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

Contents

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 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

Search for Item Number
Latest Fact Sheets
Latest MBS Item Updates (XML Files)
MBS News and Information

PROFESSION DEVELOPMENT

MBS Education for Health Professionals

To discuss further, or for more information contact your WQPHN Practice Support Team or prac_support@wqphn.com.au
Phone: 07 4573 1900

Return to Contents

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
Standard hours consultations					
In consulting rooms	3	23	36	44	123
Out of consulting rooms	4	24	37	47	124
RACH[1]	90020	90035	90043	90051	90054
After-hours					
In consulting rooms[2]	5000	5020	5040	5060	5071
Out of consulting rooms[3]	5003	5023	5043	5063	5076
RACH[1]	5010	5028	5049	5067	5077
Telehealth					
Video	91790	91800	91801	91802	91920
Phone	91890	91891	91900[4]	91910[4]	NA

[1]Residential Aged Care Home
[2]Use on: public holiday; Sunday; before 8am or after 1 pm on Saturday; before 8am or after 8pm on any other day
[3]Use on: public holiday; Sunday; before 8am or after 12 noon on Saturday; before 8am or after 6pm on any other day
[4]Patients enrolled in MyMedicare only

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

Return to Contents

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)
Standard hours consultations			
In consulting rooms	3	23, 36, 44, 123	
Out of consulting rooms	4	24, 37, 47, 124	
RACH[1]	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[1]	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 – **Claim Item 75855**			

[1]Residential Aged Care Home

Health Workforce Locator

Return to Contents

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[1]	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[1]	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 – **Claim Item 75856**			

[1]Residential Aged Care Home

Health Workforce Locator

Return to Contents

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[1]	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[1]	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 – **Claim Item 75857**			

[1]Residential Aged Care Home

Health Workforce Locator

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[1]	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[1]	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 – **Claim Item 75858**			

[1]Residential Aged Care Home

Health Workforce Locator

Return to Contents

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, 761	5223, 5227, 5228, 5261, 763, 766, 769, 2198
After hours consultations - residential aged care home	5260, 772	5263, 5265, 5267, 5262, 776, 788, 789, 2200

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.

Return to Contents

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

- 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.
- 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.
- 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.

Co-Claiming Restrictions

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:

- General Attendance Items - General Practitioners
- General Attendance Items – Medical Practitioners (MPs) and Prescribed Medical Practitioners (PMPs)

Return to Contents

7.1. GP Chronic Condition Management Plan (GPCCMP)

Note AN.0.47 | Medicare Benefits Schedule

Eligibility Criteria
No age restrictions for patients.
Patients with a chronic or terminal condition.
Patients who will benefit from a structured approach to their care.
Not for public patients in a hospital or patients in a Residential Aged Care Facility.

Clinical Content
Explain steps involved in GPCCMP, possible out of pocket costs, gain consent Assess health care needs, health problems and relevant conditions. Agree on management goals with the patient. Confirm actions to be taken by the patient Identify treatments and services required. Arrangements for providing the treatments and services. Review the GPCCPM at least once over the life of the plan. Review available once every 3 – 6 months.

Referral to Allied Health Professionals
Identify referrals to allied health professionals for patient care

Follow up Care Services
Patients can be followed up by the Practice Nurse or Aboriginal & Torres Strait Islander Health Practitioner on behalf of the GP or PMP

Essential Documentation Requirements
Record patient's consent to GPMP.
Patient needs and goals, patient actions, and treatments/services required
Set review date.
Offer copy to patient (with consent, offer to carer). Keep copy in patient file.

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

*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

Return to Contents

7.2. GP Chronic Condition Management Plan (GPCCMP) Review

Note AN.0.47 | Medicare Benefits Schedule

Clinical Content
Explain steps involved in the review and gain consent.
Discuss the patient's progress in relation to the goals of the GPCCMP and update as appropriate.
Discuss information provided by allied health professionals/multidisciplinary team referred to under GPCCMP.
Update other elements of the plan including timeframe for review.
Obtain consent to share relevant information with allied health professionals and provide relevant parts of the plan to same.

Referral to Allied Health Professionals
Identify referrals to allied health professionals for patient care

Essential Documentation Requirements
Record patient's agreement to review and consent to share relevant information. Make any required amendments to plan. Set new review date.
Offer copy to patient (with consent, offer to carer). Keep copy in patient file.

Claiming
All elements of the service must be completed to claim.
GP Items 967/92030 (V) or PMP items393/92061 (V)
Item 10997 cannot be co-claimed when a practice nurse assists with preparing or reviewing a GP chronic condition management plan
A review should be claimed at least once over the life of the GPCCMP.

MBS Items	Name	Recommended Frequency
GP 967/92030 (V) **PMP** 393/92061 (V)	GP Chronic Condition Management Plan Review	Once every 3 months)

Return to Contents

8. Multidisciplinary Case Conferencing Items

Note AN.0.49 | Medicare Benefits Schedule

Item Description	GP Item Number	PMP Item Number	Allied Health
Organise and coordinate			
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	
Participate			
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

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.

A multidisciplinary case conference as a process by which a multidisciplinary case conference team carries out all of the following activities:

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

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:

- The patient is living in the community.
- The patient is a resident in a residential aged care home.
- The case conference is for an admitted patient of a hospital prior to their discharge.

Return to Contents

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 **have** 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 **have not** 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 (GP or MP/PMP) 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	GP	PMP
Duration < 20 mins	930	969
Duration 20 < 40 mins	933	971
Duration 40+ mins	935	972
Case Conference GP participating	GP	PMP
Duration < 20 mins	937	973
Duration 20 < 40 mins	943	975
Duration 40+ mins	945	986

Services provided under Better Access

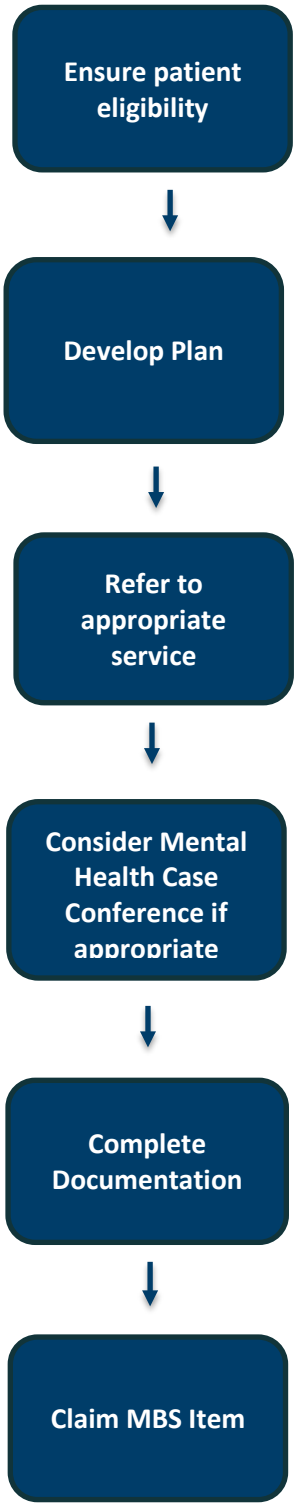
Through Better Access, eligible patients can claim a Medicare benefit for up to 10 individual and 10 group mental health treatment services per calendar year. These services consist of:

- Psychological therapy provided by eligible clinical psychologists (refer to explanatory note MN.6.2 - Provision of Psychological Therapy).
- Focussed psychological strategies provided by GPs, PMPs and eligible psychologists, occupational therapists, and social workers (refer to explanatory note MN.7.4 – Provision of Focussed Psychological Strategies).

Return to Contents

9.1. Mental Health Treatment Plan

Note AN.0.56 | Medicare Benefits Schedule



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

Clinical Content
Explain steps involved and possible out of pocket costs. Gain patient's consent. Relevant history - biological, psychological, social and presenting complaint.
Mental state examination, assessment of risk and co-morbidity, diagnosis of mental disorder and/or formulation.
Outcome measurement tool score (e.g. K10, DASS 21), 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.
Make arrangements for required referrals, treatment, appropriate support services, review and follow-up (a maximum of 6 services on the initial referral).
In addition to the 10 individual services, a patient can be referred up to a maximum of 10 group therapy mental health treatment services each calendar year on any one referral.

Consider mental health case conference if appropriate
The purpose of a case conference is to establish and coordinate the management of the care needs of a patient.

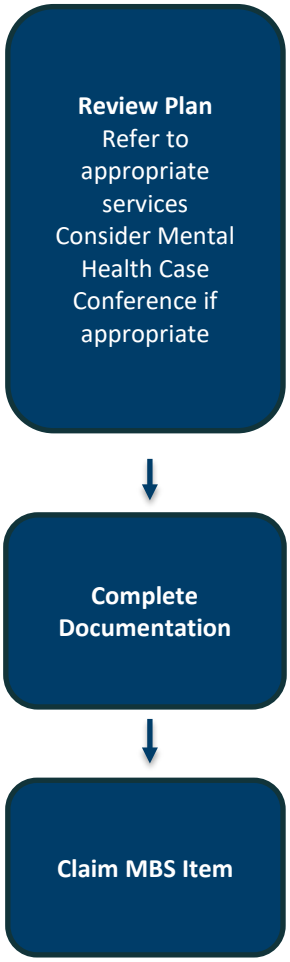
Essential Documentation Requirements
Record patient's consent to GP Mental Health Treatment Plan. Document diagnosis of mental disorder.
Results of outcome measurement tool.
Patient needs and goals, patient actions, and treatments/services required
Set review date.
Offer copy to patient (with consent,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

Claiming
All elements of the service must be completed to claim. Requires personal attendance by GP with patient.
Review using general attendance items.

Return to Contents

9.2. Review of Mental Health Treatment Plan

Note AN.0.56 | Medicare Benefits Schedule



Clinical Content

The review item is a key component for assessing and managing the patient's progress once a GP Mental Health Treatment Plan has been prepared.

Explain steps involved and possible out of pocket costs. Gain patient's consent. Review patient's progress against goals outlined in the GP Mental Health Treatment Plan.

Check, reinforce and expand 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.

Make arrangements for required referrals, treatment, appropriate support services, review and follow-up.

Consider mental health case conference if appropriate.

Essential Documentation Requirements

Record patient's consent to Review.

Results of re-administered outcome measurement tool document relevant changes to GP Mental Health Treatment Plan.

Offer copy to patient (with consent, offer to carer). Keep copy in patient file.

Claiming

All elements of the service must be completed to claim. Requires personal attendance by GP with patient. A Mental Health Treatment Plan should be reviewed at least once a year using time-tiered general attendance items. A review of a Mental Health Treatment Plan should not be undertaken more than once in a 3-month period, or within 4 weeks following a claim for a Mental Health Treatment Plan item.

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: • Collection of relevant information, including taking a patient history and • A basic physical examination and • Initiating interventions and referrals as indicated and • Providing the patient with preventive health care advice and information.
703	225	Standard Health Assessment 30 - 44 minutes	Professional attendance by a general practitioner to perform: • Detailed information collection, including taking a patient history and • An extensive physical examination and • Initiating interventions and referrals as indicated and • Providing a preventive health care strategy for the patient.
705	226	Long Health Assessment 45 - 59 minutes	Professional attendance by a general practitioner to perform: • Comprehensive information collection, including taking a patient history and • An extensive examination of the patient's medical condition and physical function and • Initiating interventions and referrals as indicated; and • Providing a basic preventive health care management plan for the patient.
707	227	Prolonged Health Assessment Lasting at least 60 minutes	Professional attendance by a general practitioner to perform: • Comprehensive information collection, including taking a patient history and • Extensive examination of the patient's medical condition, and physical, psychological, and social function and • Initiating interventions and referrals as indicated and • Providing a comprehensive preventive health care management plan for the patient.

Time-tiered health assessment items are only available to specific patient cohorts. Details of the requirements for a health assessment for each patient cohort:

- Type 2 diabetes risk evaluation (40-49 years) – **Once every 3 years to an eligible patient.**
- Health assessment for people aged 45-49 years (inclusive) who are at risk of developing chronic disease – **Once only to an eligible patient.**
- Health Assessment provided for people aged 75 years and older – **Provided annually.**
- Health Assessment provided as a comprehensive medical assessment for residents of residential aged care homes – **Provided annually.**
- Health Assessment provided for people with an intellectual disability – **Provided annually.**
- Health Assessment provided for refugees and other humanitarian entrants – **Once only.**
- One-off health assessment for veterans – **Once only.**

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.

Return to Contents

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

Perform records search to identify 'at risk' patients

↓

Identify risk factors

↓

Perform Health Check

Nurse/ATSIHW/ ATSIHP may collect information GP must see patient

↓

Claim MBS Item

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

Eligibility Criteria

Patients with newly diagnosed or existing diabetes are not eligible. Patients aged 40 to 49 years inclusive.

Patients must score ≥12 points (high risk) on Australian Type 2 Diabetes Risk Assessment Tool (AUSDRISK).

Not for patients in hospital.

Clinical Content

Explain Health Assessment process and gain consent.

Evaluate the patient's 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, including strategies to achieve lifestyle and behaviour changes.

Essential Documentation Requirements

Record patient's consent to Health Assessment.

Completion of AUSDRISK is mandatory, with a score of ≥12 points required to claim, update patient history.

Record the Health Assessment and offer the patient a copy.

Claiming

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

Return to Contents

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**

Return to Contents

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

Perform records search to identify 'at risk' patients

Time based, see MBS for complexity of care requirements of each item
Eligibility Criteria
Patients aged 45 to 49 years inclusive.
Must have an identified risk factor for chronic disease Not for patients in a 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

Nurse/ATSIHW/ ATSIHP may collect information GP must see patient

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 is recommended.

Claim MBS Item

Essential Documentation Requirements
Record patient's consent to Health Assessment.
Record the Health Assessment and offer the patient a copy.

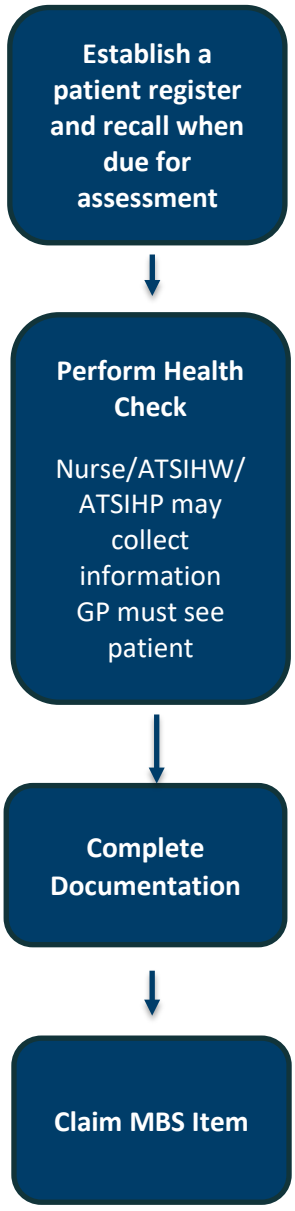
Claiming
All elements of the service must be completed to claim.

Return to Contents

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



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

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

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 vital signs.
Assessment of: Medication; Continence; Immunisation status for influenza, tetanus and pneumococcus; Physical function including activities of daily living and falls in the last 3 months; Psychological function including cognition and mood; and social function including availability and adequacy of paid and unpaid help and the patient's carer responsibilities.
Overall assessment of patient Recommend appropriate interventions Provide advice and information.
Discuss outcomes of the assessment and any recommendations with patient.

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

Essential Documentation Requirements
Record patient's/carer's consent to Health Assessment
Record the Health Assessment and offer the patient a copy (with consent, offer to carer).

Claiming
All elements of the service must be completed to claim

Return to Contents

14. Residential Aged Care Home and GPACI

Item Number GP	Item Number PMP	Item Description
731	232	Contribution or review of Multidisciplinary Care Plan 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 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 Note AN.15.8 | Medicare Benefits Schedule
701-707	224-227	Health Assessment Comprehensive medical assessment for permanent residents of a Residential Aged Care Facility (new and existing) Note AN.0.40 | Medicare Benefits Schedule
903	249	Residential Medication Management Reviews (RMMR)

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).

A Comprehensive Medical Assessment may be claimed by eligible patients:

- 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
- at 12-month intervals after that assessment.

Consent to the health assessment must be noted in the patient's records.

A health assessment must include the following elements:

- Information collection, including taking a patient history and undertaking or arranging examinations and investigations as required;
- Making an overall assessment of the patient;
- Recommending appropriate interventions;
- Providing advice and information to the patient;
- Keeping a record of the health assessment, and offering the patient a written report about the health assessment, with recommendations about matters covered by the health assessment; and
- 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.

Co-Claiming Restrictions
A Comprehensive Medical Assessment may be performed in conjunction with a consultation for another purpose but must be claimed separately.
To co-claim a Comprehensive Medical Assessment item and another item, both items must be clinically necessary and distinct services.

RMMR
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

Return to Contents

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
2 x Eligible Visits **Must be claimed in separate calendar months** MBS Items 90035-90054 OR MBS 90188-90215 OR MBS 90093-90096 OR non-urgent after-hours item **OR** Can use MBS 91800 - 91803 Telehealth Service as follow up appointment in the quarter	**2 x Eligible Visits** **Must be claimed in separate calendar months** MBS Items 90035-90054 OR MBS 90188-90215 OR MBS 90093-90096 OR non-urgent after-hours item **OR** Can use MBS 91800 - 91803 Telehealth Service as follow up appointment in the quarter	**2 x Eligible Visits** **Must be claimed in separate calendar months** MBS Items 90035-90054 OR MBS 90188-90215 OR MBS 90093-90096 OR non-urgent after-hours item **OR** Can use MBS 91800 - 91803 Telehealth Service as follow up appointment in the quarter	**2 x Eligible Visits** **Must be claimed in separate calendar months** MBS Items 90035-90054 OR MBS 90188-90215 OR MBS 90093-90096 OR non-urgent after-hours item **OR** Can use MBS 91800 - 91803 Telehealth Service as follow up appointment in the quarter

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 MT701 – 707 Health Assessment item ***Item choice depends on length of assessment and type of practitioner***	**Case Conference** MBS 235-240 **OR** MBS 735-758 Multidisciplinary Care Conference ***Item choice depends on length of conference and type of practitioner***	**Residential Medication Management Review** MBS 903 **OR** MBS249 ***Item choice depends on practitioner type***	**Case Conference** MBS 235-240 **OR** MBS 735-758 Multidisciplinary Care Conference ***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 MMM4-7 areas. Can claim up to 4 telehealth consults across the 12-months

[Return to Contents]

GPACI RACH Visits – Sample Schedule – Responsible Provider + Alternate Provider

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
2 x Eligible Visits 1 x Responsible Provider + 1 x Alternate Provider **Must be claimed in separate calendar months** MBS Items 90035-90054 **OR** MBS 90188-90215 **OR** MBS 90093-90096 **OR** MBS 82205-82215OR non-urgent after-hours item **OR** Can use MBS 91800 - 91803 Telehealth Service as follow up appointment in the quarter	**2 x Eligible Visits** 1 x Responsible Provider + 1 x Alternate Provider **Must be claimed in separate calendar months** MBS Items 90035-90054 **OR** MBS 90188-90215 **OR** MBS 90093-90096 **OR** MBS 82205-82215OR non-urgent after-hours item **OR** Can use MBS 91800 - 91803 Telehealth Service as follow up appointment in the quarter	**2 x Eligible Visits** 1 x Responsible Provider + 1 x Alternate Provider **Must be claimed in separate calendar months** MBS Items 90035-90054 **OR** MBS 90188-90215 **OR** MBS 90093-90096 **OR** MBS 82205-82215OR non-urgent after-hours item **OR** Can use MBS 91800 - 91803 Telehealth Service as follow up appointment in the quarter	**2 x Eligible Visits** 1 x Responsible Provider + 1 x Alternate Provider **Must be claimed in separate calendar months** MBS Items 90035-90054 **OR** MBS 90188-90215 **OR** MBS 90093-90096 **OR** MBS 82205-82215OR non-urgent after-hours item **OR** Can use MBS 91800 - 91803 Telehealth Service as follow up appointment in the quarter

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 MT701 – 707 Health Assessment item ***Item choice depends on length of assessment and type of practitioner***	**Case Conference** MBS 235-240 **OR** MBS 735-758 Multidisciplinary Care Conference ***Item choice depends on length of conference and type of practitioner***	**Residential Medication Management Review** MBS 903 **OR** MBS249 ***Item choice depends on practitioner type***	**Case Conference** MBS 235-240 **OR** MBS 735-758 Multidisciplinary Care Conference ***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.
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.
Note this visiting schedule is only relevant for practitioners in MMM4-7 areas. Can claim up to 4 telehealth consults across the 12-months

Return to Contents

GPACI RACH Visits – Sample Schedule – Responsible Provider + Other Care Team Member

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
2 x Eligible Visits 1 x Responsible Provider + 1 x Alternate Provider **Must be claimed in separate calendar months** MBS Items 90035-90054 **OR** MBS 90188-90215 **OR** MBS 90093-90096 **OR** MBS 82205-82215OR non-urgent after-hours item OR MBS 10997 Follow up by a Practice Nurse or Aboriginal Health Practitioner **OR** Can use MBS 91800 - 91803 Telehealth Service as follow up appointment in the quarter	**2 x Eligible Visits** 1 x Responsible Provider + 1 x Alternate Provider **Must be claimed in separate calendar months** MBS Items 90035-90054 **OR** MBS 90188-90215 **OR** MBS 90093-90096 **OR** MBS 82205-82215OR non-urgent after-hours item **OR** MBS 10997 Follow up by a Practice Nurse or Aboriginal Health Practitioner **OR** Can use MBS 91800 - 91803 Telehealth Service as follow up appointment in the quarter	**2 x Eligible Visits** 1 x Responsible Provider + 1 x Alternate Provider **Must be claimed in separate calendar months** MBS Items 90035-90054 **OR** MBS 90188-90215 **OR** MBS 90093-90096 **OR** MBS 82205-82215OR non-urgent after-hours item **OR** MBS 10997 Follow up by a Practice Nurse or Aboriginal Health Practitioner **OR** Can use MBS 91800 - 91803 Telehealth Service as follow up appointment in the quarter	**2 x Eligible Visits** 1 x Responsible Provider + 1 x Alternate Provider **Must be claimed in separate calendar months** MBS Items 90035-90054 **OR** MBS 90188-90215 **OR** MBS 90093-90096 **OR** MBS 82205-82215OR non-urgent after-hours item **OR** MBS 10997 Follow up by a Practice Nurse or Aboriginal Health Practitioner **OR** Can use MBS 91800 - 91803 Telehealth Service as follow up appointment in the quarter

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.

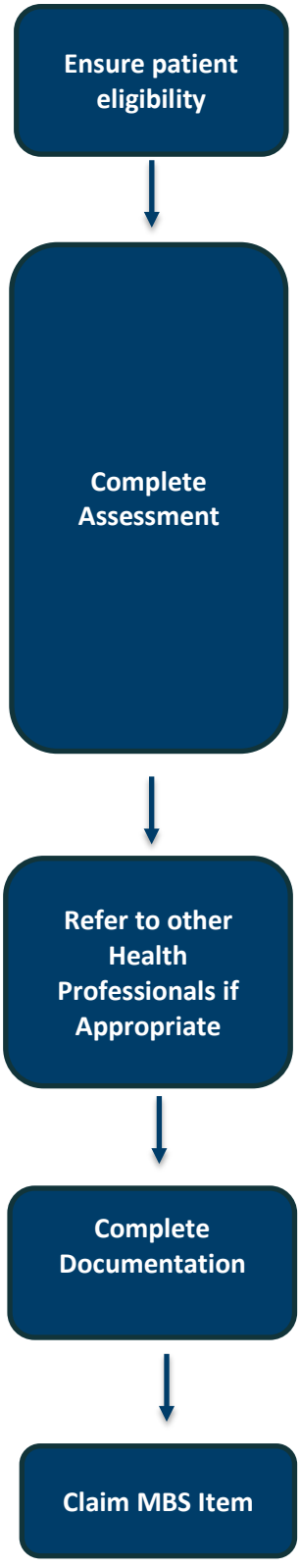
Contribution or review of Multidisciplinary Care Plan MBS 731 OR 232 can be co-claimed with any of the following: **Comprehensive Medical Assessment** MBS 703-707 OR MBS 224-227 Comprehensive Management Plan (CMA) - **OR** DVA MT701 – 707 Health Assessment item ***Item choice depends on length of assessment and type of practitioner***	**Case Conference** MBS 235-240 **OR** MBS 735-758 Multidisciplinary Care Conference ***Item choice depends on length of conference and type of practitioner***	**Residential Medication Management Review** MBS 903 **OR** MBS249 ***Item choice depends on practitioner type***	**Case Conference** MBS 235-240 **OR** MBS 735-758 Multidisciplinary Care Conference ***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.
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.

Return to Contents

15. Heath assessment for a person with an intellectual disability

Note AN.0.41 | Medicare Benefits Schedule



Eligibility Criteria

People living with an intellectual disability

Clinical Context

The health assessment must include the following matters, to the extent that they are relevant to the patient:

- checking dental health
- conducting an aural examination (ocular health)
- assessing nutritional status and a review of growth and development risk for osteoporosis
- assessing bowel and bladder function
- assessing medications
- checking immunisation status
- checking whether the support provided for activities of daily living adequately and appropriately meets the patient's needs, and considering formal review if required
- considering the need for other examinations (e.g. relating to age, sexual development, epilepsy, Down syndrome)
- checking for dysphagia and gastroesophageal disease
- assessing or reviewing treatment for comorbidities (including mental health issues)
- considering whether there are any signs of physical, psychological or sexual abuse.
- Consider need for referral to other health professionals

Essential Documentation Requirements

Record carer's/patient's (if appropriate) consent to Health Assessment

Record the Health Assessment and offer the carer/patient (if appropriate) a copy

Claiming

All elements of the service must be completed to claim.

Can only be claimed once per year.

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.

Return to Contents

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.

Return to Contents

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

Return to Contents

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

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.

Professional attendance by a general practitioner at consulting rooms or in another place other than a hospital or residential aged care facility to perform:

- Information collection, including taking a patient history and undertaking examinations and investigations as required
- Making an overall assessment of the patient;
- Recommending appropriate interventions;
- Providing advice and information to the patient; and
- 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
- 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

For children aged 0 - 14 years old.
Adults between 15- 54 years of age
Older people over 55 years

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.

Return to Contents

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

GP performs Assessment 715
Nurse/ATSIHW/ ATSIHP may collect information GP must see patient

↓

Claim MBS Item 715

↓

Referral to Allied Health Service if required
Must be at least 20 mins duration and performed by Allied Health Professional

↓

Allied Health must provide report to GP

Eligibility Criteria
Aboriginal and Torres Strait Islander children who are less than 15 years old.
An Aboriginal or Torres Strait Islander person who is aged between 15 years and 54 years. Aboriginal and Torres Strait Islander older people who are aged 55 years and over.

Mandatory
Health Assessment includes physical, psychological and social wellbeing. It also assesses what preventative health care, education and other assistance that should be offered to improve the patient's health and wellbeing. It must include:
Information collection of patient history and undertaking examinations and investigations as required. Overall assessment recommending any appropriate intervention provide advice and information.
Recording the health assessment.
Offering the patient, a written report with recommendations about matters cover by the health assessment.

Follow up Care Services
Patients can be followed up by the Practice Nurse or Aboriginal & Torres Strait Islander Health Practitioner on behalf of the GP or PMP up to 10 times per calendar year item 10987/93200 (V) & 93202(T).

Referral to Allied Health Services
Up to 10 Allied Health Services for individual allied health services for patients of Aboriginal or Torres Strait Islander descent with a chronic condition, or whose need for those services was identified through a health assessment.

Essential Documentation Requirements
If referred to an Allied Health Professional, they must provide a written report to the GP after the first and last service (more often if clinically required).

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

Return to Contents

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

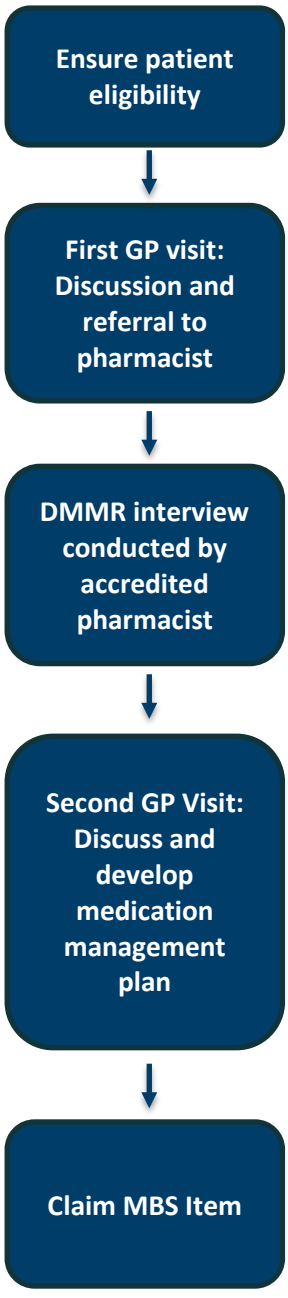
Item Number GP	Item Number PMP	Item Description
900	245	Domiciliary Medication Management Review (DMMR)
903	249	Residential Medication Management Review (RMMR)

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



Eligibility Criteria

Patients at risk of medication related problems or for whom quality use of medicines may be an issue.

Not for patients in a hospital or a Residential Aged Care Facility.

DMMRs are targeted at patients who are likely to benefit from such a review: patients for whom quality use of medicines may be an issue or; patients who are at risk of medication misadventure because of factors such as their co-morbidities, age or social circumstances, the characteristics of their medicines, the complexity of their medication treatment regimen, or a lack of knowledge and skills to use medicines to their best effect.

Initial Visit with GP

Explain purpose, possible outcomes, process, information sharing with pharmacist and possible out of pocket costs.

Gain and record patient's consent to HMR. Inform patient of need to return for second visit.

Complete HMR referral and send to patient's preferred pharmacy or accredited pharmacist.

HMR Interview

Pharmacist holds review in patient's home unless patient prefers another location.

Pharmacist prepares a report and sends to the GP covering review findings and suggested medication management strategies.

Pharmacist and GP discuss findings and suggestions.

Second 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.

Claiming

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

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

Return to Contents

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

Note AN.7.18 | Medicare Benefits Schedule

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

GP Initiates Service
Explain RMMR process and gain resident's consent.
Send referral to accredited pharmacist to request collaboration in medication review.
Provide input from Comprehensive Medical Assessment or relevant clinical information for RMMR and the resident's records.

Accredited Pharmacist Component
Review resident's clinical notes and interview resident. Prepare Medication Review report and send to GP.

GP and Pharmacist Post Review Discussion
Discuss: Findings and recommendations of the Pharmacist.
Medication management strategies; issues; implementation; follow up; outcomes.
If no (or only minor) changes recommended a post review discussion is not mandatory.

Essential Documentation Requirements
Record resident's consent to RMMR.
Develop and/or revise Medication Management Plan which should identify medication management goals and medication regimen.
Finalise Plan after discussion with resident.
Offer copy of Plan to resident/carer, provide copy for resident's records and for nursing staff at RACF, discuss plan with nursing staff if necessary.

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

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

Return to Contents

24. Allied Health Services

Note MN.3.1 | Medicare Benefits Schedule

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

Return to Contents

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.

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 **93048 (V)** and **93061 (T)**
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. **93200 (V)** and **93202 (T)**
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 **93201 (V)** and **93203 (T)**
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 **91850 (V)** and **91855 (T)**
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

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

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 & Torres Strait Health Service that has an exemption to claim Medicare benefits under subsection 19(2) of the Health Insurance Act 1973.

Return to Contents

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/creatine ratio in urine on a random spot collection in the management of patients with established diabetes or patients at risk of microalbuminuria.

These item numbers can only be performed in the following circumstances:
The service is rendered by or on behalf of a medical practitioner.
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.
The service is provided in accordance with that Program.

The practitioner referred to in paragraph (a) has determined the service to be necessary for his or her patient.

Items 73839, 738840 & 73844 are provided on behalf of and under the supervision of the GP or PMP by a Practice Nurse, Aboriginal & Torres Strait Islander Health Practitioner or Aboriginal Health Worker.

Return to Contents

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:
	• Has not previously received any prior transcranial magnetic stimulation therapy in a public or private setting; and
	• Is at least 18 years old; and
	• Is diagnosed with a major depressive episode; and
	• 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:
	  • the patient's adherence to antidepressant treatment has been formally assessed;
	  • the trialling of each antidepressant medication has been at the recommended therapeutic dose for a minimum of 3 weeks;
	  • where clinically appropriate, the treatment has been titrated to the maximum tolerated therapeutic dose; and
	• Has undertaken psychological therapy, if clinically appropriate

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

Return to Contents

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

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
Standard hours consultations					
In consulting rooms (MP)[1]	52	53	54	57	151
In consulting rooms (PMP)[2]	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
After-hours					
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
Telehealth					
Video (MP)	91792	91803	91804	91805	91923
Video (PMP)	91794	91806	91807	91808	91926
Phone (MP)	91892	91893	91903[3]	91913[3]	NA
Phone (PMP)			91906[3]	91916[3]	

[1]MP items can be claimed by all MPs who are not general practitioners.
[2]PMP items can be claimed by medical practitioners that are not general practitioners, specialists or consultant physicians.
[3]Available to patients enrolled in MyMedicare only.

Return to Contents

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

[1]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

Return to Contents

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

[1]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

Return to Contents

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

[1]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

Return to Contents

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

[1]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

Return to Contents

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.

Return to Contents

35. Practice Incentives

Practice Incentives Program - Health professionals - Services Australia

PIP Enquiry Line Telephone: 1800 222 032 Email: 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.

Return to Contents

General Disclaimer

While reasonable efforts have been made to ensure that the contents of this document are factually correct, this document (including any attachments to it) is provided by WQPHN on a general basis only. Neither WQPHN or any of its directors, officers, employees, advisers, consultants, contractors and agents make any representation or warranty, express or implied, as to the currency, accuracy, reliability or completeness of the information referred to or contained in this document and none of those persons or entities accepts any responsibility or liability (except a liability that cannot lawfully be excluded) for any reliance placed on the contents of this document by any person. Subject to any law to the contrary and to the maximum extent permitted by law, WQPHN and its directors, officers, employees, advisers, consultants, contractors and agents disclaim and exclude all liability for any loss, claim, demand, damages, costs and expenses of whatsoever nature (whether or not foreseeable): ·suffered or incurred by any person relying or acting on any information provided in, or omitted from, this document or any other written or oral opinions, advice or information provided by any of them; or arising because of, or in connection with information in this document being inaccurate or incomplete in any way or by reason of any reliance thereon by any person and whether caused by reason of any negligence, accident, default or however otherwise caused.

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