Department of Health

health

Summary of new Medicare Benefits Schedule (MBS) item numbers: general practice and allied health

Updated April 2013

State Government Victoria

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About this resource

The Department of Health developed this resource to provide information and support to Victorian primary healthcare agencies that may be looking to build or extend evidence-based models of care that incorporate Medicare Benefits Schedule (MBS) item numbers.

Over the past decade, MBS item numbers have been introduced by the Commonwealth Government to support new models of primary healthcare. These item numbers focus on the prevention and management of chronic disease and many mental health conditions. In addition, these items:

- help facilitate a more integrated and accessible approach to healthcare provision, including inter-agency care planning
- provide catalysts for state-funded services to strengthen partnerships with general practice and other public and private primary health providers.

By working together, community health services, general practices and other private providers, assisted by Primary Care Partnerships and Medicare Locals, can improve client access to primary healthcare services by constructing service models that are supported by the MBS.

This resource summarises[1] relevant MBS item numbers and groups them into twelve categories:

1. Health assessments
2. Prevention of chronic disease
3. Care planning and case conferencing
4. Allied health
5. Better Start disability services for children
6. Helping children with Autism
7. Mental health
8. Service incentive payments
9. Quality use of medicines
10. Bulk-billing incentives
11. Telehealth
12. MBS items for practice nurses

About Medicare

Medicare was introduced by the Commonwealth Government in 1984 to provide eligible Australian residents with affordable, accessible and high-quality healthcare. Medicare is based on the understanding that all Australians should contribute to the cost of healthcare according to their ability to pay. It is financed through progressive income taxation and an income-related Medicare levy.

Medicare Australia publishes a wide range of educational materials on its website for health providers: http://www.medicareaustralia.gov.au/provider/index.jsp

The Commonwealth Government also publishes educational materials about primary care MBS item numbers on its website: http://www.health.gov.au/mbsprimarycareitems

1 All information provided in this document is current as at 1 April 2013. Health professionals intending to use these items should refer to the *Medicare Benefits Schedule book* and the *Allied Health Schedule book* for more comprehensive information, including the MBS requirements for each item. Alternatively, you can search for specific items at <www9.health.gov.au/mbs>, telephone the Medicare Australia Provider Line on 132 150 or contact your Medicare Local. Note that the Medicare Benefits Schedule is currently updated three to four times a year.

Relevance to community health

- Models supporting effective chronic disease management and mental health care are of particular relevance to the community health sector, because a high proportion of community health clients have chronic and complex conditions and comorbidities.
- The case for integration across the sector is now stronger than ever before, with the state and Commonwealth governments focusing on better management of chronic and complex conditions in a strengthened primary healthcare sector. MBS item numbers may support integrated models of care that include general practice and other private providers.

Service models using MBS

- Community health services should work with Medicare Locals and clients to determine which models are suitable. These decisions should be based on a local analysis of client characteristics and needs, the availability of local services and providers with whom models of care can be built, the likely future impact on currently funded client services, and existing strategies and programs in the region.
- It is important to identify the client's usual GP and to strengthen relationships and communication with general practice to encourage their active participation in coordinated care.
- The implementation of multidisciplinary models of care that incorporate MBS services is relevant to all community health services, whether or not they manage medical clinics.
- Community health agencies should seek legal advice to ensure that any new service models are compliant with s. 19(2) of the *Health Insurance Act 1973* (Cwlth).
- Models adopted should not result in a reduction of state-funded allied health services.
- Services funded through the MBS are in addition to services funded by the Department of Health's Integrated Care Branch. As the funding source is different, MBS-funded services should not be included by community health services as part of their reporting for branch-funded activities.

Support for Aboriginal and Torres Strait Islander people to access Medicare

Medicare Australia has a communication strategy to help increase access to Medicare and other programs by Aboriginal and Torres Strait Islander people. For information and support, call the Aboriginal and Torres Strait Islander Access Line on **1800 556 955** or see: http://www.medicareaustralia.gov.au/public/services/indigenous/index.jsp

Health assessments: summary of MBS item numbers

Service type ▶▶▶	Older age health assessment	Refugee and other humanitarian entrants health check	Health assessment for people with an intellectual disability	Medical assessment for residents of an aged care facility	Healthy Kids Check	Aboriginal and Torres Strait Islander people health check
Client eligibility ▶▶▶	For clients aged 75 years or over, living in the community	Client is a refugee or other humanitarian entrant who has arrived in Australia in the last 12 months	Client is a person with an intellectual disability[2]	For clients who are permanent residents of a Commonwealth-funded residential aged care facility	For clients aged three to five years old who have received or will receive their course of four-year-old immunisation	Client is an Aboriginal or Torres Strait Islander person
Relevant MBS item numbers ▶▶▶	One of the following, per service: Health assessment[3] – brief #701 Health assessment – standard #703 Health assessment – long #705 Health assessment – prolonged #707				One of the following, per service: Health assessment[3] – brief #701 Health assessment – standard #703 Health assessment – long #705 Health assessment – prolonged #707 **or** Healthy kids check provided by a practice nurse or registered Aboriginal health worker #10986	Aboriginal and Torres Strait Islander people health check #715

2 For the purposes of this item, a person will be deemed to have an intellectual disability if they have significantly sub-average general intellectual functioning (two standard deviations below the average intelligence quotient (IQ) and would benefit from assistance with daily living activities. Where GPs wish to confirm intellectual disability and a patient's need for assistance with activities of daily living, they may seek verification from a paediatrician registered to practice in Australia or from a government-provided or funded disability service that has assessed the person's intellectual function.

3 A medical practitioner may select one of the time-based health assessment item numbers to claim after performing the service. The item chosen will depend on the length of the consultation as determined by the complexity of the patient's presentation.

Health assessments: summary of MBS item numbers

	Older age health assessments #701, #703, #705, #707	Refugee and other humanitarian entrants health check #701, #703, #705, #707	Health assessment for people with an intellectual disability #701, #703, #705, #707	Comprehensive medical assessment (CMA) #701, #703, #705, #707	Healthy Kids Check #701, #703, #705, #707, #10986	Aboriginal and Torres Strait Islander people health check #715
Steps that must be taken to claim the Medicare item	• Medical component, including blood pressure, medications, immunisation • Physical component, including activities of daily living and mobility • Psychological component, including cognition and mood • Social component, including adequacy of social support, carers and help arrangements	• Taking the client's medical history • Physical examination • Undertaking or arranging any required investigations • Assessing the client, using the information gained • Making or arranging any necessary interventions and referrals • Developing a plan	• Medical component, including blood pressure, medications, immunisation • Physical component, including activities of daily living, exercise, growth and development, sexual activity, nutritional status • Preventive component including identifying risk factors for disease • Psychological component, including cognition and mood • Social component, including social support, carers and help arrangements • Dental component	• Detailed medical history and comprehensive medical examination • Developing a list of diagnoses or problems • Providing a written summary of the outcomes of the CMA for the resident's records to inform the provision of care for the resident by the facility and reviewing pharmacist	• Information collection including a history, examinations and investigations as required • Making an overall assessment of the child • Recommending appropriate interventions • Providing advice and recommendations to the child's parent(s) or carer • Ensuring the course of four-year-old immunisation has been delivered • Noting if the Get Set 4 Life guide has been provided • Offering the child's parent(s) or carer a written report of the assessment and its recommendations • Updating records, for example parent-held child health record	• Information collection including a history, examinations and investigations as required • Making an overall assessment of the client • Recommending appropriate interventions • Providing advice and recommendations to the client • Offering a written report of the assessment and its recommendations to the client and their carer as appropriate
Medicare rules relating to frequency of service	Once per client for any 12-month period	Benefits are available on one occasion only	Once per client for any 12-month period	Once per client for any 12-month period	Benefits are available on one occasion only	Once per client for any nine-month period
Role of the GP	• Determining client eligibility, gaining consent and initiating service, if appropriate • Central coordinating role, including at least one client consultation • Medical components that cannot be delegated	• Determining client eligibility and initiating the service, if appropriate • Central coordinating role, including at least one client consultation • Medical components that cannot be delegated	• Determining client eligibility and initiating the service, if appropriate • Central coordinating role, including at least one client consultation • Medical components that cannot be delegated	• To provide all services. The GP may be assisted by a practice nurse • The client's usual GP may delegate the provision of a CMA to a medical locum, who would provide a written summary	• The check may be undertaken by the GP or the nurse, or by both in a team approach • In all cases, the medical practitioner under whose supervision the health assessment is being provided retains responsibility for the health, safety and clinical outcomes of the child	• Determining client eligibility and initiating the service, if appropriate • Central coordinating role, including at least one client consultation • Medical components that cannot be delegated
Roles that can be performed by practice nurses (PNs) or Aboriginal health workers (AHWs) on behalf of and under the supervision of the GP	• Explaining the item and any fees • Information collection, including taking or reviewing medical history • Investigations for which the PN/AHW is qualified	• Explaining the item and any fees and obtaining consent • Information collection • Investigations and interventions for which the PN/AHW is qualified	• Explaining the item and any fees and obtaining consent • Information collection • Investigations and interventions for which the PN/AHW is qualified	Nurses can assist the GP in obtaining information relevant to the CMA, in taking the resident's history and in the examination, but cannot replace the GP's involvement in any components of the CMA	The check may be undertaken by the GP or the nurse, or by both in a team approach	• Explaining the item and any fees and obtaining consent • Information collection • Investigations and interventions for which the PN/AHW is qualified
Main information web link	http://www.health.gov.au/mbsprimarycareitems					

Prevention of chronic disease: summary of MBS item numbers

Service type ▶▶▶	Prevention of the onset of chronic disease, when risk factors are present	Prevention of the onset of type 2 diabetes when risk factors are present
Client eligibility ▶▶▶	For any client aged 45–49 years of age (inclusive) who is at risk of developing a chronic disease[4]	For any client aged 40–49 years of age (inclusive), or aged 15–54 if an Aboriginal and Torres Strait Islander person, who is at high risk of developing type 2 diabetes mellitus[5] and has not been diagnosed with type 2 diabetes mellitus
Relevant MBS item numbers ▶▶▶	One of the following, per service: Health assessment[6] – brief #701 Health assessment – standard #703 Health assessment – long #705 Health assessment – prolonged #707	One of the following, per service: Health assessment[6] – brief #701 Health assessment – standard #703 Health assessment – long #705 Health assessment – prolonged #707

4 The decision about whether an individual is at risk of developing a chronic disease rests with the clinical judgment of the GP, but a specific risk factor must be identified.

5 The decision about whether an individual is at high risk of developing type 2 diabetes mellitus is based on a review of the risk factors underlying the patient's 'high risk' score as identified by the Australian Type 2 Diabetes Risk Assessment Tool. This tool is available at: http://www.health.gov.au/preventionoftype2diabetes

6 A medical practitioner may select one of the time-based health assessment item numbers to claim after performing the service. The item chosen will depend on the length of the consultation as determined by the complexity of the patient's presentation.

Prevention of chronic disease: summary of web links and explanatory notes

	45+ health check #701, #703, #705, #707	Type 2 diabetes risk evaluation #701, #703, #705, #707
Steps that must be taken to claim the Medicare item	• Information collection, including taking a client history and undertaking examinations and investigations as required • Overall client assessment • Interventions as indicated • Providing advice and information to the client	• Evaluating a client's 'high risk' score as determined by the Australian Type 2 Diabetes Risk Assessment Tool • Updating the client's history and undertaking examinations and investigations • Overall client assessment • Initiating interventions if appropriate, including referral to a lifestyle modification program and addressing identified risk factors (lifestyle, biomedical, and familial) • Providing advice and information to the client, including strategies to achieve lifestyle and behavioural change if appropriate
Medicare rules relating to frequency of service	One occasion only for each eligible client	Once every three years for each eligible client
Role of the GP	• The GP is responsible for the overall health check, including reviewing and analysing information, investigations, making the overall assessment, referrals, and providing client advice	• The GP is responsible for the overall health check, including reviewing and analysing information, investigations, making the overall assessment, referrals (including to lifestyle modification programs through the GP referral form[7]), and providing client advice
Roles that can be performed by practice nurses (PNs) or Aboriginal health workers (AHWs) on behalf of and under the supervision of the GP	Identifying clients who may be eligible, collecting client information, providing advice to clients about recommended interventions	Identifying clients who may be eligible, collecting client information, providing advice to clients about recommended interventions
Main information web link	45+ health check and type 2 diabetes risk evaluation: http://www.health.gov.au/mbsprimarycareitems	

7 The GP referral form can be obtained from: http://www.health.gov.au/preventionoftype2diabetes

GP-led care planning and access to MBS-rebateable allied health services for clients with chronic disease and complex care needs

Client eligibility for MBS-rebateable allied health services

Clients living in the community[8] are eligible for up to five Medicare rebates per calendar year for allied health services provided by Medicare-registered providers if during the last two years their usual GP[9] has prepared a care plan for them and

- has claimed a GP Management Plan service (#721) **and** Coordination of Team Care Arrangements (#723) service[10]

  or
- has claimed a Review of GP Management Plan (#732) or Coordinate a Review of Team Care Arrangements (#732) service.[10]

These types of care plans are sometimes referred to as Enhanced Primary Care (EPC) care plans or Medicare Benefits Schedule (MBS) care plans. Note that the GP must refer to allied health providers using the referral form[11] issued by the Department of Health and Ageing, or another form that is similar and contains all the components of that form.

Client eligibility for GP Management Plans and Coordination of Team Care Arrangements

- A client with a chronic condition is eligible for a GP Management Plan.
- A client with a chronic condition and complex care needs is eligible for a Coordination of Team Care Arrangements service.

Care planning with general practice

The Victorian Government has provided advice to agencies in relation to integrated chronic disease management involving GPs through GP-led care plans. The resource is available at: http://www.health.vic.gov.au/pch/downloads/factsheet06.pdf

8 Clients living in a Commonwealth-funded residential aged care facility are also eligible if they are being managed under a care plan to which their usual GP has contributed (#731).

9 The term 'usual GP' means the doctor (or practice) that has provided the majority of services to the client over the previous 12 months, or that will provide the majority of services over the next 12 months.

10 It is acceptable for practices to claim remuneration for both items at the same time, providing the Medicare criteria for both items have been fulfilled.

11 Available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/Chronic+Disease+Allied+Health+Individual+Services

Care planning and case conferencing: summary of MBS item numbers

Service type ▶▶▶	Care planning by a GP[12] Chronic disease management (CDM) items		Case conferencing organised and coordinated by a GP		GP contribution to a care plan prepared by another provider Chronic disease management (CDM) items		GP participation in case conferencing organised and coordinated by another provider		Practice nurse or registered Aboriginal Health Worker monitoring and support
Client eligibility ▶▶▶	Client has a chronic or terminal medical condition and is living in the community[13]	Client has a chronic or terminal medical condition **and** complex care needs and is living in the community and requires ongoing care from at least three healthcare providers, one of whom is the GP	Client has a chronic or terminal medical condition and is living in the community or is a resident of a Commonwealth-funded residential aged care facility or is an in-patient being discharged from a hospital or day-hospital facility into the community	Client has cancer and is living in the community	Client has a chronic or terminal medical condition and is not a resident of a Commonwealth-funded residential aged care facility	Client has a chronic or terminal medical condition and is a resident of a Commonwealth-funded residential aged care facility	Client has a chronic or terminal medical condition and is living in the community or is a resident of a Commonwealth-funded residential aged care facility or is an in-patient being discharged from a hospital or day-hospital facility into the community	Client has cancer	Client has a chronic or terminal condition, has a GPMP, TCA or multi-disciplinary MBS care plan in place, and is not an admitted client of a hospital
Relevant MBS item numbers ▶▶▶	GP Management Plan (GPMP) #721 Review of GP Management Plan #732	Coordination of Team Care Arrangements (TCA) #723 Coordinate a Review of Team Care Arrangements #732	Organise and coordinate a case conference 15–20 mins #735 20–40 mins #739 > 40 mins #743	Lead and coordinate a case conference for a patient with cancer #871	Contribution to a care plan, or a review of a care plan, being prepared by another provider[14] #729	Contribution to a care plan, or a review of a care plan, being prepared by the residential aged care facility or hospital from which the resident is being discharged #731	Participation in a case conference 15–20 mins #747 20–40 mins #750 > 40 mins #758	Participation in a case conference for a patient with cancer #872	Provision of monitoring and support for people with a chronic disease, on behalf of a GP #10997

12 Note: A GP may also refer a patient with at least two morbidities to a consultant physician to undertake a comprehensive assessment to develop a treatment and management plan (#132 and #133).

13 Items #721 and #723 are also available to private in-patients (including residents of aged care facilities) being discharged from hospital, where their usual GP is providing in-patient care.

14 Note: If a community health service seeks to engage a GP in a community health-led care coordination plan, it may be better to request input through a #721 and #723 (or a review of these items – #732) rather than a #729, because clients on a #729 are not eligible for MBS-subsidised (private) allied health services.

GP care planning: summary of web links and explanatory notes

	Care planning prepared by a GP				Practice nurse (PN) and Aboriginal health worker (AHW) provision of monitoring and support #10997
	GP Management Plan (GPMP) #721	Review of GP Management Plan #732	Coordination of Team Care Arrangements (TCA) #723	Coordinate a Review of Team Care Arrangements #732	
Steps that must be taken to claim the Medicare item	• Assessing the client to identify and confirm needs, problems and conditions • Explaining the service and any associated costs with the client, and gaining and recording consent to proceed • Agreeing on management goals with the client for changes to be achieved by the treatment and services identified in the plan • Identifying required client actions • Identifying treatment and services that the client is likely to need, and making arrangements for them • Services and ongoing management • Preparation of a comprehensive written plan describing the client's needs, goals, client actions, treatment/services and a review date • Offering a copy of the plan to the client and adding it to medical records	• Explaining the service and any associated costs with the client, and gaining and recording consent to proceed • Reviewing the client's needs and goals, client actions and treatment/services • Making relevant changes to the documented GPMP • Adding a new review date • Offering a copy of the plan to the client and adding it to medical records	• Explaining the service and any associated costs with the client, and gaining consent to proceed • Discussing with the client which providers should collaborate with the GP (each of whom must provide a different kind of ongoing care), gaining client consent to share information • Contacting the proposed providers, obtaining their agreement to participate, and providing them with relevant information or allowing time for them to see the client, if necessary • Collaborating with the other providers to discuss potential treatments/services to be provided to achieve client goals • Preparing a document that describes treatment and service goals, providers involved, client actions and a nominated review date • Providing copy of the TCA document to other providers (with consent), offering a copy to the client/carer, and adding it to the medical records	• Explaining the service and any associated costs with the client, and gaining and recording consent to proceed • Discussing with the client which providers should be asked to collaborate in the review • Collaborating with the providers to establish client progress against care plan goals and reviewing the plan • Documenting any changes to the plan • Providing a copy to other providers (with consent), offering a copy to client or carer, and adding it to the medical records	• Assisting clients on an MBS Care Plan who require access to ongoing care, routine treatment and ongoing monitoring and support between the more structured reviews of the care plan by the client's usual GP. Note: Cannot be claimed at the same time as GP Care Planning items #721, #723, #732, #729 or #731.
Medicare rules relating to frequency of service	Maximum of once per client in a 12-month period. The recommended frequency is one #721 every two years (if required) with six-monthly reviews.	Maximum of once per client in a three-month period. The recommended frequency is every six months.	Maximum of once per client in a 12-month period. The recommended frequency is one #723 every two years (if required) with six-monthly reviews.	Maximum of once per client in a three-month period. The recommended frequency is every six months.	A maximum of five services per client per calendar year.
Role of the GP	• The GP has ultimate responsibility for delivery of the service, which must include a personal attendance by a single medical practitioner with a single client (the consultation may include the client's carer or representative as necessary)				• The GP retains responsibility for the outcomes
Roles that can be performed by practice nurses (PNs) or Aboriginal health workers (AHWs) on behalf of and under the supervision of a GP	• Assist in aspects of client assessment, identification of client needs, and making arrangements for services • Managing review appointments system • Assistance to clients as per #10997	• Recalling the client for the care plan review • Other tasks as per GPMP column	• Assist in aspects of client assessment, identification of client needs, and making arrangements for services • Managing review appointments system • Assistance to clients as per #10997	• Recalling the client for the care plan review • Other tasks as per TCA column	• All tasks • Check web link for examples of specific services
Main information web link	http://www.health.gov.au/mbsprimarycareitems				

GP case conferencing: summary of web links and explanatory notes

	Case conferencing prepared by a GP			
	Organise and coordinate a community case conference #735, #739, #743	Lead and coordinate a case conference for a patient with cancer #871	Organise and coordinate a case conference in a residential aged care facility #735, #739, #743	Organise and coordinate a discharge case conference #735, #739, #743
Steps that must be taken to claim the Medicare item	• Obtaining and recording client consent • Recording names of participants, date, start and end times, and minutes • Discussing the client's history and identifying their needs • Identifying outcomes to be achieved by members of the team and tasks that need to be undertaken by each member • Assessing whether previously identified outcomes (if any) have been achieved • Placing all notes in the client's medical record and offering copies to the client, carer, and members of the team • Discussing outcomes with the client	• Coordinating the participation of at least three other medical practitioners from different areas of medical practice, and allied health practitioners if appropriate • Ensuring that at least one of the practitioners has explained the nature of the meeting, gained client consent for it to occur and for information to be shared with members of the conference team, and explained any associated fees • Leading the development of a multidisciplinary treatment plan • Ensuring that the case conference lasts at least 10 minutes	• Obtaining and recording consent • Organising participants, who must include a medical practitioner and at least two other members, each of whom provides a different kind of care to the client • Recording participant names, date, start and end times, and minutes • Discussing the client's history and identifying care needs • Identifying outcomes to be achieved by team members and tasks that need to be undertaken by each • Assessing whether previously identified goals have been achieved • Placing all notes in the client's medical record and offering copies to the client and their carer, to the client's regular GP if not a member of the team, and to the facility • Discussing outcomes with the client	• Obtaining and recording client consent • Organising participants, who must include a medical practitioner and at least two other members each of whom provides a different kind of client care • Recording participant names, date, start and end times, and minutes • Discussing the client's history and identifying their needs • Identifying outcomes to be achieved by members of the team and tasks that need to be undertaken by each member • Assessing whether previously identified outcomes (if any) have been achieved • Placing all notes in the client's medical record and, with client consent, offering copies to the client and their carer, to the client's regular GP if not a member of the team, and to the hospital • Discussing outcomes with the client
Medicare rules relating to frequency of service	Not more than five case conferences in a 12-month period	Not more than two cancer case conferences per client in a 12-month period	Not more than five case conferences in a 12-month period	Not more than five case conferences in a 12-month period
Role of the GP	• Being a member of the case conference team (this cannot be delegated) • Discussing outcomes with the client • Medical components that cannot be delegated	• Ensuring the client understands what is to occur and has provided consent • Leading the development of the treatment plan	• Being a member of the case conference team (this cannot be delegated) • Discussing outcomes with the client • Medical components that cannot be delegated	• Being a member of the case conference team (this cannot be delegated) • Discussing outcomes with the client • Medical components that cannot be delegated
Roles that can be performed by practice nurses (PNs) or Aboriginal health workers (AHWs) on behalf of and under the supervision of a GP	• Gathering and documenting relevant information for the GP • Making arrangements for services • Managing appointments system	• Gathering and documenting relevant information for the GP • Contacting other providers • Making arrangements for services • Managing appointments system	• Gathering and documenting relevant information for the GP • Making arrangements for services • Managing appointments system	• Gathering and documenting relevant information for the GP • Making arrangements for services • Managing appointments system
Main information web links	Case conferencing: http://www.health.gov.au/mbsprimarycareitems Cancer case conferencing: http://www.nbcc.org.au/bestpractice/resources/MDCC_informationaboutthen.pdf			

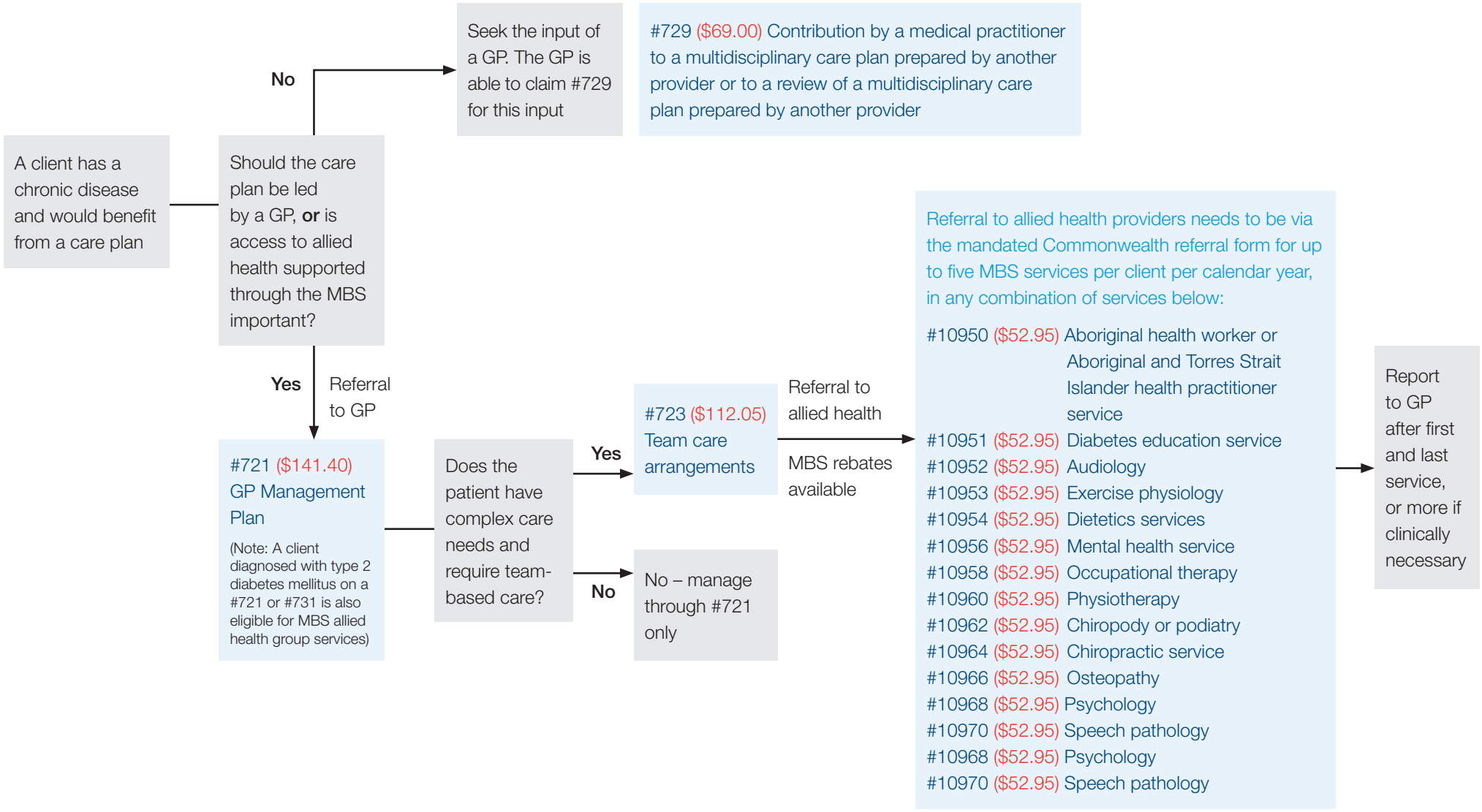
GP contribution to a care plan prepared by another provider: summary of web links and explanatory notes

	GP contribution to a care plan which is being prepared by another provider		Practice nurse (PN)/Aboriginal health worker (AHW) provision of monitoring and support #10997
	Contribution to a care plan or to a review of a care plan being prepared or reviewed by another provider #729	Contribution to a care plan or to a review of a care plan being prepared by the residential aged care facility or hospital from which the resident is being discharged #731	
Steps that must be taken to claim the Medicare item	• Gaining or confirming the client's agreement for the GP to contribute to the care plan or to the review of the care plan, and to share relevant information with the other providers • Collaborating with the person preparing the care plan to set goals and specify the treatment/services to be provided by the GP • Adding to the client's records a copy or notation of the GP's contribution to the plan (either the treatment/services to be provided by the GP or the GP's advice to the person preparing the plan)	• Responding to a request from the residential aged care facility or hospital to contribute to the care plan • Gaining or confirming the resident's agreement for the GP to contribute to the care plan, or to the review of the care plan and to share relevant information with the other providers • Collaborating with the person preparing the care plan to set goals and specify the treatment/services to be provided by the GP • Adding to the client's medical records and the records at the residential aged care facility or hospital a copy or notation of the GP's contribution to the plan (either the treatment/services to be provided by the GP or the GP's advice to the person preparing the plan)	• Assisting clients on an MBS care plan who require access to ongoing care, routine treatment and ongoing monitoring and support between the more structured reviews of the care plan by the client's usual GPNote: cannot be claimed at the same time as MBS care planning items #721, #723, #729, #731 or #732
Medicare rules relating to frequency of service	One per client in a three-month period. The recommended frequency is one every six months (if required). Other than in exceptional circumstances, a rebate will not be paid within 12 months of a GP Management Plan (GPMP) or Coordination of Team Care Arrangements (TCA) claimed by the same practitioner for that client	One per client in a three-month period. The recommended frequency is one every six months (if required). Other than in exceptional circumstances, a rebate will not be paid within three months of a GPMP or TCA claimed by the same practitioner for that client	A maximum of five services per client per calendar year
Role of the GP	• Ultimate responsibility for the Medicare service	• Ultimate responsibility for the Medicare service	• The GP retains responsibility for the health, safety and clinical outcomes of the client
Roles that can be performed by practice nurses (PNs) or Aboriginal health workers (AHWs) on behalf of and under the supervision of a GP	• Liaising with the person preparing the care plan to organise the collaboration, or to gather information necessary for consideration by the GP	• Liaising with the facility or hospital to organise the collaboration, or to gather information necessary for consideration by the GP	• All tasks • Check web link for examples of specific services
Main information web link	http://www.health.gov.au/mbsprimarycareitems		

GP participation in case conferencing: summary of web links and explanatory notes

	GP participation in case conferencing organised and coordinated by another provider			
	Participation in a case conference #747, #750, #758	Participation in a case conference on a patient with cancer #872	Participate in a case conference in a residential aged care facility #747, #750, #758	Participate in a discharge case conference #747, #750, #758
Steps that must be taken to claim the Medicare item	• Responding to a request to participate, and agreeing on timing • Obtaining and recording client consent for GP involvement • Recording all notes and decisions • Discussing the client's history and identifying their needs • Identifying outcomes to be achieved by members of the case conference team, and tasks that need to be undertaken by each member of the team • Assessing whether previously identified outcomes (if any) have been achieved • Placing all notes in the client's medical record and offering copies to the client an their carer	• Ensuring that at least one of the practitioners has explained the nature of the meeting, gained client consent for it to occur and for information that the practitioners intend to share, and explained any associated fees • Contributing to the development of a multidisciplinary treatment plan • Ensuring that the case conference lasts at least 10 minutes	• Responding to a request to participate, and agreeing on timing • Obtaining and recording client consent for GP involvement • Recording all notes and decisions • Discussing the client's history and identifying their needs • Identifying outcomes to be achieved by members of the case conference team, and tasks that need to be undertaken by each member of the team • Assessing whether previously identified outcomes (if any) have been achieved • Placing all notes in the client's medical record and offering copies to the client and their carer, to the client's regular GP if not a member of the team, and to the facility	• Responding to a request to participate, and agreeing on timing • Obtaining and recording client consent for GP involvement • Recording all notes and decisions • Discussing the client's history and identifying their needs • Identifying outcomes to be achieved by members of the case conference team, and tasks that need to be undertaken by each member of the team • Assessing whether previously identified outcomes (if any) have been achieved • Placing all notes in the client's medical record and offering copies to the client and their carer
Medicare rules relating to frequency of service	Not more than five case conferences in a 12-month period	Not more than two conferences per client in a 12-month period	Not more than five case conferences in a 12-month period	Not more than five case conferences in a 12-month period
Role of the GP	• Being a member of the case conference team (this cannot be delegated) • Discussing outcomes with client • Medical components that cannot be delegated	• Ensuring the client understands what is to occur and has provided consent • Contributing to the development of the treatment plan	• Being a member of the case conference team (this cannot be delegated) • Discussing outcomes with the client • Medical components that cannot be delegated	• Being a member of the case conference team (this cannot be delegated) • Discussing outcomes with client • Medical components that cannot be delegated
Roles that can be performed by practice nurses (PNs) or Aboriginal health workers (AHWs) on behalf of and under the supervision of a GP	• Gathering and documenting relevant information for the GP • Making arrangements for services • Managing appointments system	• Gathering and documenting relevant information for the GP • Contacting other providers • Making arrangements for services • Managing appointments system	• Gathering and documenting relevant information for the GP • Making arrangements for services • Managing appointments system	• Gathering and documenting relevant information for the GP • Making arrangements for services • Managing appointments system
Main information web link	www.health.gov.au/mbsprimarycareitems			

Access to MBS-rebateable (private) allied health services through GP-led care plans



Note: MBS rebates are increased annually on 1 November. The rebate amounts are current as at 1 November 2012 but will change. Check at: http://www9.health.gov.au/mbs

All remuneration shown is the benefit that the provider can claim from Medicare if the service is bulk-billed, or the rebate that the patient can claim from Medicare if the service is privately billed.

All information is current as at 1 November 2012. Health professionals intending to use these items and seeking more comprehensive information, including the MBS requirements for each item, should refer to the website: www.health.gov.au/mbsprimarycareitems, the Medicare Benefits Schedule (MBS) book and/or the Allied Health MBS book. Health professionals can search for specific items at <http://www9.health.gov.au/mbs>, telephone Medicare Australia on 03 9605 7964 or contact their Medicare Local.

Allied health (services to individuals): summary of MBS item numbers

Service type ▶▶▶	Allied health professional service (provided to an individual)							Allied health professional service (provided to an individual who has self-identified as being of Aboriginal or Torres Strait Islander descent)						
Client eligibility ▶▶▶	Client has a chronic medical condition[15] and complex care needs[16], is being managed by a GP under an MBS care plan (#721 and #723) and is not an admitted patient of a hospital							Client has self-identified as being of Aboriginal or Torres Strait Islander descent, has received an Aboriginal and Torres Strait Islander people health check (#715) during which the GP has identified a need for follow-up allied health services, and is not an admitted patient of a hospital						
Relevant MBS item numbers[17] ▶▶▶	Aboriginal Health Worker service #10950	Diabetes education service #10951	Audiology #10952	Exercise physiology #10953	Dietetics services #10954	Mental health service #10956	Occu-pational therapy #10958	Aboriginal Health Worker service #81300	Diabetes education service #81305	Audiology #81310	Exercise physiology #81315	Dietetics services #81320	Mental health service #81325	Occu-pational therapy #81330
	Physio-therapy #10960	Podiatry #10962	Chiropractic service #10964	Osteopathy #10966	Psychology #10968	Speech pathology #10970		Physio-therapy #81335	Podiatry #81340	Chiropractic service #81345	Osteopathy #81350	Psychology #81355	Speech pathology #81360	

15 A chronic medical condition is one that has been or is likely to be present for six months or longer, including but not limited to asthma, cancer, cardiovascular illness, diabetes mellitus, musculoskeletal conditions and stroke. For more information and guidance, see 'Consolidated questions and answers' in the Chronic Disease Management (CDM) Medicare Items section at: http://www.health.gov.au/mbsprimarycareitems

16 Complex care needs means requiring care from a multidisciplinary team. Team care arrangements are likely to be indicated where a patient has complex healthcare needs and one or more of the following: little or no capacity to access or receive needed services by the usual referral process; an unstable or deteriorating condition and comorbidities; increasing frailty and dependence; increasing incidence and complexity of health problems; complications, including falls or incontinence; significant change in social circumstances (such as death, illness or 'burnout' of carer); two or more hospital admissions for their chronic condition in the past six months; inability to comply with required treatment without ongoing management and coordination; a need to see other providers on regular, frequent and ongoing basis to manage the chronic condition. For more information and guidance, see 'Consolidated questions and answers' in the Chronic Disease Management (CDM) Medicare Items section at: http://www.health.gov.au/mbsprimarycareitems

17 The item numbers can only be claimed for services provided by allied health practitioners registered with Medicare Australia.

Allied health (services to groups): summary of MBS item numbers

Service type ▶▶▶	Allied health professional services (provided to a group)		
Client eligibility ▶▶▶	Client has been diagnosed with type 2 diabetes mellitus, is being managed in the community by a GP under a GP Management Plan service (#721) or, if a resident of a Commonwealth-funded aged care facility, is being managed under a multidisciplinary care plan to which the GP has contributed (#731), and is not an admitted patient of a hospital		
Relevant MBS item numbers[18] ▶▶▶	Assessment for group services		
	Diabetes education service – assessment for group services #81100	Exercise physiology service – assessment for group services #81110	Dietetics service – assessment for group services #81120
	Group services		
	Diabetes education service – group service #81105	Exercise physiology service – group service #81115	Dietetics service – group service #81125

18 The item numbers can only be claimed for services provided by allied health practitioners and dental practitioners registered with Medicare Australia.

Allied health (services to individuals through a care plan): summary of web links and explanatory notes

	Allied health professional (AHP) service (provided to an individual) #10950, #10951, #10952, #10953, #10954, #10956, #10958, #10960, #10962, #10964, #10966, #10968, #10970
Steps that must be taken to claim the Medicare item	• GP has placed the client on a multidisciplinary MBS care plan and recommended this service as part of the plan • GP has referred the client to the AHP using the mandated Commonwealth referral form, or a form that substantially complies with it • Service of at least 20 minutes is provided by the AHP, individually and in person • Following the provision of first and last services, the AHP provides a written report to the referring GP
Medicare rules relating to frequency of service or capped benefits	A client is eligible for a maximum total of five services in any calendar year, in any combination of the AHP item numbers
Role of the GP	• Placing the client on an MBS care plan • If the care plan recommends allied health services, referral to AHP using mandated referral form (or form which substantially complies) • Consideration of reports from AHPs and reviewing the client's care plan, if necessary
Roles that can be performed by practice nurses (PNs) or Aboriginal health workers (AHWs) on behalf of and under the supervision of the GP	• Gathering and documenting relevant information for the GP • Arranging services and managing appointments • Monitoring client progress against the MBS care plan and a review of the plan
Main information web link	http://www.health.gov.au/mbsprimarycareitems

Allied health (individual service for an Aboriginal or Torres Strait Islander person, following a health check): summary of web links and explanatory notes

	Allied health professional (AHP) service (provided to an individual) #81300, #81305, #81310, #81315, #81320, #81325, #81330, #81335, #81340, #81345, #81350, #81355, #81360
Steps that must be taken to claim the Medicare item	• Client has identified as being of Aboriginal and Torres Strait Islander descent • GP has performed an Aboriginal and Torres Strait Islander person health check and has identified the need for follow up allied health services as part of the check • GP has referred the client to the AHP using the mandated Commonwealth referral form, or a form that substantially complies with it • Service of at least 20 minutes is provided by the AHP, individually and in person • Following the provision of first and last services, the AHP provides a written report to the referring GP
Medicare rules relating to frequency of service or capped benefits	A client is eligible for a maximum total of five services in any calendar year, in any combination of the AHP item numbers
Role of the GP	• Ensuring completion of the health assessment • If the assessment identified the need for follow-up AH services, referral to AHP using mandated referral form (or form which substantially complies) • Consideration of reports from AHPs and reviewing care, if necessary
Roles that can be performed by practice nurses (PNs) or Aboriginal health workers (AHWs) on behalf of and under the supervision of the GP	• Gathering and documenting relevant information for the GP • Arranging services and managing appointments following the health assessment
Main information web link	http://www.health.gov.au/mbsprimarycareitems

Allied health (services to groups): summary of web links and explanatory notes

	Allied health services (provided to a group)	
	Assessment for group services #81100, #81110, #81120	Group services #81105, #81115, #81125
Steps that must be taken to claim the Medicare item	• Receipt of referral from the medical practitioner managing the client on an MBS care plan[19] • Taking a comprehensive client history, identifying individual goals and preparing the client for an appropriate group service, if they are suitable (this service should be provided individually and in person, and last at least 45 minutes) • Provision of written report back to the referring medical practitioner outlining the assessment undertaken, whether the client is suitable for group services and, if so, the nature of the group services to be delivered	• Receipt of the referral for group services form for each person to receive a group service • Provision of service to a group of between two and 12 people, lasting at least 60 minutes • Provision of, or contribution to, a written report back to the referring GP in respect of each client, describing the group services provided and the outcomes achieved[20]
Medicare rules relating to frequency of service	Once only in any calendar year	A maximum of eight group services per calendar year, in any combination of these item numbers as recommended by the client's GP
Role of the GP	• Manage the client on an MBS care plan • Referral to the allied health practitioner using the referral form provided by the Commonwealth or one that substantially complies with it, with the client's care plan attached if the client has consented	• Receipt of written reports from the allied health practitioners and consideration of client progress in relation to a review of their existing care plan
Roles that can be performed by practice nurses (PNs) or Aboriginal health workers (AHWs) on behalf of and under the supervision of the GP	• Gathering and documenting relevant information for the GP • Making arrangements for services • Managing appointments system • Monitoring client progress against the MBS care plan and assisting the GP in a review of the client's plan, if necessary	
Main information web link	http://www.health.gov.au/mbsprimarycareitems	

19 Unlike the individual allied health services that attract a Medicare rebate under items #10950 to #10970, there is no additional requirement for the client to have a Coordination of Team Care Arrangements (#723) service in place in order attract a rebate for these allied health group services. Having a care plan arranged under items #721 or #731 alone is sufficient to be eligible for Medicare rebateable allied health group services.

20 While each allied health professional is required to provide feedback to the GP in relation to the group services that they provide to the client, allied health professionals involved in the provision of a multidisciplinary program are encouraged to combine feedback into a single report to the referring GP.

Better Start disability services for children: summary of new MBS item numbers

<table>
<tr><td>Service type ▶▶▶</td><td colspan="2">Assessment, diagnosis and treatment/management plan</td><td colspan="3">Assessment services by allied health providers on referral[21]</td><td colspan="3">Early intervention treatment services by allied health providers on referral, following a diagnosis[21]</td></tr>
<tr><td>Client eligibility ▶▶▶</td><td colspan="2">Client is aged under 13 years and has been diagnosed with a disability that renders the child eligible for Better Start services[21]</td><td colspan="3">Client is aged under 13 years and a referral has been made by a specialist, consultant physician or general practitioner who, as part of the referral, requests the allied health professional's assistance in assessing the client
or
Client is aged under 13 years and a referral has been made by a consultant psychiatrist or paediatrician using a specific item (items #296–#370 inclusive except #359 for consultant psychiatrists or items #110–#131 inclusive for paediatricians) who, as part of the referral, requests the allied health professional's assistance in assessing the client</td><td colspan="3">Client is aged under 15 years and a referral has been made by a specialist, consultant physician or general practitioner and the child is being managed under an assessment and management plan (item #139 for a GP or item #137 for a consultant physician)
or
Client is aged under 15 years and a referral has been made by a consultant psychiatrist or paediatrician and the child is being managed under an assessment and management plan (item #289 for a consultant psychiatrist or item #135 for a paediatrician)</td></tr>
<tr><td rowspan="2">Relevant MBS item numbers[22] ▶▶▶</td><td rowspan="2">GP assessment, diagnosis and treatment/ management plan
#139</td><td rowspan="2">Consultant physician assessment, diagnosis and treatment/management plan
#137</td><td>Psychologist
#82000</td><td>Speech pathologist
#82005</td><td>Occupational therapist
#82010</td><td>Psychologist
#82015</td><td>Speech pathologist
#82020</td><td>Occupational therapist
#82025</td></tr>
<tr><td colspan="3">Audiologist, optometrist, orthoptist or physiotherapist
#82030</td><td colspan="3">Audiologist, optometrist, orthoptist or physiotherapist
#82035</td></tr>
<tr><td>Other relevant funding [23] ▶▶▶</td><td colspan="8">The Commonwealth also provides funding for early intervention services (eligible children are aged from newborn to six years) through a 'provider panel' scheme for the Better Start for Children with a Disability scheme.</td></tr>
</table>

21 The Better Start initiative provides funding for the provision of assessment and early intervention services for children in relation to the following conditions: cerebral palsy, Down syndrome, Fragile X syndrome, and moderate (or greater) vision and hearing impairments. For further information see: http://www.fahcsia.gov.au/our-responsibilities/disability-and-carers/program-services/for-people-with-disability/better-start-for-children-with-disability-initiative

22 The item numbers can only be claimed for services provided by practitioners registered with Medicare Australia.

23 For further information see: http://www.fahcsia.gov.au/our-responsibilities/disability-and-carers/program-services/for-people-with-disability/better-start-for-children-with-disability-initiative

Better Start disability services for children: summary of web links and explanatory notes

	GP assessment, diagnosis and treatment/management plan #139	Consultant physician assessment, diagnosis and treatment/management plan #137
Steps that must be taken to claim the Medicare item	• Undertaking a comprehensive assessment of the child (referring to other providers for assessment services as appropriate) • Forming a diagnosis, referring to other providers for assistance with diagnosis as appropriate • Assessing the risks for the child and formulating a written risk assessment • Assessing treatment options and making decisions about ongoing treatment required • Making recommendations about medications and prescribing as appropriate	• Conducting an assessment of the child • Formulating a diagnosis • Assessing the risks for the child and formulating a written risk assessment • Assessing treatment options and making decisions about ongoing treatment required • Making recommendations about medications and prescribing as appropriate
Medicare rules relating to frequency of service	Benefits are available on one occasion only, and where there has been no previous claim for items #135 or #289	
Role of the GP	All parts of the consultation must be rendered by the GP	
Roles that can be performed by practice nurses (PNs) or Aboriginal health workers (AHWs) on behalf of and under the supervision of the GP	None specified	
Main information web link	http://www.health.gov.au/mbsprimarycareitems	

Better Start disability services for children: summary of web links and explanatory notes

	Allied health assessment services #82000, #82005, #82010, #82030	Allied health treatment services #82015, #82020, #82025, #82035
Steps that must be taken to claim the Medicare item	• Providing an assessment service of at least 30-minutes duration • Providing a written report back to the referring practitioner	• Providing a treatment service of at least 30-minutes duration • Providing a written report back to the referring practitioner for the first course of treatment (maximum of 10 services), and after the last course of treatment, which provides information about treatment provided, recommendations for future treatment and any advice to be provided to third parties
Medicare rules relating to frequency of service	Four assessment services in total per eligible client Prerequisite MBS items: #104 - #131 or #296 - #370 excluding #359 (consultant physician) or #3 - #51 (GP).	20 treatment services in total per eligible client, with a second referral from the referring practitioner required after the first 10 services Prerequisite MBS items: #139 (consultant physician) or #137 (GP).
Main information web link	http://www.health.gov.au/mbsprimarycareitems	

Helping children with autism: summary of new MBS item numbers

Service type ▶▶▶	Assessment, diagnosis and treatment/management plan		Assessment services by allied health providers on referral			Early intervention treatment services by allied health providers on referral, following a diagnosis [24]		
Client eligibility ▶▶▶	Client is aged under 13 years and is undergoing assessment or treatment for autism or any other pervasive developmental disorder and they have not already accessed services under the *Better Start for Children with a Disability* initiative.		Client is aged under 13 years and a referral has been made by a consultant paediatrician as an outcome of the service provided under one of the MBS items #110-131 **Or** Client is aged under 13 years and a referral has been made by a consultant psychiatrist as an outcome of a service provided under one of the MBS items #296-370 inclusive except #359.			Client is aged under 15 years and a referral has been made by a consultant psychiatrist or paediatrician and the child is being managed under a specialist's assessment and management plan (item #289 for a consultant psychiatrist or item #135 for a paediatrician)		
Relevant MBS item numbers ▶▶▶	Paediatrician assessment, diagnosis and treatment/ management plan #135 [25]	Psychiatrist assessment, diagnosis treatment/ management plan #289 [26]	Psychologist #82000	Speech pathologist #82005	Occupational therapist #82010	Psychologist #82015	Speech pathologist #82020	Occupational therapist #82025
			Audiologist, Optometrist, Orthoptist or Physiotherapist #82030			Audiologist, Optometrist, Orthoptist or Physiotherapist #82035		
Other relevant funding [27] ▶▶▶	The Commonwealth also provides funding for early intervention services (eligible children are aged newborn to six years) through a 'provider panel' scheme through the *Helping Children with Autism* scheme.							

24 Associated with MBS items: #135 (paediatrician) or # 289 (psychiatrist).

25 Children with an existing treatment and management plan created under MBS items 135 can be reviewed under attendance items for a consultant paediatrician.

26 Children with an existing treatment and management plan created under MBS items 289 can be reviewed under attendance items for a psychiatrist

27 For further information, see http://www.fahcsia.gov.au/our-responsibilities/disability-and-carers/program-services/for-people-with-disability/helping-children-with-autism

Helping children with autism: summary of web links and explanatory notes

	Consultant physician assessment, diagnosis and treatment/ management plan Paediatrician #135 Psychiatrist #289	Allied health treatment services #82015, #82020, #82025, #82035	Allied Health Treatment #82015, #82020, # 82025, #82035
Medicare rules relating to frequency of service	• Undertaking a comprehensive assessment of the child (referring to the other providers for assessment services as appropriate) • Forming a diagnosis, referring to other providers for assistance with diagnosis as appropriate • Assessment of the risks for the child and formulating a written risk assessment • Assessment treatment options and making decisions about ongoing treatment required • Making recommendations about medications and prescribing as appropriate • Providing a copy of the plan to the referring practitioner and relevant allied health providers (where appropriate)	• Providing an assessment service of at least 30 minutes duration • Providing a written report back to the referring practitioner	• Providing treatment service of at least 30 minutes duration • Providing a written report back to the referring practitioner for the first course of treatment (maximum of 10 services) and after the last course of treatment which provides information about treatment provided, recommendations regarding the need for future treatment and any advice to be provided to third parties.
Medicare rules relating to frequency of service	Only one autism treatment and management plan can be prepared for a child in their lifetime. Children with an existing treatment and management plan created under MBS items #135 or #289 can be reviewed under attendance items for a consultant paediatrician or psychiatrist. Cannot claim if payment has previously been made under items #137, #139 or #289 (Paediatrician) or #135, #137 or #139 (Psychiatrist)	Four diagnostic/assessment services in total per eligible client. Prerequisite MBS items: #110-131 (paediatrician) or items #296-370 (psychiatrist).	Twenty treatment services in total per eligible client, with a second referral from the referring practitioner required after the first 10 services Prerequisite MBS items: #135 (paediatrician) or# 289 (psychiatrist).
Main information web link	http://www.health.gov.au/internet/main/publishing.nsf/Content/autism-children		

Access to MBS-rebateable mental health services

MBS items are available for GPs, psychiatrists and paediatricians to provide continuing management of patients with a mental disorder.[28] There is also a suite of items for allied mental health providers to lead or contribute to care. These mental health MBS items are collectively referred to as the Better Access to Mental Health Services items.

Allied mental health services under this program include psychological assessment and therapy provided by eligible clinical psychologists, and focused psychological strategies provided by eligible psychologists, social workers, occupational therapists and GPs with additional training.

A client is eligible to access Medicare rebates for up to 10 individual and 10 group services from a clinical psychologist or other allied mental health professional in a calendar year.

These 10 individual and 10 group service rebates are available for clients who are referred by:

- a medical practitioner managing the patient under a GP Mental Health Treatment Plan (#2700, #2701, #2715 or #2717) or under a Psychiatrist Assessment and Management Plan (#291)

  or
- a psychiatrist or paediatrician following the provision of a service and a claim under a specific Medicare item number (for specialist psychiatrists and paediatricians, following a claim for any item within the range #104–#109; for consultant physician psychiatrists, following a claim for any item within the range #293–#370; and for consultant physician paediatricians, following a claim for any item within the range #110–#133).

Client eligibility for MBS-rebateable mental health services

Clients are eligible for these services if they are judged by a GP, psychiatrist or paediatrician to have a mental disorder as per World Health Organization guidelines (1996) – see footnote 23 below.

Limitations

The Better Access to Mental Health Services item numbers will not suit all community health clients with mental health issues because:

- there may be substantial gap fees if the relevant private provider chooses to charge above the schedule fee
- access to Medicare-registered practitioners may be limited, particularly in rural and outer urban areas
- the item numbers do not fund
  - non-therapy interventions, such as casework
  - family therapy sessions where the client is not present.

Despite these limitations, the items have the potential to complement community health counselling in local communities.

28 Mental disorder is a term used to describe a range of clinically diagnosable disorders that significantly interfere with an individual's cognitive, emotional or social abilities (refer to World Health Organization 1996, *Diagnostic and management guidelines for mental disorders in primary care: ICD-10,* Chapter V, primary care version). Dementia, delirium, tobacco-use disorder and mental retardation are not regarded as mental disorders for the purposes of these item numbers.

Better Access to Mental Health items

Following assessment, the community health practitioner has decided that the client has a 'mental disorder'* and may benefit from treatment by a GP

* see definition on next page

No

Treatment through standard consultation items or #2713

#2713 ($70.30) GP Mental Health Consultation

In consultation with client and GP – is an MBS treatment plan appropriate?

Yes

GP and client decision – Who is going to lead client's mental health treatment plan?

GP

#2700 ($70.30) or
#2701 ($103.50) or
#2715 ($89.25) or
#2717 ($131.45)
GP Mental Health Treatment Plan

Psychiatrist

#291 ($384.80) Assessment and Management Plan provided to the GP

#293 ($240.55) Review of Management Plan provided to the GP

Specialists' referral to rebateable services

Private psychiatrists and paediatricians can also refer a client for 10 rebateable mental health services per calendar year, without the need for referral from a GP or completion of a #291, as long as they have claimed one of a number of specific MBS item numbers (see previous page).

Referral to allied mental health provider for up to 10 individual services per client per calendar year, comprising of:

- up to six sessions then a review by the original referring practitioner, and
- up to an additional four sessions in the same calendar year if necessary.

Refer to GP for FPS*	#2721 ($90.95) 30–40 mins #2723 ($90.95) +$25.45/n[1]) 30–40 mins #2725 ($130.15) 40+ mins #2727 ($130.15 + $25.45 /n[1]) 40+ mins
Refer to clinical psychologist for psych therapy	#80000 ($84.80) 30-50 mins #80005 ($106.00) 30-50 mins OTCR** #80010 ($124.50) 50+ mins #80015 ($145.65) 50+ mins OTCR**
Refer to psychologist for FPS*	#80100 ($60.10) 20–50 mins #80105 ($81.75) 20–50 mins OTCR** #80110 ($84.80) 50+ mins #80115 ($106.55) 50+ mins OTCR**
Refer to social worker or occupational therapist for FPS*	#80125 ($52.95) OT 20–50 mins #80130 ($74.55) OT 20–50 mins OTCR** #80135 ($74.80) OT 50+ mins #80140 ($96.35) OT 50+ mins OTCR** #80150 ($52.95) SW 20–50 mins #80155 ($74.55) SW 20–50 mins OTCR** #80160 ($74.80) SW 50+ mins #80165 ($96.35) SW 50+ mins OTCR**
Group psychological therapy	#80020 ($31.65 pp) Clinical Psychologists #80120 ($21.65 pp) Psychologists #80145 ($19.00 pp) OTs #80170 ($19.00pp) SWs

Report to GP after first and last service.

* FPS = focused psychological services

** OTCR = at a place other than consulting rooms

Note also that MBS rebates are increased annually on 1 November. The rebate amounts are current as at 1 November 2012 but will change – check at: http://www9.health.gov.au/mbs

All remuneration shown is the benefit that the provider can claim from Medicare if the service is bulk-billed, or the rebate that the patient can claim from Medicare if the service is privately billed.

[1] n = number of patients seen (provision of FPS out-of-surgery)

Better Access to Mental Health – treatment plans: summary of MBS item numbers

Service type ▶▶▶	GP mental health treatment plans			Consultant psychiatrist assessment and management plans	
Client eligibility ▶▶▶	Client has a mental disorder[29] and would benefit from a structured approach to the management of their treatment needs	Client has a mental disorder[29] and would benefit from a structured approach to the management of their treatment needs and is being managed through a GP mental health treatment plan	Client has a mental disorder[29]	Client has a mental illness and has been referred from a GP for an assessment and management plan	Client is on a #291 and has been referred from a GP for a review of the assessment and management plan previously provided by the same psychiatrist
Relevant MBS item numbers ▶▶▶	GP mental health treatment plan: (Service lasts at least **20 minutes**, and the GP **has not** undertaken mental health skills training[30]) **#2700** (Service lasts at least **40 minutes**, and the GP **has not** undertaken mental health skills training) **#2701** (Service lasts at least **20 minutes**, and the GP **has** undertaken mental health skills training) **#2715** (Service lasts at least **40 minutes**, and the GP **has** undertaken mental health skills training) **#2717**	Review of a GP mental health treatment plan **#2712**	GP mental health consultation[31] **#2713**	Referred patient assessment and management plan **#291**	Review of referred patient assessment and management plan **#293**

29 Mental disorder is a term used to describe a range of clinically diagnosable disorders that significantly interfere with an individual's cognitive, emotional or social abilities (refer to World Health Organization 1996, *Diagnostic and management guidelines for mental disorders in primary care: ICD-10,* Chapter V, primary care version). Dementia, delirium, tobacco-use disorder and mental retardation are not regarded as mental disorders for the purposes of these item numbers.

30 Mental health skills training refers to training that has been accredited through the General Practice Mental Health Standards Collaboration. For further information see http://www.racgp.org.au/education/gpmhsc

31 This item may be used for ongoing management of a patient with a mental disorder. This item should not be used for the development of a GP Mental Health Treatment Plan.

Better Access to Mental Health – psychological assessment and therapy: summary of MBS item numbers

Service type ▶▶▶	Provision of focused psychological strategies (FPS) services on referral from a GP, psychiatrist or paediatrician							Provision of psychological therapy services by a clinical psychologist on referral from a GP, psychiatrist or paediatrician	
Client eligibility ▶▶▶	Client has a mental disorder[32] and would benefit from a structured approach to the management of their treatment needs, and has been referred following a claim for a GP mental health treatment plan (#2700, #2701, #2715 or #2717) or GP mental health treatment plan review (#2712), or consultant psychiatrist assessment and management plan or review (#291 or #293), or by a psychiatrist or paediatrician following a claim for a specified Medicare item number							Client has a mental disorder,[32] would benefit from a structured approach to the management of their treatment needs and has been referred following a claim for a #2700, #2701, #2715 or #2717, or referred by a psychiatrist or paediatrician	
Relevant MBS item numbers ▶▶▶	FPS[33] provided by registered[34] GPs #2721, #2723, #2725, #2727	FPS provided by registered[34] psychologists #80100, #80105, #80110, #80115	FPS provided by registered[34] occupational therapists #80125, #80130, #80135, #80140	FPS provided by registered[34] social workers #80150, #80155, #80160, #80165	Group[35] FPS provided by a registered[34] psychologist #80120	Group[35] FPS provided by a registered[34] occupational therapist #80145	Group[35] FPS provided by a registered[34] social worker #80170	Psychological assessment and therapy #80000, #80005, #80010, #80015	Group[35] psychological therapy #80020

32 Mental disorder is a term used to describe a wide range of clinically diagnosable disorders that significantly interfere with an individual's cognitive, emotional or social abilities (refer to the World Health Organization 1996, *Diagnostic and management guidelines for mental disorders in primary care: ICD-10,* Chapter V, primary care version). Dementia, delirium, tobacco use disorder and mental retardation are not regarded as mental disorders for the purposes of these item numbers.

33 Focused psychological strategies (FPS) services may only be provided by medical practitioners who are registered with Medicare Australia as having satisfied the requirements for higher level mental health skills for the provision of the service. The medical practitioner must provide the service in a general practice participating in the Practice Incentives Program or which is accredited. It is acceptable for a GP who is managing a client through a #2700, #2701, #2712, #2715 or #2717 to refer to themselves for the provision of FPS and use a GP FPS MBS item number if they are registered with Medicare Australia as a provider of FPS. Information about registration is available through the Medicare provider telephone enquiry line:132 150.

34 The allied health professional must be registered with Medicare Australia to provide this service. Information about registration is available through the Medicare provider telephone enquiry line: 132 150.

35 For the purpose of these item numbers, a group means 6–10 persons. These sessions need to run for at least 60 minutes for a Medicare rebate to be available.

Better Access to Mental Health – treatment plans: summary of web links and explanatory notes

	GP mental health treatment plans and consultations			Consultant psychiatrist-led assessment and management plans	
	GP mental health treatment plan #2700, #2701, #2715, #2717	GP mental health treatment plan review #2712	GP mental health consultation #2713	Referred patient assessment and management plan #291	Referred patient review of assessment and management plan #293
Steps that must be taken to claim the Medicare item	• Client assessment, including consent, relevant history, mental state examination, using an outcome measurement tool if appropriate • Diagnosis, including associated risk and any comorbidities • Preparation of a treatment plan, including discussing assessment, referral and treatment options with the client, agreeing goals and client actions, providing psycho-education, planning for crisis intervention and relapse prevention, arranging referrals, treatment and support services and documenting this in the client's plan	• Recording the client's consent • Reviewing progress against goals outlined in the client's treatment plan • Modifying the treatment plan, if required • Checking, reinforcing and expanding education • Re-administering outcome measurement tool (if appropriate)	Consultation of at least 20 minutes, including: • taking relevant history and identifying presenting problems • providing treatment, advice and referral for other services • documenting outcomes in client record and relevant mental health plan (where applicable)	Consultation of at least 45 minutes, at which: • an outcome tool is used where appropriate • a mental state examination is conducted • a psychiatric diagnosis is made • the consultant psychiatrist decides that the client can be appropriately managed by the referring GP without the need for ongoing treatment by the psychiatrist • a 12–month management plan, appropriate to the diagnosis, is provided to the referring GP • the diagnosis and management plan is explained and provided, unless clinically inappropriate, to the client and carer (with the client's agreement) • the diagnosis and management plan is communicated in writing to the referring GP within two weeks	Consultation of at least 30 minutes but less than 45 minutes for a client for whom a #291 has been provided, at which: • an outcome tool is used where appropriate • a mental state examination is conducted • a psychiatric diagnosis is made • the management plan provided under #291 is reviewed or revised • the reviewed management plan is explained and provided, unless clinically inappropriate, to the client and carer (with the client's agreement) • the reviewed management plan is communicated in writing to the referring GP within two weeks
Medicare rules relating to frequency of service	A new plan should not be prepared unless clinically required, and generally not within 12 months of a previous plan, unless needed due to exceptional circumstances (a significant change in the client's clinical conditions or care requirements)	Initial review 4–24 weeks after initial treatment plan, and second review three months after the first – flexible according to client needs	Nil	May be claimed once only for each eligible client. In circumstances in which the psychiatrist is not sure in the initial consultation whether the client is eligible for a management plan, it is appropriate to bill other items and use #291 later if the client is eligible	Once per client for any 12-month period
Role of the GP	All parts of the consultation must be rendered by the GP			Refer a client to these services; receive written report and continue to provide overall management of the client's mental health care	
Roles that can be performed by practice nurses (PNs) or Aboriginal health workers (AHWs) on behalf of and under the supervision of the GP	A specialist mental health nurse, other allied health practitioner or Aboriginal Health Worker with appropriate mental health qualifications and training may provide general assistance to GPs in provision of mental health care			Assistance to the GP in coordination of services	
Main information link	http://www.health.gov.au/internet/main/publishing.nsf/content/mental-ba				

Better Access to Mental Health – psychological assessment and therapy: summary of web links and explanatory notes

	Provision of focused psychological strategies (FPS) services on referral from a GP, psychiatrist or paediatrician							Provision of psychological therapy services by a clinical psychologist on referral from a GP, psychiatrist or paediatrician	
	FPS provided by registered GPs #2721, #2723, #2725, #2727	FPS provided by registered psychologists #80100, #80105, #80110, #80115	FPS provided by registered occupational therapists #80125, #80130, #80135, #80140	FPS provided by registered social workers #80150, #80155, #80160, #80165	Group FPS provided by registered a psychologist #80120	Group FPS provided by a registered occupational therapist #80145	Group FPS provided by a registered social worker #80170	Psychological assessment and therapy #80000, #80005, #80010, #80015	Group psychological therapy #80020
Services that must be performed to claim the Medicare item	A range of acceptable strategies has been approved for use by practitioners in this context, such as • psycho-education • cognitive-behavioural therapy • relaxation strategies • skills training • interpersonal therapy. There is flexibility to include narrative therapy for Aboriginal and Torres Strait Islander people. Following an initial course of therapy (up to six services), a report should be provided back to the referring GP that includes: • information on assessments carried out on the client • treatment provided • recommendations on future management of the client's disorder. Reports must also be provided back to the referring medical practitioner following any subsequent referred courses of treatment.							In addition to psycho-education, it is recommended that cognitive behaviour therapy be provided. However, other evidence-based therapies, such as interpersonal therapy, may be used if considered clinically relevant. Following an initial course of therapy (up to six services), a report should be provided back to the referring practitioner which includes: • information on assessments carried out on the client • treatment provided • recommendations on future management of the client's disorder. Reports must also be provided back to the referring practitioner following any subsequent referred courses of treatment.	
Medicare rules relating to frequency of service	Up to 10 services per client per calendar year. If six consultations are provided and more are warranted, the client must be referred back to the GP for a review, after which the GP is able to refer again for further consultations.								
Role of the GP	Refer a client to these services, receive written report and continue to provide overall management of the client's mental health care.								
Roles that can be performed by practice nurses (PNs) or Aboriginal health workers (AHWs) on behalf of and under the supervision of the GP	A specialist mental health nurse, other allied health practitioner or Aboriginal Health Worker with appropriate mental health qualifications and training may provide general assistance to GPs in provision of mental health care.								
Main information web link	http://www.health.gov.au/internet/main/publishing.nsf/content/health-pcd-programs-amhpm								

Service incentive payments: summary of MBS item numbers

Service type ▶▶▶	Provision of good care for a client with diabetes mellitus[37] (completion of a diabetes cycle of care)	Provision of best practice care for a client with moderate to severe[38] asthma (completion of an asthma cycle of care)	Provision of a cervical cancer screening service for a woman who is unscreened or significantly under-screened[39]
Client eligibility ▶▶▶	Client has been diagnosed with diabetes mellitus	Client has been diagnosed with moderate to severe asthma	Client is female, has a cervix, has had intercourse, is aged 20–69 inclusive, and has not had a cervical smear within the last four years
MBS item numbers[40] if cycle is completed **in consulting rooms** ▶▶▶	Level 'B' type attendance #2517 Level 'C' type attendance #2521 Level 'D' type attendance #2525	Level 'B' type attendance #2546 Level 'C' type attendance #2552 Level 'D' type attendance #2558	Level 'A' type professional attendance #2497 Level 'B' type professional attendance #2501 Level 'C' type professional attendance #2504 Level 'D' type professional attendance #2507
MBS item numbers[40] if cycle is completed **out-of-surgery** ▶▶▶	Level 'B' type attendance #2518 Level 'C' type attendance #2522 Level 'D' type attendance #2526	Level 'B' type attendance #2547 Level 'C' type attendance #2553 Level 'D' type attendance #2559	Level 'B' type professional attendance #2503 Level 'C' type professional attendance #2506 Level 'D' type professional attendance #2509
Additional billing information ▶▶▶	All visits as part of the cycle of care should be billed under normal or usual attendance items, with the exception of the visit that **completes** all of the minimum requirements of the relevant annual cycle of care. This 'completing' visit should be billed using one of the item numbers listed above, which will trigger an incentive payment through the Practice Incentives Program (PIP) in addition to attracting the usual Medicare rebate.		Any of the GP items above will trigger an incentive payment through the Practice Incentives Program (PIP) in addition to attracting the usual Medicare rebate.

37 The requirements for claiming this item are the minimum needed to provide good care for a client with diabetes. Additional levels of care will be needed by insulin-dependent clients and those with abnormal review findings, complications and comorbidities. Refer to clinical guidelines at: http://www.racgp.org.au/guidelines/diabetes

38 Generally, clients who meet the following criteria can be assumed to have been assessed as having moderate to severe asthma: symptoms on most days **or** use of preventer medication **or** bronchodilator use at least three times per week **or** hospital attendance or admission following an acute exacerbation of asthma.

39 For the purposes of this Medicare item number, an 'unscreened or under-screened' client is defined as a woman aged 20–69, with a cervix, who has had intercourse, and who has not had a pap test in the last four years.

40 Note that these MBS item numbers are claimable for services provided by General Practitioners, as defined within Note 4 (General Practice) of the MBS. Practising community medical practitioners who are not vocationally registered (VR) are able to access remuneration for these initiatives through other item numbers. In surgery, the corresponding item numbers are #2620, #2622, and #2624 for diabetes; #2664, #2666 and #2668 for asthma; and #2598, #2600, #2603 and #2606 for cervical cancer screening. Out of surgery, the corresponding item numbers are #2631, #2633 and #2635 for diabetes; #2673, #2675 and #2677 for asthma; and #2610, #2613 and #2616 for cervical cancer screening. See <http://www9.health.gov.au/mbs> for a detailed description of these items for non-VR medical practitioners.

Service incentive payments: summary of web links and explanatory notes

	Provision of good care for a client with diabetes mellitus[41] (completion of a diabetes cycle of care) #2517, #2518, #2521, #2522, #2525, #2526, #2620, #2622, #2624, #2631, #2633, #2635	Provision of best practice care for a client with moderate to severe[42] asthma (completion of an asthma cycle of care) #2546, #2547, ##2552, #2553, #2558, #2559, #2664, #2666, #2668, #2673, #2675, #2677	Provision of a cervical cancer screening service for a woman who is unscreened or significantly under-screened #2497, #2501, #2503, #2504, #2506, #2507, #2509, #2598, #2600, #2603, #2606, #2610, #2613, #2616
Steps that must be taken to claim the Medicare item (many of these elements may be performed by qualified allied health professionals)	At least twice every cycle of care: • Measure weight and height, calculate BMI, measure blood pressure, examine feet At least once yearly: • Assess diabetes control by measuring HbA1c • Measure total cholesterol, triglycerides and HDL cholesterol • Test for microalbuminuria At least once every two years: • Comprehensive eye examination Also: • Provide self-care education and education about diabetes management • Review diet, physical activity, smoking status and client medication, and provide advice	• At least two asthma-related consultations by a GP within 12 months, one of which (the review consultation) was planned at a previous consultation • Documented diagnosis and assessment of level of asthma control, and severity of asthma • Review of the client's use of and access to asthma-related medication and devices • Provision to the client of a written asthma action plan (or if the client is unable to use a written plan, discussion about an alternative method of providing an action plan, and documentation of this discussion in client's medical record) • Provision of asthma self-management education to the client • Review of the written or documented action plan	• Ensuring the client, who is aged 20–69 inclusive, has not had a cervical smear in the last four years • Taking a cervical smear • Completing any other requirements of the relevant item number being claimed (see details of the relevant item number at: http://www9.health.gov.au/mbs)
Medicare rules relating to frequency of service	Once per client for any 11- to 13-month period	Once per eligible client for any 12-month period, unless a further cycle is clinically indicated by exceptional circumstances	Can only be claimed when provided to a woman aged between 20–69 years inclusive who has not had a cervical smear in the last four years
Role of the GP	• Determining client eligibility and initiating the service if appropriate • Central coordinating role, including at least two consultations with the client • Medical components that cannot be delegated • Formulating and agreeing on the plan in consultation with the client • Reviewing the plan in consultation with the client	• Determining client eligibility and initiating the service if appropriate • Central coordinating role, including at least two consultations with the client • Medical components that cannot be delegated • Formulating and agreeing on the plan in consultation with the client • Reviewing the plan in consultation with the client	• Ensure client is unscreened or significantly under-screened for the purpose of claiming these items. If not eligible yet still due for a smear, another item number can be claimed • The GP is able to perform the smear and claim one of the items above • Help decide which item should be billed from list above, based on services provided
Roles that can be performed by practice nurses (PNs) or Aboriginal health workers (AHWs) on behalf of and under the supervision of a GP	• Assessing the client to determine needs • Gathering and documenting all relevant information for the GP • Making arrangements for services • Managing review appointments system • Monitoring the client's progress between consultations with GP • Establishing or using a client recall and reminder system	• Assessing the client to determine needs • Gathering and documenting all relevant information for the GP • Making arrangements for services • Managing review appointments system • Monitoring client progress between consultations with GP	• Identify eligible clients and arrange appointments • Establish or manage client recall and reminder systems
Main information web link	Summary of PIP payments – see: http://www.medicareaustralia.gov.au/provider/incentives/pip/index.jsp		

41 The requirements for claiming this item are the minimum needed to provide good care for a client with diabetes. Additional levels of care will be needed by insulin-dependent clients and those with abnormal review findings, complications and comorbidities.

42 Generally, clients who meet the following criteria can be assumed to have been assessed as having moderate to severe asthma: symptoms on most days, or use of preventer medication, or bronchodilator use at least three times per week, or hospital attendance or admission following an acute exacerbation of asthma.

Quality use of medicines: summary of MBS item numbers

Service type ▶▶▶	Maximisation of an individual client's benefit from their medication regimen, and prevention of medication-related adverse events	
Client eligibility ▶▶▶	For clients living in the community, and at risk of medication-related adverse events	For clients living in a Commonwealth-funded residential aged care facility, and at risk of medication-related adverse events
Relevant MBS item numbers ▶▶▶	Relevant MBS item number Domiciliary Medication Management Review (also known as home medicines review or HMR) #900	Residential Medication Management Review #903

Quality use of medicines: summary of web links and explanatory notes

	Domiciliary Medication Management Review (DMMR) (also known as home medicines review) #900	Residential Medication Management Review (RMMR) #903
Steps that must be taken to claim the Medicare item	• Determine client eligibility, assessing medication management needs and referring to community pharmacy • Discuss review results with the reviewing pharmacist • Develop a written medication management plan with the client	• Discuss and seek consent from resident • Provide relevant clinical information for the RMMR to the reviewing pharmacist • Develop or revise a written medication management plan, following discussion with the pharmacist • Discuss with resident
Medicare rules relating to frequency of service	Once per client in any 12-month period[43]	Once per resident in any 12-month period[43]
Role of the GP	• Determine client eligibility and initiating service, if appropriate • Discuss findings with pharmacist • Agree on and finalise plan with the client	All, in collaboration with the reviewing pharmacist
Roles that can be performed by practice nurses (PNs) or aboriginal health workers (AHWs) on behalf of and under the supervision of the GP	• Identify clients who may be eligible • Organise appointments • Facilitate the referral to community pharmacy	Nil
Main information web link	http://www.medicareaustralia.gov.au/provider/pbs/fourth-agreement/hmr.jsp	http://www.medicareaustralia.gov.au/provider/pbs/fifth-agreement/residential-medication-management-review.jsp

43 Except where there has been a significant change in the client's condition or medication regimen requiring a new service.

Bulk-billing incentives: summary of MBS item numbers

Service type ▶▶▶	Bulk-billing incentive for unreferred general medical services			Bulk-billing incentive for unreferred diagnostic imaging services		Bulk-billing incentive for unreferred pathology services	
Client eligibility ▶▶▶	For clients under the age of 16 or Commonwealth concession card holders[44] for whom an unreferred[45] general medical service item number is being claimed		For clients under the age of 16 or Commonwealth concession card holders[44] for whom an **after-hours** unreferred[45] general medical service item number is being claimed	For clients under the age of 16 or Commonwealth concession card holders[44] for whom an unreferred[45] diagnostic imaging service item number is being claimed		For clients under the age of 16 or Commonwealth concession card holders[44] for whom an unreferred[45] pathology service item number is being claimed	
Relevant MBS item number ▶▶▶	Bulk-billing incentive payment for unreferred general medical services provided in any area #10990	Higher bulk-billing incentive payment for unreferred general medical services provided in an eligible area[46] #10991	Bulk-billing incentive payment for unreferred after-hours general medical services, provided in an eligible area[46, 47] #10992	Bulk-billing incentive payment for unreferred diagnostic imaging services #64990	Bulk-billing incentive payment for unreferred diagnostic imaging services, provided in an eligible area[46] #64991	Bulk-billing incentive payment for unreferred pathology services #74990	Bulk-billing incentive payment for unreferred pathology services, provided in an eligible area[46] #74991

44 Commonwealth concession card holder means a person listed on a Pensioner Concession Card, Health Care Card or Commonwealth Seniors Health Card issued by either Centrelink or the Department of Veterans' Affairs. Gold or White Cards issued by the Department of Veterans' Affairs do not attract the additional bulk-billing payment. However, if a Gold or White Card holder also holds a recognised Commonwealth concession card and chooses to be treated under the Medicare arrangements, then that patient is an eligible concession card holder.

45 'Unreferred service' means a medical service provided to a client by, or on behalf of, a medical practitioner, being a service that has not been referred to that practitioner by another medical practitioner or person with referring rights.

46 The eligible areas are rural, regional or remote areas, Tasmania, and metropolitan areas listed in the item descriptor. To see these areas, go to <http://www9.health.gov.au/mbs> and search on the relevant item number.

47 This item can only be claimed alongside the following after hours item numbers: #597, #598, #599, #600, #5003, #5007, #5010, #5023, #5028, #5043, #5049, #5063, #5067, #5220, #5223, #5227, #5228, #5260, #5263, #5265 or #5267.

Bulk billing incentives: summary of web links and explanatory notes

	Bulk-billing incentive for unreferred general medical services #10990, #10991	Bulk-billing incentive for unreferred general medical services, provided after hours #10992	Bulk-billing incentive for unreferred diagnostic imaging services #64990, #64991	Bulk-billing incentive for unreferred pathology services #74990, #74991
Steps that must be taken to claim the Medicare item, and associated rules	• Provision of an unreferred general medical service (listed in the General Medical Services table of the MBS) to a person who is under the age of 16 or is a Commonwealth concession card holder and who is not an admitted patient of a hospital or day hospital facility • That service must be bulk billed, and then the bulk-billing incentive item can be claimed alongside it. The bulk-billing incentive must also be bulk billed	• Provision of an after-hours unreferred medical service (any of MBS items #597, #598, #599, #600, #5003, #5007, #5010, #5023, #5028, #5043, #5049, #5063, #5067, #5220, #5223, #5227, #5228, #5260, #5263, #5265 or #5267) to a person who is under the age of 16 or is a Commonwealth concession card holder and who is not an admitted patient of a hospital or day hospital facility • That service must be bulk billed, and then the bulk-billing incentive item can be claimed alongside it. The bulk-billing incentive must also be bulk billed	• Provision of an unreferred diagnostic imaging service (all services listed in Category 5 – diagnostic imaging services in the MBS) by a medical practitioner or specialist with dual qualifications to a person who is under the age of 16 or is a Commonwealth concession card holder and who is not an admitted patient of a hospital or day hospital facility • That service must be bulk billed, and then the bulk-billing incentive item can be claimed alongside it. The bulk-billing incentive must also be bulk billed	• Provision of an unreferred pathology service (listed in Group P9 of the Pathology Services table of the MBS, and unreferred pathology services provided by category M laboratories) by a medical practitioner or specialist with dual qualifications to a person who is under the age of 16 or is a Commonwealth concession card holder and who is not an admitted patient of a hospital or day hospital facility • That service must be bulk billed, and then the bulk-billing incentive item can be claimed alongside it. The bulk-billing incentive must also be bulk billed
Medicare rules relating to frequency of claims	As long as the business rules for the unreferred medical service are met, and the business rules for the bulk-billing bonus item number are also met, there are no limits as to the number of bulk-billing bonus item numbers that can be claimed per batch.			
Main information web link	http://www.medicareaustralia.gov.au/provider/incentives/medicare-initiatives.jsp			

Access to specialist services through telehealth

Summary of telehealth initiative

Medicare rebates for a range of specialist, consultant physician or consultant psychiatrist consultations provided in a video consultation were listed on the Medicare Benefits Schedule on 1 July 2011. There are rebates available for specialists, consultant physicians or consultant psychiatrists as well as for primary care providers who may be with the client during the consultation. There is also a range of additional financial incentives available to eligible practitioners and aged care services that enable patients to participate in a video consultation with a specialist, consultant physician or consultant psychiatrist.

Client eligibility for telehealth services

Services are available to clients who are receiving the service in:

- an eligible regional, rural or remote location[48]
- a residential aged care service anywhere in Australia
- an Aboriginal Medical Service anywhere in Australia
- an Aboriginal Community Controlled Health Service anywhere in Australia.

Minimum distance requirement

On 1 November 2012, the MBS telehealth items were amended. The requirement now is that the patient and remote specialist must be at least 15 kilometres apart. The minimum distance requirement does not apply to residents of Aged Care facilities or patients of an Aboriginal Medical Service.

More information

Further information about the initiative is at: http://www.medicareaustralia.gov.au/provider/incentives/telehealth.jsp

48 From 1 January 2013, the geographic eligibility criteria for telehealth Medicare Benefits Schedule (MBS) items were amended to align with the Australian Standard Geographical Classification Remoteness Area (ASGC-RA) classifications. MBS benefits will now only be available for services provided to patients who are located outside of RA1–Major Cities. You can check if a location is telehealth eligible at http://www.doctorconnect.gov.au Go to "search the map", choose the "ASGC Remoteness Areas Layer" and enter the address of your patient's location during the consultation. The definitions of eligible areas are subject to change by the Department of Health and Ageing – see http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/connectinghealthservices-2012-13BudgetFactsheet.htm for the latest information.

Telehealth services by a specialist, consultant physician or consultant psychiatrist: summary of MBS item numbers

Service type ▶▶▶	Specialist, consultant physician or consultant psychiatrist service provided via video conferencing.										
Client eligibility ▶▶▶	Client has been referred by their GP, and is not an admitted hospital in-patient, and is located in a telehealth-eligible area, which is defined as • located in an eligible geographic area[49] • care recipient is at least 15 kms away from the practitioner • a care recipient at a residential aged care facility • a care recipient at an Aboriginal medical service • a care recipient at an Aboriginal community controlled health service										
MBS item numbers that can be claimed after a video conference ▶▶▶	Specialist service #99 Short consult (10 mins or less) #113 (stand alone item)[50]	Consultant physician service #112 Short consult (10 mins or less) #114 (stand alone item)[50]	Geriatric medicine service (consultant physician or specialist) #149	Consultant psychiatrist service #288	Consultant occupational physician service #389 Short consult (10 mins or less) #384 (stand alone item)[50]	Pain medicine attendances #2820 Short consult (10 mins or less) #2799 (stand alone item)[50]	Palliative medicine attendances #3015 Short consult (10 mins or less) #3003 (stand alone item)[50]	Neurosurgery attendances #6016 Short consult (10 mins or less) #6004 (stand alone item)[50]	Assisted reproductive services #13210	Obstetrics #16399	Anaesthesia #17609
Associated MBS item numbers[51] ▶▶▶	#104 #105	#110 #116 #119 #132 #133	#141 #143	#291 #293 #296 #300 #302 #304 #306 #308 #310 #312 #314 #316 #318 #319 #348 #350 #352	#385 #386	#2801 #2806 #2814	#3005 #3010 #3014	#6007–#6015 series	#13209	#16401 #16404 #16406 #16500 #16590 #16591	#17655 series

49 ibid

50 The specialist, consultant physician or consultant psychiatrist must claim the video conference MBS item number alongside an associated item number. The video conference item number is a derived fee – that is, it is derived from the associated item number and adds an additional fee to the base item fee. This additional fee recognises the increased time and complexity of undertaking a consultation via video conferencing. For example a specialist may claim both #104 and #99 after the provision of a service provided by video conference. It is important to note that the new "stand alone" items do not have an associated item that they are billed with. Patients are unable to be billed for an initial consultation via videoconference (eg #113) and an initial face to face consultation (eg #104) as part of the same course of treatment.

Patient-end services during telehealth consultations with a specialist, consultant physician or consultant psychiatrist: summary of MBS item numbers

Service type ▶▶▶	GP or other medical practitioner – patient-end service[51]			Practice nurse or Aboriginal health worker – patient-end service for and on behalf of a GP		Midwife – patient-end Service	Nurse practitioner – patient-end service	
Client eligibility ▶▶▶	Client is in a telehealth-eligible area and is receiving a telehealth consultation with a specialist, consultant physician or consultant psychiatrist whilst **in consulting rooms**	Client is in a telehealth-eligible area and is receiving a telehealth consultation with a specialist, consultant physician or consultant psychiatrist whilst **in an area other than consulting rooms**[52]	Client is in a telehealth-eligible area and is receiving a telehealth consultation with a specialist, consultant physician or consultant psychiatrist whilst **in a residential aged care facility**[53]	Client is in a telehealth-eligible area and is receiving a telehealth consultation with a specialist, consultant physician or consultant psychiatrist whilst **in any area except a residential aged care facility**	Client is in a telehealth eligible area and is receiving a telehealth consultation with a specialist, consultant physician or consultant psychiatrist whilst **in a residential aged care facility**	Client is in a telehealth-eligible area and is receiving a telehealth consultation with a specialist, consultant physician or consultant psychiatrist whilst **in any area except a residential aged care facility**	Client is in a telehealth-eligible area and is receiving a telehealth consultation with a specialist, consultant physician or consultant psychiatrist whilst **in a residential aged care facility**	Client is in a telehealth-eligible area and is receiving a telehealth consultation with a specialist, consultant physician or consultant psychiatrist whilst **in any area except a residential aged care facility**
Relevant MBS item number ▶▶▶	Level A #2100 Level B #2126 Level C #2143 Level D #2195	Level A #2122 Level B #2137 Level C #2147 Level D #2199	Level A #2125 Level B #2138 Level C #2179 Level D #2220	#10983	#10984	Less than 20 minutes #82150 At least 20 minutes #82151 At least 40 minutes #82152	Less than 20 minutes #82220 At least 20 minutes #82221 At least 40 minutes #82222	Less than 20 minutes #82223 At least 20 minutes #82224 At least 40 minutes #82225

51 'Patient-end service' refers to a consultation delivered at the site at which the patient is physically present.

52 Examples include care provided in institutions and during home visits. Additional rebates are available when the GP is consulting with more than one patient at the same time during the video consultation.

53 Additional rebates are available when the GP is consulting with more than one resident at the same time during the video consultation.

Summary of practice nurse MBS item numbers

About practice nurse MBS item numbers

Medicare rebates are available where practice nurses (or Aboriginal health workers) provide specific types of services on behalf of a general practitioner. These items are for:

- provision of monitoring and support for a person with a chronic disease on a GP Management Plan, Team Care Arrangements or an MBS multidisciplinary care plan
- provision of follow-up services for Aboriginal and Torres Strait Islander people who have received a health check #715
- antenatal service provided from an eligible practice location in a regional, rural or remote area
- Healthy Kids Check for children receiving or having received their four-year-old course of immunisation
- patient-end consultation during a telehealth consultation with a specialist, consultant physician or consultant psychiatrist.

A summary of the relevant MBS items is provided on the next page.

Practice Nurse Incentive Program

The Commonwealth government introduced the Practice Nurse Incentive Program (PNIP) on 1 January 2012. The program provides incentive payments to eligible general practices to offset the costs of employing a practice nurse and support an expanded role for nurses working in general practice.

General practices, including those in urban areas as well as Aboriginal Medical Services and Aboriginal Community Controlled Health Services, may be eligible for these incentive payments. One of the eligibility requirements is that the practice is accredited under the Royal Australian College of General Practitioners *Standards for general practice*.

Payments are made to eligible general practices that apply for the PNIP. Practices not eligible for incentive payments under the PNIP may be eligible for grandparenting payments if they are financially disadvantaged by the removal of the six MBS practice nurse items related to immunisation, wound management and pap smears.

For further information about the range of financial incentives available through the PNIP, see: http://www.medicareaustralia.gov.au/provider/incentives/pnip.jsp

Practice nurse services: summary of MBS item numbers

	Service provided by a practice nurse (or Aboriginal health worker) on behalf of, and under the supervision of, a medical practitioner for clients who are not admitted patients of a hospital or day-hospital facility					
MBS item numbers	Patient-end telehealth service, **not** in a residential aged care facility #10983	Patient-end telehealth service, **in** a residential aged care facility #10984	Healthy Kids Check for a child > three years of age and < five years of age #10986	Follow-up service for a person who has received an Aboriginal and Torres Strait Islander Person Health Check (#715) #10987	Chronic disease service for a person with an MBS care plan (#721, #723, #729, #731 or #732) in place #10997	Antenatal service at or from a practice location in a regional, rural or remote area #16400