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Desktop guide to frequently used MBS item numbers for General Practice

March 2021

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Frequently used MBS Item Numbers

For a comprehensive explanation of each MBS Item Number, please refer to the Medicare Benefits Schedule online at [www.mbsonline.gov.au](http://www.mbsonline.gov.au)

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| **Commonly Used Item Numbers** |
| **Item** | **Name** | **$** | **Description/Recommended Frequency** |
| 3 | Level A | $17.75 | Brief – see MBS for complexity of care requirements |
| 23 | Level B | $38.75 |  20 min – see MBS |
| 36 | Level C | $75.05 | ≥ 20 min – see MBS |
| 44 | Level D | $110.50 | ≥ 40 min – See MBS |
| 10990 | Bulk Billing item | $6.50 | DVA, under 16’s and Commonwealth Concession Card holders. Can be claimed concurrently for eligible patients. |
| 10991 | Bulk Billing item | $9.80 | DVA, under 16’s and Commonwealth Concession Card holders. Service provided at various locations. See MBS. Can be claimed concurrently for eligible patients. |
| 11505 | Spirometry | $36.05 | Measurement of spirometry, that: (a) involves a permanently recorded tracing, performed before and after inhalation of a bronchodilator; and (b) is performed to confirm diagnosis of: (i) asthma; or (ii) chronic obstructive pulmonary disease (COPD); or (iii) another cause of airflow limitation; each occasion at which 3 or more recordings are made. Applicable only once in any 12 month period. |
| 11506 | Spirometry | $18.05 | Measurement of spirometry, that: (a) involves a permanently recorded tracing, performed before and after inhalation of a bronchodilator; and (b) is performed to: (i) confirm diagnosis of chronic obstructive pulmonary disease (COPD); or (ii) assess acute exacerbations of asthma; or (iii) monitor asthma and COPD; or (iv) assess other causes of obstructive lung disease or the presence of restrictive lung disease; each occasion at which recordings are made. |
| 11707 | ECG Trace only | $16.15 | Twelve-Lead Electrocardiography, tracing only |

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| **Residential Aged Care Facility – GP Call out Fee and consults** |
| **Item** | **Name** | **$** | **Description/Recommended Frequency** |
| 90001 | Single site call out fee | $56.75 | A flag fall service to which item 90020, 90035, 90043 or 90051 applies. For the initial attendance at one residential aged care facility on one occasion, applicable to a maximum of one patient attended on. Please refer to MBS Online for full description. |
| 90035 | Standard | $38.75 |  20 min – see MBS for complexity of care requirements. |
| 90043 | Long | $75.05 | ≥ 20 min – see MBS for complexity of care requirements. |
| 90051 | Prolong | $110.50 | ≥ 40 min – see MBS for complexity of care requirements. |

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

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

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| **Practice Nurse Item Numbers** |
| **Item** | **Name** | **$** | **Description/Recommended Frequency** |
| 10987 | Follow Up Health Services for Indigenous people | $24.75 | Follow up services for an Indigenous person who has received a Health Assessment. Not an admitted patient of a hospital. Maximum of 10 services per patient per calendar year. |
| 10997 | Chronic Disease Management | $12.40 | Monitoring and support for patients being managed under a GPMP or TCA. Not more than 5 per patient per year. |
| 10988 | Immunisation for Indigenous people | $12.40 | Immunisation proved to a person by Aboriginal and Torres Strait Island health practitioner on behalf of a Medical Practitioner |
| 10989 | Treatment of Wound for Indigenous people | $12.40 | Treatment of a person’s wound (other than normal aftercare) provided by Aboriginal or Torres Strait Island health practitioner on behalf of a Medical Practitioner |

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| **Women’s Health** |
| 73806 | Urine Pregnancy Test | $8.65 | Pregnancy test by 1 or more immunochemical methods |
| 16500 | Routine antenatal attendance | $41.35 | Antenatal attendance |
| 16591 | Management of Pregnancy | $125.05 | Planning and management of a pregnancy if; (a) the pregnancy has progressed beyond 28 weeks gestation; (b) the service includes a mental health assessment (including screening for drug and alcohol use and domestic violence) of the patient; (c) a service to which item 16590 applies is not provided in relation to the same pregnancy |
| 14206 | Administration of hormone implant by cannula (including Implanon) | $31.20 | Hormone or Living tissue implantation by cannula |
| 30062 | Removal of Implanon | $53.30 | Etonogestrel subcutaneous implant, removal of, as an independent procedure |
| 35503 | Insertion of IUD | $46.95 | Intra uterine contraceptive device, introduction of, if the service is not associated with a service to which another item in the group applies (other than a service mentioned in item 30062) |

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

COVID-19 TEMPORARY MBS ITEMS

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| **MBS Telehealth Items** |
| **Name** | **Telehealth Items via video conference** | **Telephone Items – for when video conferencing is not available** | **$** |
| Attendance for an obvious problem | 91790 | 91795 | $17.75 |
| Attendance less than 20 minutes | 91800 | 91809 | $38.75 |
| Attendance at least 20 minutes | 91801 | 91810 | $75.05 |
| Attendance at least 40 minutes | 91802 | 91811 | $110.50 |
| Indigenous Health Assessment | 92004 | 92016 | $218.90 |
| Health Assessment for people of Aboriginal or Torres Strait Islander descent | 92011 | 92023 | $175.10 |
| Preparation of a GP management plan (GPMP) | 92024 | 92068 | $148.75 |
| Coordination of Team Care Arrangements (TCA) | 92025 | 92069 | $117.90 |
| Contribution to a Multidisciplinary Care Plan, or to a review of a Multidisciplinary Care Plan, for a patient who is not a care recipient in a residential aged care facility | 92026 | 92070 | $72.60 |
| Contribution to a Multidisciplinary Care Plan, or to a review of a multidisciplinary care plan, for a resident in an aged care facility | 92027 | 92071 | $72.60 |
| Review of a GPMP or Coordination of a Review of TCAs | 92028 | 92072 | $74.30 |
| Non-directive pregnancy support counselling, at least 20 minutes | 92136 | 92138 | $79.00 |
| Routine antenatal attendance | 91853 | 91858 | $41.35 |
| GP without mental health skills training, preparation of an eating disorder treatment and management plan, at least 40 minutes | 92147 | 92155 | $108.85 |
| GP with mental health skills training, preparation of an eating disorder treatment and management plan, lasting at least 20 minutes, but less than 40 minutes | 92148 | 92156 | $93.90 |
| GP with mental health skills training, preparation of an eating disorder treatment and management plan, at least 40 minutes | 92149 | 92157 | $138.30 |
| Review of an eating disorder treatment and management plan | 92170 | 92176 | $73.95 |
| GP without mental health skills training, preparation of a GP mental health treatment plan, lasting at least 20 minutes, but less than 40 minutes | 92112 | 92124 | $73.95 |
| GP without mental health skills training, preparation of a GP mental health treatment plan, at least 40 minutes | 92113 | 92125 | $108.85 |
| Review of a GP mental health treatment plan or Psychiatrist Assessment and Management Plan | 92114 | 92126 | $73.95 |
| Mental health treatment consultation at least 20 minutes | 92115 | 92127 | $73.95 |
| GP with mental health skills training, preparation of a GP mental health treatment plan, lasting at least 20 minutes, but less than 40 minutes | 92116 | 92128 | $93.90 |
| GP with mental health skills training, preparation of a GP mental health treatment plan, at least 40 minutes | 92117 | 92129 | $138.30 |
| GP, focussed psychological strategies treatment service, 30 - 40 minutes, GP registered with Chief Executive Medicare, patient to access 10+ Better Access services | 93301 | 93302 | $95.65 |
| GP, focussed psychological strategies treatment service, at least 40 minutes, GP registered with Chief Executive Medicare, patient to access 10+ Better Access services | 93304 | 93305 | $136.85 |
| Urgent attendance, unsociable after hours | 92210 | 92216 | $157.80 |

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| **Vaccine** **Suitability Assessment Items** |
| **Item** | **Name** | **$** | **Description/Recommended Frequency** |
| 93624 | Assessing Patient Suitability for First Dose of a COVID-19 Vaccine – Business Hours – Modified Monash area 1 | $30.75 | Professional attendance by a general practitioner for the purpose of assessing a patient’s suitability for the first dose of a COVID-19 vaccine if all of the following apply (a) one or both of the following is undertaken, where clinically relevant: (i) a short patient history; (ii) limited examination and management; (b) the patient is eligible for a COVID-19 vaccine; (c) the service is bulk billed; (d) the service is provided at, or from, a practice location in a Modified Monash 1 area |
| 93625 | Assessing Patient Suitability for First Dose of a COVID-19 Vaccine – Business Hours – Modified Monash areas 2-7 | $37.35 | Professional attendance by a general practitioner for the purpose of assessing a patient’s suitability for the first dose of a COVID-19 vaccine if all of the following apply: (a) one or both of the following is undertaken, where clinically relevant: (i) a short patient history; (ii) limited examination and management; (b) the patient is eligible for a COVID-19 vaccine; (c) the service is bulk billed; (d) the service is provided at, or from, a practice location in a Modified Monash areas 2-7 |
| 93626 | Assessing Patient Suitability for the First Dose of a COVID-19 Vaccine – Business Hours – Modified Monash area 1 | $24.00 | Professional attendance by a medical practitioner (other than a general practitioner) for the purpose of assessing a patient’s suitability for the first dose of a COVID-19 vaccine if all of the following apply: (a) one or both of the following is undertaken, where clinically relevant: (i) a short patient history; (ii) limited examination and management; (b) the patient is eligible for a COVID-19 vaccine; (c) the service is bulk billed; (d) the service is provided at, or from, a practice location in a Modified Monash 1 area |
| 93627 | Assessing Patient Suitability for the First Dose of a COVID-19 Vaccine – Business Hours – Modified Monash areas 2-7 | $33.80 | Professional attendance by a medical practitioner (other than a general practitioner) for the purpose of assessing a patient’s suitability for the first dose of a COVID-19 vaccine if all of the following apply: (a) one or both of the following is undertaken, where clinically relevant: (i) a short patient history; (ii) limited examination and management; (b) the patient is eligible for a COVID-19 vaccine; (c) the service is bulk billed; (d) the service is provided at, or from, a practice location in a Modified Monash areas 2-7 |
| 93634 | After Hours Assessing Patient Suitability for the First Dose of a COVID-19 Vaccine – Modified Monash area 1 | $42.90 | Professional attendance by a general practitioner for the purpose of assessing a patient’s suitability for the first dose of a COVID-19 vaccine if all of the following apply: (a) one or both of the following is undertaken, where clinically relevant; (i) a short patient history; (ii) limited examination and management; (b) the patient is eligible for a COVID-19 vaccine; (c) the service is bulk billed; (d) the service is provided at, or from, a Modified Monash 1 area; (e) the service is rendered in an after-hours period |
| 93635 | After Hours Assessing Patient Suitability for the First Dose of a COVID-19 Vaccine – Modified Monash areas 2-7 | $49.50 | Professional attendance by a general practitioner for the purpose of assessing a patient’s suitability for the first dose of a COVID-19 vaccine if all of the following apply: (a) one or both of the following is undertaken, where clinically relevant: (i) a short patient history; (ii) limited examination and management; (b) the patient is eligible for a COVID-19 vaccine; (c) the service is bulk billed; (d) the service is provided at, or from, a practice location in a Modified Monash areas 2-7; (e) the service is rendered in an after-hours period |
| 93636 | After Hours Assessing Patient Suitability for the First Dose of a COVID-19 Vaccine – Modified Monash area 1 | $34.00 | Professional attendance by a medical practitioner (other than a general practitioner) for the purpose of assessing a patient’s suitability for the first dose of a COVID-19 vaccine if all of the following apply: (a) one or both of the following is undertaken, where clinically relevant: (i) a short patient history; (ii) limited examination and management; (b) the patient is eligible for a COVID-19 vaccine; (c) the service is bulk billed; (d) the service is provided at, or from, a practice location in a Modified Monash 1 area; (e) the service is rendered in an after-hours period |
| 93637 | After Hours Assessing Patient Suitability for the First Dose of a COVID-19 Vaccine – Modified Monash areas 2-7 | $43.50 | Professional attendance by a medical practitioner (other than a general practitioner) for the purpose of assessing a patient’s suitability for the first dose of a COVID-19 vaccine if all of the following apply: (a) one or both of the following is undertaken, where clinically relevant: (i) a short patient history; (ii) limited examination and management; (b) the patient is eligible for a COVID-19 vaccine; (c) the service is bulk billed; (d) the service is provided at, or from, a practice location in a Modified Monash areas 2-7; (e) the service is rendered in an after-hours period |
| 93644 | Assessing Patient Suitability for the Second or Subsequent Dose of a COVID-19 Vaccine – Business Hours – Modified Monash area 1 | $24.25 | Professional attendance by a general practitioner for the purpose of assessing a patient’s suitability for the second or subsequent dose of a COVID-19 vaccine if all of the following apply: (a) one or both of the following is undertaken, where clinically relevant: (i) a short patient history; (ii) limited examination and management; (b) the patient is eligible for a COVID-19 vaccine; (c) the service is bulk billed; (d) the service is provided at, or from, a practice location in a Modified Monash 1 area |
| 93645 | Assessing Patient Suitability for the Second or Subsequent Dose of a COVID-19 Vaccine – Modified Monash areas 2-7 | $27.55 | Professional attendance by a general practitioner for the purpose of assessing a patient’s suitability for the second or subsequent dose of a COVID-19 vaccine if all of the following apply: (a) one or both of the following is undertaken, where clinically relevant: (i) a short patient history; (ii) limited examination and management; (b) the patient is eligible for a COVID-19 vaccine; (c) the service is bulk billed; (d) the service is provided at, or from, practice locations in Modified Monash 2-7 areas |
| 93646 | Assessing Patient Suitability for the Second or Subsequent Dose of a COVID-19 Vaccine – Modified Monash area 1 | $17.50 | Professional attendance by a medical practitioner (other than a general practitioner) for the purpose of assessing a patient’s suitability for the second or subsequent dose of a COVID-19 vaccine if all of the following apply: (a) one or both of the following is undertaken, where clinically relevant: (i) a short patient history; (ii) limited examination and management; (b) the patient is eligible for a COVID-19 vaccine; (c) the service is bulk billed; (d) the service is provided at, or from, a practice location in a Modified Monash 1 area |
| 93647 | Assessing Patient Suitability for the Second or Subsequent Dose of a COVID-19 Vaccine – Modified Monash areas 2-7 | $24.00 | Professional attendance by a medical practitioner (other than a general practitioner) for the purpose of assessing a patient’s suitability for the second or subsequent dose of a COVID-19 vaccine if all of the following apply: (a) one or both of the following is undertaken, where clinically relevant: (i) a short patient history; (ii) limited examination and management; (b) the patient is eligible for a COVID-19 vaccine; (c) the service is bulk billed; (d) the service is provided at, or from, practice locations in Modified Monash 2-7 areas |
| 93653 | After Hours Assessing Patient Suitability for the Second or Subsequent Dose of a COVID-19 Vaccine – Modified Monash area 1 | $36.40 | Professional attendance by a general practitioner for the purpose of assessing a patient’s suitability for the second or subsequent dose of a COVID-19 vaccine if all of the following apply: (a) one or both of the following is undertaken, where clinically relevant: (i) a short patient history; (ii) limited examination and management; (b) the patient is eligible for a COVID-19 vaccine; (c) the service is bulk billed; (d) the service is provided at, or from, a practice location in a Modified Monash 1 area; (e) the service is rendered in an after-hours period |
| 93654 | After Hours Assessing Patient Suitability for the Second or Subsequent Dose of a COVID-19 Vaccine – Modified Monash areas 2-7 | $39.70 | Professional attendance by a general practitioner for the purpose of assessing a patient’s suitability for the second or subsequent dose of a COVID-19 vaccine if all of the following apply: (a) one or both of the following is undertaken, where clinically relevant: (i) a short patient history; (ii) limited examination and management; (b) the patient is eligible for a COVID-19 vaccine; (c) the service is bulk billed; (d) the service is provided at, or from, practice locations in Modified Monash 2-7 areas; (e) the service is rendered in an after-hours period |
| 93655 | After Hours Assessing Patient Suitability for the Second or Subsequent Dose of a COVID-19 Vaccine – Modified Monash area 1 | $27.50 | Professional attendance by a medical practitioner (other than a general practitioner) for the purpose of assessing a patient’s suitability for the second or subsequent dose of a COVID-19 vaccine if all of the following apply: (a) one or both of the following is undertaken, where clinically relevant: (i) a short patient history; (ii) limited examination and management; (b) the patient is eligible for a COVID-19 vaccine; (c) the service is bulk billed; (d) the service is provided at, or from, a practice location in a Modified Monash 1 area; (e) the service is rendered in an after-hours period |
| 93656 | After Hours Assessing Patient Suitability for the Second Dose of a COVID-19 Vaccine – Modified Monash areas 2-7 | $33.70 | Professional attendance by a medical practitioner (other than a general practitioner) for the purpose of assessing a patient’s suitability for the second or subsequent dose of a COVID-19 vaccine if all of the following apply: (a) one or both of the following is undertaken, where clinically relevant: (i) a short patient history; (ii) limited examination and management; (b) the patient is eligible for a COVID-19 vaccine; (c) the service is bulk billed; (d) the service is provided at, or from, practice locations in Modified Monash 2-7 areas; (e) the service is rendered in an after-hours period |

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| **Mental Health Item Numbers** |
| **Item** | **Name** | **$** | **Description/Recommended Frequency** |
| 2700 | GP Mental Health Treatment Plan | $73.95 | Min 20 minutes. Prepared by GP who has **not** undertaken Mental Health Skills Training. Assessment of patient and preparation of a care plan with option to refer for rebated psychological services. Not more than once yearly. |
| 2701 | GP Mental Health Treatment Plan | $108.85 | Min 40 minutes. Prepared by GP who has **not** undertaken Mental Health Skills Training. Assessment of patient and preparation of a care plan with option to refer for rebated psychological services. Not more than once yearly. |
| 2712 | Review of GP Mental Health Treatment Plan | $73.95 | Plan should be reviewed between 1 – 6 months and no more than 2 per year. |
| 2713 | Mental Health Consultation | $73.95 | Consult ≥ 20 minutes, for the ongoing management of a patient with mental disorder. No restriction on the number of these consultations per year. |
| 2715 | GP Mental Health Treatment Plan | $93.90 | Min 20 minutes. Prepared by GP who **has** undertaken Mental Health Skills Training. Assessment of patient and preparation of a care plan with option to refer for rebated psychological services. Not more than once yearly. |
| 2717 | GP Mental Health Treatment Plan | $138.30 | Min 40 minutes. Prepared by GP who **has** undertaken Mental Health Skills Training. Assessment of patient and preparation of a care plan with option to refer for rebated psychological services. Not more than once yearly. |
| 2721 | GP Focussed Psychological Strategies | $95.65 | 30 – 40 minutes. Provision of focussed psychological strategies by an appropriately trained and registered GP working in an accredited practice. |
| 2723 | GP Focussed Psychological Strategies | Derived fee | Out of surgery consultation. 30 – 40 minutes. Provision of focussed psychological strategies by an appropriately trained and registered GP working in an accredited practice. |
| 2725 | GP Focussed Psychological Strategies | $136.85 | >40 minutes. Provision of focussed psychological strategies by an appropriately trained and registered GP working in an accredited practice. |
| 2727 | GP Focussed Psychological Strategies | Derived fee | Out of surgery consultation. >40 minutes. Provision of focussed psychological strategies by an appropriately trained and registered GP working in an accredited practice. |
| 93300 | COVID-19 Additional focussed psychological strategies | $95.65 | GP, focussed psychological strategies treatment service, 30 - 40 minutes, GP registered with Chief Executive Medicare, patient to access 10+ Better Access services |
| 93303 | COVID-19 Additional focussed psychological strategies | $136.85 | GP, focussed psychological strategies treatment service, at least 40 minutes, GP registered with Chief Executive Medicare, patient to access 10+ Better Access services |

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| **Skin Procedures** |
| **Item** | **Name** | **$** | **Description/Recommended Frequency** |
| 30071 | Biopsy of skin | $45.80 | Diagnostic skin biopsy |
| 30072 | Biopsy of mucous membrane | $45.80 | Diagnostic biopsy of mucous membrane, as an independent procedure, if the biopsy is sent for pathological examination |
| 30192 | Cryotherapy >10 lesions | $34.70 | Premalignant lesion treatment (>10) by ablative techniques |
| 30202 | Malignant cryotherapy <10 | $42.40 | Cryotherapy for removal of malignant neoplasm of skin or mucous membrane |
| 30196 | Shave Excision Malignant Neoplasm <10 | $110.70 | Malignant neoplasm of skin or mucous membrane proven by histopathology or confirmed by specialist opinion, removal of, by serial curettage or carbon dioxide laser or erbium laser excision ablation, including any associated cryotherapy or diathermy |
| 31357 | Nose, lip, ear, digit, genitalia, eyelid, eyebrow, or contagious area <6mm | $96.15 | Non-malignant skin lesion where the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit, or genitalia, or from a contagious area and the necessary excision diameter is less than 6mm |
| 31360 | Nose, lip, ear, digit, genitalia, eyelid, eyebrow, or contagious area >6mm | $147.35 | Non-malignant skin, where the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit, or genitalia, or from a contagious area, and the necessary excision diameter is 6mm or more |
| 31362 | Face, neck, scalp, nipple, lower leg, distal upper limb <14mm | $117.40 | 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 | $147.35 | 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 | $83.70 | 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 | $110.05 | 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 | $125.85 | 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 |
| 31356 | Nose, lip, ear, digit, genitalia, eyelid, eyebrow <6mm | $194.05 | Malignant skin lesion where the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit, or genitalia, or from a contagious area and the necessary excision diameter is less than 6mm |
| 31358 | Nose, eyelid, eyebrow, lip, ear, digit, genitalia, contiguous area >6mm | 237.45 | 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 | $255.40 | 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 | $163.70 | 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-areola, distal upper and distal lower limb >14mm | $214.15 | 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 | Body <15mm | $138.80 | 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 | Body 15-30mm | $187.25 | 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 | Body >30mm | $215.60 | Malignant skin lesion where the lesion is excised from any other part of the body, and the necessary excision diameter is more than 30mm |
| 31371 | Nose, lip, ear, digit, genitalia, eyelid, eyebrow, or contiguous area >6mm | $312.95 | 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 | $270.60 | 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 | $312.80 | 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 14mmn or more |
| 31374 | Body <15mm | $247.10 | Malignant tumour, where the tumour is excised from any other part of the body, and the necessary excision diameter is less than 15mm |
| 31375 | Body 15-30mm | $265.95 | 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 | Body >30mm | $308.25 | Malignant tumour, where the tumour is excised from any other part of the body, and the necessary excision diameter is more than 30mm |
| 30026 | Superficial, other than on face or neck <7cm | $45.80 | Skin and subcutaneous tissue or mucous membrane, repair of wound not on face or neck, small no more than 7cm long |
| 30029 | Small deep wound repair <7cm (not face/neck) | $78.90 | 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 | Small superficial wound repair <7cm (on face/neck) | $72.30 | 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 | $103.10 | 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 | $78.90 | 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 | $103.10 | 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 | $162.70 | 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 | $222.65 | Full thickness laceration of ear, eyelid, nose or lip, repair of with accurate apposition of each layer of tissue |

Allied Health Services

**Allied Health Services for Chronic Conditions Requiring Team Care**

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

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

|  |  |  |
| --- | --- | --- |
| **Item** | **Name** | **Description/Recommended Frequency** |
| 10950 | Aboriginal Health Worker Services | * Allied Health Provider must be Medicare registered
* Maximum of 5 allied health services per patient per calendar year
* Can be 5 sessions with one provider or a combination e.g. 3 dietitian and 2 diabetes education sessions
* GP refers to allied health professional using “Referral Form for Chronic Disease Allied Health (Individual) Services under Medicare” or a referral form containing all components. One for each provider
* Services must be at least 20 minutes duration and provided to an individual not a group
* Allied health professionals must report back to the referring GP after first and last visit
 |
| 10951 | Diabetes Educator Services |
| 10952 | Audiologist Services |
| 10953 | Exercise Physiologist Services |
| 10954 | Dietitian Services |
| 10958 | Occupational Therapist Services |
| 10960 | Physiotherapist Services |
| 10962 | Podiatrist Services |
| 10964 | Chiropractor Services |
| 10966 | Osteopath Services |
| 10970 | Speech Pathologist Services |
| 10956 | Mental Health Worker Services | * For mental health conditions, use Better Access Mental Health Care items – 10 sessions
* For chronic physical conditions, use GPMP and TCA – 5 sessions
* Better access and GPMP can be used for the same patient where eligible
 |
| 10968 | Psychologist Services |

Allied Health Group Services for Patients with Type 2 Diabetes

For a comprehensive explanation of each MBS Item number, please refer to the Medicare Benefits Schedule online at [www.mbsonline.gov.au](http://www.mbsonline.gov.au)

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| **Assessment and Provision of Group Services***GP must have completed a GP Management Plan (721), or reviewed an existing GPMP (732), or contributed to, or reviewed a Multidisciplinary Care Plan in a Residential Aged Care Facility (731).* |
| **Item** | **Name** | **Description/Recommended Frequency** |
| 81100 | Assessment for Group Services by Diabetes Educator | * One assessment session only by either Diabetes Educator, Exercise Physiologist or Dietitian per calendar year
* Medicare Allied Health Group Services for Type 2 Diabetes Referral Form
 |
| 81110 | Assessment for Group Services by Exercise Physiologist |
| 81120 | Assessment for Group Services by Dietitian |
| 81105 | Diabetes Education Group Services | * 8 group services per calendar year, can be 8 sessions with one provider or a combination e.g. 3 diabetes education, 3 dietitian and 2 exercise physiology sessions
* Medicare Allied Health Group Services for Type 2 Diabetes Referral Form
 |
| 81115 | Exercise Physiologist – Group Service |
| 81125 | Dietetic Service – Group Service |

After Hours Services

|  |  |  |  |
| --- | --- | --- | --- |
| **Attendance Period** | **Item No** | **MBS Payment** | **Brief Guide** |
| **Urgent attendance – after hours** | 585 (GP)[[1]](#footnote-2)588 (Non-VR GP, rural area)[[2]](#footnote-3)591 (Non-VR GP metropolitan area) 594 (additional patients at one location)2 | $133.90$133.90$92.80$43.25 | * These items can only be used for the first patient, if more than one patient is seen on the one occasion, standard (non-urgent) after hours items apply.
* The urgent after-hours items can only be used where the patient has a medical condition that requires urgent assessment which could not be delayed until the next in-hours period.
* For consultations at the health centre it is necessary for the practitioner to return to, and specially open the consulting rooms for the attendance.
 |
| **Mon – Fri**7 – 8am and6 – 11pm | **Sat**7 – 8am and12 noon – 11pm | **Sun & Pub Holidays**7am – 11pm |
| **Urgent attendance – unsociable hours**Between 11pm-7am | 599 (GP)1600 (Non-VR GP) | $157.80$126.10 |
| **Non-urgent after hours at a place other than consulting rooms****Mon – Fri**Before 8am or after 6pm**Sat**Before 8am or after 12pm**Sun & Pub Holidays**All day | Home5003 (Brief)5023 (Standard)5043 (Long)5063 (Prolonged)RACFs5010 (Brief)5028 (Standard)5049 (Long)5067 (Prolonged) | $56.65$77.30$113.35$148.20$78.05$98.70$134.75$169.60 |
| **In the surgery** | GP:5000 (Brief)5020 (Standard)5040 (Long)5060 (Prolonged)Non-VR GP:5220522352275228 | $29.90$98.70$86.60$121.45$18.50$26.00$45.50$67.50 |
| The above MBS Payments are for the 1st patient only. Please refer to MBS Online for multiple patient fee schedules. |

GP Multidisciplinary Case Conferences

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

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.

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| **Item** | **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 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 9-12 months). |
| 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 |
| 81350 | Osteopathy Health Service |
| 81355 | Psychology Health Service |
| 81360 | Speech Pathology Health Service |

Health Assessments

For a comprehensive explanation of each MBS Item number, please refer to the Medicare Benefits Schedule online at [www.mbsonline.gov.au](http://www.mbsonline.gov.au)

|  |  |  |
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| **Item** | **Name** | **Description/Recommended Frequency** |
| 699 | Heart Health Assessment | >20 minutes1. Collection of relevant information including taking a patient history that is aimed at identifying cardiovascular disease risk factors, including diabetes status, alcohol intake, smoking status, cholesterol status (if not performed within the last 12 months) and blood glucose.
2. A physical examination, which must include recording of blood pressure.
3. Initiating interventions and referrals to address the identified risk factors.
4. Implementing management plan for appropriate treatment of identified risk factors.
5. Providing the patient with preventative health care advice and information, including lifestyle factors.
 |
| 701 | Brief Health Assessment | 30 minutes1. Collection of relevant information, including taking a patient history.
2. A basic physical examination.
3. Initiating interventions and referrals as indicated.
4. Providing the patient with preventive health care advice and information.

Incorporating:* **Health Assessment – Type 2 Diabetes Risk Evaluation**

Provision of lifestyle modification advice and interventions for patients aged 40-49 years who score ≥ 12 on AUSDRISK. Once every 3 years.* **Health Assessment – 45 – 49 Year Old**

Once only health assessment for patients 45 – 49 years who are at risk of developing a chronic disease.* **Health Assessment – 75 Years and Older**

Health assessment for patients aged 75 years and older. Once every 12 months.* **Health Assessment – Comprehensive Medical Assessment**

Comprehensive Medical Assessment for permanent residents of Residential Aged Care Facilities. Available for new and existing residents. Not more than once yearly.* **Health Assessment for patient with Intellectual Disability**

Health assessment for patient with Intellectual Disability. Not more than once yearly.* **Health Assessment for Refugees and other Humanitarian Entrants**

Once only health assessment for new refugees and other humanitarian entrants, as soon as possible after their arrival (within 12 months of their arrival).A desktop guide – Caring for Refugee Patients in General Practice is available on the RACGP website [www.racgp.org.au](http://www.racgp.org.au) |
| 703 | Standard Health Assessment | 30 – 44 minutes1. Detailed information collection, including taking patient history.
2. An extensive physical examination.
3. Initiating interventions and referrals as indicated.
4. Providing a preventative health care strategy for the patient.
 |
| 705 | Long Health Assessment | 45 – 49 minutes1. Comprehensive information collection, including taking a patient history.
2. An extensive examination of the patient’s medical condition and physical function.
3. Initiating interventions and referrals and indicated.
4. Providing a basic preventive health care management plan for the patient.

Incorporating the Health Assessment categories listed in 701. |
| 707 | Prolonged Health Assessment | >60 minutes1. Comprehensive information collection, including taking a patient history.
2. An extensive examination of the patient’s medical condition, and physical, psychological and social function.
3. Initiating interventions and referrals as indicated.
4. Providing a comprehensive preventive health care management plan for the patient.

Incorporating the Health Assessment categories listed in 701. |
| 715 | Aboriginal and Torres Strait Islander People Health Assessment  | No designated time or complexity requirements.Incorporating:* **Aboriginal and Torres Strait Islander Child Health Assessment**

Health Assessment for Indigenous patients 0 – 14 years old. Not available to inpatients of hospitals or RACF. Not more than once every 9 months.* **Aboriginal and Torres Strait Islander Adult Health Assessment**

Health Assessment for Indigenous patients 15 – 54 years old. Not available to inpatients of hospitals or RACF. Not more than once every 9 months.* **Aboriginal and Torres Strait Islander Health Assessment for an Older Person**

Health Assessment for Indigenous patients 55 years and over. Not available to inpatients of hospitals or RACF. Not more than once every 9 months. |

Residential Aged Care Facility Item Numbers

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

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| **Item** | **Name** | **Description/Recommended Frequency** |
| 701 | Brief Health Assessment | 30 minutes – see MBS for complexity of care requirementsIncorporating:**Health Assessment – Comprehensive Medical Assessment**Comprehensive Medical Assessment (CMA) for permanent residents of Residential Aged Care Facilities. Available for new and existing residents. Not more than once yearly. |
| 703 | Standard Health Assessment | 30 – 44 minutes – see MBS for complexity of care requirements.Incorporating:**Health Assessment – CMA** |
| 705 | Long Health Assessment | 45 – 60 minutes – see MBS for complexity of care requirements.Incorporating:**Health Assessment – CMA** |
| 707 | Prolonged Health Assessment | >60 minutes – see MBS for complexity of care requirements.Incorporating:**Health Assessment – CMA** |
| **CMA Activities:*** Time based, see MBS for complexity of care requirements for each item.
* CMA requires assessment of the resident’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 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
* Give advice to a person (e.g. nursing staff in RACF) who prepares or reviews the plan and record in writing any advice provided on the patient’s medical records.
 |
| 735 | Organise and coordinate a case conference | 15 – 19 minutes. GP organises and coordinates case conference in RACF, community, or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs. |
| 739 | Organise and coordinate a case conference | 20 – 39 minutes. GP organises and coordinates case conference in RACF, community, or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs. |
| 743 | Organise and coordinate a case conference | >40 minutes. GP organises and coordinates case conference in RACF, community, or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs. |
| 747 | Participate in a case conference | 15 – 20 minutes. GP participates in a case conference in RACF, community, or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs. |
| 750 | Participate in a case conference | 30 – 40 minutes. GP participates in a case conference in RACF, community, or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs. |
| 758 | Participate in a case conference | >40 minutes. GP participates in a case conference in RACF, community, or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs. |
| **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, participant names, all matters discussed and identified;
* Discuss outcomes with patient and carer and offer a summary of the conference to them and team members
* Keep records in the patient’s medical file
 |
| **Telehealth – Residential MBS Items**Professional attendance by a general practitioner at a Residential Aged Care Facility that requires the provision of clinical support to a patient who is:1. A care recipient receiving care in a residential aged care service (other than a professional attendance at a self-contained unit); or
2. 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. |

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| **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 a 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
* 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 exemptions apply) regarding the findings, medication management strategies issues, implementation, follow up and outcomes.

Develop and/or review Medication Management Plan and finalise plan after discussion with resident. |

Systematic Care Claiming Rules

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| --- | --- | --- |
| **MBS Item Number** | **Name** | **Recommended Months Until Next Claim for Service** |
| 721\* | GP Management Plan (GPMP) | 24 |
| 723\* | Team Care Arrangement (TCA) | 6 |
| 732\*\* | Review of GPMP and/or TCA | 6 |
| 900 | Home Medication Review | 12 |
| 2700/2701 | GP Mental Health Treatment Plan | 12 |
| 2712\*\*\* | Review of GP Mental Health Treatment Plan | 3 |
| 2713 | GP Mental Health Consultation |  |
| 2715/2717 | GP Mental Health Treatment Plan | 12 |

Additional Claiming Rules

\*721 & 723 Recommended claiming period 24 months minimum claiming period 12 months.

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

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

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

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

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

**Perform records search to identify “at risk” patients**

**Eligibility Criteria**

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

**Identify Risk Factors**

**Clinical Content**

* Explain Health Assessment process and gain consent
* Evaluate the patient’s high risk score determined by AUSDRISK, which has been completed within a period of 3 months prior to undertaking Type 2 Diabetes Risk Evaluation
* Update patient history and undertake physical examinations and clinical investigations in accordance with relevant guidelines

**Perform Health Check**
Nurse may collect information, GP must see patient.

* Make an overall assessment of the patient’s risk factors, and results of relevant examinations and investigations
* Initiate interventions where appropriate, and follow-up relating to management of any risk factors identified
* Provide advice and information, such as Lifescripts resources, including strategies to achieve lifestyle and behaviour changes

**Essential Documentation Requirements**

* Record patient’s consent to Health Assessment
* Completion of AUSDRISK is mandatory, with score of ≥ 12 points required to claim; update patient history

**Claim MBS Item**

* 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

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

Heart Health Assessment – Item 699

**Perform records search to identify “at risk” patients**

**Eligibility Criteria**

* Aboriginal or Torres Strait Islander persons who are aged 30 years and above
* Adults aged 45 years and above
* The absolute cardiovascular disease risk must be calculated as per the Australian Absolute Cardiovascular Disease Risk Calculator which can be viewed at <http://www.cvdcheck.org.au/calculator/>
* Not for patients in hospital

**Identify Risk Factors**

**Risk Factors**

Include, but are not limited to:

* Lifestyle: Smoking, physical inactivity, poor nutrition, alcohol use, biomedical, high cholesterol, high BP, impaired glucose metabolism, excessive weight
* Family history of chronic disease

**Clinical Content**

**Perform Health Check**
Nurse may collect information, GP must see patient.

Mandatory

* Explain Health Assessment process and gain consent
* Collection of relevant information including taking a patient history that is aimed at identifying cardiovascular disease risk factors, including diabetes status, alcohol intake, smoking status, cholesterol status (if not performed within the last 12 months) and blood glucose
* A physical examination, which must include recording of blood pressure
* Initiating interventions and referrals to address the identified risk factors
* Implementing a management plan for appropriate treatment of identified risk factors
* Providing the patient with preventative health care advice and information, including modifiable lifestyle factors

**Claim MBS Item**

Non-mandatory

* Written patient information is recommended

**Claiming**

* All elements of the service must be completed to claim

|  |  |  |  |
| --- | --- | --- | --- |
| ***MBS Item*** | ***Name*** | ***Age Range*** | ***Recommended Frequency*** |
| 699 | Heart Health Assessment | * Aboriginal and Torres Strait Islander over 30 years
* Adults over 45 years
 | Annually |

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

**Perform records search to identify “at risk” patients**

 **Eligibility Criteria**

* Patients aged 45 – 49 years inclusive
* Must have an identified risk factor for chronic disease
* Not for patients in hospital

 **Risk Factors**

 Include, but are not limited to:

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

**Identify Risk Factors**

* Family history of chronic disease

 **Clinical Content**

Mandatory

* Explain Health Assessment process and gain consent
* Information collection – takes patient history, undertake examinations and investigations as clinically required
* Overall assessment of the patient’s health, including their readiness to make lifestyle changes

**Perform Health Check**
Nurse may collect information, GP must see patient.

* Initiate interventions and referrals as clinically indicated. Advice and information about lifestyle modification programs and strategies to achieve lifestyle and behaviour changes

Non – Mandatory

* Written patient information is recommended

**Essential Documentation Requirements**

* Record patient’s consent to Health Assessment

**Claim MBS Item**

* Record the Health Assessment and offer the patient a copy

 **Claiming**

* All elements of the service must be completed to claim

|  |  |  |  |
| --- | --- | --- | --- |
| ***MBS Item*** | ***Name*** | ***Age Range*** | ***Recommended Frequency*** |
| 701, 703, 705, 707 | Health Assessment – 45 – 49 Year Old | 45 – 49 Years | Once only |

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

**Establish a patient register and recall when due for assessment**

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

**Eligibility Criteria**

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

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

**Clinical Content**Mandatory

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

**Complete Documentation**

Non-Mandatory

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

**Claim MBS Item**

**Essential Documentation Requirements**

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

 **Claiming**

* All elements of the service must be completed to claim

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

Aboriginal and Torres Strait Islander People – Health Assessment – Item 715

**GP performs Health Assessment 715.

 Nurse/ATSIHW/
ATSIHP may collect information.

GP must see patient.**

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

**Items 81300 to 81360 – Allied Health Service**

**Eligibility Criteria**

* Items 81300 to 81360 with the exception of 81305 (which does not require a health assessment) are in addition to items 10950 to 10970 and provide an alternative to the referral pathway to access Allied Health Services

**Claim MBS Item 715**

* Items available to individual patients only, not a group service
* This patient is not an admitted patient of a hospital
* Eligible patients may access Medicare rebates for up to 5 allied health services in a calendar year. Allied Health Professionals may set their own fees. Charges in excess of the Medicare benefit for these items are the responsibility of the patient

**If Allied Health Service is required**

**Essential Documentation Requirements**

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

 Mandatory

**Allied Health Service**
Must be of at least 20 minutes duration. Allied Health Professional must perform Service personally

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

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

**Allied Health must provide written report to GP**

Optional

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

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

Domiciliary Medication Management Review (DMMR) – Item 900

Also known as Home Medicines Review (HMR)

**Ensure Patient Eligibility**

**Eligibility Criteria**

* Patients at risk of medication related problems or for whom quality use of medications may be an issue
* Not for patients in hospital or a Residential Aged Care Facility

**First GP Visit** Discussion and referral to pharmacist

**Initial Visit with GP**

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

**HMR Interview** Conducted by accredited pharmacist

**HMR Interview**

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

**Second GP Visit** Discuss and develop medication management plan

**Second GP Visit**

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

**Claim MBS Item**

**Claiming**

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

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| ***MBS Item*** | ***Name*** | ***Recommended Frequency*** |
| 900 | Domiciliary Medication Management Review | Once every 12 months |

Residential Medication Management Review (RMMR) – Item 903

**Ensure Patient Eligibility**
Patients likely to benefit from review

**Eligibility Criteria**

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

**Refer to Pharmacist**
Obtain patient/carer consent

**GP Initiates Serviced**

* Explain RMMR process and gain resident’s consent
* Send referral to accredited pharmacist to request collaboration in medication review
* Provide input form Comprehensive Medical Assessment of relevant clinical information for RMMR and the resident’s records

 **Accredited Pharmacist Component**

**Medication Review**by pharmacist

* Review resident’s clinical notes and interview resident
* Prepare Medication Review report and send to GP

 **GP and Pharmacist Post Review Discussion**

**Post Review Discussion**
Face to face or by phone

* 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**

**Complete Documentation**

* 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 cop for resident’s records and for nursing staff at RACF, discuss plan with nursing staff if necessary

**Claim MBS Item**

 **Claiming**

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

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

GP Management Plan (GPMP) – Item 721

**Ensure Patient Eligibility**

**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

**Develop Plan**
Nurse/ATSIHW/
ATSIHP may collect information. GP must see patient.

 **Clinical Content**

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

 **Essential Documentation Requirements**

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

 **Claiming**

**Complete Documentation**

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

**Claim MBS Item**

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

Team Care Arrangement (TCA) – Item 723

**Ensure Patient Eligibility**

 **Eligibility Criteria**

* No age restrictions for patients
* Patients with a chronic or terminal condition and complex care needs
* Patients who need ongoing care from a team including the GP and at least 2 other health and care providers
* Not for public patients in a hospital or patients in a Residential Aged Care Facility

**Develop TCA**
Nurse/ATSIHW/
ATSIHP may collect information and collaborate with providers. GP must see patient.

**Clinical Content**

* Explain steps involved in TCA, possible out of pocket costs, gain consent
* Treatment and service goals for the patient
* Discuss with patient which 2 providers the GP will collaborate with and the treatment and services the 2 providers will deliver
* Actions to be taken by the patient
* Gain patient’s agreement on what information will be shared with other providers
* Ideally list all health and care services required by the patient
* Obtain potential collaborating providers’ agreement to participate
* Consult with the 2 collaborating providers and obtain feedback on treatment/services they will provide to achieve patient goals

 **Essential Documentation Requirements**

* Record patient’s consent to TCA
* Goals, collaborating providers, treatment/services, actions to be taken by patient
* Set review date

**Complete Documentation**

* Send copy of relevant parts to collaborating providers
* Offer the patient a copy (with consent, offer to carer), keep copy in patient file

 **Claiming**

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

**Claim MBS Item**

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

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

Reviewing a GP Management Plan

**Clinical Content**

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

**Essential Documentation Requirements**

**Ensure patient eligibility**

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

**Claiming**

* All elements of the service must be completed to claim
* Item 732 should be claimed at least once over the life of the plan

**Develop Plan**

**Nurse/ATSIHW/ATSIHP may collect information.**

**GP must see patient.**

* Cannot be claimed within 3 months of a GPMP (Item 721)
* Item 732 can be claimed twice on same day if review of both GPMP and TCA are completed, in this case, the Medicare claim should be annotated

Reviewing a Team Care Arrangement (TCA)

**Clinical Content**

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

 **Essential Documentation Requirements**

* Record patient’s agreement to review

**Complete Documentation**

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

 **Claiming**

* All elements of the service must be completed to claim
* Requires that there has been personal attendance by GP to assess and gain consent
* Item 732 should be claimed at least once over the life of the TCA

**Claim MBS Item**

* Cannot be claimed within 3 months of a TCA (Item 723)
* Item 732 can be claimed twice on same day if review of both GPMP and TCA are completed, in this case, the Medicare claim should be annotated.

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

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

2700/2701 – prepared by a GP who **has not** undertaken mental health skills training

2715/2717 – prepared by a GP who **has** undertaken mental health skills training

**Ensure Patient Eligibility**

**Eligibility Criteria**

* No age restrictions for patients
* Patients with a mental disorder, excluding dementia, delirium, tobacco use disorder and mental retardation (without mental health disorder)
* Patients who will benefit from structured approach to their treatment
* Not for patients in a hospital or patients in a Residential Aged Care Facility

 **Clinical Content**

* Explain steps involved, possible out of pocket costs, gain patient’s consent
* Relevant history – biological, psychological, social and presenting complaint
* Mental state examination, assessment of risk and co-morbidity, diagnosis of mental disorder and/or formulation
* Outcome measurement tool score (eg K10), unless clinically inappropriate
* Provide psycho-education

**Develop Plan**

* Plan for crisis intervention/relapse prevention, if appropriate
* Discuss diagnosis/formulation, referral and treatment options with the patient
* Agree on management goals with the patient and confirm actions to be taken by the patient
* Identify treatments/services required and make arrangements for these

 **Essential Documentation Requirements**

**Complete Documentation**

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

 **Claiming**

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

**Claim MBS Item**

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

Review of the Mental Health Treatment Plan – Item 2712

 **Clinical Content**

* Explain steps involved, possible out of pocket costs, gain patient’s consent
* Review patient’s progress against goals outlined in the GP Mental Health Treatment Plan

**Review the Plan
A credentialed mental health nurse, ATSIHW/ATSIHP can assist.**

* Check, reinforce and expand psycho-education
* Plan for crisis intervention and/or relapse prevention, if appropriate and if not-previously provided
* Re-administer the outcome measurement tool used when developing the GP Mental Health Treatment Plan (Item 2700, 2701, 2715, 2717), except where considered clinically inappropriate

**Essential Documentation Requirements**

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

**Complete Documentation**

**Claiming**

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

**Claim MBS Item**

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

**Practice Incentive Payment Summary**

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| *Item* | *Activity* | *PIP**($ per SWPE)* | *Notes (PIP Enquiry Line 1800 222 032)**http://www.humanservices.gov.au* |
| eHealth Incentive | **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 prescriptions.**Requirement 5:**My Health Record system. | $6.50 per SWPE, per annumCapped at $12 500 per quarter | To qualify, practices must meet each of the requirements:**Requirement 1:*** Apply for a Health Care Provider Identifier-Organisation (HPI-O)
* Ensure each GP within the practice has a Healthcare Provider Identifier – Individual (HPI-I)
* Use a compliant clinical software system to access, retrieve and store verified individual Healthcare Identifiers (IHI) for patients

**Requirement 2:*** Apply for a NASH PKI Certificate
* Have a standards-compliant secure messaging capability and use it where feasible
* Work with your secure messaging vendor to ensure it is installed and configured correctly
* Have a written policy to encourage its use

**Requirement 3:*** Be working towards recording the majority of diagnoses electronically using a medical vocabulary that can be mapped against a nationally recognised disease classification or terminology system
* Provide written policy to this effect to all GPs

**Requirement 4:*** Use a software system that is able to send an electronic prescription to a Prescription Exchange Services (PES)
* The majority of prescriptions are sent electronically to a PES

**Requirement 5:*** Use a compliant software to access the My Health Record system and create and post Shared Health Summaries (SHS) and Event Summaries
* Apply to participate in the My Health Record system upon obtaining a HPI-O
* Upload Shared Health Summaries for a minimum of 0.5% of the practice’s SWPE count of patients per PIP payment quarter

 Please refer to the ePIP Incentive guidelines released by Medicare Australia.<https://www.humanservices.gov.au/health-professionals/services/medicare/practice-incentives-program>  |

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| *Item* | *Activity* | *PIP**($ per SWPE)* | *Notes (PIP Enquiry Line 1800 222 032)**https://www.humanservices.gov.au* |
| Quality Improvement Incentive | The PIP QI Incentive rewards practices for participating in continuous quality improvement activities in partnership with their local PHN | Maximum payment of $12 500 per quarter, based on $5.00 SWPE | To be eligible to receive PIP QI payment general practices must:* Be eligible for the PIP
* Register for the PIP QI Incentive (via PRODA) from 01/08/19
* Electronically submit the de-identified PIP Eligible Data Set to their local PHN quarterly via an agreed Data Extraction Tool
* Undertake continuous quality improvement activities in partnership with their local PHN.

Commences on 1st August 2019For further information:<https://www.health.gov.au/internet/main/publishing.nsf/Content/PIP-QI_Incentive_guidance> |
| Teaching Payment | Aims to encourage general practices to provide teaching sessions to undergraduate and graduate medical students preparing for entry into the Australian Medical profession. | $200 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 day. |

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| *Item* | *Activity* | *PIP**($ per SWPE)* | *Notes (PIP Enquiry Line 1800 222 032)**https://www.humanservices.gov.au* |
| Aged Care Access Incentive | **Tier 1:**GP completes the Qualifying Service Level (QSL) 1 – 60 MBS services in RACF claimed in a financial year.**Tier 2:**GP completes the Qualifying Service Level (QSL) 2 – 140 MBS services in RACF claimed in a financial year. | $1500 per financial year$3500 per financial year | MBS items that count towards QSLs include attendances in RACF, contributions to multidisciplinary care plans and Residential Medication Management Reviews. 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. |
| Indigenous Health Incentive | Provision of better health care for Indigenous patients, including best practice management of chronic disease.Sign-on payment. | $1000 | One-off payment only. Practice must be registered for PIP – Practice:* Seeks consent to register their Aboriginal and/or Torres Strait Islander (ATSI) patients (regardless of age) who have, or are at risk, of chronic disease, with Medicare and the practice for chronic disease management in a calendar year
* Establishes a mechanism to ensure their ATSI patients aged 15 years and over with chronic disease, are followed up eg recall/reminder system to ensure they return for ongoing care
* Undertakes cultural awareness training within 12 months of joining incentive
* Annotates PBS prescriptions for eligible ATSI patients for the PBS Co-payment
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| *Item* | *Activity* | *PIP**($ per SWPE)* | *Notes (PIP Enquiry Line 1800 222 032)**https://www.humanservices.gov.au* |
| Indigenous Health Incentive - continued | Annual patient registration payments | $250 per registered ATSI patient, per calendar year | * Practice registers their eligible ATSI patients with Medicare for the PIP Indigenous Health Incentive or PBS Co-payment measure
* Practice must actively plan and manage care of their ATSI patients with chronic disease for a calendar year
* Payment made to practice for each ATSI patient who:
* Is aged 15 years or over & has chronic disease
* Has had (or has been offered) the 715 ATSI Health Assessment
* Has provided informed consent to be registered for the PIP Indigenous Health Incentive
* The patient’s registration period commences from the day they provide consent to participate in the incentive, and will end on the 31 December that year
* Practices are required to obtain consent to re-register patients each year
 |
| **Tier 1:**Outcomes payment: Chronic Disease Management | $100 per registered patient per calendar year | Payment made to practices that (in a calendar year):* Develop a 721 GP Management Plan or 723 Team Care Arrangement for the patient and undertake at least one 732 Review of the GPMP or TCA; or
* Undertake two 732 Reviews of GPMP or TCA; or
* Complete 731 contribute to, or review, a care plan for a patient in a RACF, on two occasions
 |
| **Tier 2:**Outcomes payment:Total Patient Care | $150 per registered patient per calendar year | * Payment made to practices that provide the majority (ie the highest number) of MBS services for the patient (with minimum of 5 MBS services) in a calendar year. This may include the MBS services provided for Tier 1.
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| *Item* | *Activity* | *PIP**($ per SWPE)* | *Notes (PIP Enquiry Line 1800 222 032)**https://www.humanservices.gov.au* |
| After Hours Incentive | The After Hours Incentive aims to support general practices to provide their patients with appropriate access to after-hours care.**After hours periods:**For PIP the complete after hours period is: The complete after hours period is broken into:* Outside 8am to 6pm weekdays - Sociable after hours period: 6pm to 11pm weeknights
* Outside 8am to 12 noon on Saturdays - Unsociable after hours period: 11pm to 8am weekdays, hours outside of
* All day on Sundays and public holidays 8am and 12 noon Saturdays, and all day Sundays and public holidays

**Core Eligibility Requirements**To be eligible for the PIP After Hours Incentive, practices must meet the following core eligibility requirements:1. Be registered for the PIP and meet the requirements for the payment level claimed for the entire quarter before the payment month
2. Provide after hours care for patients in accordance with the RACGP Standards for general practices
3. Clearly communicate after hours arrangements to patients, including information available within the practice, on the practice website or through a telephone answering machine

Guidelines and requirements for the new PIP After Hours Incentive are available at the Department of Human Services website. Please visit <https://www.humanservices.gov.au/health-professionals/services/practice-incentives-programme/pip-after-hours-incentive> or contact the PIP Enquiry Line on 1800 222 032. |
| **Payment level and amount** | **Description** |
| Level 1 Participation $1 per SWPE | Practices must have formal arrangements in place to ensure that practice patients have access to care in the complete after hours period (hours outside of 8am to 6pm weeknights; hours outside of 8am to 12pm Saturdays; and all day Sundays and public holidays). |

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| *Item* | *Activity* | *PIP**($ per SWPE)* | *Notes (PIP Enquiry Line 1800 222 032)**https://www.humanservices.gov.au* |
| After Hours Incentive - continued | **Payment level and amount** | **Description** |
| Level 2 Sociable after hours cooperative coverage $4 per SWPE | Practices must participate in cooperative arrangement with other general practices that provide after hours care to practice patients in the sociable after hours period (6pm to 11pm weeknights) and ensure formal arrangements are in place to cover the unsociable after hours period (11pm to 8am weekdays, hours outside of 8am to 12pm Saturdays and all day Sundays and public holidays). |
| Level 3 Sociable after hours practice coverage $5.50 per SWPE | Practices must provide after hours care to practice patients directly through the practice in the sociable after hours period (6pm to 11pm weeknights); and ensure formal arrangements are in place to cover the unsociable after hours period (11pm to 8am weekdays, hours outside of 8am and 12pm Saturdays and all day Sundays and public holidays). |
| Level 4 Complete after hours cooperative coverage $5.50 per SWPE | Practices must participate in a cooperative arrangement with other general practices that provides after hours care to practice patients for the complete after hours period (hours outside of 8am to 6pm weeknights; hours outside of 8am to 12pm Saturdays; and all day Sundays and public holidays). |
| Level 5 Complete after hours practice coverage $11 per SWPE | To be eligible for the Level 5 Complete After Hours Practice Coverage Payment, practices must provide after hours care to practice patients in the complete after hours period (hours outside of 8am to 6pm weeknights; hours outside of 8am to 12pm Saturdays; and all day Sundays and public holidays). |

1. 585 and 599 available to medical practitioners who are vocationally registered or vocationally recognised or practitioners who are holders of FRACGP who participate RACGP Quality Assurance and Continuing Medical Education program or ACRRM professional development program or undertaking an approved placement in general practice as part of a training program. [↑](#footnote-ref-2)
2. Professional attendance by a medical practitioner – each additional patient at an attendance that qualifies for item 585, 588 or 591 in relation to the first patient. [↑](#footnote-ref-3)