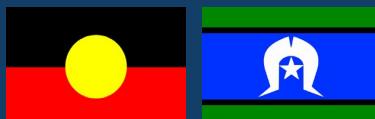




# Desktop Guide to MBS Item Numbers

## For Primary Health Care Services

Western Queensland PHN acknowledges the traditional owners of the country on which we work and live and recognises their continuing connection to land, waters and community.



**phn**  
WESTERN QUEENSLAND

An Australian Government Initiative

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This guide highlights the most commonly used MBS Item Numbers in primary care and helps ensure correct claiming. Before submitting a claim, please check the full item descriptions and criteria at [www.mbsonline.gov.au](http://www.mbsonline.gov.au) to confirm eligibility. This guide is based on the latest information from MBS Online. While we've made every effort to keep it accurate and up to date, please use your own professional judgement and always refer to MBS Online for the most current details.

#### MBS ONLINE

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[MBS Education for Health Professionals](#)

*To discuss further, or for more information contact your WQPHN Practice Support Team or*

[\*prac\\_support@wqphn.com.au\*](mailto:prac_support@wqphn.com.au)

Phone: 07 4573 1900

## 1. General Attendance Items - General Practitioners

Consultation Items: [Note AN.0.74 | Medicare Benefits Schedule](#)

	Level A Straightforward	Level B 6-20 minutes	Level C 20+ minutes	Level D 40+ minutes	Level E 60+ minutes
<b>Standard hours consultations</b>					
In consulting rooms	3	23	36	44	123
Out of consulting rooms	4	24	37	47	124
RACH <sup>1</sup>	90020	90035	90043	90051	90054
<b>After-hours</b>					
In consulting rooms <sup>2</sup>	5000	5020	5040	5060	5071
Out of consulting rooms <sup>3</sup>	5003	5023	5043	5063	5076
RACH <sup>1</sup>	5010	5028	5049	5067	5077
<b>Telehealth</b>					
Video	91790	91800	91801	91802	91920
Phone	91890	91891	91900 <sup>4</sup>	91910 <sup>4</sup>	NA

<sup>1</sup>Residential Aged Care Home

<sup>2</sup>Use on: public holiday; Sunday; before 8am or after 1 pm on Saturday; before 8am or after 8pm on any other day

<sup>3</sup>Use on: public holiday; Sunday; before 8am or after 12 noon on Saturday; before 8am or after 6pm on any other day

<sup>4</sup>Patients enrolled in MyMedicare only

Video and phone items are subject to eligibility criteria. ([see Note AN.1.1 | Medicare Benefits Schedule](#))

## 2. Bulk Billing Incentives for General Practitioners – Modified Monash 3 and 4 (Medium and Large Rural Towns)

[Note MN.1.5 | Medicare Benefits Schedule](#)

Applicable BBI item	75855	75873	75882 (MyMedicare enrolled patients only)
<b>Standard hours consultations</b>			
In consulting rooms	3	23, 36, 44, 123	
Out of consulting rooms	4	24, 37, 47, 124	
RACH <sup>1</sup>	90020	90035, 90043, 90051, 90054	
<b>Telehealth</b>			
Video	91790 (all) 91801, 91802, 91920 (if not MyMedicare enrolled)	91800	91801, 91802, 91920
Phone	91890	91891	91900, 91910
<b>After hours consultations</b>			
In consulting rooms	5000	5020, 5040, 5060, 5071	
Out of consulting rooms	5003	5023, 5043, 5063, 5076	
RACH <sup>1</sup>	5010	5028, 5049, 5067, 5077	
<b>Other</b>	All other “unreferred services”, including but not limited to: chronic condition management items, Better Access mental health items, health assessments, minor procedures etc – <b>Claim Item 75855</b>		

<sup>1</sup>Residential Aged Care Home

[Health Workforce Locator](#)

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### 3. Bulk Billing Incentives for General Practitioners – Modified Monash 5 (Small Rural Towns)

[Note MN.1.6 | Medicare Benefits Schedule](#)

Applicable BBI item	75856	75874	75883 (MyMedicare enrolled patients only)
Standard hours consultations			
In consulting rooms	3	23, 36, 44, 123	
Out of consulting rooms	4	24, 37, 47, 124	
RACH <sup>1</sup>	90020	90035, 90043, 90051, 90054	
Telehealth			
Video	91790 (all) 91801, 91802, 91920 (if not MyMedicare enrolled)	91800	91801, 91802, 91920
Phone	91890	91891	91900, 91910
After hours consultations			
In consulting rooms	5000	5020, 5040, 5060, 5071	
Out of consulting rooms	5003	5023, 5043, 5063, 5076	
RACH <sup>1</sup>	5010	5028, 5049, 5067, 5077	
Other	All other “unreferred services”, including but not limited to: chronic condition management items, Better Access mental health items, health assessments, minor procedures etc – <b>Claim Item 75856</b>		

<sup>1</sup>Residential Aged Care Home

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## 4. Bulk Billing Incentives for General Practitioners – Modified Monash 6 (Remote Communities)

[Note MN.1.7 | Medicare Benefits Schedule](#)

Applicable BBI item	75857	75875	75884 (MyMedicare enrolled patients only)
Standard hours consultations			
In consulting rooms	3	23, 36, 44, 123	
Out of consulting rooms	4	24, 37, 47, 124	
RACH <sup>1</sup>	90020	90035, 90043, 90051, 90054	
Telehealth			
Video	91790 (all) 91801, 91802, 91920 (if not MyMedicare enrolled)	91800	91801, 91802, 91920
Phone	91890	91891	91900, 91910
After hours consultations			
In consulting rooms	5000	5020, 5040, 5060, 5071	
Out of consulting rooms	5003	5023, 5043, 5063, 5076	
RACH <sup>1</sup>	5010	5028, 5049, 5067, 5077	
Other	All other “unreferred services”, including but not limited to: chronic condition management items, Better Access mental health items, health assessments, minor procedures etc – <b>Claim Item 75857</b>		

<sup>1</sup>Residential Aged Care Home

[Health Workforce Locator](#)

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## 5. Bulk Billing Incentives for General Practitioners – Modified Monash 7 (Very Remote Communities)

[Note MN.1.8 | Medicare Benefits Schedule](#)

Applicable BBI item	75858	75876	75885 (MyMedicare enrolled patients only)
Standard hours consultations			
In consulting rooms	3	23, 36, 44, 123	
Out of consulting rooms	4	24, 37, 47, 124	
RACH <sup>1</sup>	90020	90035, 90043, 90051, 90054	
Telehealth			
Video	91790 (all) 91801, 91802, 91920 (if not MyMedicare enrolled)	91800	91801, 91802, 91920
Phone	91890	91891	91900, 91910
After hours consultations			
In consulting rooms	5000	5020, 5040, 5060, 5071	
Out of consulting rooms	5003	5023, 5043, 5063, 5076	
RACH <sup>1</sup>	5010	5028, 5049, 5067, 5077	
Other	All other “unreferred services”, including but not limited to: chronic condition management items, Better Access mental health items, health assessments, minor procedures etc – <b>Claim Item 75858</b>		

<sup>1</sup>Residential Aged Care Home

[Health Workforce Locator](#)

## 6. Bulk Billing Incentives for MM1 located Practitioners Outreach to MM2-7 - General Practitioners (GPs), Medical Practitioners (MPs) and Prescribed Medical Practitioners (PMPs)

If service is provided in an MM 2 – 7 area by a GP, MP or PMP whose practice is located in an MM 1 area, then BBI item number 10992 or 7 is claimed.

Applicable BBI item	10992	75872
General Practitioners		
After hours consultations - out of consulting rooms	5003	5023, 5043, 5063, 5076
After hours consultations - residential aged care home	5010	5028, 5049, 5067, 5077
MPs and PMPs		
After hours consultations - out of consulting rooms	5220, <u>761</u>	5223, 5227, 5228, 5261, <u>763</u> , <u>766</u> , <u>769</u> , <u>2198</u>
After hours consultations - residential aged care home	5260, <u>772</u>	5263, 5265, 5267, 5262, <u>776</u> , <u>788</u> , <u>789</u> , <u>2200</u>

Items underlined can only be claimed by prescribed medical practitioners, that is, medical practitioners that are not GPs, specialists or consultant physicians.

Items **10992** and **75872** can only be claimed in conjunction with specified after-hours MBS items. In addition to the standard requirements for use of BBIs, the following additional requirements apply:

- The service is not provided in consulting rooms
- The service is provided in a Modified Monash 2-7 area, and
- The service is provided by, or on behalf of, a medical practitioner whose practice is in a Modified Monash 1 area.

**Co-Claiming Restrictions**

BBIs must be claimed in conjunction with an eligible MBS item. BBIs can only be claimed when the patient is bulk billed for the medical service. Only one BBI can be claimed in conjunction with each medical service (i.e. each MBS item) that is provided.

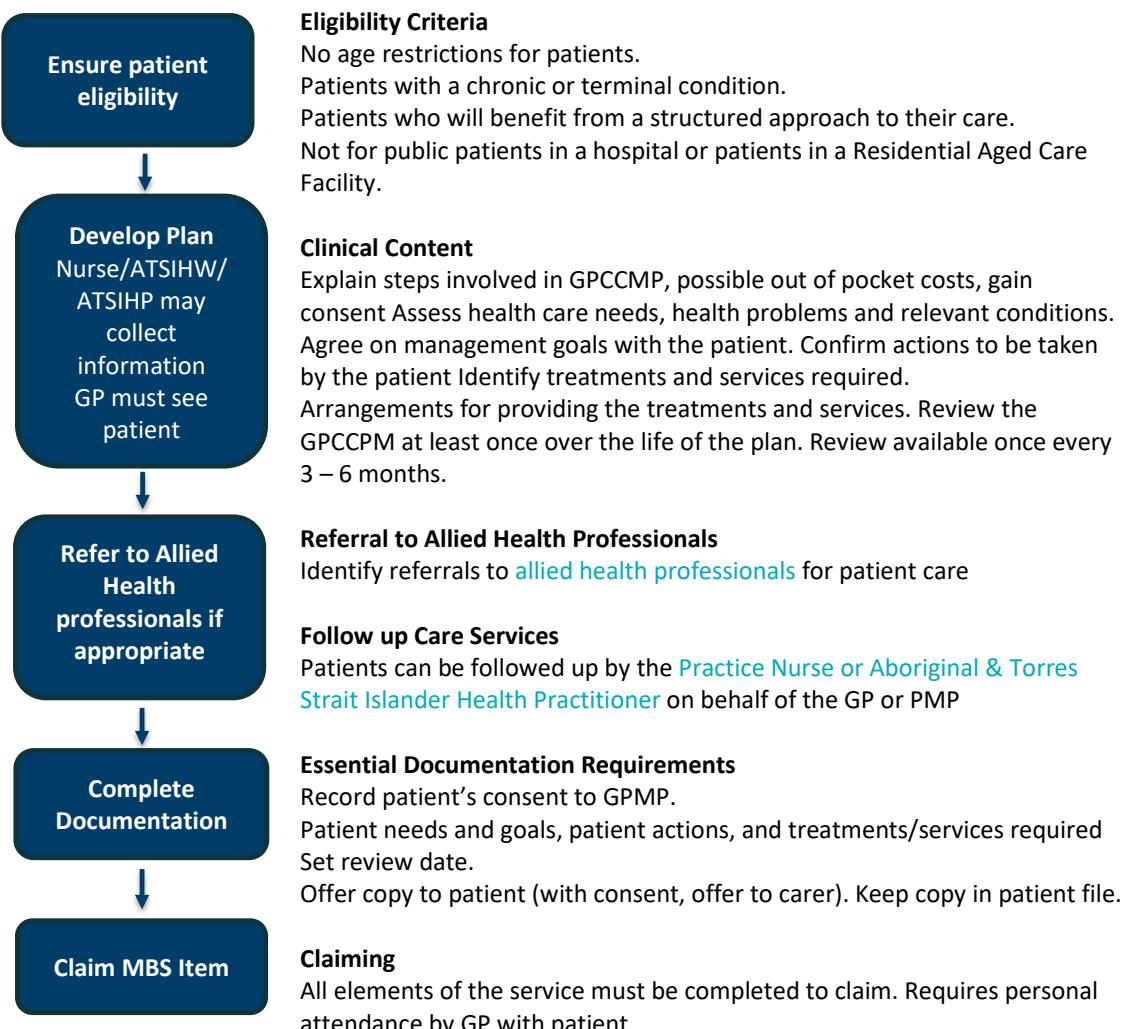
BBIs cannot be claimed in conjunction with diagnostic imaging or pathology services. A separate set of incentives are available to use in conjunction with diagnostic imaging and pathology services.

## 7. Chronic Conditions Management Plan Items for General Practitioners and Prescriber Medical Practitioners

Service	GP Item Number	PMP Item Number	Frequency of Claiming
Prepare GPCCMP			
Prepare a GP chronic condition management plan – face to face	965	392	Initial plan development. New plan only if clinically necessary.
Prepare a GP chronic condition management plan – video	92029	92060	Initial plan development. New plan only if clinically necessary.
Review GPCCMP			
Review a GP chronic condition management plan – face to face	967	393	Up to every 3 months if clinically relevant
Review a GP chronic condition management plan – video	92030	92061	Up to every 3 months if clinically relevant
<ul style="list-style-type: none"><li>There is no list of eligible conditions. It is up to the GP or PMP's clinical judgment to determine whether an individual patient with a chronic condition would benefit from a GPCCMP.</li><li>Patients registered with MyMedicare must access GPCCMP items through the practice where they are enrolled. Patients who are not registered must access GPCCMP items through their usual GP. These requirements are the same for face to face and telehealth items.</li><li>GPCCMP's are not available to patients who are care recipients in a residential aged care facility. Allied Health services are available to these patients through the multidisciplinary care plan.</li></ul>			
<b>Co-Claiming Restrictions</b> Planning and review items for GP chronic condition management plans cannot be co-claimed by the same practitioner on the same day for the same patient as general attendance items (note the date of service should be recorded as the date the attendance occurred). See: <ul style="list-style-type: none"><li>General Attendance Items - General Practitioners</li><li>General Attendance Items – Medical Practitioners (MPs) and Prescribed Medical Practitioners (PMPs)</li></ul>			

## 7.1. GP Chronic Condition Management Plan (GPCCMP)

[Note AN.0.47 | Medicare Benefits Schedule](#)

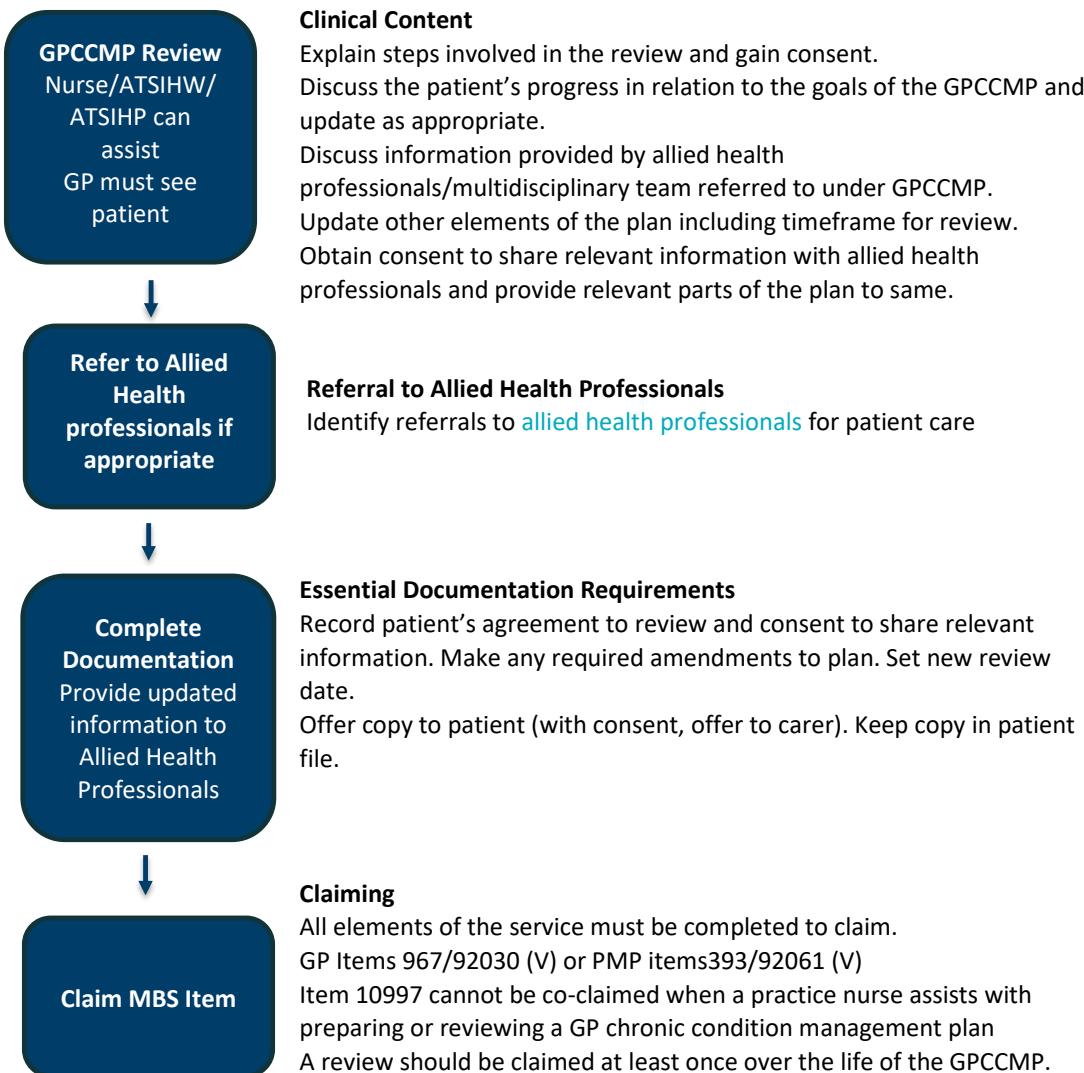


\*Exceptional circumstances exist for a patient if there has been a significant change in the patient's clinical condition or care requirements that necessitate the performance of the service for the patient.

MBS Items	Name	Recommended Frequency
10997 93201 (V) 93203 (T)	Service provided by a practice nurse or an Aboriginal and Torres Strait Islander health practitioner to a person with a chronic condition	Up to 5 services per calendar year

## 7.2. GP Chronic Condition Management Plan (GPCCMP) Review

[Note AN.0.47 | Medicare Benefits Schedule](#)



MBS Items	Name	Recommended Frequency
GP <a href="#">967/92030</a> (V) PMP <a href="#">393/92061</a> (V)	GP Chronic Condition Management Plan Review	Once every 3 months

## 8. Multidisciplinary Case Conferencing Items

[Note AN.0.49 | Medicare Benefits Schedule](#)

Item Description	GP Item Number	PMP Item Number	Allied Health
<b>Organise and coordinate</b>			
At least 15 minutes but less than 20 minutes	735	235	
At least 20 minutes but less than 40 minutes	739	236	
At least 40 minutes	743	237	
<b>Participate</b>			
At least 15 minutes but less than 20 minutes	747	238	10955
At least 20 minutes but less than 40 minutes	750	239	10957
At least 40 minutes	758	240	10959
<p>A multidisciplinary case conference team must include, at a minimum, a medical practitioner and at least two (2) other members, one of whom may be another medical practitioner. Each member must provide a different kind of care or service to the patient.</p> <p>A multidisciplinary case conference as a process by which a multidisciplinary case conference team carries out all of the following activities:</p> <ul style="list-style-type: none"><li>• Discussing a patient's history.</li><li>• Identifying a patient's multidisciplinary care needs.</li><li>• Identifying outcomes to be achieved by members of the multidisciplinary case conference team giving care and service to the patient.</li><li>• Identifying tasks that need to be undertaken to achieve these outcomes and allocating those tasks to members of the multidisciplinary case conference team.</li><li>• Assessing whether previously identified outcomes (if any) have been achieved.</li></ul> <p>Multidisciplinary case conference items for GPs and PMPs are time tiered. There are separate items for organising and coordinating a multidisciplinary case conference and participating in a multidisciplinary case conference that has been organised by another person. The multidisciplinary case conference items can be used when:</p> <ul style="list-style-type: none"><li>• The patient is living in the community.</li><li>• The patient is a resident in a residential aged care home.</li><li>• The case conference is for an admitted patient of a hospital prior to their discharge.</li></ul>			

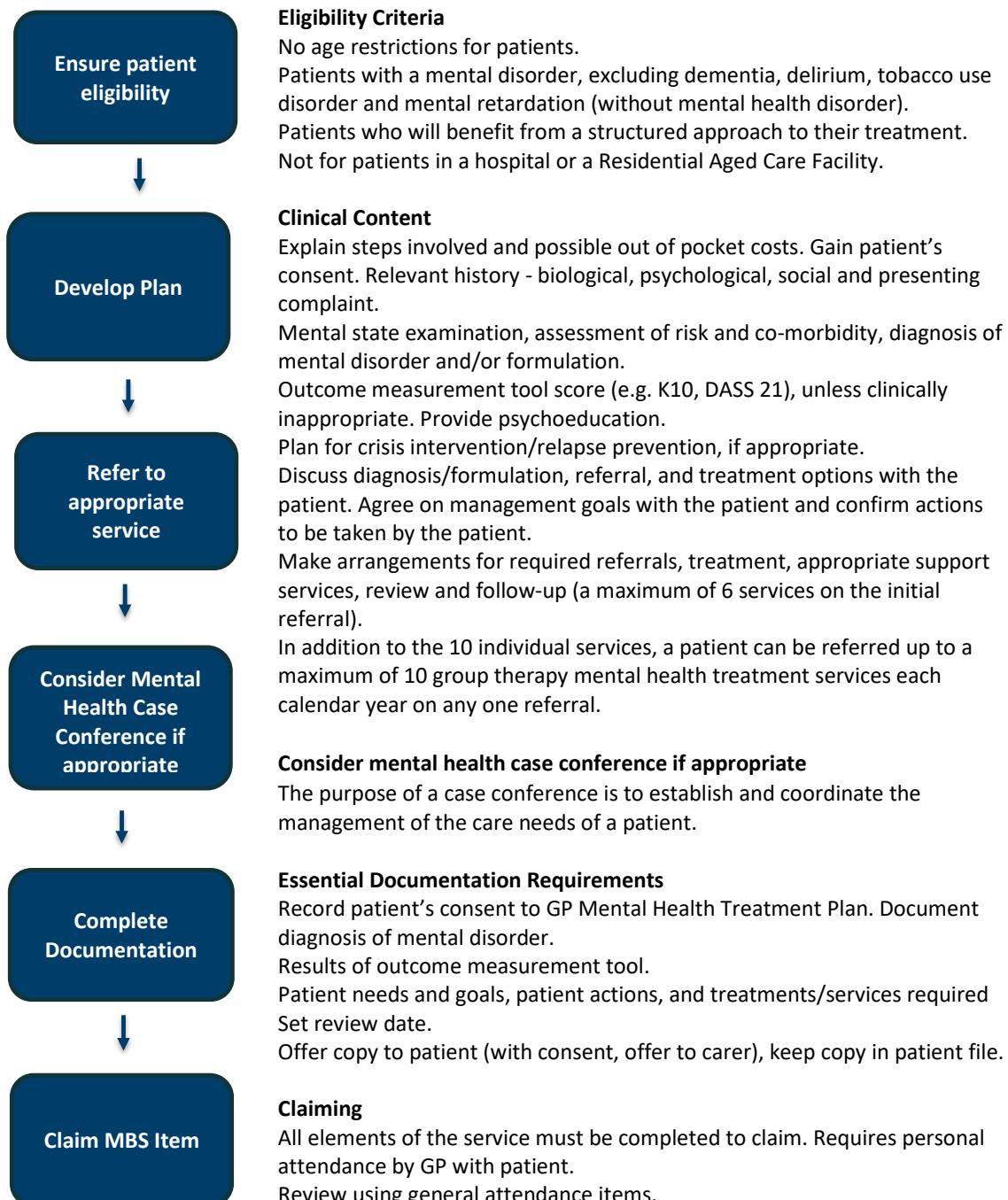
## 9. Better Access Mental Health

### Note AN.0.78 | Medicare Benefits Schedule

Item Description	Face to Face	Telehealth
Mental Health Treatment Plans for GP/PMPs who <b>have</b> undertaken mental health skills training		
MHTP for GP 20 < 40 mins duration	2715	92116
MHTP for GP 40+ mins duration	2717	92117
MHTP for PMP 20 < 40 mins duration	281	92122
MHTP for PMP 40+ mins duration	282	92123
Mental Health Treatment Plans for GP/PMPs who <b>have not</b> undertaken mental health skills training		
MHTP for GP 20 < 40 mins duration	2700	92112
MHTP for GP 40+ mins duration	2701	92113
MHTP for PMP 20 < 40 mins duration	272	92118
MHTP for PMP 40+ mins duration	276	92119
Note: A new plan should not be prepared unless clinically required, and generally not within 12 months of a previous plan, unless exceptional circumstances exist.		
MHTP Review/Refer/Ongoing Mental Health Consultation		
^Phone Level C and D general attendance items ( <b>GP</b> or <b>MP/PMP</b> ) can only be claimed for MyMedicare registered patients by the patients' MyMedicare practice.	Level B, C, D, E	Level B, C^, D^, E
Case Conferencing GP Organises		
Duration < 20 mins	930	969
Duration 20 < 40 mins	933	971
Duration 40+ mins	935	972
Case Conference GP participating		
Duration < 20 mins	937	973
Duration 20 < 40 mins	943	975
Duration 40+ mins	945	986
<b>Services provided under Better Access</b> Through Better Access, eligible patients can claim a Medicare benefit for up to 10 individual and 10 group mental health treatment services per calendar year. These services consist of:		
<ul style="list-style-type: none"><li>• Psychological therapy provided by eligible clinical psychologists (refer to explanatory note <a href="#">MN.6.2 – Provision of Psychological Therapy</a>).</li><li>• Focussed psychological strategies provided by GPs, PMPs and eligible psychologists, occupational therapists, and social workers (refer to explanatory note <a href="#">MN.7.4 – Provision of Focussed Psychological Strategies</a>).</li></ul>		

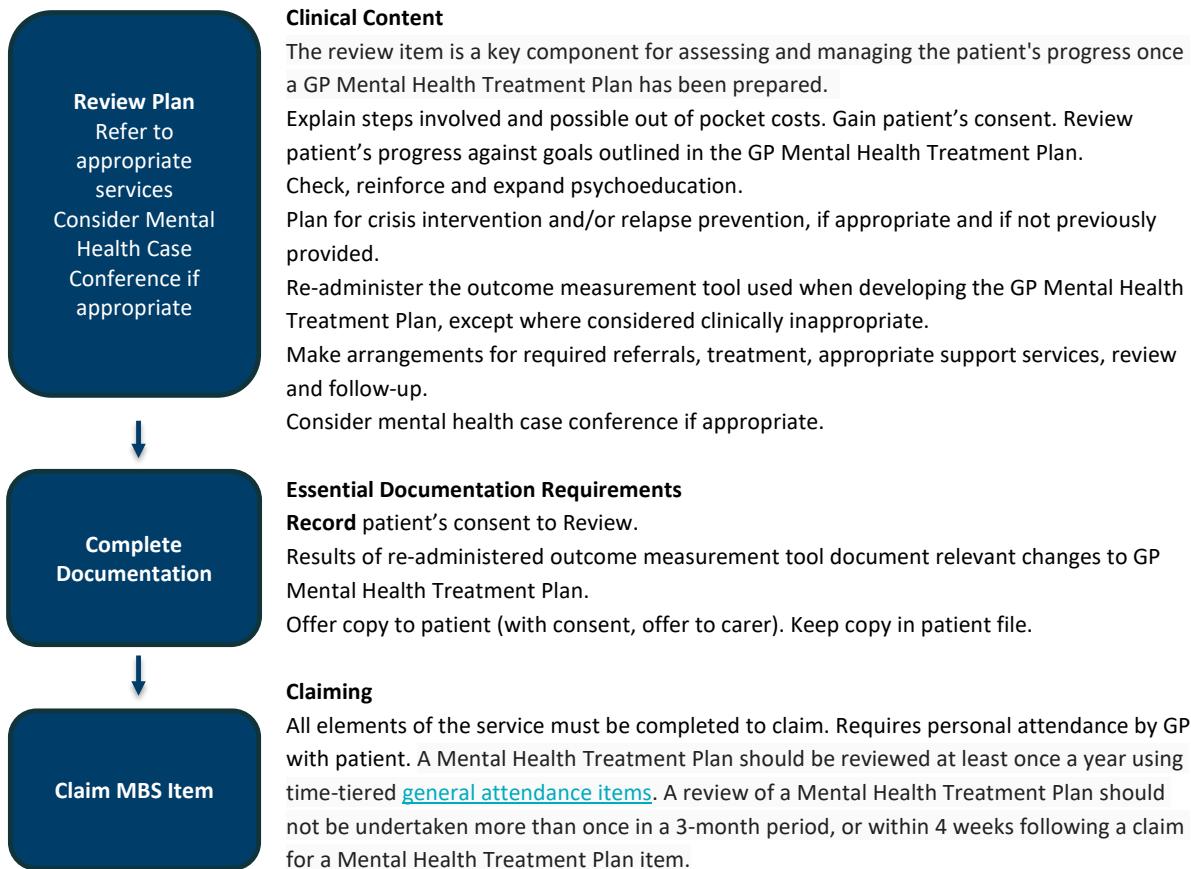
## 9.1. Mental Health Treatment Plan

[Note AN.0.56 | Medicare Benefits Schedule](#)



## 9.2. Review of Mental Health Treatment Plan

[Note AN.0.56 | Medicare Benefits Schedule](#)



### Mental Health Case Conference service requirements

[Note AN.15.1 | Medicare Benefits Schedule](#)

A case conference is a process by which a multidisciplinary team carries out the following activities:

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

The GP/PMP can organise or participate in the case conference.

A mental health case conference must be organised by a GP, PMP or consultant physician specialising in the practice of their field of psychiatry or paediatrics and involve at least 2 other members of the multidisciplinary case conference team providing different kinds of treatment to the patient.

Other members of the case conference team may include allied health professionals, home and community service providers, and care organisers. Participating providers must be invited to attend by the organising practitioner.

## 10. Time-tiered Health Assessments

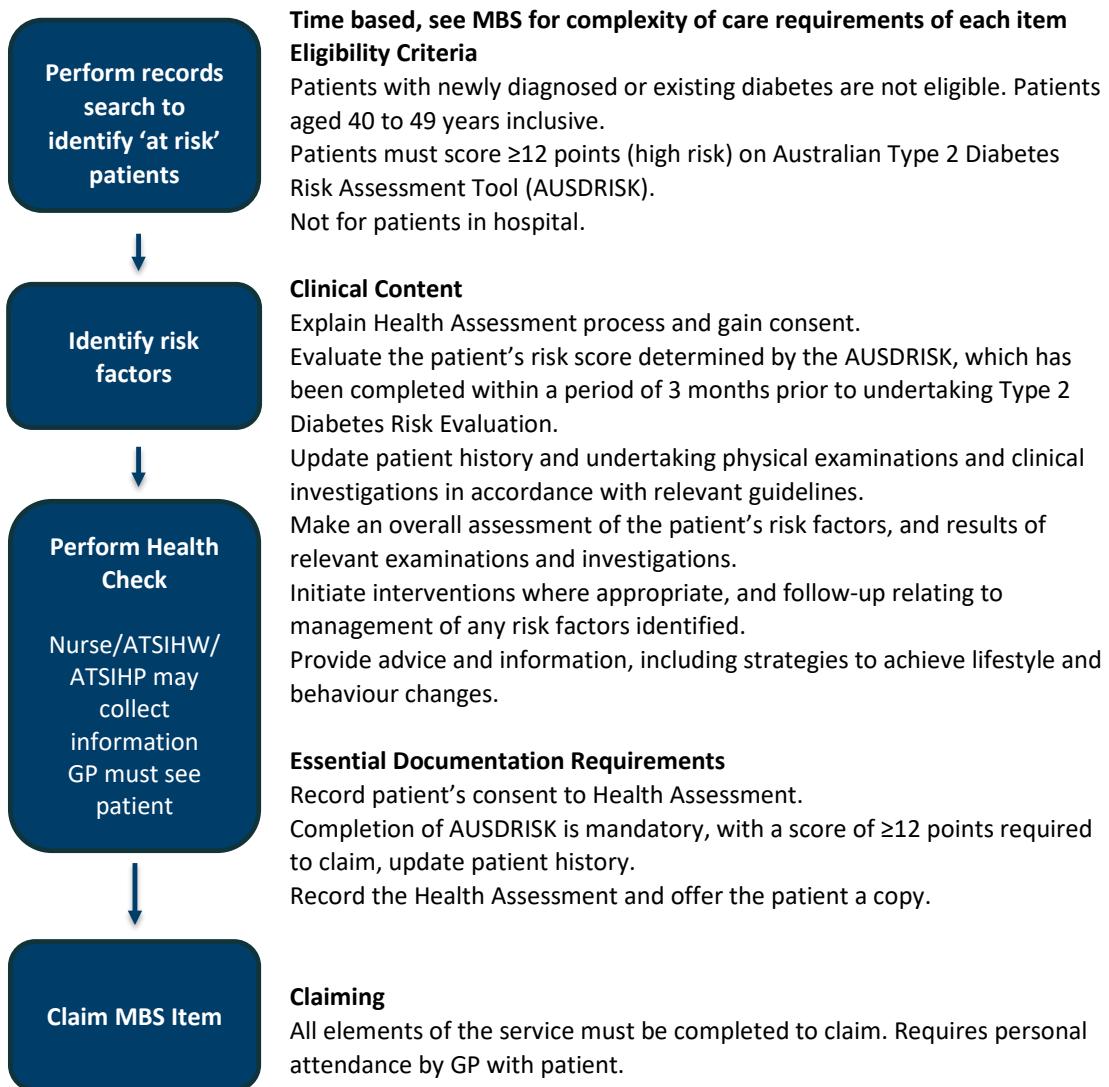
[Note AN.0.36 | Medicare Benefits Schedule](#)

Item Number GP	Item Number PMP	Item Name	Description
701	224	Brief Health Assessment < 30 mins	Professional attendance by a general practitioner to perform: <ul style="list-style-type: none"><li>Collection of relevant information, including taking a patient history and</li><li>A basic physical examination and</li><li>Initiating interventions and referrals as indicated and</li><li>Providing the patient with preventive health care advice and information.</li></ul>
703	225	Standard Health Assessment 30 - 44 minutes	Professional attendance by a general practitioner to perform: <ul style="list-style-type: none"><li>Detailed information collection, including taking a patient history and</li><li>An extensive physical examination and</li><li>Initiating interventions and referrals as indicated and</li><li>Providing a preventive health care strategy for the patient.</li></ul>
705	226	Long Health Assessment 45 - 59 minutes	Professional attendance by a general practitioner to perform: <ul style="list-style-type: none"><li>Comprehensive information collection, including taking a patient history and</li><li>An extensive examination of the patient's medical condition and physical function and</li><li>Initiating interventions and referrals as indicated; and</li><li>Providing a basic preventive health care management plan for the patient.</li></ul>
707	227	Prolonged Health Assessment Lasting at least 60 minutes	Professional attendance by a general practitioner to perform: <ul style="list-style-type: none"><li>Comprehensive information collection, including taking a patient history and</li><li>Extensive examination of the patient's medical condition, and physical, psychological, and social function and</li><li>Initiating interventions and referrals as indicated and</li><li>Providing a comprehensive preventive health care management plan for the patient.</li></ul>
Time-tiered health assessment items are only available to specific patient cohorts. Details of the requirements for a health assessment for each patient cohort:			
<ul style="list-style-type: none"><li>Type 2 diabetes risk evaluation (40-49 years) – <b>Once every 3 years to an eligible patient.</b></li><li>Health assessment for people aged 45-49 years (inclusive) who are at risk of developing chronic disease – <b>Once only to an eligible patient.</b></li><li>Health Assessment provided for people aged 75 years and older – <b>Provided annually.</b></li><li>Health Assessment provided as a comprehensive medical assessment for residents of residential aged care homes – <b>Provided annually.</b></li><li>Health Assessment provided for people with an intellectual disability – <b>Provided annually.</b></li><li>Health Assessment provided for refugees and other humanitarian entrants – <b>Once only.</b></li><li>One-off health assessment for veterans – <b>Once only.</b></li></ul>			
Practice nurses, Aboriginal health workers and Aboriginal Torres Strait Islander health practitioners may assist in accordance with accepted medical practice under the supervision of the medical practitioner.			

## 11. Type 2 Diabetes Risk Evaluation – Health Assessment

**GP Items 701/ 703/ 705/ 707 & PMP Items 224/ 225/ 226/ 227**

[Note AN.0.37 | Medicare Benefits Schedule](#)



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## 11.1. Diabetes Cycle of Care

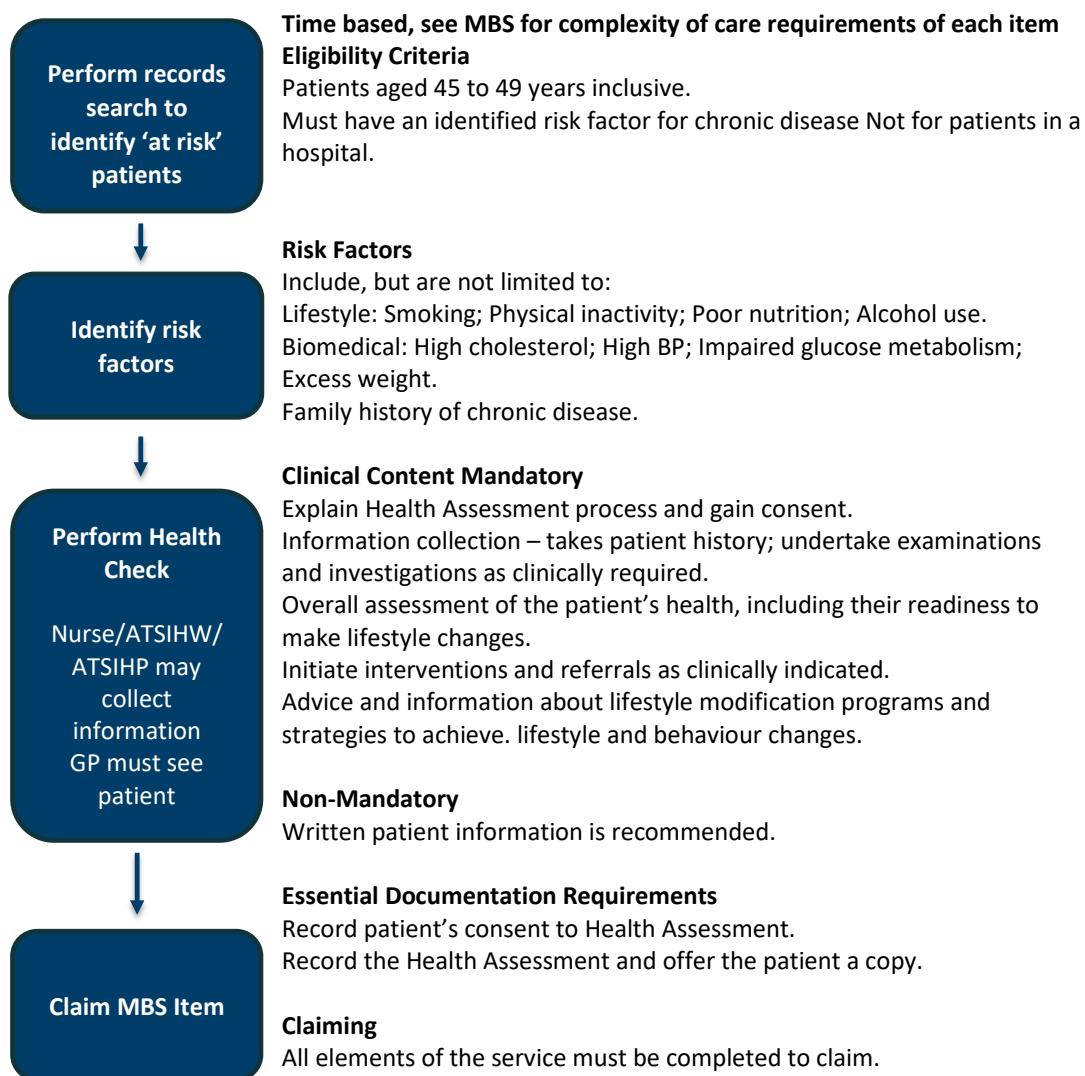
[RACGP - Assessment of the person with type 2 diabetes](#)

Check	Frequency
Foot assessment for high risk feet	Every 1-3 months
Foot assessment for moderate risk feet	Every 3-6 months
Blood Pressure	At least every 6 months
Weight	At least every 6 months
Waist circumference	At least every 6 months
HbA1c	At least every 6-12 months
Foot assessment for Very-low and low-risk feet	At least every year
Kidney health	At least every year
Blood fats	At least every year
Healthy eating review	At least every year
Physical activity review	At least every year
Medication review	At least every year
Smoking	At least every year
Diabetes management	At least every year
Eye examination	At least every two years
Emotional health	As needed

## 12. 45 – 49-Year-Old Health Assessment

**GP Items 701/ 703/ 705/ 707 & PMP Items 224/ 225/ 226/ 227**

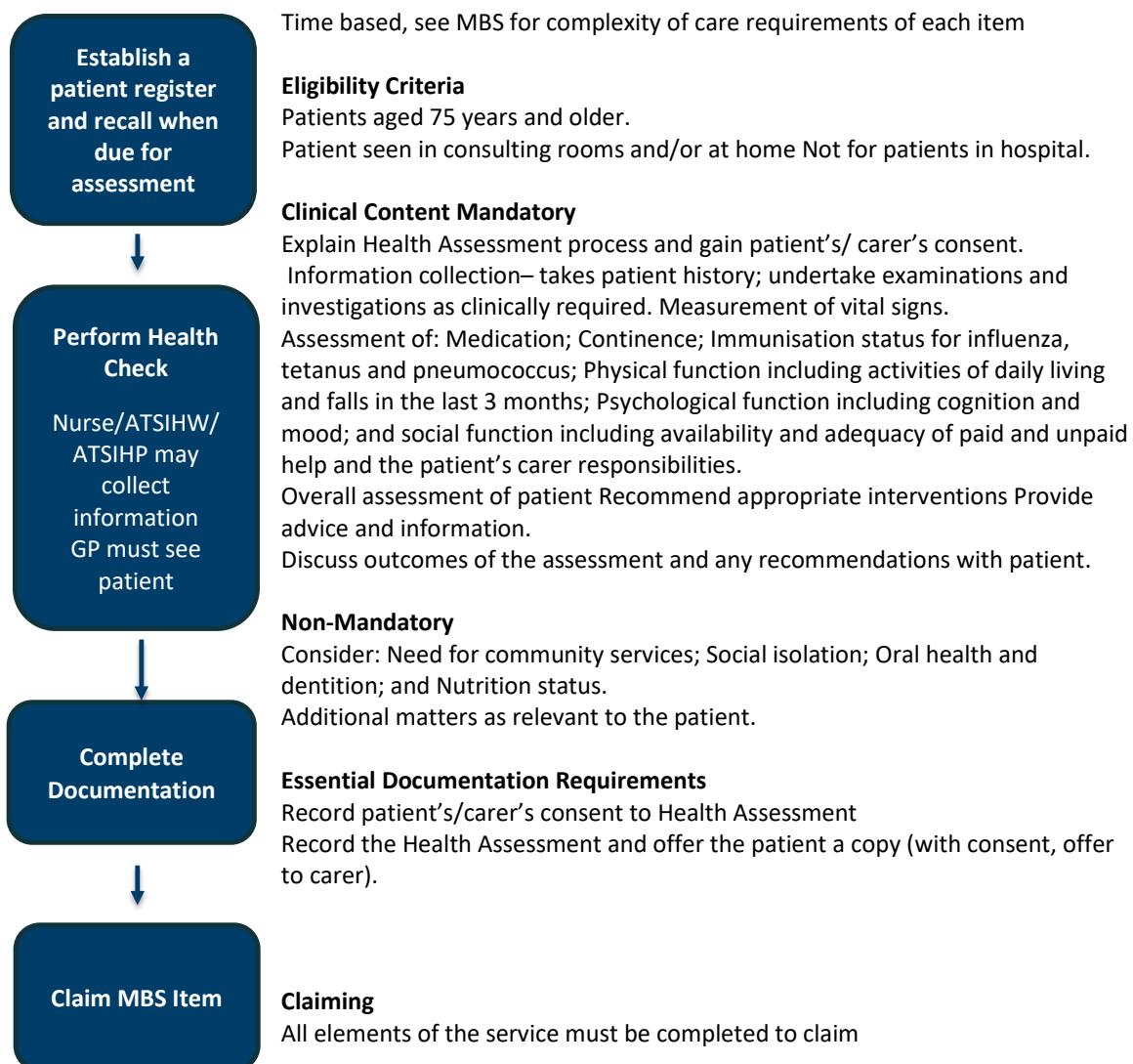
[Note AN.0.38 | Medicare Benefits Schedule](#)



## 13. 75 Years and Older - Health Assessment

### GP Items 701/ 703/ 705/ 707 & PMP Items 224/ 225/ 226/ 227

[Note AN.0.39 | Medicare Benefits Schedule](#)



## 14. Residential Aged Care Home and GPACI

Item Number GP	Item Number PMP	Item Description
731	232	<p>Contribution or review of Multidisciplinary Care Plan</p> <p>A multidisciplinary care plan for a patient in a residential aged care facility, prepared by that facility, or to a review of such a plan prepared by such a facility; or</p> <p>A multidisciplinary care plan prepared for a patient by another provider before the patient is discharged from a hospital, or to a review of such a plan prepared by another provider</p> <p><a href="#">Note AN.15.8   Medicare Benefits Schedule</a></p>
701-707	224-227	<p><b>Health Assessment</b></p> <p>Comprehensive medical assessment for permanent residents of a Residential Aged Care Facility (new and existing)</p> <p><a href="#">Note AN.0.40   Medicare Benefits Schedule</a></p>
903	249	<p><a href="#">Residential Medication Management Reviews (RMMR)</a></p>
Time-tiered health assessment items may be used to undertake a Comprehensive Medical Assessment for a care recipient of a residential aged care home (RACH).		
<p>A Comprehensive Medical Assessment may be claimed by eligible patients:</p> <ul style="list-style-type: none"><li>on admission to a residential aged care facility, if a Comprehensive Medical Assessment has not already been provided in another residential aged care facility in the last 12 months, and</li><li>at 12-month intervals after that assessment.</li></ul>		
Consent to the health assessment must be noted in the patient's records.		
A health assessment must include the following elements:		
<ul style="list-style-type: none"><li>Information collection, including taking a patient history and undertaking or arranging examinations and investigations as required;</li><li>Making an overall assessment of the patient;</li><li>Recommending appropriate interventions;</li><li>Providing advice and information to the patient;</li><li>Keeping a record of the health assessment, and offering the patient a written report about the health assessment, with recommendations about matters covered by the health assessment; and</li><li>Offering the patient's carer (if any, and if the general practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report relevant to the carer.</li></ul>		
<p><b>Co-Claiming Restrictions</b></p> <p>A Comprehensive Medical Assessment may be performed in conjunction with a consultation for another purpose but must be claimed separately.</p> <p>To co-claim a Comprehensive Medical Assessment item and another item, both items must be clinically necessary and distinct services.</p>		
<p><b>RMMR</b></p> <p>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</p>		

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## GPACI RACH Visits – Sample Schedule – Responsible Provider Visiting Only

Practicing in MM4-7 where telehealth appointments can be used as follow up

Quarter 1	Quarter 2	Quarter 3	Quarter 4
<p> <b>2 x Eligible Visits</b></p> <p>Must be claimed in separate calendar months</p> <p>MBS Items 90035-90054 OR MBS 90188-90215 OR MBS 90093-90096 OR non-urgent after-hours item</p> <p><b>OR</b> Can use MBS 91800 - 91803 Telehealth Service as follow up appointment in the quarter</p>	<p> <b>2 x Eligible Visits</b></p> <p>Must be claimed in separate calendar months</p> <p>MBS Items 90035-90054 OR MBS 90188-90215 OR MBS 90093-90096 OR non-urgent after-hours item</p> <p><b>OR</b> Can use MBS 91800 - 91803 Telehealth Service as follow up appointment in the quarter</p>	<p> <b>2 x Eligible Visits</b></p> <p>Must be claimed in separate calendar months</p> <p>MBS Items 90035-90054 OR MBS 90188-90215 OR MBS 90093-90096 OR non-urgent after-hours item</p> <p><b>OR</b> Can use MBS 91800 - 91803 Telehealth Service as follow up appointment in the quarter</p>	<p> <b>2 x Eligible Visits</b></p> <p>Must be claimed in separate calendar months</p> <p>MBS Items 90035-90054 OR MBS 90188-90215 OR MBS 90093-90096 OR non-urgent after-hours item</p> <p><b>OR</b> Can use MBS 91800 - 91803 Telehealth Service as follow up appointment in the quarter</p>

### Across the 12-month period must provide 2 of the below Eligible Care Planning Items

These can be claimed at any point across the 12-months. Claiming MBS 731 early in the cycle (Q1) enables other MBS items and referrals. MBS 731 can be co-claimed with other items.



#### Contribution or review of Multidisciplinary Care Plan

MBS 731 OR 232 can be co-claimed with any of the following:

#### Comprehensive Medical Assessment

MBS 703-707 OR MBS 224-227

Comprehensive Management Plan (CMA) - **OR** DVA MTT01 – 707

Health Assessment item

**\*Item choice depends on length of assessment and type of practitioner\***

#### Residential Medication Management Review

#### Case Conference

#### Residential Medication Management Review

#### Case Conference

MBS 235-240 OR MBS 735-758

Multidisciplinary Care Conference

MBS 903 OR MBS249

Multidisciplinary Care Conference

MBS 235-240 OR MBS 735-758

Multidisciplinary Care Conference

MBS 903 OR MBS249

Multidisciplinary Care Conference

**\*Item choice depends on length of conference and type of practitioner\***

**\*Item choice depends on practitioner type\***

**\*Item choice depends on length of conference and type of practitioner\***

**NOTE:** Completing 2 Regular Visits with your patient per quarter triggers the incentive payment to both the Responsible Practitioner and the Practice. Payments will not be triggered if the two visits are not completed within the quarter in two separate calendar months. Triple Bulk Billing applies with eligible patients.

**Note this visiting schedule is only relevant for practitioners in MM4-7 areas. Can claim up to 4 telehealth consults across the 12-months**

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<b>GPACI RACH Visits – Sample Schedule – Responsible Provider + Alternate Provider</b> Other GP/Prescribed Medical Practitioner/Nurse Practitioner + Practicing in MM4-7 where telehealth appointments can be used as follow up			
Quarter 1	Quarter 2	Quarter 3	Quarter 4
 <b>2 x Eligible Visits</b>  <b>2 x Eligible Visits</b>  <b>2 x Eligible Visits</b>  <b>2 x Eligible Visits</b>  <b>2 x Eligible Visits</b>	 <b>1 x Responsible Provider + 1 x Alternate Provider</b> <b>Must be claimed in separate calendar months</b> MBS Items 90035-90054 <b>OR</b> MBS 90188-90215 <b>OR</b> MBS 90093-90096 <b>OR</b> MBS 82205-82215 OR non-urgent after-hours item  <b>OR</b> Can use MBS 91800 - 91803 Telehealth Service as follow up appointment in the quarter	 <b>1 x Responsible Provider + 1 x Alternate Provider</b> <b>Must be claimed in separate calendar months</b> MBS Items 90035-90054 <b>OR</b> MBS 90188-90215 <b>OR</b> MBS 90093-90096 <b>OR</b> MBS 82205-82215 OR non-urgent after-hours item  <b>OR</b> Can use MBS 91800 - 91803 Telehealth Service as follow up appointment in the quarter	 <b>1 x Responsible Provider + 1 x Alternate Provider</b> <b>Must be claimed in separate calendar months</b> MBS Items 90035-90054 <b>OR</b> MBS 90188-90215 <b>OR</b> MBS 90093-90096 <b>OR</b> MBS 82205-82215 OR non-urgent after-hours item  <b>OR</b> Can use MBS 91800 - 91803 Telehealth Service as follow up appointment in the quarter
<b>Across the 12-month period must provide 2 of the below Eligible Care Planning Items</b> These can be claimed at any point across the 12-months. Claiming MBS 731 early in the cycle (Q1) enables other MBS items and referrals. MBS 731 can be co-claimed with other items.			
 <b>Contribution or review of Multidisciplinary Care Plan</b> MBS 731 OR 232 can be co-claimed with any of the following:	 <b>Case Conference</b> MBS 235-240 <b>OR</b> MBS 735-758   <b>Residential Medication Management Review</b> MBS 235-240 <b>OR</b> MBS 735-758   <b>Case Conference</b> MBS 235-240 <b>OR</b> MBS 735-758   <b>Multidisciplinary Care Conference</b> MBS 903 <b>OR</b> MBS249   <b>Multidisciplinary Care Conference</b> MBS 235-240 <b>OR</b> MBS 735-758	 <b>2 x Eligible Visits</b>  <b>2 x Eligible Visits</b>  <b>2 x Eligible Visits</b>  <b>2 x Eligible Visits</b>  <b>2 x Eligible Visits</b>	 <b>1 x Responsible Provider + 1 x Alternate Provider</b> <b>Must be claimed in separate calendar months</b> MBS Items 90035-90054 <b>OR</b> MBS 90188-90215 <b>OR</b> MBS 90093-90096 <b>OR</b> MBS 82205-82215 OR non-urgent after-hours item  <b>OR</b> Can use MBS 91800 - 91803 Telehealth Service as follow up appointment in the quarter
<b>*Item choice depends on length of conference and type of practitioner*</b>  <b>*Item choice depends on length of conference and type of practitioner*</b>	<b>*Item choice depends on practitioner type*</b>  <b>*Item choice depends on length of conference and type of practitioner*</b>	<b>*Item choice depends on length of conference and type of practitioner*</b>  <b>*Item choice depends on length of conference and type of practitioner*</b>	
<b>NOTE:</b> Completing 2 Regular Visits with your patient per quarter triggers the incentive payment to both the Responsible Practitioner and the Practice. Payments will not be triggered if the two visits are not completed within the quarter in two separate calendar months. Triple Bulk Billing applies with eligible patients. Also note, the <b>RESPONSIBLE PROVIDER</b> must complete <b>4 of the eligible regular services - 1 per quarter</b> across the 12-months, another GP or Nurse Practitioner can provide the other regular visits. <b>Note this visiting schedule is only relevant for practitioners in MM4-7 areas. Can claim up to 4 telehealth consults across the 12-months</b>			

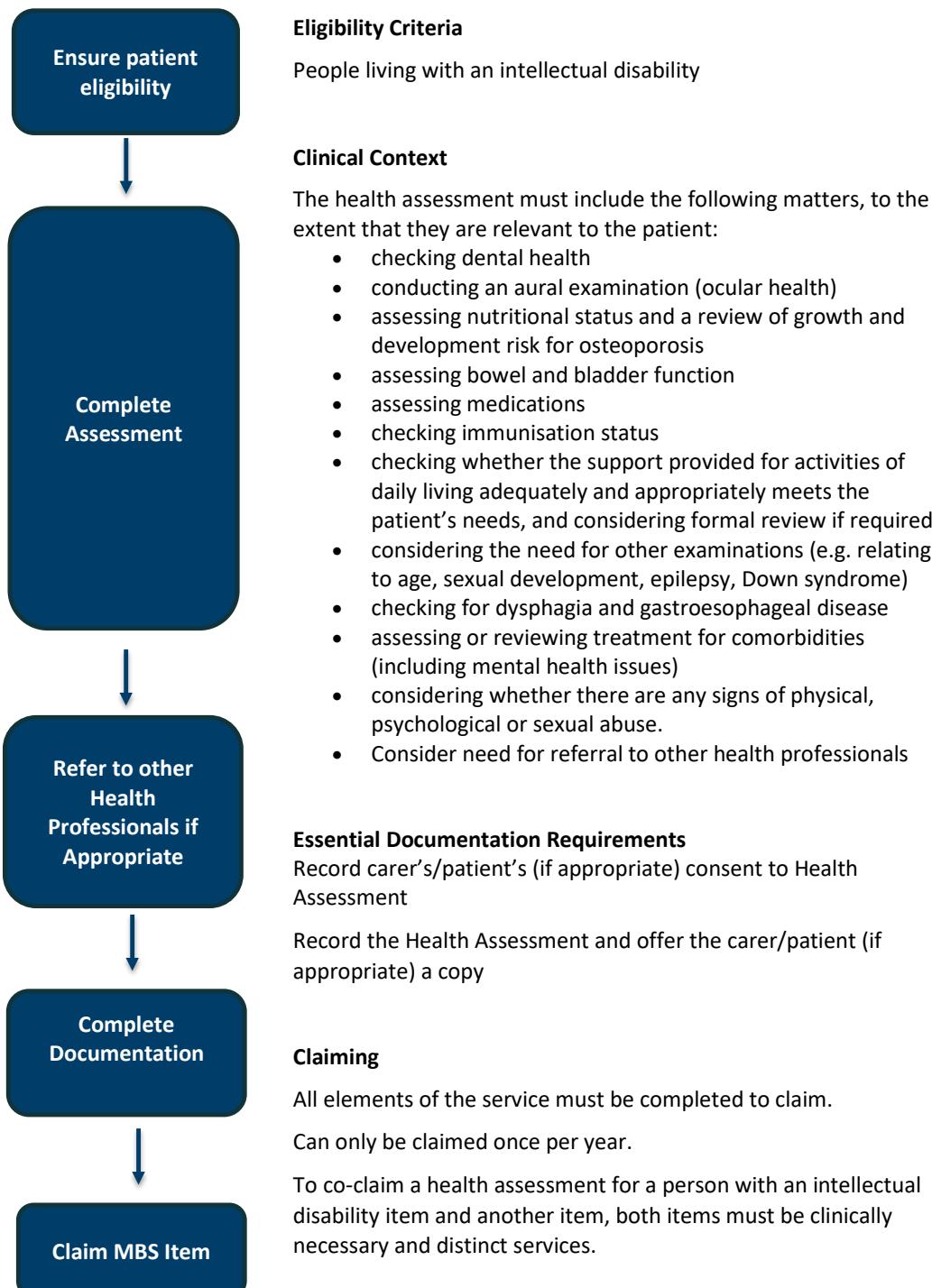
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<b>GPACI RACH Visits – Sample Schedule – Responsible Provider + Other Care Team Member</b>			
Other GP/Prescribed Medical Practitioner/Nurse Practitioner/ Aboriginal &/Or Torres Strait Islander Health Practitioner + Practicing in MM4-7 where telehealth appointments can be used as follow up			
Quarter 1	Quarter 2	Quarter 3	Quarter 4
 <b>2 x Eligible Visits</b> 1 x Responsible Provider + 1 x Alternate Provider <b>Must be claimed in separate calendar months</b>	 <b>2 x Eligible Visits</b> 1 x Responsible Provider + 1 x Alternate Provider <b>Must be claimed in separate calendar months</b>	 <b>2 x Eligible Visits</b> 1 x Responsible Provider + 1 x Alternate Provider <b>Must be claimed in separate calendar months</b>	 <b>2 x Eligible Visits</b> 1 x Responsible Provider + 1 x Alternate Provider <b>Must be claimed in separate calendar months</b>
MBS Items 90035-90054 <b>OR</b> MBS 90188-90215 <b>OR</b> MBS 90093-90096 <b>OR</b> MBS 82205-82215 OR non-urgent after-hours item OR MBS 10997 Follow up by a Practice Nurse or Aboriginal Health Practitioner	MBS Items 90035-90054 <b>OR</b> MBS 90188-90215 <b>OR</b> MBS 90093-90096 <b>OR</b> MBS 82205-82215 OR non-urgent after-hours item <b>OR</b> MBS 10997 Follow up by a Practice Nurse or Aboriginal Health Practitioner	MBS Items 90035-90054 <b>OR</b> MBS 90188-90215 <b>OR</b> MBS 90093-90096 <b>OR</b> MBS 82205-82215 OR non-urgent after-hours item <b>OR</b> MBS 10997 Follow up by a Practice Nurse or Aboriginal Health Practitioner	MBS Items 90035-90054 <b>OR</b> MBS 90188-90215 <b>OR</b> MBS 90093-90096 <b>OR</b> MBS 82205-82215 OR non-urgent after-hours item <b>OR</b> MBS 10997 Follow up by a Practice Nurse or Aboriginal Health Practitioner
<b>OR</b> Can use MBS 91800 - 91803 Telehealth Service as follow up appointment in the quarter	<b>OR</b> Can use MBS 91800 - 91803 Telehealth Service as follow up appointment in the quarter	<b>OR</b> Can use MBS 91800 - 91803 Telehealth Service as follow up appointment in the quarter	<b>OR</b> Can use MBS 91800 - 91803 Telehealth Service as follow up appointment in the quarter
<b>Across the 12-month period must provide 2 of the below Eligible Care Planning Items</b>			
These can be claimed at any point across the 12-months. Claiming MBS 731 early in the cycle (Q1) enables other MBS items and referrals. MBS 731 can be co-claimed with other items.			
 <b>Contribution or review of Multidisciplinary Care Plan</b>	 <b>Case Conference</b>	 <b>Residential Medication Management Review</b>	 <b>Case Conference</b>
<b>Comprehensive Medical Assessment</b> MBS 703-707 OR MBS 224-227 Comprehensive Management Plan (CMA) - OR DVA MTT01 – 707 Health Assessment item	MBS 235-240 <b>OR</b> MBS 735-758 Multidisciplinary Care Conference  <b>*Item choice depends on length of conference and type of practitioner*</b>	MBS 903 <b>OR</b> MBS249  <b>*Item choice depends on practitioner type*</b>	MBS 235-240 <b>OR</b> MBS 735-758 Multidisciplinary Care Conference  <b>*Item choice depends on length of conference and type of practitioner*</b>
<b>*Item choice depends on length of assessment and type of practitioner*</b>			
<b>NOTE:</b> Completing 2 Regular Visits with your patient per quarter triggers the incentive payment to both the Responsible Practitioner and the Practice. Payments will not be triggered if the two visits are not completed within the quarter in two separate calendar months. Triple Bulk Billing applies with eligible patients. Also note, the <b>RESPONSIBLE PROVIDER</b> must complete <b>4 of the eligible regular services 1 per quarter</b> across the 12-months, another GP or Nurse Practitioner can provide the other regular visits. <b>MBS731</b> <b>MUST</b> have been billed before the follow up items can be completed by a Practice Nurse or Aboriginal &/Or Torres Strait Islander Health Practitioner.			
Desktop Guide to MBS Item Numbers _version5 Last updated: January 2026			

**NOTE:** Completing 2 Regular Visits with your patient per quarter triggers the incentive payment to both the Responsible Practitioner and the Practice. Payments will not be triggered if the two visits are not completed within the quarter in two separate calendar months. Triple Bulk Billing applies with eligible patients.  
 Also note, the **RESPONSIBLE PROVIDER** must complete **4 of the eligible regular services 1 per quarter** across the 12-months, another GP or Nurse Practitioner can provide the other regular visits. **MBS731** **MUST** have been billed before the follow up items can be completed by a Practice Nurse or Aboriginal &/Or Torres Strait Islander Health Practitioner.

## 15. Health assessment for a person with an intellectual disability

[Note AN.0.41 | Medicare Benefits Schedule](#)



## 16. Health Assessment provided for a refugee and other humanitarian entrant

[Note AN.0.42 | Medicare Benefits Schedule](#)



### Eligibility Criteria

People who are a refugee or humanitarian entrant, with Medicare eligibility, and either

- hold a relevant visa that the person has held for less than 12 months at the time of the assessment, or
- first entered Australia less than 12 months before the assessment is performed.

### Clinical Context

The health assessment must include:

- a personal attendance by a GP or prescribed medical practitioner
- taking the patient's history
- examining the patient
- performing or arranging any required investigations
- assessing the patient, using the information gained from the above points
- developing a management plan addressing the patient's health care needs, health problems and relevant conditions, and
- making or arranging any necessary interventions and referrals.

### Essential Documentation Requirements

Record patient's consent to Health Assessment

Record the Health Assessment and offer the patient a copy

### Claiming

All elements of the service must be completed to claim.

Can only be claimed once by an eligible patient.

To co-claim a health assessment for a person with an intellectual disability item and another item, both items must be clinically necessary and distinct services.

## 17. Veterans' Health Assessment

[Note AN.0.69 | Medicare Benefits Schedule](#)



### Eligibility Criteria

Former members of the Permanent Forces or a former member of the Reserves.

### Clinical Context

The health assessment must include:

- an assessment of the patient's service with the Australian Defence Force, including service type, years of service, field of work, number of deployments and reason for discharge
- the patient's social history
- the patient's current medical conditions, and
- whether the patient suffers from hearing loss or tinnitus
- the patient's use of medication
- the patient's smoking status, alcohol use, substance use, level of physical activity
- whether the patient has bodily pain
- whether the patient has difficulty getting to sleep or staying asleep
- whether the patient has psychological distress, post-traumatic stress disorder, is at risk of harm to self or others, has anger problems
- the patient's sexual health, and
- any other health concerns the patient has
- include physical examination
- making or arranging any necessary interventions and referrals.

### Essential Documentation Requirements

Record patient's consent to Health Assessment

Record the Health Assessment and offer the patient a copy

### Claiming

All elements of the service must be completed to claim.

Can only be claimed once by an eligible patient.

To co-claim a health assessment for a person with an intellectual disability item and another item, both items must be clinically necessary and distinct services.

[Quick guides and tools | Department of Veterans' Affairs](#)

[Coordinated Veterans' Care \(CVC\) Program | Department of Veterans' Affairs](#)

[Veterans' Health Hub: Resources & Support for Clinicians](#)

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## 18. Aboriginal and Torres Strait Islander Peoples Health Assessment

[Note AN.0.43 | Medicare Benefits Schedule](#)

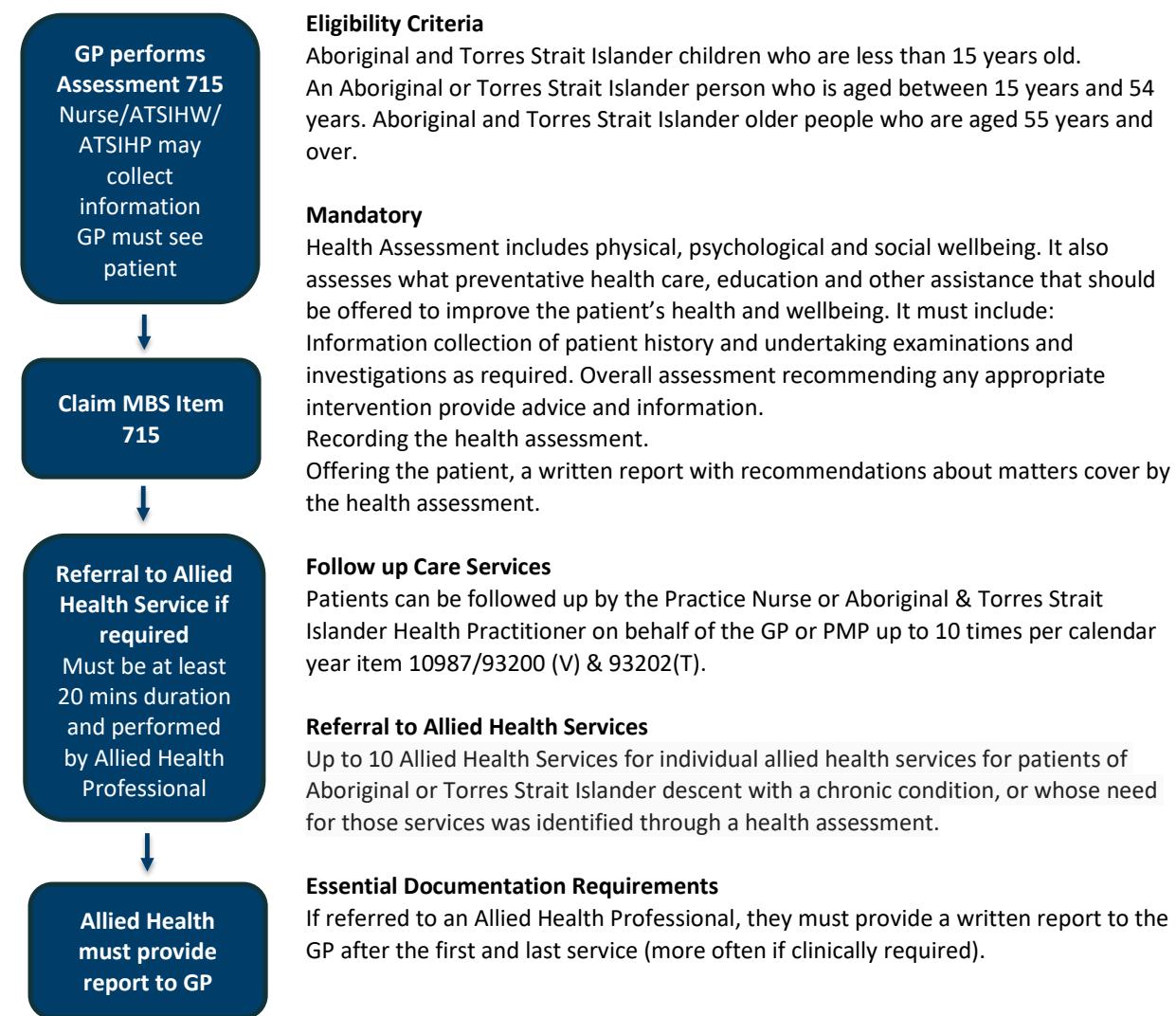
Item Number GP	Item Number PMP	Description
715	228	Aboriginal and Torres Strait Islander Peoples Health Assessment – face to face
92004	92011	Aboriginal and Torres Strait Islander Peoples Health Assessment – video
No designated time / complexity requirements		
<p>Item 10990 or 10991 (bulk billing incentives) can be claimed in conjunction with any health assessment provided to an Aboriginal and Torres Strait Islander person, provided the conditions of item 10990 and 10991 are satisfied.</p> <p>Professional attendance by a general practitioner at consulting rooms or in another place other than a hospital or residential aged care facility to perform:</p> <ul style="list-style-type: none"><li>• Information collection, including taking a patient history and undertaking examinations and investigations as required</li><li>• Making an overall assessment of the patient;</li><li>• Recommending appropriate interventions;</li><li>• Providing advice and information to the patient; and</li><li>• Keeping a record of the health assessment, and offering the patient, and/or patient's carer, a written report about the health assessment with recommendations about matters covered by the health assessment; and</li><li>• Offering the patient's carer (if any, and if the general practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report relevant to the carer</li></ul> <p>For children aged 0 - 14 years old. Adults between 15- 54 years of age Older people over 55 years</p> <p>If, after receiving this health assessment, a patient who is aged fifteen years and over but under the age of 55 years, is identified as having a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool, the general practitioner may refer that person to a subsidised lifestyle modification program, along with other possible strategies to improve the health status of the patient.</p>		

## 18.1. Aboriginal & Torres Strait Islander Health Assessment

### GP Items 715, 92004 (V) & PMP Items 228, 92011 (V)

[Note AN.0.43 | Medicare Benefits Schedule](#)

[Note AN.7.13 | Medicare Benefits Schedule](#)



MBS Item	Name	Age Range	Recommended Frequency
715/92004/228/92011	Aboriginal and Torres Strait Islander Health Assessment	All Ages	Once in a 9-month period
81300 to 81360, 93048/93061	Follow-Up Allied Health Services	All Ages	Max 10 services per calendar year
10987/93200 (V) & 93202 (T)	Service provided by practice nurse or registered Aboriginal and Torres Strait Islander Health practitioner	All Ages	Max 10 services per calendar year

## 19. Women's Health – Menopause and Perimenopause Health Assessment

[Note AN.14.3 | Medicare Benefits Schedule](#)

Item Number GP	Item Number PMP	Item Description
695	19000	Menopause and perimenopause health assessment services for patients experiencing premature ovarian insufficiency, early menopause, perimenopause and menopause

### Eligibility Criteria

Any patient who is eligible to receive Medicare benefits, has not received this service in the previous 12-month period, and is experiencing premature ovarian insufficiency, early menopause, perimenopause or menopause symptoms, or undergoing treatment for their symptoms.

The health assessment must last at least 20 minutes

### As part of the health assessment providers must include, but are not limited to the following clinical activities:

- Collection of relevant information, including taking a patient history to determine pre-, peri- or post-menopausal status, patient wellbeing and contraindications for management.
- A basic physical examination, including recording blood pressure, and review of height and weight; and initiating investigations and referrals as clinically indicated, with consideration given to the need for cervical screening, mammography and bone densitometry.
- Discussion of management options including non-pharmacological and pharmacological strategies including risks and benefits.
- Implementing a management plan which includes patient centred symptoms management.
- Providing the patient with preventative health care advice and information as clinically indicated, including advice on physical activity, smoking cessation, alcohol consumption, nutritional intake and weight management.

Practice nurses, Aboriginal health workers and Aboriginal and Torres Strait Islander health practitioners engaged by the practice may assist in accordance with accepted medical practice under the supervision of the medical practitioner. **This may include activities associated with:**

- Information collection.
- Providing patients with information about recommended interventions, at the direction of the medical practitioner.

Where eligible, patients may receive both a menopause and perimenopause health assessment service and a separate time tiered or Aboriginal and Torres Strait Islander health assessment service (for example, a Type 2 diabetes risk evaluation). There is no minimum interval of time between the provision of the different health assessments.

## 20. Heart Health Assessment

[Note AN.14.2 | Medicare Benefits Schedule](#)

Item Number GP	Item Number PMP	Item Description
699	177	Heart Health Assessment

### Eligibility Criteria

All Medicare eligible patients aged 30 years and over who would benefit from an assessment of this type.

Can be claimed once per patient in a 12-month period. The heart health assessment items cannot be claimed if a patient has had a health assessment service, excluding an [Aboriginal and Torres Strait Islander Peoples Health Assessment](#) (item 715, 228, 92004, 92011), in the previous 12 months.

Professional attendance on a patient who is 30 years of age or over for a heart health assessment at consulting rooms lasting at least 20 minutes and including:

- Collection of relevant information, including taking a patient history; and
- A basic physical examination, which must include recording blood pressure and cholesterol; and
- Initiating interventions and referrals as indicated; and
- Implementing a management plan; and
- Providing the patient with preventative health care advice and information.

## 21. Medication Management

Item Number GP	Item Number PMP	Item Description
900	245	Domiciliary Medication Management Review (DMMR)
903	249	Residential Medication Management Review (RMMR)

### DMMR

[Item 900 | Medicare Benefits Schedule](#)

Intended to maximize an individual patient's benefit from their medication regimen and prevent medication-related problems through a team approach. Once every 12 months except if there has been a significant change in the patient's condition or medication regimen requiring a new DMMR

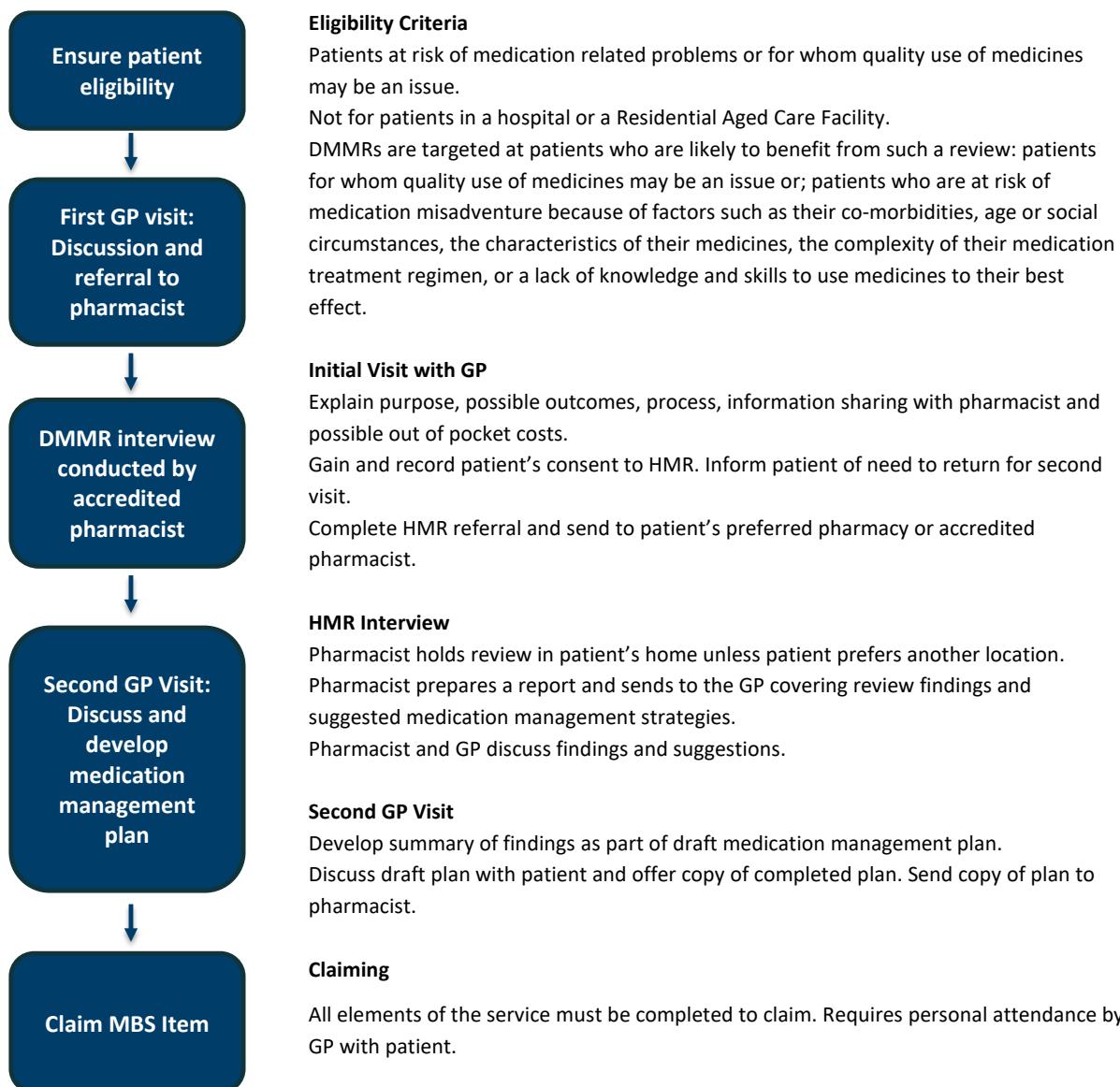
### RMMR

[Note AN.7.18 | Medicare Benefits Schedule](#)

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

## 22. Domiciliary Medication Management Review (DMMR) – Items 900 and 245

[Note AN.0.52 | Medicare Benefits Schedule](#)

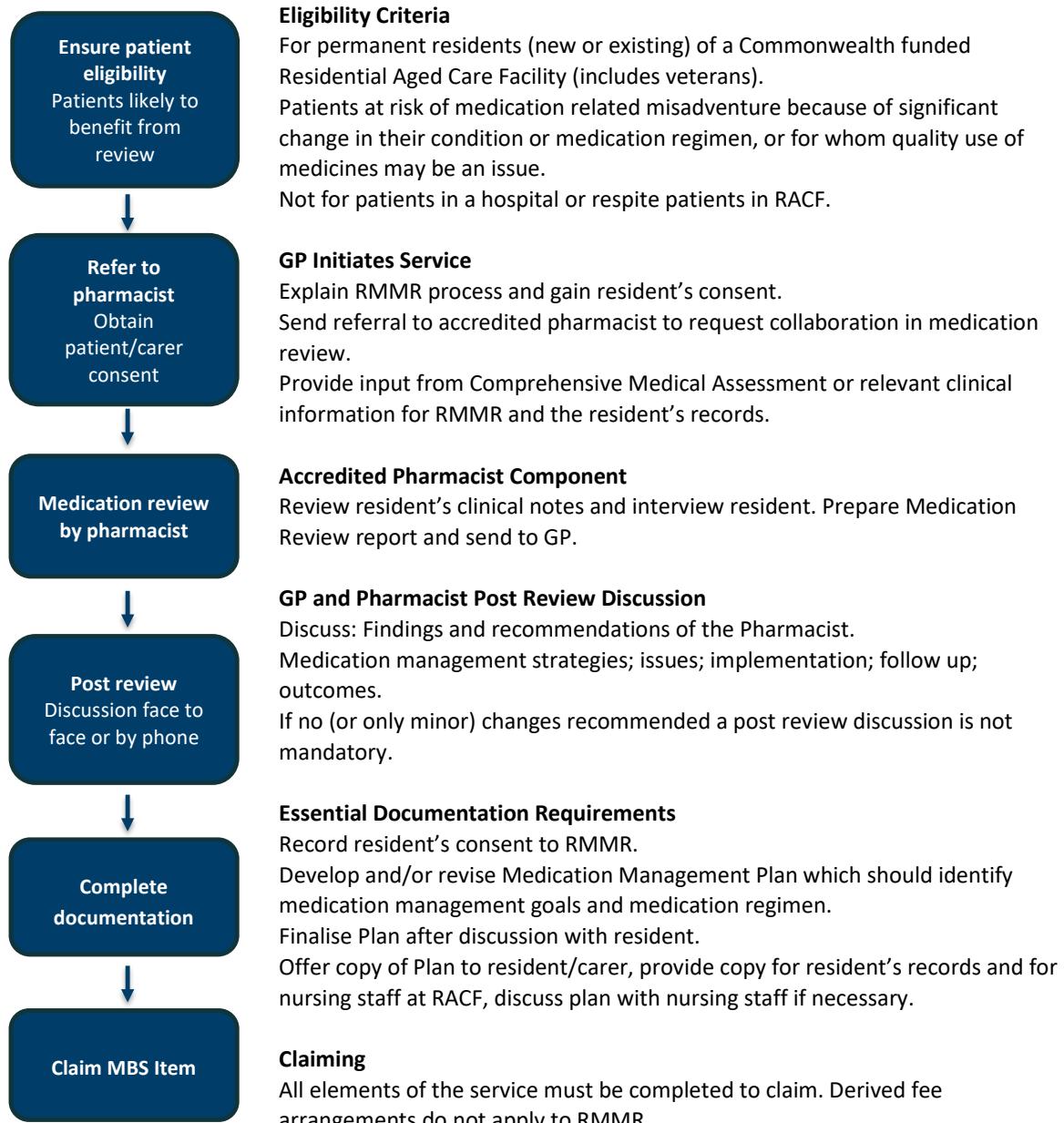


From 1 July 2027 DMMRs patients will require a GP chronic condition management plan to access DMMRs.

MBS Item	Name	Recommended Frequency
GP 900 PMP 245	Domiciliary Medication Management Review	Once every 12 months

## 23. Residential Medical Management Review (RMMR) - Items 903 and 249

[Note AN.7.18 | Medicare Benefits Schedule](#)



MBS Item	Name	Recommended Frequency
GP 903	Residential Medication Management Review	As required (Minimum 12 monthly)
PMP 249		

## 24. Allied Health Services

[Note MN.3.1 | Medicare Benefits Schedule](#)

Item Number	Service
<a href="#">10950</a>	Aboriginal & Torres Strait Health Workers (ATSIHW) or Aboriginal & Torres Strait Islander Health Practitioner (ATSIHP) Services <b>93000 (V)</b> and <b>93013 (T)</b>
<a href="#">10951</a>	Diabetes Educator Services
<a href="#">10952</a>	Audiologist Services
<a href="#">10953</a>	Exercise Physiologist Services
<a href="#">10954</a>	Dietitian Services
<a href="#">10958</a>	Occupational Therapist Services
<a href="#">10960</a>	Physiotherapist Services
<a href="#">10962</a>	Podiatrist Services
<a href="#">10964</a>	Chiropractor Services
<a href="#">10966</a>	Osteopath Services
<a href="#">10970</a>	Speech Pathologist Services
<a href="#">10956</a>	Mental Health Worker
<a href="#">10968</a>	Psychologist Services

### Patient Eligibility

- The patient has a chronic condition and complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under:
  - A GP chronic condition management plan that has been prepared or reviewed in the last 18 months; or
  - until the end of 30 June 2027—a GP Management Plan and Team Care Arrangements prepared prior to 1 July 2025; or
  - A multidisciplinary care plan; and
- The service is recommended in the patient's plan or arrangements as part of the management of the patient's chronic condition and complex care needs; and
- The service is of at least 20 minutes duration

Patients with a GP chronic condition management plan or care recipients of an aged care facility who have a multidisciplinary care plan can access up to 5 (10 for a person of Aboriginal or Torres Strait Islander descent) individual MBS-supported allied health and Aboriginal and Torres Strait Islander health and wellbeing services per calendar year. The services provided must be consistent with the patient's plan and a referral is required.

Aboriginal & Torres Strait Health Workers (ATSIHW) or Aboriginal & Torres Strait Islander Health Practitioner (ATSIHP) Services and Allied Health Providers must have a Medicare Provider number.

Patients with a mental health condition or eating disorder may be eligible for treatment through the Better Access mental health items (see [AN.0.56](#)) or eating disorder items (see [AN.36.2](#)).

## 24.1. Allied Health Group Services for Patients with Type 2 Diabetes

Item Number	Item Description
81100	Assessment for Group Services by Diabetes Educator
81110	Assessment for Group Services by Exercise Physiologist
81120	Assessment for Group Services by Dietitian
81105	Diabetes Education Group Services

### Patient Eligibility

- The patient has type 2 diabetes; and the patient is being managed by a medical practitioner (other than a specialist or consultant physician) under:
  - A GP chronic condition management plan that has been prepared or reviewed in the last 18 months; or
  - Until the end of 30 June 2027—a GP Management Plan prepared prior to 1 July 2025; or
  - A multidisciplinary care plan; and
- The patient is referred to an eligible allied health professional by the medical practitioner; and
- The service is provided to the patient individually and in person; and
- The service is of at least 45 minutes duration; and
- After the service, the eligible diabetes educator gives a written report to the referring medical practitioner; payable once in a calendar year for this or any other assessment for group services item

One assessment session only by either Diabetes Educator, Exercise Physiologist or Dietitian, per calendar year

Medicare Allied Health Group Services for Type 2 Diabetes Referral Form

A report is required to be provided to the referring GP that identifies if the patient would benefit from Group Services, before the group services are provided to the patient.

8 group per calendar year, can be 8 sessions with one provider or a combination e.g. 3 diabetes education, 3 dietitians and 2 exercise physiology sessions. Medicare Allied Health Group Services for Type 2 Diabetes Referral Form. Ensure all participants sign the Medicare Assignment of Benefits form after the group sessions. A report back to the referring GP is required at the completion of the group services and all providers who provided Group Services must contribute to this report.

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## 24.2. Follow-up Allied Health Services for Aboriginal and Torres Strait Islander Peoples who have had a Health Assessment

[Note MN.11.1 | Medicare Benefits Schedule](#)

Item Number	Service
81300	Aboriginal & Torres Strait Health Worker or Aboriginal & Torres Strait Islander Health Practitioner Services <a href="#">93048 (V)</a> and <a href="#">93061 (T)</a>
81305	Diabetes Education
81310	Audiology
81315	Exercise Physiology
81320	Dietetics
81325	Mental Health
81330	Occupational Therapy
81335	Physiotherapy
81340	Podiatry
81345	Chiropractic
81350	Osteopathy
81355	Psychology
81360	Speech Pathology

A person who is of Aboriginal or Torres Strait Islander descent may be referred by their GP for follow- up allied health services when:

- A medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; or
- The patient has a chronic condition and complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under:
- A GP chronic condition management plan that has been prepared or reviewed in the last 18 months; or
- Until the end of 30 June 2027—a GP Management Plan and Team Care Arrangements prepared prior to 1 July 2025; or
- A multidisciplinary care plan; and
- The service is recommended in the patient’s plan or arrangements as part of the management of the patient’s chronic condition and complex care needs;

to a maximum of 10 services (including any services to which this item or any other item in this Group or Subgroup 1 of Group M3 or item [93000](#), [93013](#), [93048](#) or [93061](#) of the Telehealth Attendance Determination applies) in a calendar year.

Aboriginal & Torres Strait Health Workers, or Aboriginal & Torres Strait Islander Health Practitioners and Allied Health Providers must have a current Medicare Provider number for each location in which they practice.

Patients with a mental health condition or eating disorder may be eligible for treatment through the Better Access mental health items (see [AN.0.56](#)) or eating disorder items (see [AN.36.2](#)).

**Flowchart for First Nations Australians accessing MBS individual allied health services – referral pathways:**  
[PDF version - First Nations Australians allied health services flow chart – 1 March 2024.pdf](#)

Referral requirements for allied health services: [Note AN.15.6 | Medicare Benefits Schedule](#)

## 25. Practice Nurse/Aboriginal & Torres Strait Islander Health Practitioner (ATSIHP) Item Numbers

Item Number	Service	Description
10987	Follow Up Health Services for Indigenous people	Follow-up services are available to Aboriginal & Torres Strait Islander People who have received a health assessment. Up to 10 times per patient per calendar year. Health Assessment follow up. <b>93200 (V)</b> and <b>93202 (T)</b>
10988	Immunisation	Immunisation provided to a person on behalf of the medical practitioner by an Aboriginal and Torres Strait Islander Health Practitioner. Claimed once per patient visit even if multiple vaccines given.
10989	Wound Treatment	Treatment of wound (other than normal after care) provided by an Aboriginal and Torres Strait Islander Health Practitioner if the treatment is provided on behalf of, and under supervision of, a medical practitioner and the person is not admitted to hospital.
10997	Chronic Disease Management	Monitoring and support for patients being managed under a GPCCMP. Not more than 5, per patient, per calendar year <b>93201 (V)</b> and <b>93203 (T)</b>
12325	Visual Acuity Assessment	Assessment of visual acuity and bilateral retinal photography with a non-mydriatic retinal camera, including analysis and reporting of the images for initial or repeat assessment for presence or absence of diabetic retinopathy, in a patient with medically diagnosed diabetes
13105	Dialysis	Haemodialysis for a patient with end stage renal disease
16400	Antenatal Services	Antenatal service provided by a practice midwife, nurse or an Aboriginal and Torres Strait Islander health practitioner <b>91850 (V)</b> and <b>91855 (T)</b>
10983	Video conferencing consultation support	Video conferencing consultation support service provided by a practice nurse, an Aboriginal and Torres Strait Islander health worker or an Aboriginal and Torres Strait Islander health practitioner on behalf of a medical practitioner
<p>A practice nurse means a registered or enrolled nurse or nurse practitioner who is employed by, or whose services are otherwise retained by a general practice on behalf of and under supervision of Medical Practitioner</p> <p>An Aboriginal and Torres Strait Islander health practitioner means a person who has been registered as an Aboriginal and Torres Strait Islander health practitioner by the Aboriginal and Torres Strait Islander Health Practice Board of Australia and meets the Board's registration standards. The Aboriginal and Torres Strait Islander health practitioner must be employed or retained by a general practice, or by an Aboriginal &amp; Torres Strait Health Service that has an exemption to claim Medicare benefits under subsection 19(2) of the Health Insurance Act 1973.</p>		

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## 26. Quality Assurance for Aboriginal & Torres Strait Islander Medical Services (QAAMS)

[Note PR.9.1 | Medicare Benefits Schedule](#)

Item Number	Item Description
73839	Quantitation of HbA1c (glycated haemoglobin) performed for the diagnosis of diabetes in asymptomatic patients at high risk - not more than once in a 12-month period.
73840	Quantitation of glycosylated haemoglobin performed in the management of established diabetes – each test to a maximum of 4 tests in a 12-month period.
73844	Quantitation of urinary albumin/creatinine ratio in urine on a random spot collection in the management of patients with established diabetes or patients at risk of microalbuminuria.
<p>These item numbers can only be performed in the following circumstances:</p> <p>The service is rendered by or on behalf of a medical practitioner.</p> <p>The practitioner referred to in paragraph (a), or the organisation for which the practitioner works, is participating in the Quality Assurance in Aboriginal Medical Services Program.</p> <p>The service is provided in accordance with that Program.</p> <p>The practitioner referred to in paragraph (a) has determined the service to be necessary for his or her patient.</p> <p>Items 73839, 738840 &amp; 73844 are provided on behalf of and under the supervision of the GP or PMP by a Practice Nurse, Aboriginal &amp; Torres Strait Islander Health Practitioner or Aboriginal Health Worker.</p>	

## 27. Other Items/Services

Item Number	Service
11505	Spirometry To confirm diagnosis of Asthma, COPD or another cause of airflow limitation – once in a 12-month period
11506	Spirometry Monitoring - Measurement of spirometry before and after inhalation of bronchodilator to confirm diagnosis of Asthma, COPD other causes
11309	Audiometry - Audiogram, air conduction
11707	EGC - 12 lead electrocardiography, tracing only by medical practitioner
73806	Pregnancy test by one or more immunochemical methods
16500	Antenatal attendance
14206	Implant - Hormone or living tissue implant (implanon) by cannula
30062	Removal of Etonogestrel subcutaneous implant (e.g. implanon)
73812	Quantitation of glycated haemoglobin (HbA1C) performed in the management of established diabetes, if performed as a point -of-care test, on behalf of a medical practitioner who works in a general practice that is accredited to the RACGP standards for point-of-care testing under the National General Accreditation Scheme – not more than 3 times per 12months per patient.
11610	MEASUREMENT OF ANKLE: BRACHIAL INDICES AND ARTERIAL WAVEFORM ANALYSIS, measurement of posterior tibial and dorsalis pedis (or toe) and brachial arterial pressures bilaterally using Doppler or plethysmographic techniques, the calculation of ankle (or toe) brachial systolic pressure indices and assessment of arterial waveforms for the evaluation of lower extremity arterial disease, examination, hard copy trace and report.
14216	Professional attendance on a patient by a psychiatrist, who has undertaken training in Repetitive Transcranial Magnetic Stimulation (rTMS), for treatment mapping for rTMS, if the patient: <ul style="list-style-type: none"><li>• Has not previously received any prior transcranial magnetic stimulation therapy in a public or private setting; and</li><li>• Is at least 18 years old; and</li><li>• Is diagnosed with a major depressive episode; and</li><li>• Has failed to receive satisfactory improvement for the major depressive episode despite the adequate trialling of at least 2 different classes of antidepressant medications, unless contraindicated, and all of the following apply:<ul style="list-style-type: none"><li>• the patient's adherence to antidepressant treatment has been formally assessed;</li><li>• the trialling of each antidepressant medication has been at the recommended therapeutic dose for a minimum of 3 weeks;</li><li>• where clinically appropriate, the treatment has been titrated to the maximum tolerated therapeutic dose; and</li><li>• Has undertaken psychological therapy, if clinically appropriate</li></ul></li></ul>
14217	Repetitive Transcranial Magnetic Stimulation (rTMS) treatment of up to 35 services provided by, or on behalf of, a psychiatrist who has undertaken training in rTMS, if the patient has previously received a service under item 14216—each service up to 35 services

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## 28. Skin Lesion Treatment and Biopsy Items

Item Number	Item Description
30071	Diagnostic biopsy of skin
30072	Diagnostic biopsy of mucous membrane

Use this item when you:

- Perform the biopsy as an independent procedure.
- Send the specimen for pathological examination.
- Decide the biopsy is necessary to confirm the diagnosis, so you can manage the lesion.

if the shave biopsy results in definitively excising a lesion. Select additional item numbers if biopsy results show that the patient requires further treatment. Select the item numbers based on the results and treatment method.

When performing multiple biopsies on separate lesions on the one day, ensure that it is noted on the claim or account either:

- 'Separate sites'.
- The exact location of the biopsy.

Note: If this is not included Medicare will reject the subsequent item/s.

**Services Australia have the following infographic resources for guidance for removal of lesions and the requirements:**

- [MBS billing for skin lesion treatment and biopsy items - Health professionals - Services Australia](#)
- [MBSM02INFO9-Type of Skin Defects Guide](#)
- [MBSM02INFO6-Removal of Tumour, Cysts, Ulcer or Scar Medicare Benefits Schedule \(MBS\) Item Selection Guide](#)
- [MBSM02INFO1-Determining lesion size for Medicare Benefits Schedule \(MBS\) Item Selection Guide](#)
- [MBSM02INFO2-Malignant Melanoma Skin Lesion Medicare Benefits Schedule \(MBS\) Item Selection Guide](#)
- [MBSM02INFO4-Malignant Skin Lesion Medicare Benefits Schedule \(MBS\) Item Selection Guide](#)
- [MBSM02INFO11-Suspected Melanoma Skin Lesions Medicare Benefits Schedule \(MBS\) Item Selection Guide](#)
- [MBSM02INFO3-Non-malignant Skin Lesion Medicare Benefits Schedule \(MBS\) Item Selection Guide](#)

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## 29. General Attendance Items – Medical Practitioners (MPs) and Prescribed Medical Practitioners (PMPs)

[Note AN.7.2 | Medicare Benefits Schedule](#)

	Level A Straightforward	Level B 6-20 minutes	Level C 20+ minutes	Level D 40+ minutes	Level E 60+ minutes
<b>Standard hours consultations</b>					
In consulting rooms (MP) <sup>1</sup>	52	53	54	57	151
In consulting rooms (PMP) <sup>2</sup>	179	185	189	203	301
Out of consulting rooms (MP)	58	59	60	65	165
Out of consulting rooms (PMP)	181	187	191	206	303
RACH (MP)	90092	90093	90095	90096	90098
RACH (PMP) MM2-7	90183	90188	90202	90212	90215
<b>After-hours</b>					
In consulting rooms (MP)	5200	5203	5207	5208	5209
In consulting rooms (PMP)	733	737	741	745	2197
Out of consulting rooms (MP)	5220	5223	5227	5228	5261
Out of consulting rooms (PMP)	761	763	766	769	2198
RACH (MP)	5260	5263	5265	5267	5262
RACH (PMP)	772	776	788	789	2200
<b>Telehealth</b>					
Video (MP)	91792	91803	91804	91805	91923
Video (PMP)	91794	91806	91807	91808	91926
Phone (MP)	91892	91893	91903 <sup>3</sup>	91913 <sup>3</sup>	NA
Phone (PMP)			91906 <sup>3</sup>	91916 <sup>3</sup>	

<sup>1</sup>MP items can be claimed by all MPs who are not general practitioners.

<sup>2</sup>PMP items can be claimed by medical practitioners that are not general practitioners, specialists or consultant physicians.

<sup>3</sup>Available to patients enrolled in MyMedicare only.

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## 30. Bulk Billing Incentives for Medical Practitioners (MPs) and Prescribed Medical Practitioners (PMPs) – Modified Monash 3 and 4 (Medium and Large Rural Towns)

[Note MN.1.5 | Medicare Benefits Schedule](#)

Applicable BBI item	<a href="#">75855</a>	<a href="#">75873</a>	<a href="#">75882 (MyMedicare enrolled patients only)</a>
Standard hours consultations			
In consulting rooms	<a href="#">52</a> , <a href="#">179</a>	<a href="#">53</a> , <a href="#">54</a> , <a href="#">57</a> , <a href="#">151</a> , <a href="#">185</a> , <a href="#">189</a> , <a href="#">203</a> , <a href="#">301</a>	
Out of consulting rooms	<a href="#">58</a> , <a href="#">181</a>	<a href="#">59</a> , <a href="#">60</a> , <a href="#">65</a> , <a href="#">165</a> , <a href="#">187</a> , <a href="#">191</a> , <a href="#">206</a> , <a href="#">303</a>	
RACH <sup>1</sup>	<a href="#">90092</a> , <a href="#">90183</a>	<a href="#">90093</a> , <a href="#">90095</a> , <a href="#">90096</a> , <a href="#">90098</a> , <a href="#">90188</a> , <a href="#">90202</a> , <a href="#">90212</a> , <a href="#">90215</a>	
Telehealth			
Video	<a href="#">91792</a> , <a href="#">91794</a> (all) <a href="#">91804</a> , <a href="#">91805</a> , <a href="#">91923</a> , <a href="#">91807</a> , <a href="#">91808</a> , <a href="#">91926</a> (if not MyMedicare enrolled)	<a href="#">91803</a> , <a href="#">91806</a>	<a href="#">91804</a> , <a href="#">91805</a> , <a href="#">91923</a> , <a href="#">91807</a> , <a href="#">91808</a> , <a href="#">91926</a>
Phone	<a href="#">91892</a>	<a href="#">91893</a>	<a href="#">91903</a> , <a href="#">91913</a> , <a href="#">91906</a> , <a href="#">91916</a>
After hours consultations			
In consulting rooms	<a href="#">5200</a> , <a href="#">733</a>	<a href="#">5203</a> , <a href="#">5207</a> , <a href="#">5208</a> , <a href="#">5209</a> , <a href="#">737</a> , <a href="#">741</a> , <a href="#">745</a> , <a href="#">2197</a>	
Out of consulting rooms	<a href="#">5220</a> , <a href="#">761</a>	<a href="#">5223</a> , <a href="#">5227</a> , <a href="#">5228</a> , <a href="#">5261</a> , <a href="#">763</a> , <a href="#">766</a> , <a href="#">769</a> , <a href="#">2198</a>	
RACH <sup>1</sup>	<a href="#">5260</a> , <a href="#">772</a>	<a href="#">5263</a> , <a href="#">5265</a> , <a href="#">5267</a> , <a href="#">5262</a> , <a href="#">776</a> , <a href="#">788</a> , <a href="#">789</a> , <a href="#">2200</a>	
Other	All other “unreferred services”, including but not limited to: chronic condition management items, Better Access mental health items, health assessments, minor procedures etc – <b>Claim Item 75855</b>		

<sup>1</sup>Residential Aged Care Home

Items underlined can only be claimed by prescribed medical practitioners, that is, medical practitioners that are not GPs, specialists or consultant physicians. Other items can be claimed by medical practitioners that are not GPs

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## 31. Bulk Billing Incentives for Medical Practitioners (MPs) and Prescribed Medical Practitioners (PMPs) – Modified Monash 5 (Small Rural Towns)

[Note MN.1.6 | Medicare Benefits Schedule](#)

Applicable BBI item	75856	75874	75883 (MyMedicare enrolled patients only)
<b>Standard hours consultations</b>			
In consulting rooms	<a href="#">52</a> , <a href="#">179</a>	<a href="#">53</a> , <a href="#">54</a> , <a href="#">57</a> , <a href="#">151</a> , <a href="#">185</a> , <a href="#">189</a> , <a href="#">203</a> , <a href="#">301</a>	
Out of consulting rooms	<a href="#">58</a> , <a href="#">181</a>	<a href="#">59</a> , <a href="#">60</a> , <a href="#">65</a> , <a href="#">165</a> , <a href="#">187</a> , <a href="#">191</a> , <a href="#">206</a> , <a href="#">303</a>	
RACH <sup>1</sup>	<a href="#">90092</a> , <a href="#">90183</a>	<a href="#">90093</a> , <a href="#">90095</a> , <a href="#">90096</a> , <a href="#">90098</a> , <a href="#">90188</a> , <a href="#">90202</a> , <a href="#">90212</a> , <a href="#">90215</a>	
<b>Telehealth</b>			
Video	<a href="#">91792</a> , <a href="#">91794</a> (all) <a href="#">91804</a> , <a href="#">91805</a> , <a href="#">91923</a> , <a href="#">91807</a> , <a href="#">91808</a> , <a href="#">91926</a> (if not MyMedicare enrolled)	<a href="#">91803</a> , <a href="#">91806</a>	<a href="#">91804</a> , <a href="#">91805</a> , <a href="#">91923</a> , <a href="#">91807</a> , <a href="#">91808</a> , <a href="#">91926</a>
Phone	<a href="#">91892</a>	<a href="#">91893</a>	<a href="#">91903</a> , <a href="#">91913</a> , <a href="#">91906</a> , <a href="#">91916</a>
<b>After hours consultations</b>			
In consulting rooms	<a href="#">5200</a> , <a href="#">733</a>	<a href="#">5203</a> , <a href="#">5207</a> , <a href="#">5208</a> , <a href="#">5209</a> , <a href="#">737</a> , <a href="#">741</a> , <a href="#">745</a> , <a href="#">2197</a>	
Out of consulting rooms	<a href="#">5220</a> , <a href="#">761</a>	<a href="#">5223</a> , <a href="#">5227</a> , <a href="#">5228</a> , <a href="#">5261</a> , <a href="#">763</a> , <a href="#">766</a> , <a href="#">769</a> , <a href="#">2198</a>	
RACH <sup>1</sup>	<a href="#">5260</a> , <a href="#">772</a>	<a href="#">5263</a> , <a href="#">5265</a> , <a href="#">5267</a> , <a href="#">5262</a> , <a href="#">776</a> , <a href="#">788</a> , <a href="#">789</a> , <a href="#">2200</a>	
<b>Other</b>	All other “unreferred services”, including but not limited to: chronic condition management items, Better Access mental health items, health assessments, minor procedures etc – <b>Claim Item 75856</b>		

<sup>1</sup>Residential Aged Care Home

Items underlined can only be claimed by prescribed medical practitioners, that is, medical practitioners that are not GPs, specialists or consultant physicians. Other items can be claimed by medical practitioners that are not GPs

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## 32. Bulk Billing Incentives for Medical Practitioners (MPs) and Prescribed Medical Practitioners (PMPs) – Modified Monash 6 (Remote Communities)

[Note MN.1.7 | Medicare Benefits Schedule](#)

Applicable BBI item	75857	75875	75884 (MyMedicare enrolled patients only)
Standard hours consultations			
In consulting rooms	<a href="#">52</a> , <a href="#">179</a>	<a href="#">53</a> , <a href="#">54</a> , <a href="#">57</a> , <a href="#">151</a> , <a href="#">185</a> , <a href="#">189</a> , <a href="#">203</a> , <a href="#">301</a>	
Out of consulting rooms	<a href="#">58</a> , <a href="#">181</a>	<a href="#">59</a> , <a href="#">60</a> , <a href="#">65</a> , <a href="#">165</a> , <a href="#">187</a> , <a href="#">191</a> , <a href="#">206</a> , <a href="#">303</a>	
RACH <sup>1</sup>	<a href="#">90092</a> , <a href="#">90183</a>	<a href="#">90093</a> , <a href="#">90095</a> , <a href="#">90096</a> , <a href="#">90098</a> , <a href="#">90188</a> , <a href="#">90202</a> , <a href="#">90212</a> , <a href="#">90215</a>	
Telehealth			
Video	<a href="#">91792</a> , <a href="#">91794</a> (all) <a href="#">91804</a> , <a href="#">91805</a> , <a href="#">91923</a> , <a href="#">91807</a> , <a href="#">91808</a> , <a href="#">91926</a> (if not MyMedicare enrolled)	<a href="#">91803</a> , <a href="#">91806</a>	<a href="#">91804</a> , <a href="#">91805</a> , <a href="#">91923</a> , <a href="#">91807</a> , <a href="#">91808</a> , <a href="#">91926</a>
Phone	<a href="#">91892</a>	<a href="#">91893</a>	<a href="#">91903</a> , <a href="#">91913</a> , <a href="#">91906</a> , <a href="#">91916</a>
After hours consultations			
In consulting rooms	<a href="#">5200</a> , <a href="#">733</a>	<a href="#">5203</a> , <a href="#">5207</a> , <a href="#">5208</a> , <a href="#">5209</a> , <a href="#">737</a> , <a href="#">741</a> , <a href="#">745</a> , <a href="#">2197</a>	
Out of consulting rooms	<a href="#">5220</a> , <a href="#">761</a>	<a href="#">5223</a> , <a href="#">5227</a> , <a href="#">5228</a> , <a href="#">5261</a> , <a href="#">763</a> , <a href="#">766</a> , <a href="#">769</a> , <a href="#">2198</a>	
RACH <sup>1</sup>	<a href="#">5260</a> , <a href="#">772</a>	<a href="#">5263</a> , <a href="#">5265</a> , <a href="#">5267</a> , <a href="#">5262</a> , <a href="#">776</a> , <a href="#">788</a> , <a href="#">789</a> , <a href="#">2200</a>	
Other	All other “unreferred services”, including but not limited to: chronic condition management items, Better Access mental health items, health assessments, minor procedures etc – <b>Claim Item 75857</b>		

<sup>1</sup>Residential Aged Care Home

Items underlined can only be claimed by prescribed medical practitioners, that is, medical practitioners that are not GPs, specialists or consultant physicians. Other items can be claimed by medical practitioners that are not GPs

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### 33. Bulk Billing Incentives for Medical Practitioners (MPs) and Prescribed Medical Practitioners (PMPs) – Modified Monash 7 (Very Remote Communities)

[Note MN.1.8 | Medicare Benefits Schedule](#)

Applicable BBI item	75858	75876	75885 (MyMedicare enrolled patients only)
<b>Standard hours consultations</b>			
In consulting rooms	<a href="#">52</a> , <a href="#">179</a>	<a href="#">53</a> , <a href="#">54</a> , <a href="#">57</a> , <a href="#">151</a> , <a href="#">185</a> , <a href="#">189</a> , <a href="#">203</a> , <a href="#">301</a>	
Out of consulting rooms	<a href="#">58</a> , <a href="#">181</a>	<a href="#">59</a> , <a href="#">60</a> , <a href="#">65</a> , <a href="#">165</a> , <a href="#">187</a> , <a href="#">191</a> , <a href="#">206</a> , <a href="#">303</a>	
RACH <sup>1</sup>	<a href="#">90092</a> , <a href="#">90183</a>	<a href="#">90093</a> , <a href="#">90095</a> , <a href="#">90096</a> , <a href="#">90098</a> , <a href="#">90188</a> , <a href="#">90202</a> , <a href="#">90212</a> , <a href="#">90215</a>	
<b>Telehealth</b>			
Video	<a href="#">91792</a> , <a href="#">91794</a> (all) <a href="#">91804</a> , <a href="#">91805</a> , <a href="#">91923</a> , <a href="#">91807</a> , <a href="#">91808</a> , <a href="#">91926</a> (if not MyMedicare enrolled)	<a href="#">91803</a> , <a href="#">91806</a>	<a href="#">91804</a> , <a href="#">91805</a> , <a href="#">91923</a> , <a href="#">91807</a> , <a href="#">91808</a> , <a href="#">91926</a>
Phone	<a href="#">91892</a>	<a href="#">91893</a>	<a href="#">91903</a> , <a href="#">91913</a> , <a href="#">91906</a> , <a href="#">91916</a>
<b>After hours consultations</b>			
In consulting rooms	<a href="#">5200</a> , <a href="#">733</a>	<a href="#">5203</a> , <a href="#">5207</a> , <a href="#">5208</a> , <a href="#">5209</a> , <a href="#">737</a> , <a href="#">741</a> , <a href="#">745</a> , <a href="#">2197</a>	
Out of consulting rooms	<a href="#">5220</a> , <a href="#">761</a>	<a href="#">5223</a> , <a href="#">5227</a> , <a href="#">5228</a> , <a href="#">5261</a> , <a href="#">763</a> , <a href="#">766</a> , <a href="#">769</a> , <a href="#">2198</a>	
RACH <sup>1</sup>	<a href="#">5260</a> , <a href="#">772</a>	<a href="#">5263</a> , <a href="#">5265</a> , <a href="#">5267</a> , <a href="#">5262</a> , <a href="#">776</a> , <a href="#">788</a> , <a href="#">789</a> , <a href="#">2200</a>	
<b>Other</b>	All other “unreferred services”, including but not limited to: chronic condition management items, Better Access mental health items, health assessments, minor procedures etc – <b>Claim Item 75858</b>		

<sup>1</sup>Residential Aged Care Home

Items underlined can only be claimed by prescribed medical practitioners, that is, medical practitioners that are not GPs, specialists or consultant physicians. Other items can be claimed by medical practitioners that are not GPs

## 34. Closing the Gap (CTG) PBS Co-payment Program

The CTG PBS Co-payment Program improves access to affordable PBS medicines for First Nations people living with, or at risk of, chronic disease, and who in their doctor's opinion would experience setbacks in the prevention or ongoing management of chronic disease if they did not take their prescribed medicine and would be unlikely to adhere to their medicine's regimen without assistance through the program.

Under the CTG PBS Co-payment Program, eligible First Nations people who are registered on the CTG PBS Co-payment Register and who would normally pay the full general PBS co-payment amount, pay the concessional rate when obtaining PBS medicines from their local community pharmacy, approved medical practitioner, or a private or public hospital. Eligible patients who would normally pay the concessional rate receive their PBS medicines at nil cost if prescribed the generic brand, a co-payment may occur if the premium brand is prescribed by the medical practitioner.

Complementing this program and recognising that there may not be pharmacies available to dispense in some remote areas, the Remote Area Aboriginal Health Services (RAAHS) Program allows clients of approved RAAHS to receive PBS medicines directly from their RAAHS, without the need for a normal PBS script, and without charge.

### Patient Eligibility

The CTG PBS Co-payment Program is available to First Nations people of any age who are registered with Medicare, and in the opinion of a prescriber or Aboriginal Health Practitioner (AHP):

- Would experience setbacks in the prevention or ongoing management of a condition if the person did not take their prescribed medicine.
- Are unlikely to adhere to their medicine's regimen without assistance through the program.

### How to Register a Patient for the CTG PBS Co-payment Program

Any PBS prescriber or eligible AHP can register eligible First Nations people for the CTG PBS Co-payment Program. Registration of eligible First Nations people is completed via the Services Australia [Health Professional Online Services \(HPOS\)](#) portal and is a one-off registration process.

Once a First Nations person has been assessed as being eligible for the program, their PBS prescriber or eligible AHP can authorise a HPOS delegate to act on their behalf to enter the registration details into HPOS. A delegate will need to register for their own [PRODA \(Provider Digital Access\)](#) account before being linked to a prescriber or health practitioner's HPOS account.

If a patient is unsure whether they are registered for the program, their practitioner or the pharmacist will be able to check via HPOS on their behalf.

In remote areas with limited internet access, a health service or clinic can phone Services Australia on 132 290 to register the patient for the program.

Further information about this program is available: [Pharmaceutical Benefits Scheme \(PBS\) | Closing the Gap \(CTG\) PBS Co-payment Program](#) & [Closing the Gap PBS co-payment for health professionals - Health professionals - Services Australia](#).

## 35. Practice Incentives

[Practice Incentives Program - Health professionals - Services Australia](#)

PIP Enquiry Line Telephone: 1800 222 032

Email: [PIP@humanservices.gov.au](mailto:PIP@humanservices.gov.au)

### 35.1. Indigenous Health Incentive (PIP IHI)

[Practice Incentives Program – Indigenous Health Incentive](#)

Encourages health services to meet the health care needs of Aboriginal and Torres Strait Islander people with a chronic disease. Health services include general practices, Aboriginal Medical Services and Aboriginal Community Controlled Health Services.

The PIP IHI meets its goals by providing incentive payments to health services. The incentives help services to deliver high quality, comprehensive primary health care to Aboriginal and Torres Strait Islander people living with a chronic disease.

**Sign on payment.** This is a once only payment. Practices agree to undertake specified activities to improve the care of their Aboriginal and Torres Strait Islander patients with a chronic disease or mental disorder.

**Outcome payment Tier 1.** A payment to practices that meet the requirements of the Tier 1 Outcome payment within a 12-month assessment period.

**Outcome payment Tier 2.** A payment to practices that provide a target level of care for a registered patient within a 12-month assessment period.

### 35.2. Quality Improvement Incentive

The [Practice Incentives Program \(PIP\) Quality Improvement \(QI\) Incentive](#) is a payment to general practices for activities that support continuous quality improvement in patient outcomes and the delivery of best practice care.

A general practice needs to meet 2 components to qualify for a PIP QI Incentive payment:

#### 1. Participate in continuous quality improvement

The PIP QI Incentive rewards practices for participating in continuous quality improvement activities in partnership with their local Primary Health Network (PHN).

Practices may focus their quality improvement activities on specified improvement measures. There are no set targets for the improvement measures.

Alternatively, practices can choose to focus their activities on other areas. These areas must be informed by their clinical information system data and meet the needs of their patients.

#### 2. Provide the PIP Eligible Data Set to your local PHN

The PIP Eligible Data Set is the data collected against specified improvement measures. General practices must submit the PIP Eligible Data Set to their local PHN quarterly from their general practice clinical information system. PHNs will use the de-identified data to provide feedback to general practices. This will help the practices identify key priority areas and quality improvement activities.

[PIP QI Program Guidelines](#)

### 35.3. General Practice in Aged Care Incentive

The [General Practice in Aged Care Incentive](#) (MyMedicare Incentive) will make it easier for older people living in Residential Aged Care Homes (RACH) to receive regular visits and care planning services from their responsible GP and practice. This supports improved continuity of care and aims to reduce avoidable hospitalisations.

Eligible GPs and practices will receive incentive payments for providing services to each of their registered patients in a RACH rather than at their practice.

Information, including benefits, eligibility and registration requirements, can be found in the [Program Guidelines](#).

[Fact sheets](#), resources for [GPs and practices](#) and resources for [residents and carers](#) are found on the Department of Health, Disability and Ageing websites.

### 35.4. Bulk Billing Practice Incentive Program (BBPIP)

The [Bulk Billing Practice Incentive Program](#) (BBPIP) supports General Practices to bulk bill patients. Practices participating in BBPIP receive an additional quarterly 12.5% incentive payment on MBS benefits paid from [eligible services](#), split evenly between the GP and the practice. The even split of the BBPIP incentive payment recognises the role of both practices and GPs in delivering bulk billed services to patients.

Practices can use the [bulk billing incentives calculator](#) to estimate billing changes.

More information on the program, including eligibility criteria, billing requirements and payments, can be found in the [Program Guidelines](#) and [BBPIP Resources](#) page.

### 35.5. After Hours Incentive

Incentive to support general practices to provide their patients with appropriate access to after-hours care.

#### After hours periods:

Practices to ensure their patients have access to care throughout the after-hours periods.

For the Practice Incentives Program (PIP) the complete after-hours period is:

- Outside 8 am to 6 pm weekdays.
- Outside 8 am to 12 noon on Saturdays.
- All day on Sundays and public holidays.
- The complete after-hours period is further broken into:
  - Sociable after-hours period – 6 pm through to 11 pm weeknights.
  - Unsociable after-hours period – 11 pm through to 8 am weekdays, hours outside of 8 am and 12 noon Saturdays, and all-day Sundays and public holidays.

Practices that use medical deputising services to meet their requirements and obligations under the PIP must make sure the medical deputising service is independently registered for accreditation or is fully accredited as a medical deputising service as defined by the RACGP guidelines.

[After hours PIP Guidelines](#)

## 35.6. eHealth Incentive

The eHealth Incentive aims to encourage general practices to keep up to date with the latest developments in digital health and adopt new digital health technology as it becomes available. It aims to help practices improve administration processes and patient care.

To be eligible for the PIP eHealth Incentive, practices must be registered in the PIP and meet each of the five eligibility requirements:

Requirement 1—Integrating Healthcare Identifiers into Electronic Practice Records

Requirement 2—Secure Messaging Capability

Requirement 3—Data Records and Clinical Coding

Requirement 4—Electronic Transfer of Prescriptions

Requirement 5—My Health Record system

[eHealth PIP Guidelines](#)

## 35.7. Teaching Payment

The Teaching payment is to encourage general practices to provide teaching sessions to undergraduate and graduate medical students preparing to enter the Australian medical profession.

The Teaching Payment compensates eligible practices for the reduced number of consultations due to a student's presence.

The Teaching Payment compensates eligible practices for the reduced number of consultations due to a student's presence. GPs are expected to have normal consultations when the student is present.

[Teaching Payment Program Guidelines](#)

## 35.8. Rural Support Stream Incentive

Rural support stream payments aim to encourage quality patient care in rural and remote areas.

### Procedural GP Payment

This incentive is to encourage general practitioners (GPs) in rural and remote areas to maintain local access to surgical, anaesthetic and obstetric services.

Procedural general practitioners (GPs) provide non-referred procedural services in a hospital theatre, maternity care setting or other appropriately equipped facility, which in urban areas would normally be a specific referral-based specialty.

[Procedural GP Payment Guidelines](#)

### Rural Loading Incentive

Practices participating in the PIP, with a main practice located outside capital cities and other major metropolitan centres, are automatically paid a rural loading.

[Rural Loading PIP Guidelines](#)

## 36. MyMedicare Overview

MyMedicare is a voluntary patient registration scheme available to all patients, practices and primary care providers who meet eligibility requirements.

It is the government's response to the taskforce recommendation to support better continuity of care, a strengthened relationship between the patient and their care team, and more integrated, person-centred care through the introduction of voluntary patient registration.

MyMedicare is the foundation upon which a stronger, more personalised Medicare will be built. Patients will receive more tailored, quality care from their regular general practice and primary care team.

### Benefits for patients

#### Patients registering in MyMedicare benefit from:

- Greater continuing of care with their registered practice, improving health outcomes.
- Longer Medicare benefit schedule (MBS) funded telehealth consultations with their GP.
- More regular visits from a responsible GP and better care planning for people living in a residential aged care home.

#### Benefits to providers and practices include:

- Incentive for longer MBS telehealth consultations for patients under 16, pensioners, and concessional card holders.
- Payments for visiting patients in an aged care home, rather than at the practice.
- Funding to practices managing care for registered patients living in an aged care facility.
- Supporting continuity of care for people with chronic and complex conditions.
- Strengthening and formalising relationships between patient, GP, practice, and other members of a patient's care team.

### Patient eligibility requirements

#### To be eligible for MyMedicare registration, patients must meet the following criteria:

- Have a valid Medicare or Department of Veterans' Affairs (DVA) card.
- Have had two face-to-face eligible MBS services with the practice in the previous 24 months on separate days, or
- Be registering in a practice in Monash Modified Model (MMM) 6 or a MMM7 category and have had one face-to-face eligible MBS service with the practice in 24 months.

The MyMedicare incentives program include the **General Practice in Aged Care Incentive (GPACI)** and **Bulk Billing Incentive Program (BBPIP)**.

Information, including benefits, eligibility and registration requirements, can be found in the [Program Guidelines](#) and [MyMedicare resources](#) page.

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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)