) 1 – 60 to 99 MBS services in RACF claimed in a financial year		$2,000		
	Tier 1b: GP completes the Qualifying Service Level (QSL) 1 –100 to 139 MBS services in RACF claimed in a financial year		$2,500		
	Tier 2a: GP completes the Qualifying Service Level (QSL) 1 – 140 to 179 MBS services in RACF claimed in a financial year		$2,500		
	Tier 2b: GP completes the Qualifying Service Level (QSL) 1 – 180 or more MBS services in RACF claimed in a financial year		$3,000		
PIP INDIGENOUS HEALTH INCENTIVE (effective Dec 2019)	Provision of better health care for Indigenous patients, including best practice management of chronic disease. Sign-on payment	$1000		One-off payment only. Practice must be registered for PIP. Practice: - Seeks consent to register their Aboriginal and Torres Strait Islander patients who have a chronic disease, with Medicare and the practice for chronic disease management in a calendar year. - Establishes a mechanism to ensure their Aboriginal and Torres Strait Islander patients aged 15 years and over with a 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	
	Annual patient registration payments	$250 per registered Aboriginal and Torres Strait Islander patient, per calendar year		Practice registers their eligible Aboriginal and Torres Strait Islander patients with Medicare for the PIP Indigenous Health Incentive. Practice must actively plan and manage care of their Aboriginal and Torres Strait Islander patients with chronic disease for a calendar year. Payment made to practice for each Aboriginal and Torres Strait Islander patient who: - Is aged 15 years or over, has a chronic disease, Has had (or has been offered) the 715 Aboriginal and Torres Strait Islander Health Assessment Has provided informed consent to be registered for the PIP Indigenous Health Incentive The patient's registration period commences from the date they provide consent to participate in the incentive and cease 31 December that year. Practices are to obtain consent to re-register patients each calendar year.	
	Tier 1 Outcomes payment: Chronic Disease Management	$100 per registered patient, per calendar year		Payment made to practices that (in a calendar year): 1. 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 2. Undertake two 732 Reviews of GPMP or TCA; or 3. 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 per registered patient, per calendar year		Payment made to practices that provide the majority (i.e. the highest number) of MBS services for the patient (with a minimum of 5 MBS services) in a calendar year. This may include the MBS services provided to qualify for Tier 1.	

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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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