Frequently used desktop guide to MBS item numbers for primary health care services

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Northern Queensland Primary Health Network acknowledges the Traditional Custodians of the lands and seas on which we live and work, and pay our respects to Elders past and present.

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General disclaimer

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

Commonly used item numbers

Item no.	Name	Scheduled fee	Description/recommended frequency
3	Level A	$17.20	Brief—see MBS for complexity of care requirements
23	Level B	$37.60	< 20 min—see MBS for complexity of care requirements
36	Level C	$72.80	≥ 20 min—see MBS for complexity of care requirements
44	Level D	$107.15	≥ 40 min—see MBS for complexity of care requirements
10990	Bulk billing item	$7.40	DVA, under 16s and Commonwealth Concession Card holders Can be claimed concurrently for eligible patients
10991	Bulk billing item	$11.15	DVA, under 16s and Commonwealth Concession Card holders Region specific Can be claimed concurrently for eligible patients
11700	ECG	$31.25	Twelve-lead electrocardiography, tracing, and report
73806	Pregnancy test	$10.15	Pregnancy test by one or more immunochemical methods
16500	Antenatal attendance	$47.15	Antenatal attendance
11505	Spirometry	$41.10	Measurement of respiratory function involving a permanently recorded tracing performed before and after inhalation of bronchodilator, 3 or more recordings (diagnosis)
11506	Spirometry	$20.55	Measurement of respiratory function involving a permanently recorded tracing performed before and after inhalation of bronchodilator (monitor)
11309	Audiometry	$26.30	Audiogram, air conduction
14206	Implant (Implanon)	$36.50	Hormone or living tissue implantation by cannula
30062	Implant removal	$60.75	Removal of implant (Implanon)
2100	Telehealth short < 5 minutes	$22.90	Video consultation of less than 5 minutes in duration, for GP providing clinical support to the patient
2126	Telehealth standard 5–20 minutes	$49.95	Video consultation of less than 20 minutes in duration, for GP providing clinical support to the patient
2143	Telehealth long 20–40 minutes	$96.85	Video consultation of at least 20 minutes in duration, for GP providing clinical support to the patient
2195	Telehealth prolonged > 40 minutes	$142.50	Video consultation of at least 40 minutes in duration, for GP providing clinical support to the patient

Skin procedures

Item no.	Name	Scheduled fee	Description/recommended frequency
30071	Biopsy	$52.20	Diagnostic biopsy of skin, if the biopsy specimen is sent for pathological examination
30192	Cryotherapy > 10 lesions	$39.55	Premalignant skin lesions, treatment of, by ablative technique (10 or more lesions)
30202	Malignant cryotherapy < 10	$48.35	Malignant neoplasm of skin or mucous membrane proven by histopathology or confirmed by the opinion of a dermatology specialist, removal of, by liquid nitrogen cryotherapy using repeat freeze-thaw cycles
30196	Shave Excision Malignant Neoplasm < 10	$126.30	Malignant neoplasm of skin or mucous membrane proven by histopathology or confirmed by the opinion of a dermatology specialist, removal of, by serial curettage or carbon dioxide laser or erbium laser excision-ablation, including any associated cryotherapy or diathermy

Skin procedures: Excisions—non-malignant

Non-malignant skin lesion including cyst, ulcer, or scar, excision and repair of, where specimen is sent for histological examination.

Item no.	Name	Scheduled fee	Description/recommended frequency
31357	Nose, lip, ear, digit, genitalia, eyelid, eyebrow, or contagious area < 6mm	$109.70	Non-malignant skin lesion where the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit, or genitalia, or from a contiguous area and the necessary excision diameter is less than 6mm
31360	Nose, lip, ear, digit, genitalia, eyelid, eyebrow, or contagious area > 6mm	$168.05	Non-malignant skin, where the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit, or genitalia, or from a contiguous area, and the necessary excision diameter is 6mm or more
31362	Face, neck, scalp, nipple, lower leg, distal upper limb < 14mm	$133.90	Non-malignant skin lesion where the lesion is excised from face, neck, scalp, nipple-areola complex, distal lower limb, or distal upper limb, and the necessary excision diameter is less than 14mm
31364	Face, neck, scalp, nipple, lower leg, distal upper limb > 14mm	$168.05	Non-malignant skin lesion where the lesion is excised from face, neck, scalp, nipple, distal lower limb, and/or distal upper limb, and the necessary excision diameter is 14mm or more
31366	Other areas < 15mm	$95.45	Non-malignant skin lesion where the lesion is excised from any other part of the body, and the necessary excision diameter is less than 15mm
31368	Other areas 15–30mm	$125.55	Non-malignant skin lesion where the lesion is excised from any other part of the body, and the necessary excision diameter is at least 15mm, but no more than 30mm
31370	Other areas > 30mm	$143.55	Non-malignant skin lesion where the lesion is excised from any other part of the body, and the necessary excision diameter is more than 30mm

Skin procedures: Excisions—malignant

Malignant skin lesion surgical excision (other than by shave excision) and repair of, where the specimen is sent for histological examination and the malignancy is confirmed from the excised specimen or previous biopsy.

Item no.	Name	Scheduled fee	Description/recommended frequency
31356	Nose, lip, ear, digit, genitalia, eyelid, eyebrow < 6mm	$221.35	Malignant skin lesion where the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit, or genitalia, or from a contiguous area and the necessary excision diameter is less than 6mm
31358	Nose, lip, ear, digit, genitalia, eyelid, eyebrow > 6mm	$270.85	Malignant skin where the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit, or genitalia, or from a contiguous area, and the necessary excision diameter is 6mm or more
31359	Nose, lip, ear, digit, genitalia, eyelid, eyebrow 1/3 area	$330.15	Malignant skin, where the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit, or genitalia, or from a contiguous area, and the necessary excision area is at least one third of the surface area of the applicable site
31361	Face, neck, scalp, nipple, lower leg, distal upper limb < 14mm	$186.70	Malignant skin lesion where the lesion is excised from face, neck, scalp, nipple-areola complex, distal lower limb, or distal upper limb and the necessary excision diameter is less than 14mm
31363	Face, neck, scalp, nipple, lower leg, distal upper limb > 14mm	$244.30	Malignant skin lesion where the lesion is excised from face, neck, scalp, nipple, distal lower limb, and/or distal upper limb and the necessary excision diameter is 14mm or more
31365	Other areas < 15mm	$158.30	Malignant skin lesion where the lesion is excised from any other part of the body, and the necessary excision diameter is less than 15mm
31367	Other areas 15–30mm	$213.60	Malignant skin lesion, where the lesion is excised from any other part of the body, and the necessary excision diameter is at least 15mm, but no more than 30mm
31369	Other areas > 30mm	$245.90	Non-malignant skin lesion where the lesion is excised from any other part of the body, and the necessary excision diameter is more than 30mm

Skin procedures: Excisions—malignant tumour

Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of skin, or merkel cell carcinoma of skin, definitive surgical excision (other than by shave excision and repair of, where the specimen is sent for histological examination and malignancy is confirmed from the excised specimen or previous biopsy).

Item no.	Name	Scheduled fee	Description/recommended frequency
31371	Nose, lip, ear, digit, genitalia, eyelid, eyebrow, or contagious area > 6mm	$357.00	Malignant tumour where the tumour is excised from nose, eyelid, eyebrow, lip, ear, digit, or genitalia, or from a contiguous area and the necessary excision diameter is more than 6mm
31372	Face, neck, scalp, nipple, lower leg, distal upper limb < 14mm	$308.70	Malignant tumour where the tumour is excised from face, neck, scalp, nipple-areola complex, distal lower limb, or distal upper limb, and the necessary excision diameter is less than 14mm
31373	Face, neck, scalp, nipple, lower leg, distal upper limb > 14mm	$356.80	Malignant tumour where the tumour is excised from face, neck, scalp, nipple, distal lower limb, and/or distal upper limb, and the necessary excision diameter is 14mm or more
31374	Other areas < 15mm	$281.90	Malignant tumour, where the tumour is excised from any other part of the body, and the necessary excision diameter is less than 15mm
31375	Other areas 15–30mm	$303.40	Malignant tumour, where the tumour is excised from any other part of the body, and the necessary excision diameter is at least 15mm, but no more than 30mm
31376	Other areas > 30mm	$351.60	Malignant tumour, where the tumour is excised from any other part of the body, and the necessary excision diameter is more than 30mm

Skin procedures: Repair of wounds, skin, and subcutaneous tissue or mucous membrane

Item no.	Name	Scheduled fee	Description/recommended frequency
30026	Superficial, other than on face or neck < 7cm	$52.20	Skin and subcutaneous tissue or mucous membrane, repair of wound not on face or neck, small no more than 7cm long
30029	Deep other than on face or neck < 7cm	$90.00	Skin and subcutaneous tissue or mucous membrane, repair of wound not on face or neck, small, involving deeper tissue, no more than 7cm long
30032	Superficial on face or neck < 7cm	$82.50	Skin and subcutaneous tissue or mucous membrane, repair of wound on face or neck, small no more than 7cm long
30035	Deep, face and neck < 7cm	$117.55	Skin and subcutaneous tissue or mucous membrane, repair of wound on face or neck, small, involving deeper tissue, no more than 7cm long
30038	Superficial, other than on face or neck > 7cm	$90.00	Skin and subcutaneous tissue or mucous membrane, repair of wound not on face or neck, large, more than 7cm long
30045	Superficial, face or neck > 7cm	$117.55	Skin and subcutaneous tissue or mucous membrane, repair of wound on face or neck, large, superficial, more than 7cm long
30049	Deep, face or neck > 7cm	$185.60	Skin and subcutaneous tissue or mucous membrane, repair of wound on face or neck, large, involving deeper tissue, more than 7cm long
30052	Full thickness laceration of ear, eyelid, nose, or lip	$254.00	Full thickness laceration of ear, eyelid, nose, or lip, repair of with accurate apposition of each layer of tissue

Chronic disease management

Item no.	Name	Scheduled fee	Description/recommended frequency
721	GP Management Plan (GPMP)	$144.25	Management plan for patients with a chronic or terminal condition. Not more than once yearly unless clinically required (e.g. patient unable to meet the goals set due to chronic condition or hospital stay). GP needs to indicate in the clinical notes on the Medicare Bulk Bill form prior to billing the service.
723	Team Care Arrangement (TCA)	$114.30	Management plan for patients with a chronic or terminal condition and complex needs requiring ongoing care from a team, including the GP and at least 2 other health or care providers. Enables referral for 5 rebated allied health services. Not more than once yearly unless clinically required (e.g. patient unable to meet the goals set due to chronic condition or hospital stay). GP needs to indicate in the clinical notes on the Medicare Bulk Bill form prior to billing the service.
732	Review of GP Management Plan and/or Team Care Arrangement	$72.05	The recommended frequency is every 6 months. Minimum claiming period is 3 months. If a GPMP and TCA are both reviewed on the same date, item 732 can be claimed twice on the same day.
729	GP Contribution to, or Review of, Multidisciplinary Care Plan	$70.40	Contribution by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) to a multidisciplinary care plan prepared by another provider or a review of a multidisciplinary care plan prepared by another provider (other than a service associated with a service to which any of items 735 to 758 apply). Not more than once every 3 months.
731	GP Contribution to, or Review of, Multidisciplinary Care Plan prepared by RACF	$70.40	GP contribution to, or review of, a multidisciplinary care plan prepared by RACF, at the request of the facility, for patients with a chronic or terminal condition and complex needs requiring ongoing care from a team including the GP and at least 2 other health or care providers. Not more than once every 3 months.

Health assessments

Item no.	Name	Scheduled fee	Description/recommended frequency
701	Brief Health Assessment	$59.35	Lasting not more than 30 minutes
703	Standard Health Assessment	$137.90	>30 – ≤45 minutes—see MBS for complexity of care requirements
705	Long Health Assessment	$190.30	>45 – <60 minutes—see MBS for complexity of care requirements
707	Prolonged Health Assessment	$268.80	> 60 minutes—see MBS for complexity of care requirements
715	Aboriginal and Torres Strait Islander Health Assessment	$212.25	Not timed—frequency 9–12 months

Medication management

Item no.	Name	Scheduled fee	Description/recommended frequency
900	Home Medicines Review (HMR)	$154.80	Review of medications in collaboration with a pharmacist for patients at risk of medication related misadventure. Once every 12 months.
903	Residential Medication Management Review (RMMR)	$106.00	For permanent residents of residential aged care facilities who are at risk of medication related misadventure. Performed in collaboration with the resident's pharmacist. Once every 12 months.

Practice nurse/Aboriginal and Torres Strait Islander Health Practitioners (ATSIHP)* item numbers (as of November, 2015)

Item no.	Name	Scheduled fee	Description/recommended frequency
10987	Follow Up Health Services for Indigenous people	$24.00	Follow-up services for an Indigenous person who has received a Health Assessment, not an admitted patient of a hospital. Maximum of 10 services per patient, per calendar year.
10997	Chronic Disease Management	$12.00	Monitoring and support for patients being managed under a GPMP or TCA. Not more than 5, per patient, per year.

*A practice nurse means a registered or enrolled nurse or nurse practitioner who is employed by, or whose services are otherwise retained by a general practice.

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

Mental health

Item no.	Name	Scheduled fee	Description/recommended frequency
283	Focused Psychological Strategies	$74.20	30–40 minutes—provision of focused psychological strategies by an appropriately credentialed medical practitioner.
285	Focused Psychological Strategies	$94.95	Out of surgery consultation. 30–40 minutes—provision of focused psychological strategies by an appropriately credentialed medical practitioner.
286	Focused Psychological Strategies	$106.20	> 40 minutes—provision of focused psychological strategies by an appropriately credentialed medical practitioner.
287	Focused Psychological Strategies	$126.95	Out of surgery consultation. > 40 minutes—provision of focused psychological strategies by an appropriately credentialed medical practitioner.
371	Focused Psychological Strategies	$74.20	30–40 minutes—provision of focused psychological strategies by an appropriately credentialed medical practitioner (telehealth). ***
372	Focused Psychological Strategies	$106.20	> 40 minutes—provision of focused psychological strategies by an appropriately credentialed medical practitioner (telehealth). ***
2700	GP Mental Health Treatment Plan	$71.70	Minimum 20 minutes—prepared by GP who has not undertaken Mental Health Skills training. Assessment of patient and preparation of a Care Plan with option to refer for rebated psychological services. *Only when clinically required.
2701	GP Mental Health Treatment Plan	$105.55	Minimum 40 minutes—prepared by GP who has not undertaken Mental Health Skills training. Assessment of patient and preparation of a Care Plan with option to refer for rebated psychological services. *Only when clinically required.
2715	GP Mental Health Treatment Plan	$91.05	Minimum 20 minutes—prepared by GP who has undertaken Mental Health Skills training. Assessment of patient and preparation of a Care Plan with option to refer for rebated psychological services. *Only when clinically required.
2717	GP Mental Health Treatment Plan	$134.10	Minimum 40 minutes—prepared by GP who has undertaken Mental Health Skills training. Assessment of patient and preparation of a Care Plan with option to refer for rebated psychological services. *Only when clinically required.
2712	Review of GP Mental Health Treatment Plan	$71.70	An initial review, which should occur between four weeks to six months, after the completion of a GP Mental Health Treatment Plan, and if required, a further review can occur three months after the first review.**
2713	Mental Health Consultation	$71.70	Consult ≥ 20 minutes, for the ongoing management of a patient with mental disorder. No restriction on the number of these consultations per year.
2721	GP Focused Psychological Strategies	$92.75	30–40 minutes—provision of focused psychological strategies by an appropriately trained and registered GP working in an accredited practice.
2723	GP Focused Psychological Strategies	Derived fee	Out of surgery consultation of 30–40 minutes. Provision of focused psychological strategies by an appropriately trained and registered GP working in an accredited practice.
2725	GP Focused Psychological Strategies	$132.75	> 40 minutes—provision of focused psychological strategies by an appropriately trained and registered GP working in an accredited practice.
2727	GP Focused Psychological Strategies	Derived fee	Out of surgery consultation. > 40 minutes—provision of focused psychological strategies by an appropriately trained and registered GP working in an accredited practice.

Mental health (continued)

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

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

- an initial review, which should occur between four weeks to six months after the completion of a GP Mental Health Treatment Plan
- and if required, a further review can occur three months after the first review

***In general, most patients should not require more than two reviews in a 12-month period, with ongoing management through the GP Mental Health Treatment Consultation and standard consultation items, as required.

Item 371 and Item 372—services are delivered in a telehealth area that is within the Modified Monash 4, 5, 6, or 7 area.

Allied health services for chronic conditions requiring team care

GPs must have completed a GP Management Plan (GPMP) (721) and Team Care Arrangement (TCA) (723), or contributed to a Multidisciplinary Care Plan in a Residential Aged Care Facility (731) or have had a review of a GPMP and TCA item 732.

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

Item no.	Name	Description/recommended frequency
10950	Aboriginal and Torres Strait Islander Health Workers (ATSIHW) or Aboriginal and Torres Strait Islander Health Practitioner (ATSIHP) Services	Aboriginal and Torres Strait Health Workers (ATSIHW) or Aboriginal and Torres Strait Islander Health Practitioner (ATSIHP) Services and Allied Health Providers must have a Medicare Provider number. Maximum of 5 allied health services per patient each calendar year. Can be 5 sessions with one provider or a combination (e.g. 3 dietitians' and 2 diabetes educators' sessions). GP refers to allied health professional using 'Referral Form for Chronic Disease Allied Health (Individual) Services under Medicare' or a referral form containing all components. One for each provider. Services must be of at least 20 minutes duration and provided to an individual, not a group. Allied health professionals must report back to the referring GP after first and last visit.
10951	Diabetes Education Service	
10952	Audiology	
10953	Exercise Physiology	
10954	Dietetic Services	
10958	Occupational Therapy	
10960	Physiotherapy	
10962	Podiatry	
10964	Chiropractic Service	
10966	Osteopathy	
10970	Speech Pathology	
10956	Mental Health Service	For mental health conditions use Better Access Mental Health Care items—10 sessions. For chronic physical conditions use GPMP and TCA—5 sessions. Better access and GPMP can be used for the same patient where eligible.
10968	Psychology	For mental health conditions, use Better Access Mental Health Care items—10 sessions. For chronic physical conditions, use GPMP and TCA—5 sessions. Better access and GPMP can be used for the same patient, where eligible.

Follow-up allied health services for Aboriginal and Torres Strait Islander peoples who have had a health assessment

Assessment and provision of services

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

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

Item no.	Name	Description/recommended frequency
81300	Aboriginal and Torres Strait Health Service	Aboriginal and Torres Strait Health Workers, or Aboriginal and Torres Strait Islander Health Practitioners and Allied Health Providers must have a current Medicare provider number for each location in which they practice. Maximum of 5 allied health services per patient each calendar year (in addition to the 5 services eligible from TCA 10950-10970). Services must be of at least 20 minutes duration and medical notes need to reflect same. GP refers to allied health professional using a 'Referral form for follow-up allied health services under Medicare for People of Aboriginal or Torres Strait Islander descent' or a referral form containing all components. One for each provider. Allied health professionals must report back to the referring GP after the first and last services. This also includes health professionals using the same clinical software, an internal process of feedback must be in place for the GP to review the medical notes and enter if any further action is required (e.g. recall patient, as they did not attend service or further action not required, recall patient for health assessment in 9–12months).
81305	Diabetes Education Health Service	
81310	Audiology Health Service	
81315	Exercise Physiology Health Service	
81320	Dietetics Health Service	
81325	Mental Health Service	
81330	Occupational Therapy Health Service	
81335	Physiotherapy Health Service	
81340	Podiatry Health Service	
81345	Chiropractic Health Service	
81350	Osteopathy Health Service	
81355	Psychology Health Service	
81360	Speech Pathology Health Service	

Allied health group services for patients with type 2 diabetes

Assessment and provision of services

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

Item no.	Name	Description/recommended frequency
81100	Diabetes Education Service—Assessment for Group Services	One assessment session only by either Diabetes Educator, Exercise Physiologist, or Dietitian, per calendar year. Medicare Allied Health Group Services for Type 2 Diabetes Referral Form. A report is required to be provided to the referring GP that identifies if the patient would benefit from Group Services, before the group services are provided to the patient.
81110	Exercise Physiologist—Assessment for Group Services	
81120	Dietetic Service—Assessment for Group Services	
81105	Diabetes Education Service—Group Service	8 group services per calendar year—can be 8 sessions with one provider or a combination (e.g. 3 diabetes education, 3 dietitians, and 2 exercise physiology sessions). Medicare Allied Health Group Services for Type 2 Diabetes Referral Form. Ensure all participants sign the Medicare Assignment of Benefits form after the group sessions. A report back to the referring GP is required at the completion of the group services and all providers who provided Group Services must contribute to this report.

After hours services

Assessment and provision of services

Attendance period	Item no.	Eligibility	Scheduled fee	Brief guide
Urgent assessment—after hours				
Mon–Fri | 7am–8am or 6pm–11pm **Sat |** 7am–8am or 12noon–11pm **Sun and public holidays |** 7am–11pm	585	VR MMM 1 or 2 or *Non VR	$129.80	Urgent assessment of a patient in the consulting rooms in MMM (Modified Monash Model) area 1–2.
Mon–Fri | 7am–8am or 6pm–11pm **Sat |** 7am–8am or 12noon–11pm **Sun and public holidays |** 7am–11pm	588	VR MMM 3–7 or *Non VR	$129.80	Urgent assessment of a patient in the consulting rooms in MMM (Modified Monash Model) area 3–7.
Mon–Fri | 7am–8am or 6pm–11pm **Sat |** 7am–8am or 12noon–11pm **Sun and public holidays |** 7am–11pm	594	VR or *Non VR	$41.95	Urgent assessment of each additional patient at an attendance that qualifies for item 585 or 588.
Urgent assessment—unsociable hours				
Mon–Sun and public holidays 11pm–7am	599		$153.00	For consultations at the health centre, it is necessary for the practitioner to return to, and especially open the consulting rooms for the attendance.
Non-urgent after hours at a place other than consulting rooms				
Mon–Fri | 7am–8am or 6pm–11pm **Sat |** 7am–8am or 12noon–11pm **Sun and public holidays |** 7am–11pm	5023 (1 patient) 5043 (1 patient) 5028 (1 patient) 5028 (2 patients) 5028 (3 patients) 5049 (1 patients) 5049 (2 patients) 5049 (3 patients)		$74.95 $109.90 $95.70 $72.35 $64.55 $130.65 $107.30 $99.50	
Non-urgent after hours at consulting rooms				
Mon–Fri | Before 8am or after 8pm **Sat |** Before 8am or after 1pm **Sun and/or public holidays**	5000 (Level A) 5020 (Level B <20min) 5040 (Level C >20min) 5060 (Level D >40min)		$29.00 $49.00 $83.95 $117.75	

*Non-VR medical practitioners who are participants in the After-hours Other Medical Practitioner program through an accredited practice, are eligible.

**Note: Department of Health 'Stronger Rural Health Strategy' changes effective 1 July 2018, pertaining to cut-off date of 1 November 2018 for after Hours OMPs, Medicare Plus for OMPs, Outer Metropolitan OMP, and Rural OMPs admission into the respective programs. Doctors already enrolled and participating will have until 30 June 2023 to obtain fellowship. Subject to compliance with program guidelines participating practitioners will have the eligibility to bill the higher value GP items until grandfathering finishes. Please refer to the grandfathering fee structure applicable to your individual circumstances. Email access.programs@health.gov.au for more information.

For non-VR GPs not participating in an OMP program, eligibility to bill the new item numbers will depend on where you are practising based on the Modified Monash service areas. For individual claiming eligibility information please consult access.programs@health.gov.au

Further information on support to obtain fellowship is available though RACGP (pathwayadmin@racgp.org.au) or ACRRM (acrrm@acrrm.org.au).

GP multidisciplinary case conferences

Item no.	Name	Description/recommended frequency
735	Organise and coordinate a case conference	15–20 minutes—GP organises and coordinates case conference in RACF or community, or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs.
739	Organise and coordinate a case conference	20–40 minutes—GP organises and coordinates case conference in RACF or community, or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs.
743	Organise and coordinate a case conference	> 40 minutes—GP organises and coordinates case conference in RACF or community, or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs.
747	Participate in a case conference	15–20 minutes—GP participates in a case conference in RACF or community or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs
750	Participate in a case conference	30–40 minutes—GP participates in a case conference in RACF or community or on discharge. For patients with a chronic or terminal condition complex, and multidisciplinary care needs.
758	Participate in a case conference	> 40 minutes—GP participates in a case conference in RACF or community or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs.

Health assessments

There are eight health assessment target groups:

1. **Type 2 Diabetes Risk Evaluation**
   Provision of lifestyle modification advice and interventions for patients aged 40–49 years who score ≥12 on AUSDRISK. Once every 3 years.

2. **45–49 year old**
   Once only health assessment for patients 45–49 years who are at risk of developing a chronic disease.

3. **75 years and older**
   Health assessment for patients aged 75 years and older. Once every 12 months.

4. **Aboriginal and Torres Strait Islander**
   Health assessment for patients that have identified as Aboriginal and Torres Strait Islander.

5. **Comprehensive Medical Assessment**
   Comprehensive Medical Assessment for permanent residents of Residential Aged Care Facilities. Available for new and existing residents. Not more than once yearly.

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

7. **Health assessment for Refugees and other Humanitarian Entrants**
   Once only health assessment for new refugees and other humanitarian entrants, as soon as possible after their arrival (within 12 months of arrival).

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

8. **Health assessment for former serving members of the Australian Defence Force**
   Once only health assessment for former serving members of the ADF, including former members of permanent and reserve forces.

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

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

Residential aged care facility item numbers

Item no.	Name	Description/recommended frequency
701	Brief Health Assessment	< 30 minutes—see MBS for complexity of care requirements incorporating: Health Assessment—Comprehensive Medical Assessment. Comprehensive Medical Assessment (CMA) for permanent residents of Residential Aged Care Facilities. Available for new and existing residents. Not more than once yearly.
703	Standard Health Assessment	30–44 minutes—see MBS for complexity of care requirements. Incorporating: Health Assessment—CMA.
705	Long Health Assessment	45–60 minutes—see MBS for complexity of care requirements. Incorporating: Health Assessment—CMA.
707	Prolonged Health Assessment	> 60 minutes—see MBS for complexity of care requirements. Incorporating: Health Assessment—CMA.

Comprehensive Medical Assessment (CMA) Activities:
Time based, see MBS for complexity of care requirements for each item.

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

- obtain and record resident's consent
- information collection, including taking patient history and undertaking or arranging examinations, and investigations as required
- making an overall assessment of the patient
- recommending appropriate interventions
- providing advice and information to the patient
- keeping a record of the Health Assessment—CMA, and offering the patient a written report about the health assessment, with recommendations about matters covered by the Health Assessment—CMA.

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

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

Activities:

- obtain and record resident's consent
- prepare part of the plan or amendments to the plan and add a copy to the patient's medical records
- or give advice to a person (e.g. nursing staff in RACF) who prepares or reviews the plan and record in writing, on the patient's medical records, any advice provided.

735	Organise and coordinate a case conference	15–19 minutes—GP organises and coordinates case conference in RACF or community or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs.
739	Organise and coordinate a case conference	20–39 minutes—GP organises and coordinates case conference in RACF or community or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs.
743	Organise and coordinate a case conference	> 40 minutes—GP organises and coordinates case conference in RACF or community or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs.
747	Participate in a case conference	15–20 minutes—GP participates in a case conference in RACF or community or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs.

Residential aged care facility item numbers (continued)

750	Participate in a case conference	30–40 minutes—GP participates in a case conference in RACF or community or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs.
758	Participate in a case conference	> 40 minutes—GP participates in a case conference in RACF or community or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs.

Activities:
Time based items 735–743 organise and coordinate requires:

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

Telehealth—Residential MBS time based items 2125, 2138, 2179, and 2220
Professional attendance by a general practitioner at a residential aged care facility that requires the provision of clinical support to a patient who is:

a) a care recipient receiving care in a residential aged care service (other than a professional attendance at a self-contained unit), or
b) at consulting rooms situated within such a complex where the patient is a resident of the aged care service (excluding accommodation in a self-contained unit).

Time based items 2125, 2138, 2179, and 2220.

Residential Medication Management Review (RMMR) item 903
For permanent residents (new or existing) of RACFs. A RMMR is a review of medications, in collaboration with pharmacist, for patients at risk of medication related misadventure or for whom quality use of medicines may be an issue.

Activities:
Obtain and record resident's consent:

- collaborate with reviewing pharmacist
- provide input from the resident's CMA or relevant clinical information for RMMR and resident's records
- participate in post-review discussion with pharmacist (unless exceptions apply) regarding the findings, medication management strategies, issues, implementation, follow up, and outcomes.
- develop and/or revise Medication Management Plan and finalise plan after discussion with resident.

Systematic care claiming rules

Legend MBS item numbers

	No claiming restrictions
721	GP Management Plan (GPMP)
723	Team Care Arrangement (TCA)
732	Review of GPMP and/or TCA
900	Home Medication Review
2517	Diabetes Annual Cycle of Care SIP
2546	Asthma Cycle of Care SIP
2700/2701	GP Mental Health Treatment Plan
2715/2717	GP Mental Health Treatment Plan
2712	Review of GP Mental Health Treatment Plan
2713	GP Mental Health Consultation

Months until next claim for service

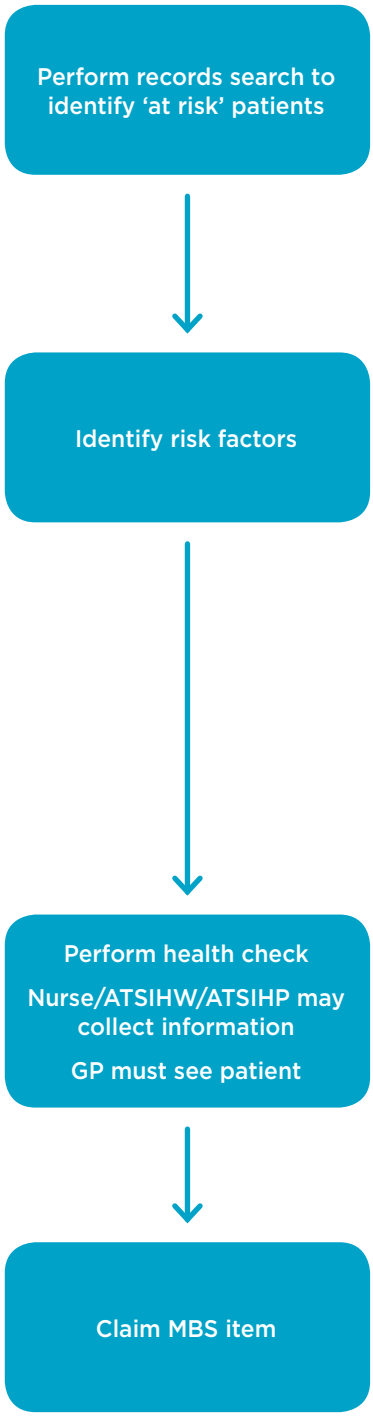
MBS Item Numbers	*721	*723	**732	900	†2517	††2546	2700/2701	§2712	2715/2717	2713
*721	24		6			12				
*723		24	6							
**732	6	6	6		3	3				
900				12						
†2517			3		11-13					
††2546	12		3			12				
2700/2701							12	3		
§2712							3	3	3	
2713										
2715/2717									12	

Additional claiming rules

Item no.	Additional rules
*721 & 723	Recommended claiming period 24 months, minimum claiming period 12 months.
**732	Recommended claiming period 6 months. Minimum claiming period 3 months. Can be claimed twice on the same day if review of both GPMP and TCA are completed. In this case the patient invoice and Medicare claim should be annotated.
†2517	Recommended not to be claimed within 3 months of review item 732, as services overlap. Can be claimed on the same day if both 721 and 723 are completed, as the patient has multidisciplinary care needs.
††2546	Recommended not to be claimed within 12 months of claiming Item 721 alone, as services significantly overlap. Can be claimed on the same day if both 721 and 723 are completed, as the patient has multidisciplinary care needs. Recommended not to be claimed within 3 months of review item 732, as services overlap.
§2712	Review recommended 1 month to 6 months after 2700, 2701, 2715, 2717, with not more than 2 reviews in a 12 month period.
Notes	Where a service is provided earlier than minimum claiming periods, the patient invoice and Medicare claim should be annotated. For example, clinically indicated/required, hospital discharge, exceptional circumstances, significant change. Standard consultations should not be claimed on the same day as health assessments, care plans, and medication reviews. If a standard consultation is provided on the same day the patient invoice and Medicare claim should be annotated, for example, clinically indicated/required, separate service.

Type 2 Diabetes Risk evaluation Health Assessment

Items 701 / 703 / 705 / 707



Eligibility criteria

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

Clinical context

- explain health assessment process and gain consent
- evaluate the patient's high risk score determined by the AUSDRISK, which has been completed within a period of three months prior to undertaking Type 2 Diabetes Risk Evaluation
- update patient history and undertaking physical examinations and clinical investigations in accordance with relevant guidelines
- make an overall assessment of the patient's risk factors, and results of relevant examinations and investigations
- initiate interventions where appropriate, and follow-up relating to management of any risk factors identified
- provide advice and information, including strategies to achieve lifestyle and behaviour changes.

Essential documentation requirements

- record patient's consent to health assessment
- completion of AUSDRISK is mandatory, with a score of ≥12 points required to claim
- update patient history
- record the health assessment and offer the patient a copy.

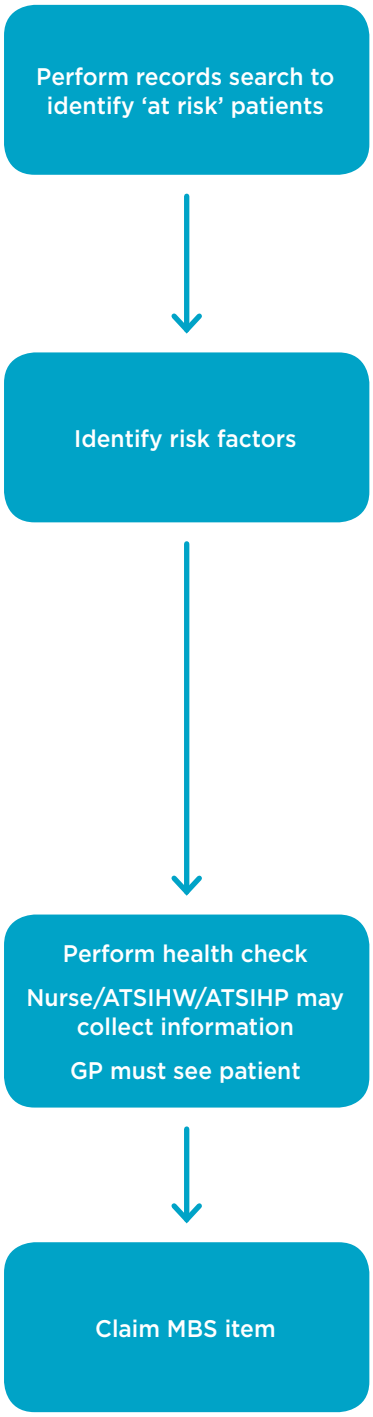
Claiming

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

Item no.	Name	Age range	Recommended frequency
701 703 705 707	Type 2 Diabetes Risk Evaluation Health Assessment	40–49 years	Once every 3 years

45–49 Year Old Health Assessment

Items 701 / 703 / 705 / 707



Eligibility criteria

- patients aged 45 to 49 years inclusive
- must have an identified risk factor for chronic disease
- not for patients in a hospital.

Risk factors

Include, but are not limited to:

- lifestyle—smoking, physical inactivity, poor nutrition, alcohol use
- biomedical—high cholesterol, high blood pressure, impaired glucose metabolism, excess weight
- family history of chronic disease.

Mandatory clinical context

- explain health assessment process and gain consent
- information collection—takes patient history, undertake examinations and investigations as clinically required
- overall assessment of the patient's health, including their readiness to make lifestyle changes
- initiate interventions and referrals as clinically indicated
- advice and information about lifestyle modification programs and strategies to achieve lifestyle and behaviour changes.

Non-mandatory clinical context

- written patient information are recommended.

Essential documentation requirements

- record patient's consent to health assessment
- record the health assessment and offer the patient a copy.

Claiming

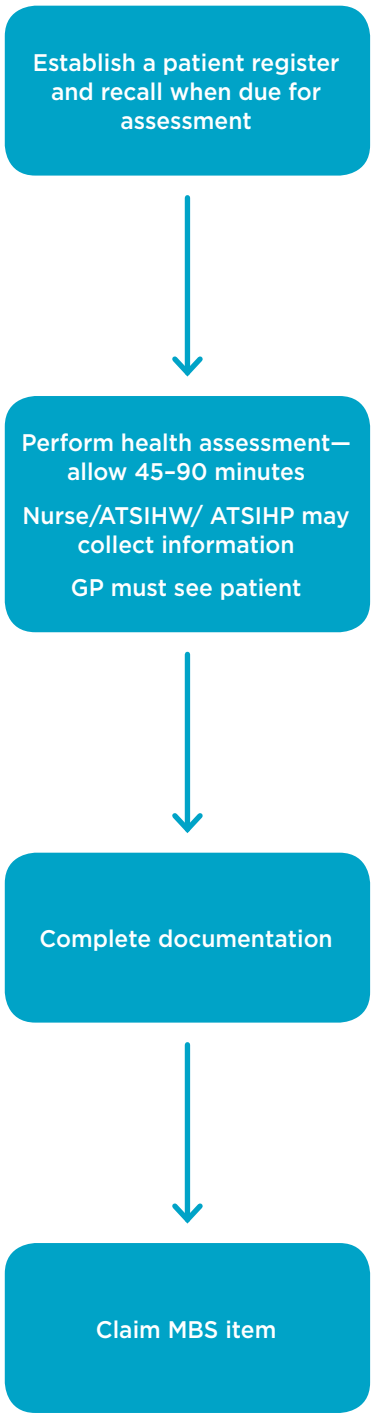
- all elements of the service must be completed to claim.

Item no.	Name	Age range	Recommended frequency
701 703 705 707	45–49 Year Old Health Assessment	45–49 years	Once only

75 Years and Older Health Assessment

Items 701 / 703 / 705 / 707

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



Eligibility criteria

- patients aged 75 years and older
- must have an identified risk factor for chronic disease
- not for patients in a hospital.

Mandatory clinical context

- explain health assessment process and gain patient's/carer's consent
- information collection—takes patient history, undertake examinations and investigations as clinically required
- measurement of blood pressure, pulse rate, and rhythm
- assessment of medication, continence, immunisation status—for influenza, tetanus, and pneumococcus—physical function—including activities of daily living and falls in the last 3 months—psychological function including cognition and mood, and social function—including availability and adequacy of paid and unpaid help and the patient's carer responsibilities
- overall assessment of patient
- recommend appropriate interventions
- provide advice and information
- discuss outcomes of the assessment and any recommendations with patient.

Non-mandatory clinical context

- consider need for community services, social isolation, oral health and dentition, and nutrition status
- additional matters as relevant to the patient.

Essential documentation requirements

- record patient's/carer's consent to health assessment
- record the health assessment and offer the patient a copy (with consent, offer to carer).

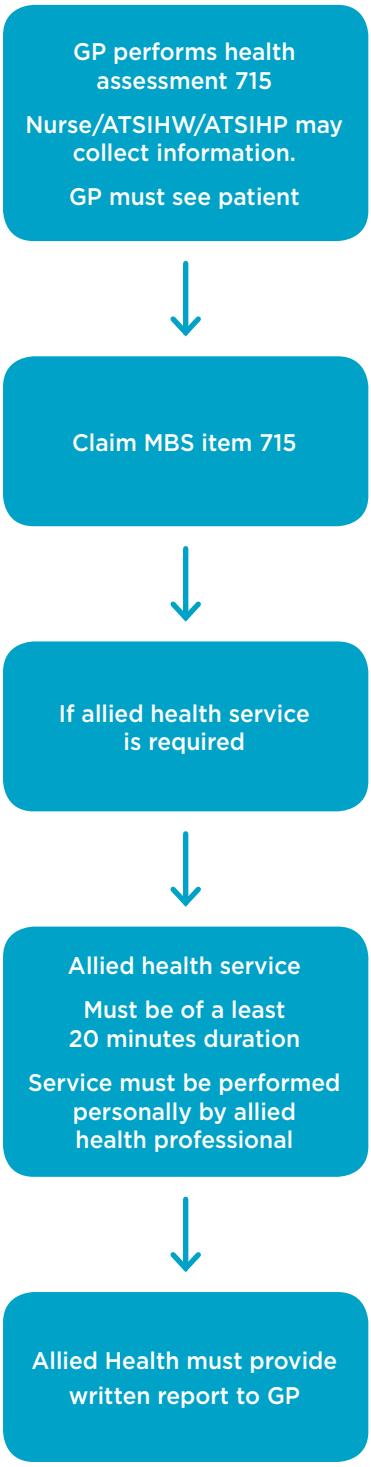
Claiming

- all elements of the service must be completed to claim.

Item no.	Name	Age range	Recommended frequency
701 703 705 707	75 Years and Older Health Assessment	75 years and older	Once every 12 months

Aboriginal and Torres Strait Islander Health Assessment

Item 715



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

Eligibility criteria

- Aboriginal and Torres Strait Islander children who are less than 15 years old
- Aboriginal and Torres Strait Islander adults who are aged 15 years and over, but under the age of 55 years
- Aboriginal and Torres Strait Islander older people who are aged 55 years and over.

Mandatory clinical context

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

- information collection of patient history and undertaking examinations and investigations as required
- overall assessment of the patient, recommending appropriate interventions, providing advice and information to the patient, recording the health assessment
- offering the patient a written report with recommendations about matters covered by the health assessment.

Non-mandatory clinical context

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

Essential documentation requirements

- if referred to an allied health professional, they must provide a written report to the GP after the first and last service (more often if clinically required).

Item no.	Name	Age range	Recommended frequency
715	Aboriginal and Torres Strait Islander Health Assessment	All ages	Once in a 9 month period
81300 to 81360	*Allied Health Services	All ages	Maximum 5 services per year *refer to page 6
10987	Service provided by practice nurse or registered Aboriginal health worker	All ages	Maximum 10 services per year

Home Medicines Review (HMR)

Item 900

HMR is also known as Domiciliary Medication Management Review (DMMR).

Eligibility criteria

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

Initial visit with GP

- explain purpose, possible outcomes, process, and information sharing with pharmacist and possible out of pocket costs
- gain and record patient's consent to HMR
- inform patient of need to return for second visit
- complete HMR referral and send to patient's preferred pharmacy or accredited pharmacist.

HMR interview

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

Second visit with GP

- develop summary of findings as part of draft medication management plan
- discuss draft plan with patient and offer copy of completed plan
- send copy of plan to pharmacist.

Claiming

- all elements of the service must be completed to claim
- requires personal attendance by GP with patient.

Item no.	Name	Recommended frequency
900	Home Medicines Review (HMR)	Once every 12 months

Residential Medication Management Review (RMMR)

Item 903

Eligibility criteria

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

GP initiates service

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

Accredited pharmacist component

- review resident's clinical notes and interview resident
- prepare Medication Review report and send to GP.

GP and pharmacist post-review discussion

- discuss findings and recommendations of the pharmacist
- medication management strategies, issues, implementation, follow-up, and outcomes
- if no (or only minor) changes recommended, a post-review discussion is not mandatory.

Essential documentation requirements

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

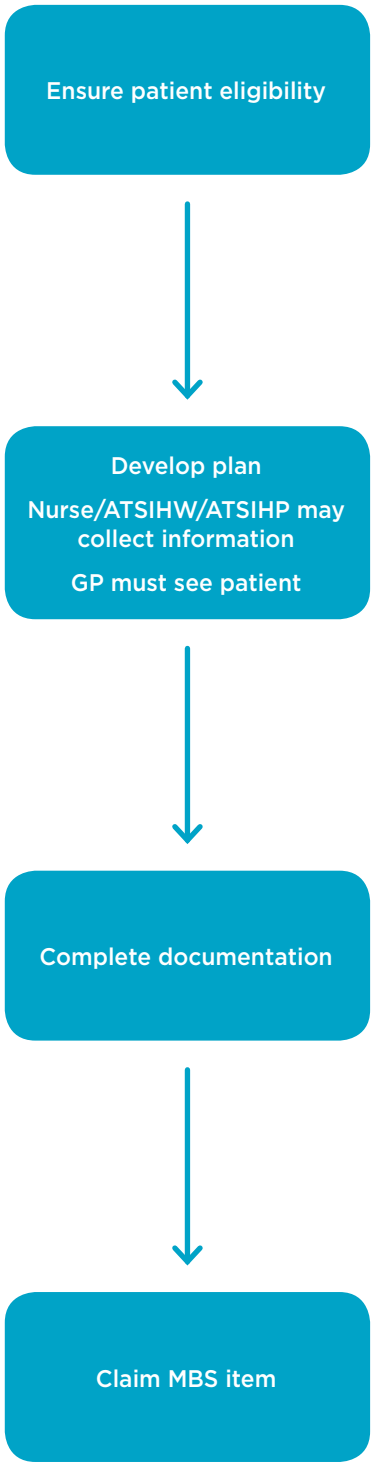
Claiming

- all elements of the service must be completed to claim
- derived fee arrangements do not apply to RMMR.

Item no.	Name	Recommended frequency
903	Residential Medication Management Review (RMMR)	As required (minimum 12 monthly)

GP Management Plan (GPMP)

Item 721



Eligibility criteria

- no age restrictions for patients
- patients with a chronic or terminal condition
- patients who will benefit from a structured approach to their care
- not for public patients in a hospital or patients in a Residential Aged Care Facility (RACF)
- a GP Mental Health Treatment Plan (item 2700/2701/2715/2717) is suggested for patients with a mental disorder only.

Clinical context

- explain steps involved in GPMP, possible out of pocket costs, gain consent, assess health care needs, health problems, and relevant conditions
- agree on management goals with the patient
- confirm actions to be taken by the patient, and identify treatments and services required
- arrangements for providing the treatments and services review using item 732 at least once over the life of the plan.

Essential documentation requirements

- record patient's consent to GPMP
- patient needs and goals, patient actions, and treatments/services required set review date
- offer copy to patient (with consent, offer to carer), keep copy in patient file.

Claiming

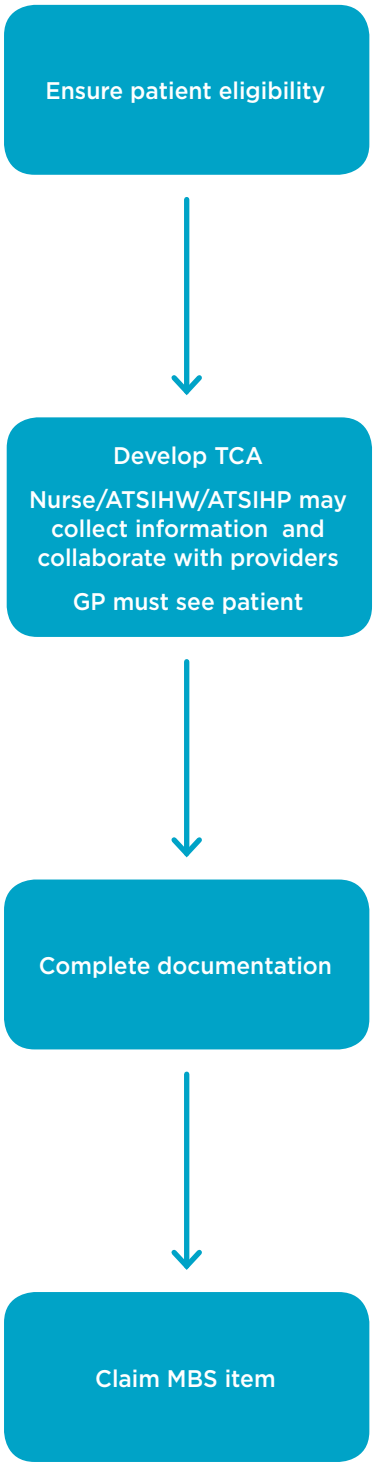
- all elements of the service must be completed to claim
- requires personal attendance by GP with patient
- review using item 732 at least once during the life of the plan.

Item no.	Name	Recommended frequency
721	GP Management Plan	2 yearly (minimum 12 monthly)*

*CDM services may be provided more frequently in exceptional circumstances. Exceptional circumstances exist for a patient if there has been a significant change in the patient's clinical condition or care requirements that necessitates the performance of the service for the patient.

Team Care Arrangement (TCA)

Item 723



Eligibility criteria

- no age restrictions for patients
- patients with a chronic or terminal condition and complex care needs
- patients who need ongoing care from a team including the GP and at least 2 other health or care providers
- not for patients in a hospital or Residential Aged Care Facility (RACF).

Clinical content

- explain steps involved in TCA, possible out of pocket costs, gain consent
- treatment and service goals for the patient
- discuss with patient which two providers the GP will collaborate with and the treatment and services the two providers will deliver
- actions to be taken by the patient
- gain patient's agreement on what information will be shared with other providers
- ideally list all health and care services required by the patient
- obtain potential collaborating providers' agreement to participate
- consult with two collaborating providers and obtain feedback on treatments/services they will provide to achieve patient goals.

Essential documentation requirements

- record patient's consent to TCA
- goals, collaborating providers, treatments/services, actions to be taken by patient
- set review date
- send copy of relevant parts to collaborating providers
- offer copy to patient (with consent, offer to carer), keep copy in patient file.

Claiming

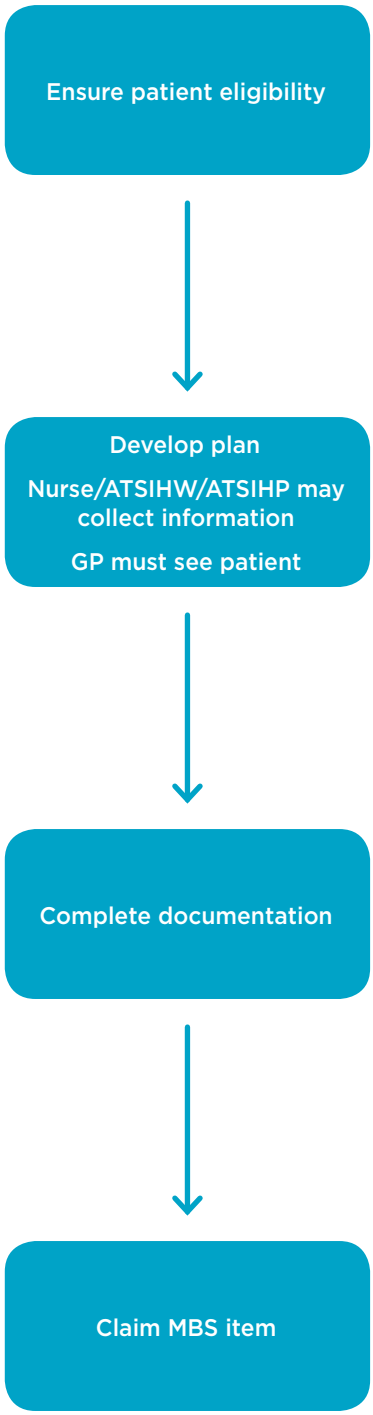
- all elements of the service must be completed to claim
- requires personal attendance by GP with patient
- review using item 732 at least once during the life of the plan
- claiming a GPMP and TCA enables patients to receive five rebated services from allied health.

Item no.	Name	Recommended frequency
723	Team Care Arrangement	2 yearly (minimum 12 monthly)*

*CDM services may be provided more frequently in exceptional circumstances. Exceptional circumstances exist for a patient if there has been a significant change in the patient's clinical condition or care requirements that necessitates the performance of the service for the patient.

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

Item 732



Reviewing a GP Management Plan (GPMP)

Clinical context

- explain steps involved in the review and gain consent
- review all matters in relevant plan.

Essential documentation requirements

- record patient's agreement to review
- make any required amendments to plan
- set new review date
- offer copy to patient (with consent, offer to carer)—keep copy in patient file.

Claiming

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

Reviewing a Team Care Arrangement (TCA)

Clinical context

- explain steps involved in the review and gain consent
- consult with two collaborating providers to review all matters in plan.

Essential documentation requirements

- record patient's consent to review
- make any required amendments to plan
- set new review date
- send copy of relevant parts of amended TCA to collaborating providers
- offer copy to patient (with consent, offer to carer)—keep copy in patient file.

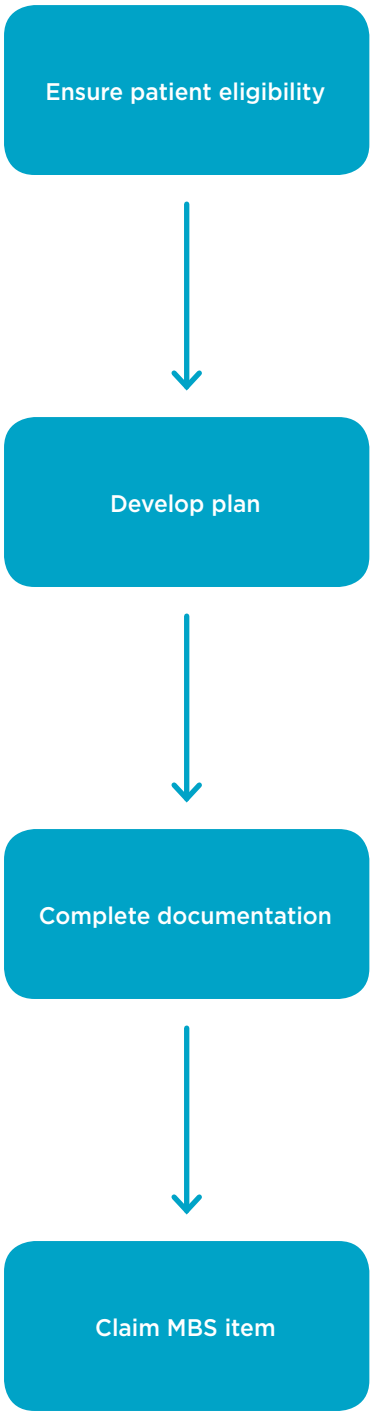
Claiming

- all elements of the service must be completed to claim
- requires personal attendance by GP with patient
- item 732 should be claimed at least once over the life of the TCA
- cannot be claimed within three months of a TCA (item 723)
- item 732 can be claimed twice on same day if review of both GPMP and TCA are completed. In this case the Medicare claim should be annotated.

Item no.	Name	Recommended frequency
732	Review of GP Management Plan and/or Team Care Arrangement	6 monthly (minimum 3 monthly)

Mental Health Treatment Plan

Items 2700 / 2701 / 2715 / 2717



Items 2700/2701 are prepared by a GP who **has not** undertaken mental health skills training. A credentialed mental health nurse, Aboriginal and Torres Strait Islander Health Worker, or Aboriginal and Torres Strait Islander practitioner that has completed mental health training can also assist the GP.

Items 2715/2717 are prepared by a GP who **has** undertaken mental health skills training. A credentialed mental health nurse, Aboriginal and Torres Strait Islander Health Worker, or Aboriginal and Torres Strait Islander practitioner that has completed mental health training can also assist the GP.

Eligibility criteria

- no age restrictions for patients
- patients with a mental disorder—excluding dementia—delirium, tobacco use disorder, and mental retardation (without mental health disorder)
- patients who will benefit from a structured approach to their treatment
- not for patients in a hospital or a Residential Aged Care Facility (RACF).

Clinical content

- explain steps involved and possible out of pocket costs
- gain patient's consent
- relevant history (biological, psychological, social, and presenting complaint)
- mental state examination, assessment of risk and co-morbidity, diagnosis of mental disorder and/or formulation
- outcome measurement tool score (e.g. K10), unless clinically inappropriate, provide psycho-education
- plan for crisis intervention/relapse prevention, if appropriate
- discuss diagnosis/formulation, referral, and treatment options with the patient
- agree on management goals with the patient and confirm actions to be taken by the patient
- identify treatments/services required and organise these.

Essential documentation requirements

- record patient's consent to GP Mental Health Treatment Plan
- document diagnosis of mental disorder
- results of outcome measurement tool
- patient needs and goals, patient actions, and treatments/services required
- set review date
- offer copy to patient (with consent, offer to carer), keep copy in patient file.

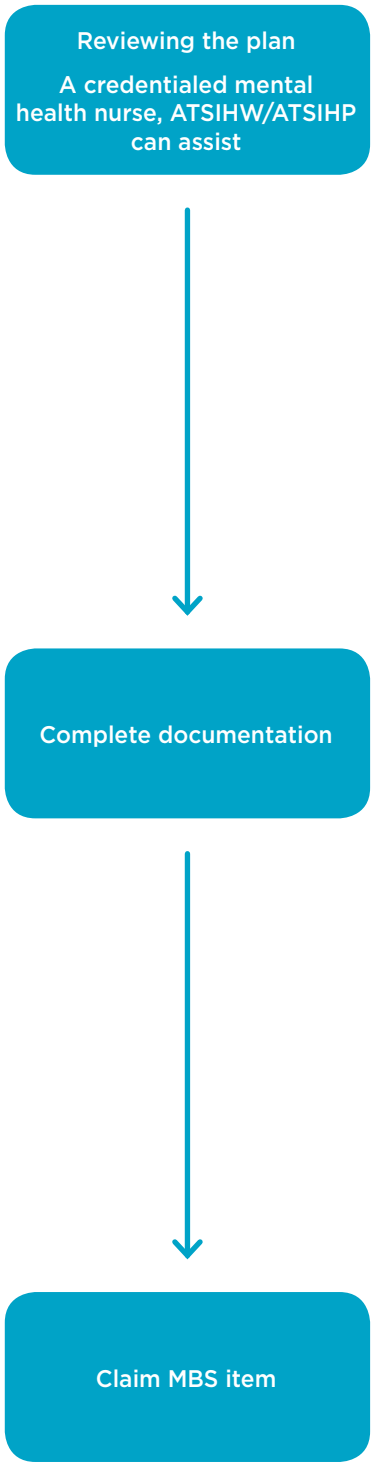
Claiming

- all elements of the service must be completed to claim
- requires personal attendance by GP with patient
- review using item 2712 at least once during the life of the plan.

Item no.	Name	Recommended frequency
2700, 2701, 2715, 2717	GP Mental Health Treatment Plan	Not more than once yearly, other than in exceptional circumstances

Review of the Mental Health Treatment Plan

Item 2712



Clinical context

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

Essential documentation requirements

- record patient's consent to review
- results of re-administered outcome measurement tool document relevant changes to GP Mental Health Treatment Plan
- offer copy to patient (with consent, offer to carer)—keep copy in patient file.

Claiming

- all elements of the service must be completed to claim
- requires personal attendance by GP with patient
- item 2712 should be claimed at least once over the life of the GP Mental Health Treatment Plan
- according to the FAQs on The Australian Government Department of Health Website (2012), it is not mandatory for the GP to see the patient to do a referral for the further four allied mental health sessions
- a review can be claimed 1–6 months after completion of the GP Mental Health Treatment Plan
- if required, an additional review can be performed three months after the first review.

Item no.	Name	Recommended frequency
2712	Review of GP Mental Health Treatment Plan	1–6 months after GP Mental Health Treatment Plan

Diabetes Annual Cycle Of Care Service Incentive Payment (SIP)

Ensure practice eligibility

Only accredited and PIP registered practices may claim the SIP

Care requirements

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

Claim SIP item in place of usual attendance item

Eligibility criteria

- no age restrictions for patients
- patients with established Diabetes Mellitus
- for patients in the community and in Residential Aged Care Facilities (RACF).

Essential clinical and documentation requirements

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

6 monthly

- measure height, weight, and calculate BMI
- measure blood pressure
- examine feet.

Yearly

- measure HbA1c*, eGFR, total cholesterol, triglycerides, and HDL cholesterol test for microalbuminuria
- provide patient education regarding diabetes management including self-care education
- review diet and levels of physical activity
- reinforce information about appropriate dietary choices and levels of physical activity
- check smoking status and encourage smoking cessation
- review medication.

2 yearly

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

Claiming

- available to GPs in accredited practices, registered for the Diabetes SIP—all elements of the service must be completed to claim
- only paid once every 11–13 month period
- the SIP item number can be claimed on the same day as a new General Practice Management Plan (GPMP). The item 2517 completes the cycle of care provided in the preceding 12 months and items 721 and 723 provide care in the following year.

**Summary for HbA1c monitoring established diabetics:*

- GPs can request a HbA1c up to four times a year
- indicate on the pathology request that it is for monitoring a known diabetic.

MBS item

Name	Frequency	In surgery	Out of surgery	SIP	Rebate
Diabetes SIP—Standard Consult. (Level B)	11–13 monthly	2517	2518	$40.00	+ Level B
Diabetes SIP—Long Consult. (Level C)	11–13 monthly	2521	2522	$40.00	+ Level C
Diabetes SIP—Prolonged Consult. (Level D)	11–13 monthly	2525	2526	$40.00	+ Level D

Asthma Cycle of Care Service Incentive Payment (SIP)

Ensure practice eligibility

Only accredited and PIP registered practices may claim the SIP

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

Claim SIP item in place of usual attendance item

Eligibility criteria

- no age restrictions for patients
- patients with moderate to severe asthma
- for patients in the community and in Residential Aged Care Facilities (RACF).

Essential requirements

- at least two asthma consultations within 12 months
- one of the consultations must be for a review
- review must be planned during previous consultation.

Clinical content

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

Essential documentation requirements

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

Claiming

- available to GPs in accredited practices, registered for the asthma SIP
- all elements of the service must be completed to claim
- only paid once every 12 months.

MBS item

Name	Frequency	In surgery	Out of surgery	SIP	Rebate
Asthma SIP - Standard Consult. (Level B)	12 monthly	2546	2547	$100	+ Level B
Asthma SIP - Long Consult. (Level C)	12 monthly	2552	2553	$100	+ Level C
Asthma SIP - Prolonged Consult. (Level D)	12 monthly	2558	2559	$100	+ Level D

Practice incentive payments and service incentive payments summary

Item	Activity	Item number and type of consult	PIP ($ per swipe)	SIP ($ per patient)	Notes
Diabetes	Patient register and re-call/ reminder system	N/A	$1.00 per SWPE (approx. $1000 per FTE GP)		• One-off payment only. • Practice must be registered for PIP. • Incentive payable with quarterly PIP payments.
	Annual Cycle of Care for patients with diabetes	Level B—2517 or 2518 Level C—2521 or 2522 Level D—2525 or 2526		$40.00 per patient with diabetes	These item numbers should be used in place of the usual attendance items, when a consultation completes the minimum annual requirements of care. The SIP item number can be claimed on the same day as a new General Practice Management Plan (GPMP). The item 2517 completes the cycle of care provided in the preceding 12 months and Items 721 and 723 provide care in the following year.
	Outcomes payment	N/A	$20.00 per diabetic patient, per annum		• Payment only made to practices that have a minimum of 2% of their patient population as diagnosed diabetics. • Payment made to practices where 50% of diabetes patients have a completed Annual Cycle of Care.
Asthma	Sign-on payment	N/A	$0.25 per SWPE (approx. $250 per FTE GP)		• One-off payment only. • Practice must be registered for PIP. • Incentive payable with quarterly PIP payments.
	Asthma Cycle of Care	Level B—2546 or 2547 Level C—2552 or 2553 Level D—2558 or 2559		$100.00 per patient, per annum plus consultation fees	• These item numbers should be used in place of the usual attendance items, when a consultation completes the minimum requirements for the Asthma Cycle of Care. • The Asthma Cycle of Care targets patients with moderate to severe asthma.
Cervical Screening	Sign-on payment	N/A	$0.25 per SWPE (approx. $250 per FTE GP)		• One-off payment only. • Practice must be registered for PIP. • Incentive payable with quarterly PIP payments.
	Screening women aged 20–69 years inclusive, who have not been screened in the past 4 years	Level A—2497 Level B—2501 or 2503 Level C—2504 or 2506 Level D—2507 or 2509		$35.00 per patient	These MBS items must be used instead of the standard consultation items, in order to be eligible for this payment
	Outcomes payment	N/A	$3.00 per female WPE aged between 20 and 69, per annum		Payment is made to practices where a minimum of 70% of women aged between 20 and 69 years inclusive have been screened in the past 30 months (paid on a quarterly basis).

The PIP program is currently under review and changes are scheduled to occur in 2019.

Item	Activity	PIP ($ per swipe)	Notes
eHealth	**Requirement 1:** Integrating healthcare identifiers into electronic practice records **Requirement 2:** Secure messaging capability **Requirement 3:** Data records and clinical coding **Requirement 4:** Electronic transfer of prescriptions **Requirement 5:** My Health Record system	$6.50 per SWPE, per annum Capped at $12,500.00 per quarter	To qualify practices must meet each of the requirements: **Requirement 1:** 1. apply for a Healthcare Provider Identifier-Organisation (HPI-O) 2. ensure each GP within the practice has a Healthcare Provider Identifier-Individual (HPI-I) 3. use a compliant clinical software system to access, retrieve, and store verified Individual Healthcare Identifiers (IHI) for patients. **Requirement 2:** 1. apply for a NASH PKI Certificate 2. have a standards-compliant secure messaging capability and use it where feasible 3. work with your secure messaging vendor to ensure it is installed and configured correctly 4. have a written policy to encourage its use. **Requirement 3:** 1. be working towards recording the majority of diagnoses electronically using a medical vocabulary that can be mapped against a nationally recognised disease classification or terminology system 2. provide a written policy to this effect to all GPs. **Requirement 4:** 1. use a software system that is able to send an electronic prescription to a Prescription Exchange Service (PES). **Requirement 5:** 1. use compliant software to access the My Health Record system and create and post Shared Health Summaries and Event Summaries when available 2. apply to participate in the eHealth record system upon obtaining a HPI-O.
Practice nurse	Practice employs or retains the services of a Registered Nurse, Enrolled Nurse, or Aboriginal and Torres Strait Health Worker	Capped at $125,000.00 per annum	This incentive aims to broaden the range of services a nurse can provide. Payments are based on practice SWPE and nurse hours. Refer to ACTML website for complete PNIP guidelines.
Quality prescribing	Practice participation in quality use of medicines programs, endorsed by the National Prescribing Service	$1.00 per SWPE	This incentive is to assist practices in keeping up to date with information on the quality use of medicines. Payment will only be made if the practice meets a minimum participation level, set at an average of three activities per FTE GP per year.
Teaching	Aims to encourage general practices to provide teaching sessions to undergraduate and graduate medical students preparing for entry into the Australian Medical profession	$100.00 per session	Practices can access a maximum of $100 for each three hour teaching session provided to medical students. Each practice can claim a maximum of two sessions per GP, per calendar day.

The PIP program is currently under review and changes are scheduled to occur in 2019.

Item	Activity	PIP ($ per swipe)	SIP ($ per patient)	Notes
Aged care access	Provision of primary care services for patients in Residential Aged Care Facilities (RACFs). **Tier 1:** GP completes the Qualifying Service Level (QSL) 1–60 MBS services in RACF claimed in a financial year.		$1500.00	MBS items that count towards QSLs include attendances in RACF, contributions to multidisciplinary care plans and Residential Medication Management Reviews. GPs need to provide the service using their PIP linked Medicare provider number. GPs do not need to apply to participate in the Incentive. Medicare will request bank details from GPs eligible to receive payments once they have reached the QSL.
	Tier 2: GP completes the QSL 2–140 MBS services in RACF claimed in a financial year		$3500.00	
PIP Indigenous Health Incentive	Provision of better health care for Indigenous patients, including best practice management of chronic disease. Sign-on payment.	$1000.00		One-off payment only. Practice must be registered for PIP. Practice must: • seek consent to register their Aboriginal and Torres Strait Islander patients who have a chronic disease, with Medicare and the practice for chronic disease management in a calendar year • establish a mechanism to ensure their Aboriginal and Torres Strait Islander patients aged 15 years and over with a chronic disease, are followed up (e.g. recall/reminder system, to ensure they return for ongoing care) • undertakes cultural awareness training within 12 months of joining incentive.
	Annual patient registration payments.	$250.00 per registered Aboriginal and Torres Strait Islander patient, per calendar year		Practice registers their eligible Aboriginal and Torres Strait Islander patients with Medicare for the PIP Indigenous Health Incentive. Practice must actively plan and manage care of their Aboriginal and Torres Strait Islander patients with chronic disease for a calendar year. Payment made to practice for each Aboriginal and Torres Strait Islander patient who: • is aged 15 years or over • has a chronic disease • has had (or has been offered) the 715 Aboriginal and Torres Strait Islander Health Assessment • has provided informed consent to be registered for the PIP Indigenous Health Incentive. The patient's registration period commences from the date they provide consent to participate in the incentive, and will end on 31 December that year. Practices are required to obtain consent to re-register patients each calendar year.
	Tier 1: Outcomes payment: Chronic Disease Management	$100.00 per registered patient, per calendar year		Payment made to practices that (in a calendar year): 1. develop a 721 GP Management Plan or 723 Team Care Arrangement for the patient and undertake at least one 732 Review of the GPMP or TCA; or 2. undertake two 732 Reviews of GPMP or TCA; or 3. complete 731 contribute to, or review, a care plan for a patient in a RACF, on two occasions.
	Tier 2: Outcomes payment: Total Patient Care	$150.00 per registered patient, per calendar year		Payment made to practices that provide the majority (i.e. the highest number) of MBS services for the patient (with a minimum of 5 MBS services) in a calendar year. This may include the MBS services provided to qualify for Tier 1.

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