Desktop guide to frequently used MBS item numbers for General Practice

November 2023

phn BRISBANE NORTH

An Australian Government Initiative

INTRODUCTION

This Desktop Guide is intended as a resource manual to assist General Practice staff. For current and comprehensive information about each MBS item number, please refer to the Medicare Benefits Schedule at MBS Online www.mbsonline.gov.au. MBS Online is frequently updated as changes to the MBS occur.

FEEDBACK/COMMENTS

If you have any enquiries, or would like to provide feedback or comments regarding information provided in this Guide, please contact Brisbane North PHN Primary Care Support via email practicesupport@brisbanenorthphn.org.au or phone 07 3490 3495.

DISCLAIMER

Whilst every effort has been made to ensure that the information included in this Desktop Guide is current and up to date, you should exercise your own independent skill and judgement before relying on it. Refer to MBS Online for current information

CONTACT DETAILS

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Web: www.brisbanenorthphn.org.au

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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

Effective July 2022 - # Benefit is 85% of the Schedule fee (value show is the Rebate85 amount)

IN SURGERY

Service	Face to Face	Telehealth (Video) Items *	Telehealth (Phone) Items *	Rebate
Phone attendance ≥ 20 mins for assessment and management of COVID-19 infection for the purpose of oral antiviral treatment eligibility			93716	$79.70
Routine Hours Consultations – In the Surgery				
Attendance brief	3	91790	91890	$18.95
Attendance 6-19 minutes	23	91800	91891	$41.40
Attendance 20-39 minutes	36			$80.10
Attendance 40-59 minutes	44			$118.00
Attendance >60 mins	123			$191.20
My Medicare Enrolled Patients -Telehealth				
Attendance 20-39 minutes		91801	91900	$80.10
Attendance 40-59 minutes		91802	91910	$118.00
Attendance 40-59 minutes		91920	91913	$191.20
After Hours Consultations (Non-Urgent) – In the Surgery				
Mon-Fri: before 8am or after 8pm Sat: before 8am or after 1pm Sun/PH: All day				
Level A	5000			$31.90
Level B	5020			$53.90
Level C	5040			$92.45
Level D	5060			$129.65
Level E	5071			$220.25
After Hours – Urgent Attendance				
GP Urgent after hours Mon-Fri: 7 - 8am, 6 - 11pm Sat: 7 - 8am, 12 noon – 11pm Sun/PH: 7am – 11pm	585			$142.20
GP Urgent unsociable after hours (between 11pm and 7am)	599	92210		$168.40

RACF

Routine Hours Consultations - Residential Aged Care Facility (RACF)				
Flag fall service for each visit, first patient seen only. Applies to return visits same day, except for continuation of earlier episode of care	90001			$60.55
Brief (applicable to each patient seen)	90020			$18.95
Standard (applicable to each patient seen)	90035			$41.40
Long (applicable to each patient seen)	90043			$80.10

Prolonged (applicable to each patient seen)	90051			$118.00
After Hours Consultations (Non Urgent) Residential Aged Care Facility (RACF)				
Mon-Fri: before 8am or after 6pm Sat: before 8am or after 12noon Sun/PH: All day				**1 patient seen**
Brief	5010			$83.35
Standard 6-19 minutes	5028			$105.35
Long 20-39 minutes	5049			$143.90
Prolonged 40-59 minutes	5067			$181.10

HOME/INSTITUTION/HOSPITAL VISITS (excluding RACF)

Home/Institution/Hospital Visits (excluding RACF)				**1 patient seen**
Brief	4			$47.95
Standard 6 to 19 mins	24			$70.40
Long >20mins	37			$109.10
Prolonged > 40 mins	47			$146.25
Prolonged > 60 mins	124			
Home/Institution/Hospital Visits (excluding RACF)				**1 patient seen**
Mon-Fri: before 8am or after 6pm Sat: before 8am or after 12noon Sun/PH: All day				
Brief	5003			$60.50
Standard 6 to 19 mins	5023			$82.50
Long >20mins	5043			$121.05
Prolonged > 40 mins	5063			$158.25

CHRONIC DISEASE MANAGEMENT

Chronic Disease Management				
GP management plan (GPMP)	721	92024		$158.00
Team care arrangement	723	92025		$125.20
Review of GPMP/TCA	732	92028		$78.90
Contribution for review of multidisciplinary care plan, non-RACF residents	729	92026		$77.10
Contribution for review of multidisciplinary care plan, for RACF residents	731	92027		$77.10
Multidisciplinary Case Conference				
Organise and coordinate a case conference – 15-20 minutes	735			$77.74
Organise and coordinate a case conference – 20-40 minutes	739			$132.45
Organise and coordinate a case conference - > 40 minutes	743			$220.80
Participate in a case conference – 15-20 minutes	747			$56.90
Participate in a case conference – 20-40 minutes	750			$97.50
Participate in a case conference - >40 minutes	758			$162.30

PRACTICE NURSE ITEM NUMBERS

Practice Nurse Item Numbers				

Service to a patient with GPMP/TCA by practice nurse/Aboriginal health practitioner (up to 5 per year)	10997	93201	93203	$13.15
Service to an Indigenous patient, following health assessment, by practice nurse/Aboriginal health practitioner (up to 10 per year)	10987	93200	93202	$26.25
Immunisation provided to a person by an Aboriginal or Torres Strait Islander health practitioner	10988			$13.15
Treatment of a person's wound (other than normal aftercare) provided by an Aboriginal or Torres Strait Island health practitioner	10989			$13.15

MEDICATION MANAGEMENT

Domiciliary medication management review	900			$169.60
Residential medication	903			$116.10

HEALTH ASSESSMENTS

Health Assessments				
Brief < 30 minutes	701			$65.00
Standard 30 – 44 minutes	703			$151.05
Long 45 – 60 minutes	705			$208.40
Prolonged ≥ 60 minutes	707			$294.45
Eligible Groups	• 40 – 49-year-olds at high risk of diabetes (3 YEARLY) • 45 – 49-year-olds at risk of developing chronic disease (ONCE ONLY) • People aged ≥ 75 years (ANNUALLY) • Permanent RACF residents (ANNUALLY) • People with an intellectual disability (ANNUALLY) • Refugees with Medicare access (ONCE ONLY) • Former serving members of the ADF (ONCE ONLY)			
Indigenous Health Assessment (every 9 months)	715	92004		$232.50
Heart health assessment, ≥ 20 minutes (annually), available to people aged ≥ 30 years or older	699			$79.70
GP early intervention services for a child under 13 with autism, pervasive developmental disorder or disability	139	92142		$147.30

MENTAL HEALTH AND EATING DISORDER MANAGEMENT

Mental Health and Eating Disorder Management				
GP mental health consult ≥ 20 minutes	2713	92115	92127	$78.55
GP **without** mental health training, prepare a mental health treatment plan (MHCP), 20-39 minutes	2700	92112		$75.80
GP **without** mental health training, prepare a MHCP, ≥ 40minutes	2701	92113		$115.60
GP **with** mental health training, prepare a MHCP, 20-39 minutes	2715	92116		$99.70

GP **with** mental health training, prepare a MHCP, ≥40 minutes	2717	92117		$146.90
Review of MHCP	2712	92114	92126	$78.55
Focussed psychological strategies for assessed mental disorders, 30-39 minutes, for credentialled GPs	2721	91818	91842	$101.60
Focussed psychological strategies for assessed mental disorders, ≥ 40 minutes, for credentialled GPs	2725	91819	91843	$145.35
Eating Disorder Mangement Plan				
GP **without** mental health training, prepare an eating disorder plan (EDP), 20-39 minutes	90250	92146		$78.55
GP **without** mental health training, prepare an EDP, ≥ 40 minutes	90251	92147		$115.60
GP **with** mental health training, prepare an EDP, 20- 39 minutes	90252	92148		$99.70
GP **with** mental health training, prepare an EDP, ≥ 40 minutes	90253	92149		$146.90
GP review of an EDP	90264	92170	92176	$78.55
Focussed psychological strategies for eating disorder, 30-39 minutes, for credentialled GPs	90271	92182	92194	$101.60
Focussed psychological strategies for eating disorder, ≥ 40 minutes, for credentialled GPs	90273	92184	92196	$145.35

WOMEN'S HEALTH

Urine pregnancy test #	73806			$8.65
Antenatal attendance #	16500	91853	91858	$43.95
Antenatal service provided by nurse, midwife or Aboriginal health practitioner on behalf of, and under the supervision of, a medical practitioner, MMM 3-7, (up to 10 times per pregnancy) #	16400	91850	91855	$25.40
Management of pregnancy >28/40 (including mental health assessment) by shared care GP who is not planning to perform the delivery #	16591			$132.80
Postnatal attendance by an obstetrician or GP, 4-8 wks after birth, ≥ 20 minutes, including mental health assessment #	16407	91851	91856	$68.80
Administration of hormone implant by cannula (including Implanon) #	14206			$33.15
Removal of hormone implant (including Implanon) #	30062			$56.5560
Insertion of IUD #	35503			$74.65
Pregnancy support item, ≥ 20 minutes, for credentialled GPs	4001	92136	92138	$83.90

NICOTINE AND SMOKING CESSATION COUNSELLING

Nicotine and Smoking Cessation Counselling				
Consultation < 20 minutes	93680	93690	93700	$41.20

Consultation ≥ 20 minutes	93683	93693	93703	$79.70

BLOOD BORNE VIRUS, SEXUAL OR REPRODUCTIVE HEALTH CHECK

Blood Borne Virus, Sexual or Reproductive Health Check				
Consultation < 5 minutes		92715	92731	$18.85
Consultation 5-20 minutes		92718	92734	$41.20
Consultation 21-40 minutes		92721	92737	$79.70
Consultation ≥ 40 minutes		92724	92740	$117.40

DIAGNOSTIC PROCEDURES

Diagnostic Procedures				
Diagnostic spirometry - pre and post bronchodilator (one annually) #	11505			$38.30
Disease monitoring spirometry - pre and post bronchodilator #	11506			$19.20
12 lead ECG tracing only, no report #	11707			$17.15
24hr BP for suspected hypertension (patient not treated), including report and treatment plan #	11607			$95.90

MINOR PROCEDURES

Minor Procedures				
Removal of subcutaneous foreign body, requiring incision and exploration +/- wound closure #	30064			$102.30
Removal of superficial foreign body, including cornea/sclera #	30061			$21.90
Aspiration of haematoma #	30216			$25.50
Incision and drainage of abscess/haematoma (including aftercare) #	30219			$25.50
Removal of foreign body from ear (other than by simply syringing) #	41500			$76.80
Removal of foreign body from in nose (other than by simple probing) #	41659			$72.25
Wound repair ≤ 7cm superficial – not face or neck #	30026			$48.65
Wound repair ≤ 7cm deep – not face or neck #	30029			$83.85
Wound repair > 7cm superficial – not face or neck #	30038			$83.85
Wound repair >7cm deep – not face or neck #	30042			$172.80
Wound repair ≤ 7cm superficial – face or neck #	30032			$76.80
Wound repair ≤ 7cm deep – face or neck #	30035			$109.45
Wound repair > 7cm superficial – face or neck #	30045			$109.45
Wound repair > 7cm deep – face or neck #	30049			$172.80
Wound repair – full thickness ear, eyelid, nose or lip #	30052			$236.45
Tapping of hydrocele #	30628			$33.15
Extirpation of tarsal cyst #	42575			$77.05

Toenail removal #	47904			$52.60
Digital nail of finger or thumb removal #	46513			$52.60
Ingrown toenail (wedge resection) #	47915			$157.80
Ingrown toenail (phenol/electrocautery/laser to nail bed) #	47916			$79.30
Incision of perianal thrombosis #	32147			$41.95
Sigmoidoscopic examination #	32072			$44.55
Dressing of localised burns #	30003			$33.85

SKIN LESIONS, EXCISIONS AND BIOPSIES

Biopsy for Diagnostic Purposes				
Biopsy of skin #	30071			$48.65
Biopsy of mucous membrane #	30072			$48.65
Tumour, cyst, ulcer, scar removal and suture				
Mucous membrane <10mm #	31206			$88.95
Mucous membrane 10 – 20mm #	31211			$114.65
Mucous membrane >20mm #	31216			$133.70
4 – 10 lesions – skin #	31220			$199.75
4 – 10 lesions – mucous membrane #	31221			$199.75
>10 lesions – skin or mucous membrane #	31225			$355.00
Benign skin lesions				
Nose, eyelid, eyebrow, lip, ear, digit, genitalia or a contiguous area - <6mm#	31357			$102.10
Nose, eyelid, eyebrow, lip, ear, digit, genitalia or a contiguous area – >6mm #	31360			$156.45
Face, neck, scalp, nipple-areola, distal lower/upper limb - <14mm #	31362			$124.70
Face, neck, scalp, nipple-areola, distal lower/upper limb – >14mm #	31364			$156.45
Body, other than above - <15mm #	31366			$88.95
Body, other than above – 15 – 30mm #	31368			$116.90
Body, other than above - >30mm #	31370			$133.70
Malignant skin lesions				
Nose, eyelid, eyebrow, lip, ear, digit, genitalia or a contiguous area - <6mm #	31356			$206.05
Nose, eyelid, eyebrow, lip, ear, digit, genitalia or a contiguous area – >6mm #	31358			$252.50
Face, neck, scalp, nipple-areola, distal lower/upper limb - <14mm #	31361			$173.85
Face, neck, scalp, nipple-areola, distal lower/upper limb – >14mm #	31363			$227.40
Body, other than above - <15mm #	31365			$147.35
Body, other than above – 15 – 30mm #	31367			$198.90
Body, other than above - >30mm #	31369			$228.95
Clinically suspected Malignant Melanoma, appendageal carcinoma, connective tissue tumour of skin or merkel cell carcinoma of skin				
Nose, eyelid, eyebrow, lip, ear, digit, genitalia or a contiguous area - <6mm #	31377			$102.10
Nose, eyelid, eyebrow, lip, ear, digit, genitalia or a contiguous area - >6mm #	31378			$156.45
Face, neck, scalp, nipple-areola, distal lower/upper limb - <14mm #	31379			$124.70

Face, neck, scalp, nipple-areola, distal lower/upper limb – >14mm #	31380			$156.45
Body, other than above - <15mm #	31381			$88.95
Body, other than above – 15 – 30mm #	31382			$116.90
Body, other than above - >30mm #	31383			$133.70
Malignant Melanoma, appendageal carcinoma, connective tissue tumour of skin or merkel cell carcinoma of skin – including excision of the primary tumour bed				
Nose, eyelid, eyebrow, lip, ear, digit, genitalia or a contiguous area - >6mm #	31371			$332.35
Face, neck, scalp, nipple-areola, distal lower/upper limb - <14mm #	31372			$287.40
Face, neck, scalp, nipple-areola, distal lower/upper limb – >14mm #	31373			$332.20
Body, other than above - <15mm #	31374			$262.45
Body, other than above – 15 – 30mm #	31375			$282.45
Body, other than above - >30mm #	31376			$327.35

BULK BILLING INCENTIVES

Standard Bulk Billing Incentives				
Eligible Groups	• Under 16 years of age • Holders of valid Commonwealth Concession Cards			
MMM 1 #	10990			$6.90
MMM 2 #	10991			$10.40
MMM 3-4 #	75855			$11.05
MMM 5 #	75856			$11.75
MMM 6 #	75857			$12.40
MMM 7 #	75858			$13.15
Pathology items #	74990			$6.45

Triple Bulk Billing Incentive Face to Face consults				
Eligible Groups	• Under 16 years of age • Holders of valid Commonwealth Concession Cards			
Level B, C, D and E consults	Face to Face	Telehealth (Video)	Telehealth (Phone)	
MMM 1 #	10990	$20.55	$20.55	
MMM 2 #	10991	$31.20	$31.20	
MMM 3-4 #	75855	$33.15	$33.15	
MMM 5 #	75856	$35.25	$35.25	
MMM 6 #	75857	$37.20	$37.20	
MMM 7 #	75858	$39.45	$39.45	

Triple Bulk Billing Incentives Telehealth for MyMedicare enrolled patients				
Eligible Groups	**MyMedicare patients enrolled patients gain access to the triple bulk billing incentives for Telehealth level C D and E.** • Under 16 years of age • Holders of valid Commonwealth Concession Cards			
Level B, C, D, E consults Face to Face				
MMM 1 #	75870			$20.65
MMM 2 #	75871			$31.40
MMM 3-4 #	75873			$33.35
MMM 5 #	75856			$35.45
MMM 6 #	75874			$37.40

MMM 7 #	75876			$39.70
Eligible Groups	**MyMedicare patients enrolled patients gain access to the triple bulk billing incentives for Telehealth level C D and E.** • Under 16 years of age • Holders of valid Commonwealth Concession Cards			
Level B, C, D, E consults (Phone & Video)				
MMM 1 #	75880			$20.65
MMM 2 #	75881			$31.40
MMM 3-4 #	75882			$33.35
MMM 5 #	75883			$35.45
MMM 6 #	75884			$37.40
MMM7 #	75885			$39.70

ALLIED HEALTH SERVICES

Allied Health Services – Chronic Disease Management				
Aboriginal or Torres Strait Island Health service #	10950	93000	93013	$58.00
Diabetes education health service #	10951			$58.00
Audiology health service #	10952			$58.00
Exercise physiology service #	10952			$58.00
Dietetics health service #	10954			$58.00
Mental health service #	10956			$58.00
Occupational health service #	10958			$58.00
Physiotherapy health service #	10960			$58.00
Podiatry health service #	10962			$58.00
Chiropractic health service #	10964			$58.00
Osteopathy health service #	10966			$58.00
Psychology health service #	10968			$58.00
Speech pathology health service #	10970			$58.00
Allied Health Services – For people of Aboriginal or Torres Strait Islander Descent who have had a Health Assessment				
Aboriginal or Torres Strait Island Health service #	81300			$58.00
Diabetes education health service	81305			$58.00
Audiology health service #	81310			$58.00
Exercise physiology service #	81315			$58.00
Dietetics health service #	81320			$58.00
Mental health service #	81325			$58.00
Occupational health service #	81330			$58.00
Physiotherapy health service #	81335			$58.00
Podiatry health service #	81340			$58.00
Chiropractic health service #	81345			$58.00
Osteopathy health service #	81350			$58.00
Psychology health service #	81355			$58.00
Speech pathology health service #	81360			$58.00
Allied Health Services – Assessment and Provision of Group Services				
Diabetes Educator – Assessment #	81100			$74.40
Exercise Physiologist – Assessment #	81110			$74.40
Dietician – Assessment #	81120			$74.40
Diabetes Educator – Group Service #	81105			$18.55
Exercise Physiologist – Group Service #	81115			$18.55
Dietician – Group Service #	81125			$18.55

Pregnancy Support Counselling by eligible psychologist, social worker, or mental health nurse at least 30 minutes				
Eligible Psychologist #	81000	93026	93029	$68.10
Eligible Social worker #	81005			$68.10
Eligible Mental health nurse #	81010			$68.10

ADDITIONAL INFORMATION AND FLOW CHARTS

CONTACT DETAILS FOR KEY ORGANISATIONS

Services Australia

Health Professionals Homepage – www.servicesaustralia.gov.au/health-professionals

Contacts - https://www.servicesaustralia.gov.au/health-professionals-contact-information?context=60090

Health Processional Education Resources - https://hpe.servicesaustralia.gov.au/

Practice Incentive Program **-** https://www.servicesaustralia.gov.au/practice-incentives-program

MBSOnline

MBS Online Homepage – www.mbsonline.gov.au

News - http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/news

Fact Sheets - http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/factsheet-current

Downloads - http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/downloads

AskMBS

AskMBS Advisories Homepage – https://www.health.gov.au/resources/collections/askmbs-advisories

AskMBS Email – askMBS@health.gov.au

Department of Health

Health Professionals Homepage - https://www1.health.gov.au/internet/main/publishing.nsf/Content/For+Health+Professionals-1

Department of Veteran Affairs

Providers Homepage - Department of Veterans' Affairs (DVA) contact | Australian Government Department of Health and Aged Care

CVC Program Homepage **-** https://www.dva.gov.au/providers/health-programs-and-services-our-clients/coordinated-veterans-care

My Health Record - www.myhealthrecord.gov.au

Digital Health Agency - www.digitalhealth.gov.au

National Asthma Council - www.nationalasthma.org.au

Cancer Screening (Breast, Bowel and Cervical Screening) - www.cancerscreening.gov.au

Diabetes Australia - www.diabetesaustralia.com.au

Brisbane North PHN Health Pathways -
https://brisbanenorth.communityhealthpathways.org/LoginFiles/Logon.aspx?ReturnUrl=%2f

Username: Brisbane
Password: North

SYSTEMATIC CARE CLAIMING RULES

For the most up to date information refer to the Medicare Benefits Schedule online at www.mbsonline.gov.au

	Item number	Service	Brief Guide	Claim Period
Chronic Disease Management	721	Preparation of a **General Practitioner Management Plan (GPMP)**	Patients with a chronic or terminal medical condition	**2 yearly** (Min 12 months)
	723	Coordination of a **Team Care Arrangement (TCA)**	Patients with a chronic disease who require ongoing care from a multidisciplinary team	**2 yearly** (Min 12 months)
	732	**Review** of a GPMP	Systemic review of the patient's progress again GPMP goals	**6 monthly** Min 3 months)
		Coordinate a review of TCA	Systemic team-based review of the patient's progress against TCA goals	
	729	**Contribution to care plan or to review the care plan** being prepared by another provider	Not available to patients of RACF	**6 monthly** Min 3 months)
	731	**Contribution to care plan or to review the care plan** for patient of RACF	Plan prepared by such a facility	**6 monthly** Min 3 months)
	139	**Assessment, diagnosis and development of a treatment and management plan for a disability**	Children aged under 13 years with an eligible disability	**Once only**
Medication Reviews	900	**Domiciliary Medication Management Review (DMMR)** for patients living in the community setting	Assessment, referral to a community pharmacy	**12 months** Except in circumstances with significant change
	903	**Residential Medication Management Review (RMMR)**	For new or existing residents of Residential Aged Care Facilities	**12 months** Except in circumstances with significant change
Practice Nurse	10997	**Monitoring and support of a person with a chronic disease**	Patient must have GPMP, TCA or multidisciplinary care plan in place	Maximum of 5 times per patient per calendar year
	10987	**Monitoring and support for a person who has had a 715 Health Assessment**	Patient must have had 715 Health Assessment completed	Maximum 10 times per patient per calendar year

Restriction of Co-Claiming of Chronic Disease and General Consultation Items

Co-claiming of GP consultation items 3, 4, 23, 24, 36, 37, 44, 47, 52, 53, 54, 57, 58, 59, 60, 65, 179, 181, 185, 187, 189, 191, 203, 206, 585, 588, 591, 594, 599, 600, 733, 737, 741, 745, 761, 763, 766, 769, 5000, 5003, 5020, 5023, 5040, 5043, 5060, 5063, 5200, 5203, 5207, 5207, 5208, 5220, 5223, 5227 and 5228 with chronic disease management items 229, 230, 233, 721, 723 or 732 is not permitted for the same patient, on the same day.

Additional Information

Items 721-732 should generally be undertaken by the patient's **usual general practitioner**. The patient's "usual GP" means the GP, or a GP working in the medical practice, who has provided the majority of care to the patient over the

previous twelve months and/or will be providing the majority of GP services to the patient over the next twelve months. The term "usual GP" would not generally apply to practice that provides only one specific CDM service.

A **practice nurse, Aboriginal and Torres Strait Island health practitioner, Aboriginal health working or other health professional** may assist a GP with items 721, 723, and 732 (e.g., in patient assessment, identification of patient needs and making arrangements for services). However, the GP must meet all regulatory requirements, review, and confirm all assessments and see the patient for billing to be completed.

For more information on CDM, read our education guide - Chronic Disease GP Management Plans and Team Care Arrangements.

Note: CDM services can also be provided more frequently in circumstances where there has been a significant change in the patient's clinical condition or care circumstances that require a new GPMP or TCA or review service. You must notate the Medicare claim as "exceptional circumstances" or "clinically indicated".

OTHER NOTES REGARDING BILLING MBS ITEMS

Multiple attendance on the same day

You can bill multiple attendances for the same patient on the same day if:

- they're separate attendances with a reasonable lapse of time between them
- the subsequent attendances aren't a continuation of the other attendances
- the services are unrelated to each other, and each item descriptor has been met and documented

Make a note on the account or include service text for electronic claims. Suitable text may include:

- times of each attendance
- 'Unrelated to x' on the attendance item where 'x' refers to the other item number

Multiple operation rule

The multiple operation rule (MOR) applies if you bill 2 or more MBS items from Category 3 Group T8 for surgical services performed on a patient on one occasion. The total schedule fee for all surgical items is calculated by applying the MOR. That is:

- 100% of the fee for the item with the highest schedule fee
- Plus 50% of the fee for the item with the next highest schedule fee
- Plus 25% of the fee for any further surgical items

Applying this rule results in one total schedule fee for all surgical items billed. The Medicare benefit payable is calculated based on this schedule fee.

Billing Procedures

Bulkbilling – Under the *Health Insurance Act 1973*, a bulk billing facility for professional services is available to all persons in Australia who are eligible for a benefit under the Medicare program. If a practitioner bulk bills for a service, the practitioner undertakes to accept the relevant Medicare benefit as full payment for the service. Additional charges for that service cannot be raised. This includes but is not limited to:

- Any consumable that would be reasonably necessary to perform the service, including bandages and/or dressings.
- Record keeping fees.

- A booking fee to be paid before each service, or.
- An annual administration or registration fee.

Where the patient is bulk billed, an additional charge can **only** be raised against the patient by the practitioner where the patient is provided with a vaccine or vaccines from the practitioner's own supply held on the practitioner's premises. This exemption only approved to general practitioners and other non-specialist practitioners in association with attendance items **3 to 96, 179 to 212, 733 to 789** and **5000 to 5267** (inclusive) and only related to vaccines that are not available to the patient free of charge through Commonwealth or State funding arrangements or available through the Pharmaceutical Benefits Scheme. The additional charge must only be to cover the supply of the vaccine.

Where a practitioner provides several services (excluding operations) on the one occasion, they can choose to bulk bill some or all those services and privately charge a fee for the other service (or services), in excess of the Medicare rebate. The privately charged fee can only be charged in relation to said services (or services). Where two or more operations are provided on the one occasion, all services must be either bulk billed or privately charged.

It should be notes, where a service is not bulk billed, a practitioner may privately raise an additional charge again a patient, such as for a consumable. An additional charge can also be raised where a practitioner does not bulk bill a patient but instead charges a fee that is equal to the rebate for the Medicare service. For example, where a general practitioner provides a professional service to which item 23 relates the practitioner could, in place of bulk billing the patient, charge the rebate for the service and then also raise an additional charge (such as for a consumable). Refer to Medicare Explanatory Note GN.7.17

MBS Interpretation

For help with interpreting the MBS contact AskMBS

AFTER HOURS SERVICES

<table>
<tr><th colspan="3">Attendance Period</th><th>Item No</th><th>Brief Guide</th></tr>
<tr><td colspan="3">Urgent attendance – after hours</td><td rowspan="3">585</td><td rowspan="5">These items can only be used for the first patient, if more than one patient is seen on the one occasion, standard (non-urgent) after hours items apply
The urgent after-hours items can only be used where the patient has a medical condition that requires urgent treatment, which could not be delayed until the next in hours period
For consultations at the health centre, it is necessary for the practitioner to return to, and specially open the consulting rooms for the attendance</td></tr>
<tr><td>Mon – Fri
7am - 8am
and
6pm – 11pm</td><td>Sat
7am – 8am and
12 noon – 11pm</td><td>Sun & Public Holidays
7am – 11pm</td></tr>
<tr><td colspan="3">Urgent attendance – unsociable hours</td></tr>
<tr><td>Mon-Fri
11pm – 7am</td><td>Sat
11pm – 7am</td><td>Sun & Public Holidays
11pm – 7am</td><td>599</td></tr>
<tr><td colspan="3">Non-urgent after hours at place other than consulting rooms</td><td rowspan="2">RACF
5010 (Brief)
5028 (Standard)
5049 (Long)
5067 (Prolonged)
Home
5003 (Brief)
5023 (Standard)
5043 (Long)
5063 (Prolonged)</td><td rowspan="2"></td></tr>
<tr><td>Mon - Fri
Before 8am
or after 6pm</td><td>Sat
Before 8am or
after 12 noon</td><td>Sun & Public Holidays
All day</td></tr>
<tr><td colspan="3">Non-urgent after hours at consulting rooms</td><td rowspan="2">5000 (Brief)
5020 (Standard)
5040 (Long)
5060 (Prolonged)</td><td rowspan="2"></td></tr>
<tr><td>Mon – Fri
Before 8am
or after 8pm</td><td>Sat
Before 8am or
after 1pm</td><td>Sun & Public Holidays
All day</td></tr>
</table>

GP MANAGEMENT PLAN (GPMP)

MBS ITEM 721

Ensure patient eligible	**Eligibility Criteria** • No age restrictions for patients • Patents with a chronic or terminal condition • Patients will benefit from a structured approach to their care • Not for patients in a hospital or in a Residential Aged Care Facility • Cannot be claimed within 12 months of another 721 or 3 months from a 732 review
Develop Plan	**Clinical Content** • Explain steps involved in GPMP, possible out of pocket costs and gain patient's 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 treatment and services • Confirm actions to be taken by the patient • Plan review date with the patient
Complete Documentation	**Essential Documentation Requirements** • Record patient's consent to GPMP • Document patient needs and goals, patient actions, and treatments/services required • Set review date (at least 3-6 months after plan date) • Offer copy to patient (with consent, offer to carer), keep copy in patient file
Claim MBS Item	**Claiming** • All elements of the service must be completed to claim • Requires personal attendance by GP with patient • Review using item 732 at least once during the life of the plan

MBS Item	Name	Age Range	Recommended Frequency
721	GP Management Plan	Not applicable	2 yearly (minimum 12 monthly)

* Nurse/Aboriginal or Torres Strait Islander Health Worker or Health Professional may assist in the collection and collation of clinical content and essential documentation requirements however patient requires personal attendance by GP for item claiming

TEAM CARE ARRANGEMENT (TCA)

MBS ITEM 723

Ensure patient eligible

Eligibility Criteria

- No age restrictions for patients
- Patents 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
- Cannot be claimed within 12 months of another 723 or 3 months from a 732 review

Develop TCA

Clinical Content

- Explain steps involved in TCA, possible out of pocket costs and gain patient's consent
- Treatment and services 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
- Confirm 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
- Plan review date with the patient
- Consult with 2 collaborating providers and obtain feedback on treatment/services they will provide to achieve patient goals
- Plan review date with the patient

Complete documentation

Essential Documentation Requirements

- Record patient's consent to TCA
- Document goals, collaborating providers, treatment/services, actions to be taken by patient
- Set review date (at least 3-6 months after plan date)
- Send copy of relevant parts to collaborative providers
- Offer copy to patient (with consent, offer to carer), keep copy in patient file

Claim MBS Item

Claiming

- All elements of the service must be completed to claim
- Requires personal attendance by GP with patient
- Review using item 732 at least once during the life of the plan
- Claiming a GPMP and TCA enables patients to receive 5 rebated services from allied health in a calendar year

MBS Item	Name	Age Range	Recommended Frequency
723	Team Care Arrangement	Not applicable	2 yearly (minimum 12 monthly)

* Nurse/Aboriginal or Torres Strait Islander Health Worker or Health Professional may assist in the collection and collation of clinical content and essential documentation requirements however patient requires personal attendance by GP for item claiming

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

MBS ITEM 732

Ensure patient eligible	**Reviewing a GP Management Plan (GPMP)** **Eligibility Criteria** • At least 3 months since GP Management Plan prepared; or • At least 3 months since last GPMP review
Review GPMP	**Clinical Content** • Explain steps involved in review and gain patient's consent • Review all matters in relevant plan
Complete documentation	**Essential Documentation Requirements** • Record patient's agreement to review • Make any amendments to the plan • Set new review date (at least 3-6 months after plan date) • Offer copy to patient (with consent, offer to carer), keep copy in patient file
Claim MBS Item	**Claiming** • All elements of the service must be completed to claim • Requires personal attendance by GP with patient • Item 732 can be claimed twice on same day if review of both GPMP and TCA, in this case the Medicare claim must be annotated appropriately
Ensure patient eligible	**Reviewing a Team Care Arrangement (TCA)** **Eligibility Criteria** • At least 3 months since Team Care Arrangement prepared; or • At least 3 months since last TCA review
Review TCA	**Clinical Content** • Explain steps involved in review and gain patient's consent • Consult with 2 collaborating providers to review all matters in plan
Complete documentation	**Essential Documentation Requirements** • Record patient's consent to review • Make any required amendments to the plan • Set new review date (at least 3-6 months after plan 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
Claim MBS Item	**Claiming** • All elements of the service must be completed to claim • Requires personal attendance by GP with patient • Item 732 can be claimed twice on same day if review of both GPMP and TCA, in this case the Medicare claim must be annotated appropriately

MBS Item	Name	Age Range	Recommended Frequency
732	Review of GPMP and/or TCA	Not applicable	6 monthly (minimum 3 monthly)

* Nurse/Aboriginal or Torres Strait Islander Health Worker or Health Professional may assist in the collection and collation of clinical content and essential documentation requirements however patient requires personal attendance by GP for item claiming

MULTIDISCIPLINARY CASE CONFERENCE
MBS ITEMS 735 / 739 / 743 / 747 / 750 / 758

The case conference items are for GPs to organise and coordinate, or to participate in a meeting or discussion held to ensure that their patient's multidisciplinary care needs are met through a planned and coordinated approach. Case conferences can be undertaken for patients in the community, for patients being discharged into the community from hospital and for people living in residential aged care facilities.

These services are for patients who:

a) have at least one medical condition that:
    i. has been (or is likely to be) present for at least six months; or
    ii. is terminal; and
b) require ongoing care from a multidisciplinary case conference team which includes:
    i. a medical practitioner; and
    ii. at least two other health or community care providers, each of whom provides a different kind of care or service to the patient and is not a family carer of the patient, and one of whom may be another medical practitioner. The patient's informal or family carer can be included as a formal member of the team but does not count towards the minimum of 3 service providers.

The patient does not have to be present, though in some cases their presence may be appropriate.

A case conference can occur face to face, by phone or by video conference or through a combination of these. The minimum 3 care providers (including the GP) must be in communication with each other throughout the conference.

For the purposes of items 735-758, a multidisciplinary case conference is a process by which a multidisciplinary case conference team:

a) discusses a patient's history; and
b) identifies the patient's multidisciplinary care needs; and
c) identifies outcomes to be achieved by members of the case conference team giving care and service to the patient; and
d) identifies tasks that need to be undertaken to achieve these outcomes, and allocates those tasks to members of the case conference team; and
e) assesses whether previously identified outcomes (if any) have been achieved.

When participating in a case conference, a GP must:

- explain the nature of the conference with the patient and obtain and record the patients consent to the GP participating in the conference
- record the details of the case conference (date, duration, names of participants) and all matters discussed by the team
- put a copy of that record in the patient's medical record

When organising and coordinating a case conference, a GP must do all the above and also:

- obtain and record the patient's consent to the conference taking place; and
- offer the patient (and their carer if appropriate) a summary of the conference and provide this summary to the other team members; and
- discuss the outcomes with the patient (and their carer is appropriate

MBS Item	Name	Recommended Frequency
735	Organise and coordinate a case conference – 15 – 19 minutes	Usually not more than 5 in 12 months
739	Organise and coordinate a case conference - 20 – 39 minutes	Usually not more than 5 in 12 months
743	Organise and coordinate a case conference - ≥ 40 minutes	Usually not more than 5 in 12 months
747	Participate in a case conference – 15 – 19 minutes	Usually not more than 5 in 12 months
750	Participate in a case conference – 20 – 39 minutes	Usually not more than 5 in 12 months
758	Participate in a case conference - ≥ 40 minutes	Usually not more than 5 in 12 months

DOMICILIARY MEDICATION MANAGEMENT REVIEW (DMMR)

MBS ITEM 900

Ensure patient eligible	**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 (RACF)
1st 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 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
2nd 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 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

MBS Item	Name	Age Range	Recommended Frequency
900	Home Medicines Review	Not applicable	Once every 12 months

RESIDENTIAL MEDICATION MANAGEMENT REVIEW (RMMR)

MBS ITEM 903

Ensure patient eligible

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 changed 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

Consent – refer to Pharmacist

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

Medication review by pharmacist

Accredited Pharmacist Component

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

Post review discussion – face to face or by phone

GP and Pharmacist Post Review Discussion

Discuss: Findings and recommendations of the Pharmacist.

- Medication management strategies; issues; implementation; follow-up; outcomes
- If no (or only minor) changes recommended a post review discussion is not mandatory

Complete documentation

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

Claim MBS Item

Claiming

- All elements of the service must be completed to claim

MBS Item	Name	Age Range	Recommended Frequency
903	Residential Medication Management Review	Not applicable	As required (minimum 12 monthly)

HEALTH ASSESSMENTS
MBS ITEMS 701 / 703 / 705 / 707 / 715 / 699 / 139

Time Based Health Assessments

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

- 701 Brief Health Assessment < 30 minutes
- 703 Standard Health Assessment 30 – 44 minutes
- 705 Long Health Assessment 45 – 59 minutes
- 707 Prolonged Health Assessment ≥ 60 minutes

There are 8 Health Assessment target groups:

- 40 – 49 years old Type 2 Diabetes Risk Evaluation
    - For patients aged 40 – 49 years of age
    - For patients who score ≥ 12 on AUSDISK
    - Provision of lifestyle modification advice and interventions
    - Claimable every 3 years
- 45 – 49 Years Old
    - For patients aged 45 – 49 years of age
    - For patients who are at risk of developing a chronic disease
    - Claimable once only
- 75 Years and Older
    - For patients aged 75 years and older
    - Claimable once every 12 months
- Comprehensive Medical Assessment
    - For permanent residents of Residential Aged Care Facilities
    - Available to new and existing residents
    - Claimable on admission provided not claimed at another RACF within the last 12 months
    - Claimable once every 12 months
- Patients with an Intellectual Disability
    - For patients with an Intellectual Disability
    - Claimable once every 12 months
- Refugees and other Humanitarian Entrants
    - For new refugees and other humanitarian entrants as soon as possible after their arrival (within 12 months of their arrival
    - Claimable once only
- Former serving members of the Australian Defence Forces
    - For former serving members of the ADF including former members of permanent and reserve forces
    - Claimable once only

Other Health Assessments:

- 715 Aboriginal and Torres Strait Islander Health Assessment
    - For all ages – child (0 – 14 years). Adult (15 -54 years), Older Person (55 years and older)
    - No designated time / complexity requirements
    - Not available to in-patients of a hospital or Residential Aged Care Facility
    - Claimable not more than once every 9 months
- 699 Heart Health Assessment
    - For patients aged 30 years and older
    - Minimum assessment time of 20 minutes

- Not available to in patients of a hospital or Residential Aged Care Facility
- Claimable once every 12 months

- 139 Early Intervention Services for Children with Autism, Pervasive Developmental Disorder or Disability
  - For patients under the age of 13 with an eligible disability
  - Minimum assessment time of 45 minutes
  - For assessment, diagnosis, and preparation of a treatment plan
  - Claimable once only

* Nurse/Aboriginal or Torres Strait Islander Health Worker or Health Professional may assist in the collection and collation of clinical content and essential documentation requirements however patient requires personal attendance by GP for item claiming

TYPE 2 DIABETES RISK EVALUATION - HEALTH ASSESSMENT

MBS ITEMS 701 / 703 / 705 / 707

Perform records search to identify 'as risk' patients	**Eligibility Criteria** • Patients with new 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 (AUSDRICK) • Not for patients in hospital
Identify Risk Factors Perform Health Check	**Clinical Content** • 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 3 months prior to undertaking Type 2 Diabetes Risk Evaluation • Update patient history and undertaking physical examinations and clinical investigations in accordance with relevant guidelines • Make an overall assessment of the patient's risk factors, and results of relevant examinations and investigations • Initiate interventions where appropriate, and follow-up relating to management of any risk factors identified • Provide advice and information, such as Lifescripts resources, including strategies to achieve lifestyle and behaviour changes
Complete documentation	**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
Claim MBS Item	**Claiming** • All elements of the service must be completed to claim • Requires personal attendance by GP with patient

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

* Nurse/Aboriginal or Torres Strait Islander Health Worker or Health Professional may assist in the collection and collation of clinical content and essential documentation requirements however patient requires personal attendance by GP for item claiming

45 - 49 YEARS OLD - HEALTH ASSESSMENT

MBS ITEMS 701 / 703 / 705 / 707

Perform records search to identify 'as risk' patients

Eligibility Criteria

- Patients aged 45 to 49 years inclusive
- Must have an identified risk factor for chronic disease
- 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; Excess weight
- Family history of chronic disease

Perform Health Check

Clinical Content

Mandatory

- Explain Health Assessment process and gain consent
- Information collection – takes patient history, undertake examinations and investigations as clinically required
- Overall assessment of the patient's health, including their readiness to make lifestyle changes
- Initiate interventions and referrals as clinically indicated
- Advice and information about lifestyle modification programs and strategies to achieve lifestyle and behaviour changes

Non-Mandatory

- Written patient information such as Lifescripts resources, are recommended

Complete documentation

Essential Documentation Requirements

- Record patient's consent to Health Assessment
- Record the Health Assessment and offer the patient a copy

Claim MBS Item

Claiming

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

MBS Item	Name	Age Range	Recommended Frequency
701 / 703 / 705 / 707	Health Assessment – 45 – 49-Year-Old	45 – 49 years	Once only

* Nurse/Aboriginal or Torres Strait Islander Health Worker or Health Professional may assist in the collection and collation of clinical content and essential documentation requirements however patient requires personal attendance by GP for item claiming

75 YEARS and OLDER - HEALTH ASSESSMENT

MBS ITEMS 701 / 703 / 705 / 707

Establish a patient register and recall when due for assessment

Eligibility Criteria

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

Perform Health Assessment

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

Non-Mandatory

- Consider: Need for community services; Social isolation; Oral health and dentition; and Nutrition status
- Additional matters as relevant to the patient

Complete documentation

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)

Claim MBS Item

Claiming

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

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

* Nurse/Aboriginal or Torres Strait Islander Health Worker or Health Professional may assist in the collection and collation of clinical content and essential documentation requirements however patient requires personal attendance by GP for item claiming

HEART HEALTH ASSESSMENT

MBS ITEM 699

Perform records search to identify 'at risk' patients

Eligibility Criteria

Patients at risk of developing cardiovascular disease. The items are intended to support:

a. Adults aged 30 years and above.

Identify Risk Factors

Risk Factors

Identifying cardiovascular risk factors including, but are not limited to:

- Diabetes status
- Alcohol intake
- Smoking status
- Cholesterol status (if not performed within the last 12 months)
- Blood glucose

Perform Health Check

Clinical Content

Mandatory

- Explain Health Assessment process and gain consent
- Information collection – takes patient history; undertake examinations and investigations as clinically required
- A physical examination which must include recording 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

Complete documentation

Essential Documentation Requirements

- Record patient's consent to Health Assessment
- Record the Health Assessment and offer the patient a copy

Claim MBS Item

Claiming

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

MBS Item	Name	Age Range	Recommended Frequency
699	Heart Health Assessment	30 years and older	Once only

* Nurse/Aboriginal or Torres Strait Islander Health Worker or Health Professional may assist in the collection and collation of clinical content and essential documentation requirements however patient requires personal attendance by GP for item claiming

MENTAL HEALTH TREATMENT PLAN

MBS ITEMS 2700 / 2701 / 2715 / 2717

2701 / 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 eligible

Eligibility Criteria

- No age restriction for patients
- Patients with a mental disorder, excluding dementia, delirium, tobacco use disorder or 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)

Develop plan

Clinical Content

- Explain steps involved, possible out of pocket costs and gain patient's consent
- Relevant history – biological, psychological, social, and presenting complaint
- Mental state examination, assessment of risk and co-morbidity, diagnosis of mental disorder and/or formulation
- Outcome measurement tool score (e.g., K10), unless clinically inappropriate
- Provide psychoeducation.
- Plan for crisis intervention/relapse prevention, if appropriate
- Discuss diagnosis/formulation, referral, and treatment options with the patient
- Agree on management goals with the patient and confirm actions to be taken by the patient
- Identify treatment/services required and make arrangements for these.

Complete documentation

Essential Documentation Requirements

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

Claim MBS Item

Claiming

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

MBS Item	Name	Age Range	Recommended Frequency
2700, 2701, 2715, 2717	GP Mental Health Treatment Plan	Not applicable	Not more than once yearly

REVIEW OF A MENTAL HEALTH TREATMENT PLAN

MBS ITEMS 2712

Ensure patient eligible

Eligibility Criteria

- Minimum 1 month since the initial plan created
- Minimum 3 month since last plan review completed

Review the plan

Clinical Content

- Explain steps involved, possible out of pocket costs and gain patient's consent
- Review patient's progress against goals outlined in the GP Mental Health Treatment Plan
- Check, reinforce and expand psychoeducation.
- Plan for crisis intervention and/or relapse prevention, if appropriate and if not previously provided
- Re-administer the outcome measurement tool used when developing the GP Mental Health Treatment Plan, except where considered clinically inappropriate

Complete documentation

Essential Documentation Requirements

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

Claim MBS Item

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
- A review can be claimed 1-6 months after completion of the GP Mental Health Treatment Plan
- If required, an additional review can be performed 3 months after the first Review

MBS Item	Name	Age Range	Recommended Frequency
2712	Review of GP Mental Health Treatment Plan	Not applicable	1-6 months after GP Mental Health Treatment Plan 3 months after last Review

EATING DISORDERS TREATMENT PLAN

MBS ITEMS 90250 / 90251 / 90252 / 90253

90250 / 90251 - prepared by a GP who has not undertaken mental health skills training
90252 / 90253 – prepared by a GP who has undertaken mental health skills training

Ensure patient eligibility

Eligibility Criteria

- No age restriction for patients
- Not for patients in a hospital

There are two cohorts of eligible patients:

a) Patients with a clinical diagnosis of anorexia nervosa; or

b) Patients who meet the eligibility criteria (below) and have a clinical diagnosis of any of:
   - bulimia nervosa
   - binge-eating disorder
   - other specified feeding or eating disorder

   Cohort b) eligibility criteria:
   - a person who has been assessed as having an Eating Disorder Examination Questionnaire (EDE-Q) score of 3 or more; and
   - the condition is characterised by rapid weight loss, or frequent binge eating, or inappropriate compensatory behaviour as manifested by 3 or more occurrence per week; and

     A person who has at least 2 of the following indicators:
   - clinically underweight with a body weight <85% of expected weight where weight loss is directly attributable to the eating disorder;
   - current or high risk of medical complications due to eating disorder behaviours and symptoms;
   - serious comorbid medical or psychological conditions significantly impacting on medical or psychological health status with impacts on function:
   - the person has been admitted to a hospital for an eating disorder in the previous 12 months;
   - inadequate treatment response to evidence-based eating disorder treatment over the past six months despite active and consistent participation.

Develop plan

Clinical Content

- Explain steps involved, possible out of pocket costs and gain patient's consent
- Relevant history – biological, psychological, behavioural, nutritional, social
- Mental state examination, assessment of risk and co-morbidity, diagnosis of mental disorder and/or formulation
- Outcome measurement tool score, unless clinically inappropriate
- Plan for crisis intervention/relapse prevention/education for patient/family/carer
- Assess associated risk and a co-morbidity (see MBS explanatory note AN.36.1)
- Discuss diagnosis/formulation, referral and treatment options, plan review date with the patient
- Agree on management goals with the patient and confirm actions to be taken by the patient
- Identify treatment/services required and make arrangements

Complete documentation

Essential Documentation Requirements

- Record patient's consent to GP Eating Disorders Treatment Plan
- Document diagnosis of mental disorder and results of outcome measurement tool
- Document patient needs, goals and actions, referrals and treatment/services required

	• Document review date • Offer copy to patient (with consent, offer to carer), keep copy in patient file
Claim MBS Item	**Claiming** • All elements of the service must be completed to claim • Requires personal attendance by GP with patient • Review using item 90264 at least once during the 12-month life of the plan • Cannot be claimed with items 2713. 735, 758

MBS Item	Name	Age Range	Recommended Frequency
90250, 90251, 90252, 90253	GP Eating Disorders Treatment Plan	Not applicable	Not more than once yearly

REVIEW OF EATING DISORDERS TREATMENT PLAN

ITEMS 90264

Ensure patient eligible

Eligibility Criteria

- Patient must have had an Eating Disorders Plan (EDP) in the previous 12 months
- The 12-month period commences from the date of the EDP

Clinical Content

Review Plan

- Explain steps involved, possible out of pocket costs and gain patient's consent
- Referral to a psychiatrist or paediatrician for review under items 90266-90269 if this has not already been initiated
- Review patient's progress against goals outlined in the GP Eating Disorders Treatment Plan and modify documented EDP if required
- Check, reinforce and expand education
- Plan for crisis intervention and/or relapse prevention, if appropriate and if not previously provided
- Review reports back from allied mental health professional on the patient's response to treatment and document whether the patient should continue another course of services
- Readminister the outcome measurement tool and mental state examination used when developing the GP Eating Disorders Treatment Plan (Item 90250/90251/90252/90253), except where considered clinically inappropriate (see specifics in MBS AN.36.3)

Essential Documentation Requirements

Complete documentation

- Record patient's consent to review
- Document results of readministered outcome measurement tool and mental state examination
- Document relevant changes to GP Eating Disorders Treatment Plan
- Document referral to psychiatrist or paediatrician
- Document recommendation on whether patient should continue with another course of EDPT services with allied mental health professional originally referred to, or change to another
- Set review date
- Offer copy to patient (with consent, offer to carer), keep copy in patient file

Claiming

Claim MBS Item

- All elements of the service must be completed to claim
- Requires personal attendance by GP with patient
- Item 90264 should be claimed at least once over the life of the GP Eating Disorders Treatment Plan
- A review should be claimed on a regular, ongoing, and as required basis. Review must occur at the end of each course of treatment as per stepped model
- Item 90264 cannot be claimed with item 2713
- See stepped model in MBS explanatory note AN.36.1

MBS Item	Name	Age Range	Recommended

			Frequency
90264	Review of GP Eating Disorders Treatment Plan	Not applicable	At least at the end of each course of treatment as per stepped model

VETERAN'S CARE

COORDINATED VETERAN'S CARE PROGRAM (CVC)

About the CVC Program

The Department of Veteran's Affairs (DVA) Coordinated Veteran's Care Program (known as the CVC Program) commenced on 1 May 2011. The CVC Program:

- Uses a proactive approach to improve the management of participants' chronic diseases and quality of care
- Involves a care team of a general practitioner (GP) plus a nurse coordinator who work with the participant (and their carer if applicable) to manage their ongoing care
- Provides new payments to GPs for initial and ongoing care

Guide for General Practice

DVA has a dedicated page of information, eligibility and training and resources for providers which can be found here.

The DVA has also developed a CVC Toolbox to help with the implementation of the Coordinated Veterans' Program. It can be downloaded here. The CVC Program items are DVA only items and do not appear in the MBS Schedule.

Eligibility

The program is aimed at veterans, war widows, war widowers and dependants who are Gold Card holders and are at risk of being admitted or readmitted to hospital. White Card holders with DVA accepted mental health conditions can also access the CVC program.

GPs can enrol participants in the program if they:

- Pass an eligibility assessment
- Give their informed consent to be involved in the program
- Use the CVC Eligibility Tool available here

Payments to GPs

By participating in the program, GPs can claim the following payments through existing payment arrangements with Medicare Australia:

- Initial Incentive Payment for enrolling a participant in the program
- Quarterly Care Payments for ongoing care

UP01 Initial Payment – LMO/GP with Practice Nurse

UP02 Initial Payment – LMO/GP without Practice Nurse

Item Description	Business Rules
The payment is to an LMO/GP, with a Practice Nurse coordinator, for enrolling a person in the CVC Program and having done all things necessary for the enrolment as described in the Guide for General Practice or Notes for CVC Program Providers and summarised as follows: • The LMO/GP has made any required changes to the Practice before enrolling the participant in the Program • The participant has been assessed by the LMO/GP as meeting the eligibility criteria for participation in the Program	This item will be claimed on enrolment of a participant in the CVC Program. Only one (1) claim or either UP01 or UP02 will be paid per participant regardless of a change in LMO/GP or in Practice Nurse arrangements.

• The LMO/GP has explained the Program and the person has provided informed consent to being enrolled in the Program and to the sharing of health and medical information • A care coordinator employed by the general practice has been appointed: either a Practice Nurse or an Aboriginal Health Worker • A comprehensive needs assessment of the participant has been carried out by the care coordinator or the LMO/GP • A care plan (GP Management Plan – GPMP) has been prepared and agreed with the participant and a patient friendly copy provided to the participant and any carer/family as agreed	Where a person ceases to be a participant and later re-enters the Program, the initial incentive payment (UP01 or UP02) will not be payable. The date of services is the date of enrolment in the Program which is the date that all steps necessary for enrolment in the Program have been completed.

UP03 – Completion of 90-day period of care – LMO/GP with Practice Nurse

UP04 – Completion of 90-day period of care -LMO/GP without Practice Nurse

Item Description	Business Rules
Completion of 90-day period of care Date of service claim calculator - here	Provide direct support and communication with the participant. Delivery of the care plan Collaboration and case coordination Monitoring of the care plan and actions

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).

<table>
<tr><th colspan="3">Allied Health Services for Chronic Conditions Requiring Team Care</th></tr>
<tr><th>Item</th><th>Name</th><th>Description</th></tr>
<tr><td>10950</td><td>Aboriginal Health Worker service</td><td rowspan="10">• Allied Health Provider must be Medicare registered
• Maximum of 5 allied health services per patient each calendar year
• Can be 5 sessions with one provider or a combination e.g., 3 Dietician and 2 Diabetes Education sessions
• GP refers to allied health providers 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</td></tr>
<tr><td>10951</td><td>Diabetes Educator service</td></tr>
<tr><td>10952</td><td>Audiologist service</td></tr>
<tr><td>10953</td><td>Exercise physiologist service</td></tr>
<tr><td>10954</td><td>Dietician services</td></tr>
<tr><td>10958</td><td>Occupational Therapist service</td></tr>
<tr><td>10960</td><td>Physiotherapist service</td></tr>
<tr><td>10962</td><td>Podiatrist service</td></tr>
<tr><td>10964</td><td>Chiropractor service</td></tr>
<tr><td>10966</td><td>Osteopath service</td></tr>
<tr><td>10970</td><td>Speech Pathologist service</td></tr>
<tr><td>10956</td><td>Mental Health Worker service</td><td rowspan="2">• 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</td></tr>
<tr><td>10968</td><td>Psychologist service</td></tr>
</table>

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

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 and identified a need for follow-up allied health services.

These items provide an alternative pathway for Aboriginal and 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.

<table>
<tr><th colspan="3">Assessment and Provision of Services</th></tr>
<tr><th>Item</th><th>Name</th><th>Description</th></tr>
<tr><td>81300</td><td>Aboriginal Health Worker service</td><td rowspan="14">Allied Health Provider must be Medicare registered
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
GP refers to allied health professional using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department of Health
Allied health professionals must report back to the referring GP after first and last visit</td></tr>
<tr><td>81305</td><td>Diabetes Educator service</td></tr>
<tr><td>81310</td><td>Audiologist service</td></tr>
<tr><td>81315</td><td>Exercise physiologist service</td></tr>
<tr><td>81320</td><td>Dietician services</td></tr>
<tr><td>81325</td><td>Mental Health Worker service</td></tr>
<tr><td>81330</td><td>Occupational Therapist service</td></tr>
<tr><td>81335</td><td>Physiotherapist service</td></tr>
<tr><td>81340</td><td>Podiatrist service</td></tr>
<tr><td>81345</td><td>Chiropractor service</td></tr>
<tr><td>81350</td><td>Osteopath service</td></tr>
<tr><td>81355</td><td>Psychologist services</td></tr>
<tr><td>81360</td><td>Speech Pathologist service</td></tr>
</table>

ALLIED HEALTH 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).

Assessment and Provision of Group Services		
Item	**Name**	**Description**
81100	Assessment for Group Services by Diabetes Educator	• One assessment session only by either Diabetes Educator, Exercise Physiologist or Dietician per calendar year • Medical Allied Health Group Services for Type 2 Diabetes Referral Form
81110	Assessment for Group Services by Exercise Physiologist	
81120	Assessment for Group Services by Dietician	
81105	Diabetes Education - Group Service	• 8 group services per calendar year, can be 8 sessions with one provider or a combination e.g., 3 diabetes education, 3 dietician and 2 exercise physiology sessions • Medicare Allied Health Group Services for Type 2 Diabetes Referral Form
81115	Exercise Physiology – Group Service	
81125	Dietician – Group Service	

ANNEXURES

COVID-19 VACCINE SUITABILTIY ASSESSMENT ITEMS

Vaccine Suitability Assessment Services	**Items**	**Rebate**
Practice located in MMM 1, in hours consultation	93644	$36.35
Practice located in MMM 1, after hours consultation	93653	$41.15
Practice located in MMM 2-7, in hours consultation	93645	$39.90
Practice located in MMM 2-7, after hours consultation	93654	$52.75
Assessment outside of practice on behalf of GP		
Practice located in MMM 1	93660	$22.10
Practice located in MMM 2-7	93661	$25.25
Other vaccine services, for co-claiming with vaccine suitability assessment items		
In-depth assessment by GP (billable ONCE ONLY)	10660	$41.15
Flag-fall service for first patient seen at RACF, care home or home visit	90005	$122.40

Department of Health – COVID-19 Information https://www.health.gov.au/health-alerts/covid-19