Frequently used desktop guide to item numbers for general practice

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BRISBANE NORTH

An Australian Government Initiative

CONTENTS

FREQUENTLY USED DESKTOP GUIDE TO ITEM NUMBERS 2
HOME VISITS 3
AFTER HOURS SERVICES 4
RESIDENTIAL AGED CARE FACILITY CONSULTS 5
RESIDENTIAL AGED CARE FACILITY HEALTH ASSESSMENTS 6
MISCELLANEOUS AND DIAGNOSTIC PROCEDURES 7
SIMPLE PROCEDURES 7
SYSTEMATIC CARE 8
ALLIED HEALTH SERVICES FOR CHRONIC CONDITIONS REQUIRING TEAM CARE 13
GP MENTAL HEALTH TREATMENT PLAN – ITEM 2700/2701/2715/2717 14
GP MENTAL HEALTH TREATMENT REVIEW ITEMS - 2712 15
GP MANAGEMENT PLAN (GPMP) – ITEM 721 16
TEAM CARE ARRANGEMENT (TCA) – ITEM 723 17
REVIEWING A GP MANAGEMENT PLAN (GPMP) AND/OR TEAM CARE ARRANGEMENT (TCA) – TEAM 732 18
HEALTHY KIDS CHECK – HEALTH ASSESSMENT 19
TYPE 2 DIABETES RISK EVALUATIONS – HEALTH ASSESSMENT ITEMS 701 / 703 / 705 / 707 20
45 – 49 YEAR OLD – HEALTH ASSESSMENT ITEMS 701/703/705/707 21
75 YEARS AND OLDER – HEALTH ASSESSMENT ITEMS 701/703/705/707 22
ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH ASSESSMENT ITEM 715 23
HOME MEDICINES REVIEW (HMR) ITEM 900 24
HOME MEDICINES REVIEW (HMR) ITEM 900 - continued 25
RESIDENTIAL MEDICATION MANAGEMENT REVIEW (RMMR) ITEM 903 26
COORDINATED VETERANS CARE PROGRAM 27
DIABETES ANNUAL CYCLE OF CARE SERVICE INCENTIVE PAYMENT (SIP) 28
DIABETES MANAGEMENT 29
ASTHMA CYCLE OF CARE 30
PRACTICE INCENTIVE PAYMENTS AND SERVICE INCENTIVE PAYMENTS SUMMARY 32

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FREQUENTLY USED DESKTOP GUIDE TO ITEM NUMBERS

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

Commonly Used Item Numbers			
Item	**Non VR**	**Name**	**Description / Recommend Frequency**
3	**52**	Level A	Brief – see MBS for complexity of care requirements
23	**53**	Level B	≤ 20 min – see MBS for complexity of care requirements
36	**54**	Level C	≥ 20 min - see MBS for complexity of care requirements
44	**57**	Level D	≥ 40 min - see MBS for complexity of care requirements
10990		Bulk Billing item	DVA, under 16's and Commonwealth Concession Card holders. Can be claimed concurrently for eligible patients
10991		Bulk Billing item Regional - see MBS for location eligibility	DVA, under 16's and Commonwealth Concession Card holders. Can be claimed concurrently for eligible patients

HOME VISITS

These items are for consultations at a place other than the consulting rooms. See explanatory notes for billing multiple patients http://www.mbsonline.gov.au			
Item	**Non VR**	**Name**	**Description**
4	**58**	Home Visit Brief LEVEL A	Obvious and straightforward cases that should be reflected in the practitioner's records. In this context, the practitioner should undertake the necessary examination of the affected part if required, and note the action taken
24	**59**	Home Visit Standard LEVEL B	For the cases that are not obvious or straightforward in relation to one or more health related issues. The medical practitioner may undertake all of some of the tasks set out in the item descriptor as clinically relevant, and this should be reflected in the practitioner's record.
37	**60**	Home Visit Long LEVEL C	
47	**65**	Home Visit Prolonged LEVEL D	

AFTER HOURS SERVICES

Attendance Period	Item	Non VR	Brief Guide
Urgent attendance – After Hours **Mon-Fri 7am-8am or 6pm-11pm** / **Sat 7am-8am or 12noon -11pm** / **Sun & Public Holidays 7am-11pm**	597	**598**	**Urgent Attendance – After Hours** • These items can only be used for the first patient, if more than one patient is seen on the one occasion. For the second and subsequent patients attending on the same occasion, standard (non- urgent) after hours items apply • The urgent after-hours items can only be used where the patient has a medical condition that requires urgent treatment, which could not be delayed until the next in-hours period • For consultations at the health centre, where it is necessary for the practitioner to return to, and specially open the consulting rooms for the attendance
Urgent attendance – unsociable hours **Mon-Fri 11pm-7am** / **Sat 11pm-7am** / **Sun & Public Holidays 11pm-7am**	599	**600**	
Non-urgent after hours at a place other than consulting rooms **Mon-Fri** Before 8am or after 6pm / **Sat** Before 8am or after 12pm / **Sun & Public Holidays** All day	5023 (Level B <20min) 5043 (Level C >20min) 5063 (Level D >40min) 5028 (Level B <20min RACF) 5049 (Level C >20min RACF) 5067 (Level D >40min RACF)	**5223** **5227** **5228** **5263** **5265** **5267**	
Non-urgent after hours at consulting rooms **Mon-Fri** Before 8am or after 8pm / **Sat** Before 8am or after 1pm / **Sun & Public Holidays** All day	5000 (Level A < 5mins) 5020 (Level B <20 min) 5040(Level C >20 min) 5060 (Level D >40 min)	**5200** **5203** **5207** **5208**	

RESIDENTIAL AGED CARE FACILITY CONSULTS

Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion each patient. For the fee for items billed refer to www.mbsonline.gov.au and their ready reckoner.

Item	Non VR	Name	Description/recommended frequency
20	**92**	Level A	A Level A item will be used for obvious and straightforward cases and this should be reflected in the practitioner's records. In this context, the practitioner should undertake the necessary examination of the affected part if required, and note the action taken.
35	**92**	Level B	A Level B item will be used for a consultation lasting less than 20 minutes for cases that are not obvious or straightforward in relation to one or more health related issues. The medical practitioner may undertake all or some of the tasks set out in the item descriptor as clinically relevant, and this should be reflected in the practitioner's record. In the item descriptor singular also means plural and vice versa.
43	**95**	Level C	A Level C item will be used for a consultation lasting at least 20 minutes for cases in relation to one or more health related issues. The medical practitioner may undertake all or some of the tasks set out in the item descriptor as clinically relevant, and this should be reflected in the practitioner's record. In the item descriptor singular also means plural and vice versa.
51	**96**	Level D	A Level D item will be used for a consultation lasting at least 40 minutes for cases in relation to one or more health related issues. The medical practitioner may undertake all or some of the tasks set out in the item descriptor as clinically relevant, and this should be reflected in the practitioner's record. In the item descriptor singular also means plural and vice versa.

RESIDENTIAL AGED CARE FACILITY HEALTH ASSESSMENTS

Item	Name	Description/recommended frequency
Items 701, 703, 705 and 707 may be used to undertake a comprehensive medical assessment of a resident of a residential aged care facility. This health assessment is available to new residents on admission into a residential aged care facility. It is recommended that new residents should receive the health assessment as soon as possible after admission, preferably within six weeks following admission into a residential aged care facility.		
701	Brief Health Assessment	< 30 mins: see MBS for complexity of care requirements Incorporating: Comprehensive Medical Assessment For permanent residents of Residential Aged Care Facilities. On admission to a residential aged care facility, provided that a comprehensive medical assessment has not already been provided in another residential aged care facility within the previous 12 months; and Not more than once yearly.
703	Standard Health Assessment	30-45 minutes: see MBS for complexity of care requirements Incorporating: Comprehensive Medical Assessment
705	Long Health Assessment	45-60 minutes: see MBS for complexity of care requirements Incorporating: Comprehensive Medical Assessment
707	Prolonged Health Assessment	>60 minutes: see MBS for complexity of care requirements Incorporating: Comprehensive Medical Assessment
731	GP Contribution to, or Review of, Multidisciplinary Care Plan prepared by RACF	GP contribution to, or review of, a multidisciplinary care plan prepared by RACF, at the request of the facility, for patients with a chronic or terminal condition and complex needs requiring ongoing care from a team including GP and at least two other health or care providers. Not more than once every three (3) months.
735	Organise and coordinate a case conference	15-20 minutes. GP organises and coordinated case conference in RACF or community or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs.
739	Organise and coordinate a case conference	20-40 minutes. GP organises and coordinated case conference in RACF or community or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs.
743	Organise and coordinate a case conference	20-40 minutes. GP organises and coordinated case conference in RACF or community or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs.
747	Participate in a case conference	15-20 minutes. GP participates in RACF or community or on discharge. For patients with a chronic or terminal condition and complex multidisciplinary care needs
750	Participate in a case conference	30-40 minutes. GP participates in RACF or community or on discharge. For patients with a chronic or terminal condition and complex multidisciplinary care needs
758	Participate in a case conference	>40 minutes. GP participates in RACF or community or on discharge. For patients with a chronic or terminal condition and complex multidisciplinary care needs
903	Residential Medication Management Review (RMMR)	For permanent residents of RACF who are at risk of medication related misadventure. Performed in collaboration with the resident's pharmacist. Available for new and existing residents. Not more than once yearly.

MISCELLANEOUS AND DIAGNOSTIC PROCEDURES

Item	Name	Description / Recommend Frequency
11506	Spirometry	Measurement of respiratory function before and after inhalation of bronchodilator
11700	ECG Tracing and report	TWELVE-LEAD ELECTROCARDIOGRAPHY, tracing and report
73806	Pregnancy test	Pregnancy test by 1 or more immunochemical methods
16500	Antenatal	Routine Attendance
16591	Antenatal	Attendance – Pregnancy > 20 weeks (only 1 per pregnancy)

SIMPLE PROCEDURES

Item No.	Item Name - Short
14206	Implanon Insertion (hormone or living tissue implantation by cannula)
30062	Implanon removal includes suturing
30023	Deep or extensively contaminated wound including suturing under anaesthesia
30026	Suture < 7cm superficial not face
30029	Suture < 7cm deep not face
30032	Suture < 7cm deep face
30038	Suture >7cm superficial not face
30041	Suture >7cm deep not face
30045	Suture >7cm deep face
30052	Suture eyelid/nose/ear
30061	Foreign body superficial – Removal of (inc Cornea/Sclera)
30064	Foreign Body Subcutaneous – Removal of
30067	Foreign body Deep – Removal of
30071	Diagnostic Biopsy skin or mucous membrane
30219	Haematoma, Furuncle, Abscess, Lesion – Incision with drainage of
41500	Foreign body ear – removal of by means other than simple syringing
41659	Foreign body nose – removal of by means other than simple probing
42644	Foreign body Cornea/Sclera – removal of imbedded

SYSTEMATIC CARE

For the most up to date information refer to the Medicare Benefits Schedule online at www.health.gov.au/mbsonline or phone the Medicare Australia Schedule Interpretation Team on 132 150.

	Item Number	Service	Description	Claim Period
Health Assessments	701	Brief Health Assessment	lasting not more than 30 minutes	
	703	Standard Health assessment	> 30 - <45 minutes - see MBS for complexity of care requirements	
	705	Long Health Assessment	> 45 - <60 minutes - see MBS for complexity of care requirements	
	707	Prolonged Health Assessment	> 60 minutes - see MBS for complexity of care requirements	
	715	Aboriginal and Torres Strait Islander Health Assessment	Not timed	
Medication Management	900	Home Medicines Review (HMR/DMMR*)	Review of medications in collaboration with a pharmacist for patients at risk of medication related misadventure. Every 2 years*.	
	903	Residential Medication Management Review (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. Every 2 years*.	
	*Except where there has been a significant change in the patient's condition or medication regimen requiring a new HMR/DMMR/RMMR. *Domiciliary Medication Management Review (DMMR)			
Pap Smear	2501	Level B Pap Smear	< 20 min surgery consultation: see MBS for complexity of care requirements. Screening of a woman aged 20 – 69 years who has not been screened in the past (4) years	
	2504	Level C Pap Smear	> 20 min surgery consultation: see MBS for complexity of care requirements. Screening of a woman aged 20-69 years who has not been screened in the past four (4) years	
	2507	Level D Pap Smear	> 40 min surgery consultation: see MBS for complexity of care requirements. Screening of a woman aged 20-69 years who has not been screened in the past four (4) years.	

Mental Health Item Numbers	Item	Description	Details	
	2700	GP Mental Health Treatment Plan	> 20 mins – Prepared by GP who has not undertaken Mental Health Skills Training. Assessment of patient and preparation of a care plan with option to refer for rebated psychological services. Not more than once yearly.	
	2701	GP Mental Health Treatment Plan	> 40 mins - Prepared by GP who has not undertaken Mental Health Skills Training. Assessment of patient and preparation of a care plan with option to refer for rebated psychological services. Not more than once yearly.	
	2715	GP Mental Health Treatment Plan	> 20 mins - Prepared by GP who has undertaken Mental Health Skills Training. Assessment of patient and preparation of a care plan with option to refer for rebated psychological services. Not more than once yearly	
	2717	GP Mental Health Treatment Plan	> 40 mins - Prepared by GP who has undertaken Mental Health Skills Training. Assessment of patient and preparation of a care plan with option to refer for rebated psychological services. Not more than once yearly	
	2712	Review of GP Mental Health Treatment Plan	Plan should be reviewed between 1-6 months and no more than 2 per year	
	2713	Mental Health Consultation	Consult >20 mins - for the ongoing management of a patient with mental disorder. No restriction on the number of these consultations per year	
	2721	GP Focused Psychological Strategies	>30 – <40 mins - provision of focused psychological strategies by an appropriately trained and registered GP working in an accredited practice	
	2723	GP Focused Psychological Strategies	>30 – <40 mins - out of surgery consultation. Provision of focused psychological strategies by an appropriately trained and registered GP working in an accredited practice	
	2725	GP Focused Psychological Strategies	>40 mins - Provision of focused psychological strategies by an appropriately trained and registered GP working in an accredited practice	
	2727	GP Focused Psychological Strategies	>40 mins - out of surgery consultation. Provision of a focused psychological strategies by an appropriately trained registered GP working in an accredited practice	

GP Multidisciplinary Case Conferences	**735**	Organise and coordinate a case conference	15-20 minutes. GP organises and coordinates case conference in RACF or community or on discharge. For patients with chronic or terminal condition and complex, multidisciplinary care needs.	
	739	Organise and coordinate a case conference	20-40 minutes. GP organises and coordinates case conference in RACF or community or on discharge. For patients with chronic or terminal condition and complex, multidisciplinary care needs.	
	743	Organise and coordinate a case conference	> 40 minutes. GP organises and coordinates case conference in RACF or community or on discharge. For patients with chronic or terminal condition and complex, multidisciplinary care needs.	
	747	Participate in a case conference	15 – 20 minutes. GP organises and coordinates case conference in RACF or community or on discharge. For patients with chronic or terminal condition and complex, multidisciplinary care needs.	
	750	Participate in a case conference	30-40 minutes. GP organises and coordinates case conference in RACF or community or on discharge. For patients with chronic or terminal condition and complex, multidisciplinary care needs.	
	758	Participate in a case conference	> 40 minutes. GP organises and coordinates case conference in RACF or community or on discharge. For patients with chronic or terminal condition and complex, multidisciplinary care needs.	
Chronic Condition (Disease) Management	**721**	Preparation of a General Practitioner Management Plan (GMMP)	Management plan for patients with a chronic or terminal condition	**2 Yearly** (minimum 12 months)
	723	Coordination of a Team Care Arrangement (TCA)	Management plan for patients with a chronic or terminal condition who require ongoing care from a team including the GP and at least two (2) other health or care providers. Enables referral for five (5) rebated allied health services	**2 Yearly** (minimum 12 months)
	732	Review of a GPMP	Recommended six (6) monthly, must be performed at least once over the life of plan	**6 monthly** (minimum 3 months)
		Coordinate a review of TCA		

	729	Contribution to care plan or to review the care plan being prepared by the other provider	Contribution to, or review of, a multidisciplinary care plan prepared by another provider (e.g. community, home or terminal condition and complex needs requiring ongoing care from a team including the GP and at least two (2) other health or care providers.	**6 monthly** (minimum 3 months)
	731	Contribution to care plan or to review the care plan for patient of RACF	GP contribution to, or review of, a multidisciplinary care plan prepared by RACF, at the request of the facility, for patients with a chronic or terminal condition and complex needs requiring ongoing care from a team including the GP and at least two (2) other health or care providers. Not more than once every three (3) months.	**6 monthly** (minimum 3 months)
	139	Assessment, diagnosis and development of a treatment and management plan for a disability (at least 45 minutes)	Children aged under 13 years with an eligible disability	**Once only**
Medication Reviews	**900**	Domiciliary Medication Management Review (DMMR) for patients living in the community setting.	Assessment, referral to a community pharmacy	**24 months** Except in circumstances with significant change
	903	Residential Medication Management Review (RMMR)	For new or existing residents of Residential Aged Care Facilities	**24 months** Except in circumstances with significant change
Practice Nurse	**10987** **10997**	Monitoring and support for a person who has had a 715 Health Assessment Monitoring and support for a person with a chronic disease	715 Health Assessment on Aboriginal Torres Strait Islander people Patient must have GPMP, TCA or multidisciplinary care plan in place	Maximum 10 per Patient per year Maximum of 5 times per patient per calendar year.

PIP/SIP Incentive Payments				
	 2501 **2504** **2507**	Cervical smear Level B Level C Level D	In Surgery Consultation for patient between the ages of 20 & 69 years inclusive	Patient who has not had a smear in the last 4 years
	  2517 **2521** **2525**	Diabetes Annual Cycle of Care Level B Level C Level D	Minimum requirements of care needed to be completed	Only paid once every 11-13 month period per patient
	2546 **2552** **2558**	Asthma Cycle of Care Level B Level C Level D	Completion of minimum the Asthma Cycle of Care within 12 months for a patient with moderate to severe asthma	One Asthma Cycle of Care for each eligible patient per 12 month period

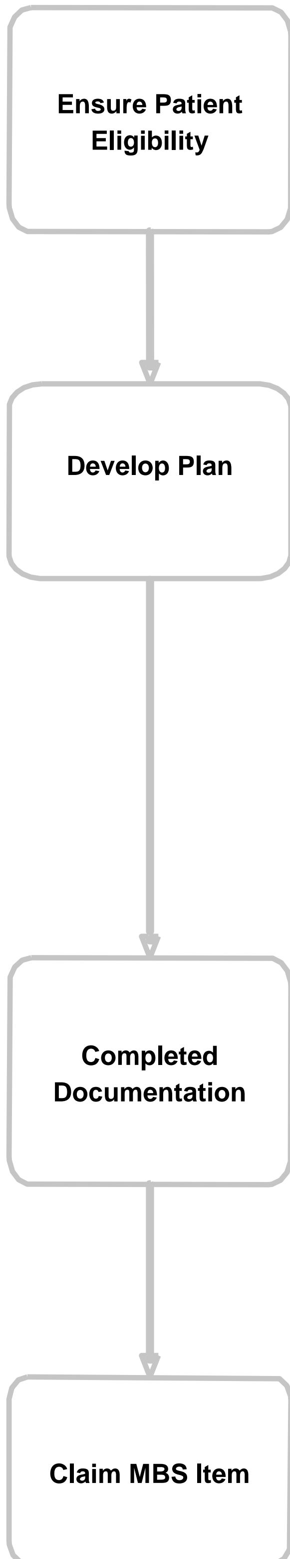
Asthma may be treated in General Practice using either the Asthma Cycle of Care or the General Practitioner Management Plan (GPMP). Both schemes **should not be claimed in the same twelve months** for the same patient due to overlap in the services provided. For patients with complex needs, GPMP, TCA (Team Care Arrangements) and Asthma Cycle of Care can be provided.

ALLIED HEALTH SERVICES FOR CHRONIC CONDITIONS REQUIRING TEAM CARE

Allied Health Services for Chronic Conditions Requiring Team Care *GP must have completed a GP Management Plan (721) and Team Care Arrangement (723) or contributed to a Multidisciplinary Care Plan in a Residential Aged Care Facility (731)*		
Item	**Name**	**Description / Recommended Frequency**
10950	Aboriginal Health Worker Services	Five allied health services per calendar year. Can be five sessions with one (1) provider or a combination e.g. Three dietitian and two diabetes education sessions. Medicare Chronic Disease Management (CDM) form (Formerly Enhanced Primary Care EPC) for each provider. Allied Health Provider must be Medicare registered
10951	Diabetes Educator Services	
10952	Audiologist Services	
10953	Exercise Physiologist Services	
10954	Dietician Services	
10958	Occupational Therapist Services	
10960	Physiotherapist Services	
10964	Chiropractor Services	
10966	Osteopath Services	
10970	Speech Pathologist Services	
10956	Mental Health Worker Services	Use Better Access Mental Health Care items for mental health conditions: 10 sessions. GPMP and TCA for chronic medical conditions: five (5) sessions.
10968	Psychologist Services	

ALLIED HEALTH GROUP SERVICES FOR PATIENTS WITH TYPE 2 DIABETES *GP must have completed and claimed a GP Management Plan (721) and Team Care Arrangement (723) or contributed to a care plan in a Residential Aged Care Facility (731)*		
Item	**Name**	**Description / recommended frequency**
81100	Assessment for group services by Diabetes Educator	One (1) assessment session only by a Diabetes Educator, Exercise Physiologist or Dietician per calendar year Medicare Allied Health Group Services for Type 2 Diabetes referral form
81110	Assessment for group services by Exercise Physiologist	
81120	Assessment for group services by Dietician	
81105	Diabetes Education Group Services	Eight (8) group services per calendar year (can be eight (8) sessions with one (1) provider or a combination) eg. Three (3) dietician and two (2) exercise physiology sessions. Medicare Allied Health Group Services for Type 2 Diabetes referral form.
81115	Exercise Physiology Group	
81125	Dietetics Group Service	

GP MENTAL HEALTH TREATMENT PLAN – ITEM 2700/2701/2715/2717



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 an Residential Aged Care Facility

Clinical Content

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

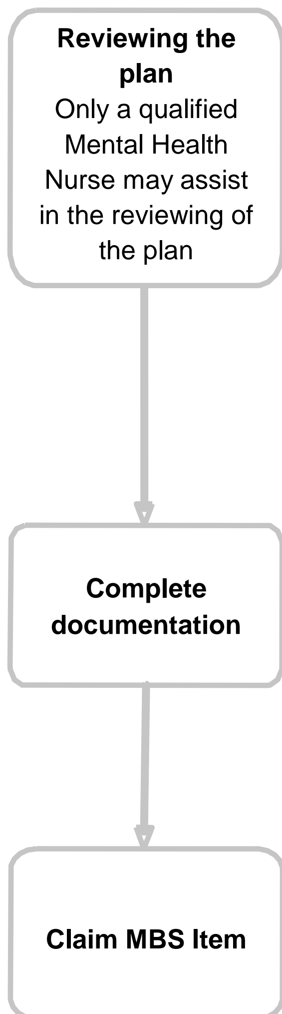
Essential Documentation Requirements

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

Claiming

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

GP MENTAL HEALTH TREATMENT REVIEW ITEMS - 2712



Clinical Content

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

Essential documentation requirements

- Record patient's consent to review
- Results of readministered 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

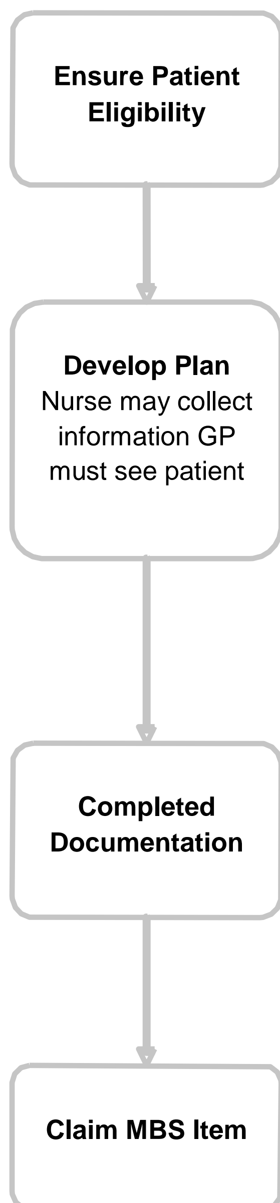
- All elements of the service must be completed to claim
- Requires personal attendance by GP with patient
- Claiming a 2712 enables patients to receive an additional set of 4 individual or 4 group psychology services
- Item 2712 should be claimed at least once over the life of the GP Mental Health Treatment Plan
- The recommended frequency for the review service, allowing for variation in patients' needs, should occur between 4 to 6 weeks after the completion of the GP Mental Health Treatment Plan and if required, a further review can occur three months after the first review. In general, most patients should not require more than two reviews in a 12 month period, with ongoing management through the GP
- Mental Health Treatment Consultation and standard consultation items, as required. A rebate will not be paid within three months of a previous claim for the same item/s or within four weeks following a claim for a GP Mental Health Treatment Plan item other than in exceptional circumstances.

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

MBS item 10991 (bulk billing incentive) may also be claimed for eligible patients

GP MANAGEMENT PLAN (GPMP) – ITEM 721

(Review using item 732 at least once over life of the plan)



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
- A GP Mental Health Treatment Plan (Item 2700/2701/2715/2717) is suggested for patients with a mental disorder only

Clinical Content

- Explain steps involved in GPMP, possible out of pocket costs, gain consent
- Assess health care needs, health problems and relevant conditions
- Agree on management goals with the patient
- Confirm actions to be taken by the patient
- Identify treatments and services required
- Arrangements for providing the treatments and services

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

- Record patient's consent to GPMP
- All elements of the service must be completed to claim
- Requires personal attendance by GP with patient
- Review using item 732 at least one during the life of the plan

MBS Item	Name	Recommended Frequency
721	GP Management Plan	2 yearly (Minimum 12 monthly)

TEAM CARE ARRANGEMENT (TCA) – ITEM 723

(Review using item 732 at least once over life of the plan)

Eligibility Criteria

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

Clinical Content

- Explain steps involved in TCA, possible out of pocket costs, gain consent
- Treatment and service goals for the patient
- Discuss with patient which 2 providers the GP will collaborate with and the treatment and services the 2 providers will deliver
- Actions to be taken by the patient
- Gain patient's agreement on what information will be shared with other providers
- Ideally list all health and care services required by the patient
- Obtain potential collaborating providers' agreement to participate
- To achieve patient goals, consult with all collaborating providers (minimum 2 providers) and obtain feedback on treatments/services they will provide to achieve patient goals. This must be done before TCA billed.

Essential Documentation Requirements

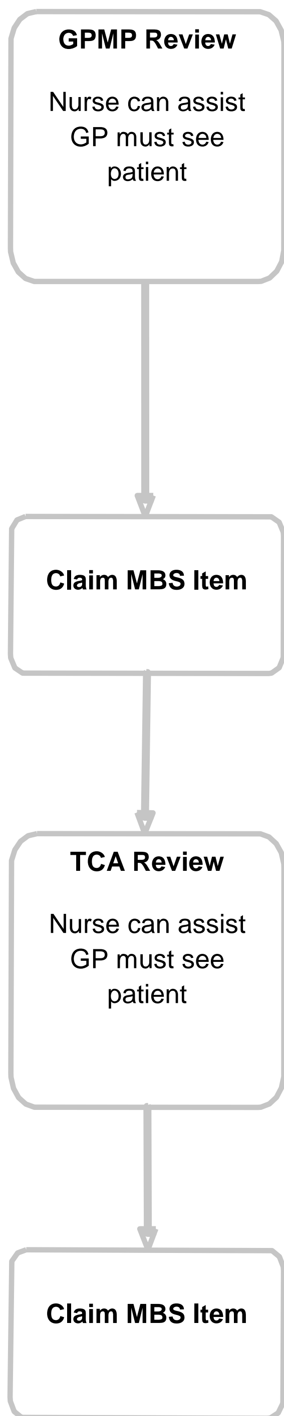
- Record patient's consent to TCA
- Goals, collaborating providers, treatments/services, actions to be taken by patient
- Set review date
- Send copy of relevant parts to collaborating providers
- Offer copy to patient (with consent, offer to carer), keep copy in patient file

Claiming

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

MBS Item	Name	Recommended Frequency
723	Team Care Arrangement	2 yearly (Minimum 12 monthly)

REVIEWING A GP MANAGEMENT PLAN (GPMP) AND/OR TEAM CARE ARRANGEMENT (TCA) – TEAM 732



Reviewing a GP Management Plan (GPMP)

Clinical Content

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

Essential Documentation Requirements

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

Claiming

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

Reviewing a Team Care Arrangement (TCA)

Clinical Content

- Explain steps involved in the review and gain consent
- Consult with collaborating providers (minimum 2 providers) to review all matters in plan

Essential Documentation Requirements

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

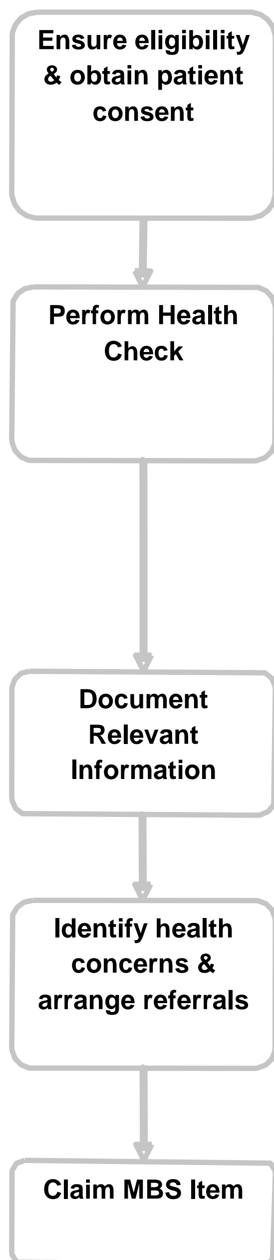
Claiming

- All elements of the service must be completed to claim
- Requires personal attendance by GP with patient
- Item 732 should be claimed at least once over the life of the TCA
- Cannot be claimed within 3 months of a TCA (item 723)
- Item 732 can be claimed twice on same day if review of both GPMP and
- TCA are completed, in this case the Medicare claim should be annotated

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

HEALTHY KIDS CHECK – HEALTH ASSESSMENT

General Practitioners can continue to have the option of providing health assessments under Medicare general consultation items i.e. Level A, B, C, D



Eligibility Criteria

- Children at least 3 years of age and less than 5 years Children who have not previously had a health assessment Children who are receiving or have received their 4 year old immunisation

Clinical Content

- Explain Health Assessment process and gain parent's/carer's consent
- Information collections - takes patient history and undertake, or arrange examinations and investigations as required
- Make an overall assessment of the patient
- Recommend appropriate interventions
- Provide advice and information e.g. 'Get Set 4 Life' online information to patient
- Physical examinations and assessments: Height and Weight (plot and interpret growth curve/calculate BMI); Eyesight; Hearing; Oral health (teeth and gums); Toileting; and Allergies
- Discuss: Eating habits; Physical activity; Speech and language development; Fine and gross motor skills; Behaviour and mood and any other examinations considered necessary

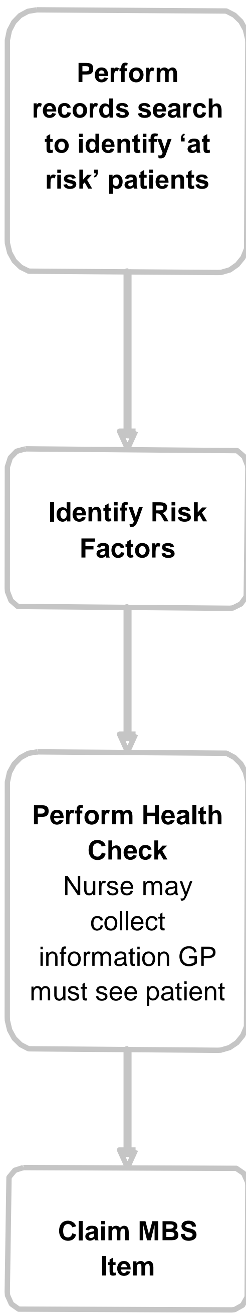
Documentation Requirements

- Record parent's/carer's consent to Health Assessment
- Record that 4 year old immunisation was given
- Record the Health Assessment and offer the parent/carer a copy
- Update parent-held child health record

Claiming

- General Practitioners can continue to have the option of providing health assessments under Medicare general consultation items i.e. Level A, B, C, D. Please note: Nurse time not included in these items.

TYPE 2 DIABETES RISK EVALUATIONS – HEALTH ASSESSMENT ITEMS 701 / 703 / 705 / 707



Eligibility Criteria

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

Clinical Content

- Explain Health Assessment process and gain consent
- Evaluate the patient's high risk score determined by the AUSDRISK, which has been completed within a period of 3 months prior to undertaking Type 2
- Diabetes Risk Evaluation
- Update patient history and undertaking physical examinations and clinical investigations in accordance with relevant guidelines
- Make an overall assessment of the patient's risk factors, and results of relevant examinations and investigations
- Initiate interventions where appropriate, and follow-up relating to management of any risk factors identified
- Provide advice and information, such as Lifescripts resources, including strategies to achieve lifestyle and behaviour changes

Essential Documentation Requirements

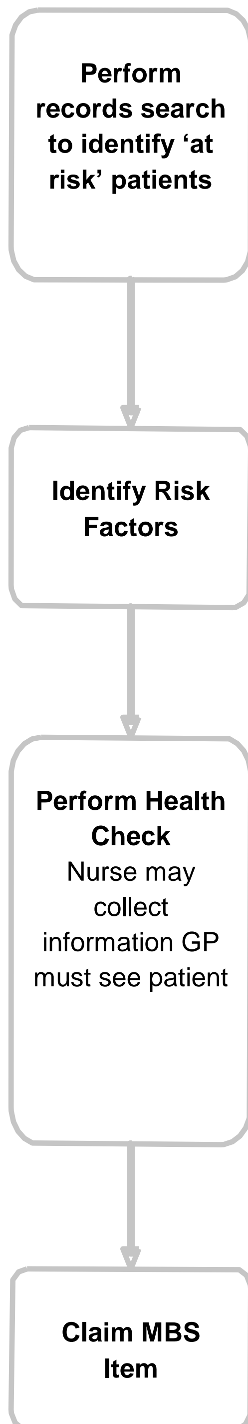
- Record patient's consent to Health Assessment
- Completion of AUSDRISK is mandatory, with a score of ≥ 12 points required to claim; Update patient history
- Record the Health Assessment and offer the patient a copy

Claiming

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

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

45 – 49 YEAR OLD – HEALTH ASSESSMENT ITEMS 701/703/705/707



Eligibility Criteria

- Patients aged 45 to 49 years inclusive
- Must have an identified risk factor for chronic disease
- Not for patients in a hospital

Risk Factors

- Include, but are not limited to:
  Lifestyle: Smoking; Physical inactivity; Poor nutrition; Alcohol use
  Biomedical: High cholesterol; High BP; Impaired glucose metabolism; Excess weight; Family history of chronic disease

Clinical Content

Mandatory

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

Non-Mandatory:

- Written patient information such as the Lifescripts resources, are recommended

Essential Documentation Requirements

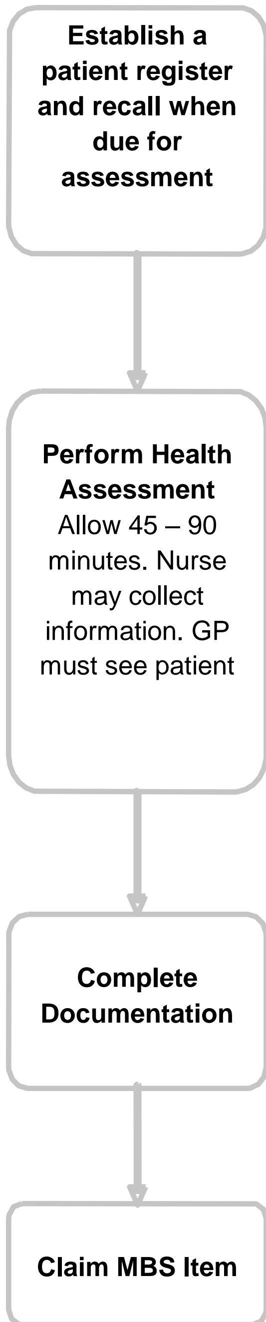
- Record patient's consent to Health Assessment
- Record the Health Assessment and offer the patient a copy

Claiming

- All elements of the service must be completed to claim

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

75 YEARS AND OLDER – HEALTH ASSESSMENT ITEMS 701/703/705/707



701 / 703 / 705 / 707 - 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 BP, Pulse rate and Rhythm
- Assessment of Medication; Continence; Immunisation status for influenza, tetanus and pneumococcus; Physical function including activities of daily living and falls in the last 3 months; Psychological function including cognition and mood; and Social function including availability and adequacy of paid and unpaid help and the patient's carer responsibilities
- Overall assessment of 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

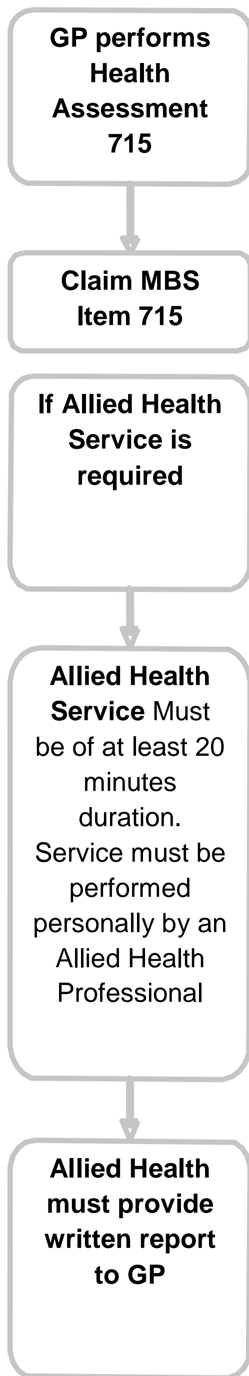
- Record patient's/carer's consent to Health Assessment
- Record the Health Assessment and offer the patient a copy (with consent, offer to carer)

Claiming

- All elements of the service must be completed to claim

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

ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH ASSESSMENT ITEM 715



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

Items 81300 to 81360 – Allied Health Service
Eligibility Criteria

- Items 81300 to 81360 with the exception of 81305 (which does not require a health assessment) are in addition to items 10950 to 10970 and provide an alternative to the referral pathway to access Allied Health Services
- Items available to individual patients only, not a group service
- The person is not an admitted patient of a hospital
- Eligible patients may access Medicare rebates for up to 5 allied health services in a calendar year. Allied health professionals may set their own fees.
- Charges in excess of the Medicare benefit for these items are the responsibility of the patient

Essential Documentation Requirements

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

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 of the patient; Recommending appropriate interventions
  - Providing advice and information to the patient Recording the health assessment; and
  - Offering the patient a written report with recommendations about matters covered by the health assessment

Optional

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

MBS Item	Name	Age Range	Recommended Frequency
715	Aboriginal and Torres Strait Islander Health Assessment	All Ages	Once in a 9 month period
81300 to 81360	Allied Health Services	All Ages	Max 5 services per year
10987	Service provided by practice nurse or registered Aboriginal health worker	All Ages	Max 10 services per year
10950 – 10970	Allied Health Referral (Chronic Disease)	All Ages	Max 5 services per year

HOME MEDICINES REVIEW (HMR) ITEM 900

Also known as Domiciliary Medication Management Review (DMMR)

Eligibility Criteria

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

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

HOME MEDICINES REVIEW (HMR) ITEM 900 - continued

MBS Item	Name	Recommended Frequency
900	Home Medicines Review	As required (min 24 months) (unless the medical practitioner believes there has been a significant change to a patient's condition or medicine regimen)
CP42 (DVA)	Medication Review DVA Patient	Once every 6 months GP is required to ring Veteran Affairs Pharmaceutical Advisory Centre (VAPAC) 1800 552 580 for Authority Prescriptions for 6 months of DAA service and discuss suitability with pharmacist or an accredited pharmacist

For 900 and 903, examples of risk factors known to predispose people to medication related adverse events are:

- Currently taking five (5) or more regular medications
- Taking more than 12 doses of medication per day
- Significant changes made to medication treatment regimen in the last three (3) months
- Medication with a narrow therapeutic index or medications requiring therapeutic monitoring
- Symptoms suggestive of an adverse drug reaction
- Sub-optimal response to treatment with medicines
- Suspected non-compliance or inability to manage medication related therapeutic devices
- Patients having difficulty managing their own medicines because of literacy or language difficulties, dexterity problems or impaired sight, confusion/dementia or other cognitive difficulties
- Patients attending a number of different doctors, both general practitioners and specialists
- Recent discharge from a facility/hospital (in the last four (4) weeks)

RESIDENTIAL MEDICATION MANAGEMENT REVIEW (RMMR) ITEM 903

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
903	Residential Medication Management Review	As required (min 24 months) *(unless the medical practitioner believes there has been a significant change to a patient's condition or medicine regimen)*

COORDINATED VETERANS CARE PROGRAM

Coordinated Veterans' Care (CVC) is a Department of Veterans' Affairs (DVA) program that aims to improve the wellbeing of veterans, war widows/ers and their dependents and to keep them out of hospital. The program offers GPs the opportunity to be funded to provide planned and coordinated care for Gold Card holders who have chronic conditions and complex care needs and are at risk of being hospitalised.

Patients can self-refer or be identified by their doctor or the DVA.

For further information about the program, resources and templates:
http://www.dva.gov.au/providers/provider-programmes/coordinated-veterans-care

Online Training

Accredited online learning modules are available to free of charge to health professionals implementing CVC from https://cvcprogram.flinders.edu.au/

Nursing Services for CVC

For those General Practitioners who need to engage the services of suitable nursing coordinator, the following are DVA contracted community nursing providers:

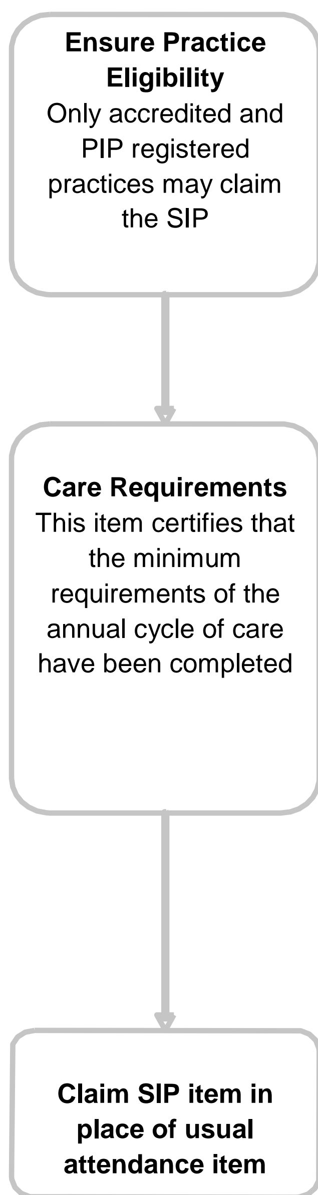
Ozcare, North Lakes
(07) 3482 1800
http://www.ozcare.org.au/

Ozcare, Chermside
(07) 3624 0500
http://www.ozcare.org.au/

Blue Care, Sandgate
(07) 3869 7777
https://www.bluecare.org.au/

LINCS Healthcare
1300 131 186
http://www.lincshealthcare.com.au/

DIABETES ANNUAL CYCLE OF CARE SERVICE INCENTIVE PAYMENT (SIP)



Eligible Criteria

- No age restrictions for patients
- Patients with established Diabetes Mellitus
- For patients in the community and in Residential Aged Care Facilities

Essential Clinical and Documentation Requirements

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

6 Monthly

- Measure height, weight and calculate BMI
- Measure BP
- Examine feet

Yearly

- Measure HbA1c, eGFR, total cholesterol, triglycerides and HDL cholesterol
- Test for microalbuminuria
- Provide patient education regarding diabetes management including self-care education
- Review diet and levels of physical activity – reinforce information about appropriate dietary choices and levels of physical activity
- Check smoking status – encourage smoking cessation
- Review medication

2 Yearly

- Comprehensive eye examination by ophthalmologist or optometrist to detect and prevent complications – requires dilation of pupils

Claiming

- Available to GPs in accredited practices, registered for the Diabetes SIP
- All elements of the service must be completed to claim
- Only paid once every 11-13 month period

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

DIABETES MANAGEMENT

1st visit

Item 721: Prep GP Management Plan

If relelvant, GP can commence coordination of a Team Care Arrangements.

Patient may also be referred to type 2 diabetes group services (up to 8 per calendar year). If relevant, GP can refer to aliied health for up to 5 rebateable visits (in calendar year).

2nd visit
if eligible

Item 723: Coordination of Team Care Arrangements (TCA)

GP may also identify need to commence Diabetes Annual Cycle of Care.

3rd visit
4th visit
5th visit

Item 10997: Practice Nurse appointment

Possible activities:

- ongoing assistance with requirements of Diabetes Annual Cycle of Care
- monitoring medication compliance
- self-management
- patient education
- checks on clinical progress

6th visit
6 months from initial GPMP and TCA

Item 732: Review of GP Management Plan
Item 732: Review of TCA

Check when / if patient qualifies for 5 more allied health services.

7th visit
8th visit

Item 10997: Practice Nurse appointment

Note: item 10997 cannot be claimed at the same time as items 721, 723 or 732.

9th visit

Complete Diabetes Annual Cycle of Care

Item 2517 level B; or 2521 level C; or 2525 level D

Completion of a Diabetes Annual Cycle of Care SIP must not be claimed with 3 months of a GPMP / TCA Review (item 732).

Recommended 6 monthly

Item 732: Review of GP Management Plan
Item 732: Review of TCA

ASTHMA CYCLE OF CARE

Patient Eligibility

Patients must have moderate to severe asthma:

- Frequency of episodes.
- Use of preventer medication.
- Bronchodilator use >3 x week.
- Hospital attendance following an acute attack.

Completion of the Asthma Cycle of Care

- At least 2 asthma related consultations in 4 weeks (min) to 12 months (max).
- At least one of these consultations should be a review consultation that was planned at a previous consultation.

These visits must include:

- Diagnosis and assessment of severity.
- Review of medication.
- Written asthma action plan and education of the patient.

Sign-on payment	N/A	$0.25 (per FTE GP)	One-off payment only Practice must be registered for PIP Incentive payable with quarterly PIP payments
Asthma Cycle of Care – Completion of 2nd visit	Level B – 2546 & 2547 Level C – 2552 & 2553 Level D – 2558 & 2559	$100 per patient PLUS consultation fees	These item numbers should be used in place of the usual attendance items, when a consultation completes the minimum requirements for the Asthma Cycle of Care. The Asthma Cycle of Care targets patients with moderate to severe asthma

Utilising a practice nurse for the Asthma Cycle of Care

A practice nurse can be used to assist GPs with the Asthma Cycle of Care. A nurse can provide patient education, record peak-flow or Spirometry results, take detailed patient and medication history and review device techniques.

The following is an example of a general practice utilising practice nurses for the best implementation of the Asthma Cycle of Care.

Visit 1 - Practice nurse and GP

- Spirometry (where available) or peak flow: asthma history, symptoms and medications documented, device use, education.
- GP review results: medication review, oversees patient education requirements and completes written Asthma Action Plan for patient.
- GP reinforces need for next visit and follow up appointment booked.

Visit 2 – Practice nurse and GP

- Spirometry (where available) or peak flow, review of symptom diary: medication review, follow-up education.
- GP review of Asthma Action Plan.
- GP reinforces need for next visit and follow up appointment booked.

Asthma may be treated in General Practice using either the Asthma Cycle of Care or the General Practice Management Plan (GPMP). Both schemes **should not be claimed in the same twelve months** for the same patient due to the overlap in the services provided.

For patients with complex needs, GPM and TCA and Asthma Cycle of Care can be provided.

Suggestions for Asthma Cycle of Care visit structure

Visit 1 – Date

This will often be the visit at which your patient presents with an unrelated problem and doesn't mention asthma until the end of the consultation.

- Manage the issue that caused the asthma to be discussed e.g. asthma symptoms, request for a script.
- Introduce the concept of a contract of care and the reasons for review.
- Reinforce need for next visit and follow up appointment booked.

Visit one should be billed under normal MBS items (23/36 or 44).

Visit 2 – Date Approx. 2 weeks later

New Patient - ascertain status, including history, medication and management.
Existing Patient - assess present situation, including review of medical records and consolidation/collection of information on history, medication and management.

- What do they know and what do they need to know? (Knowledge)
- How do they feel about their asthma? (Perception)
- What do they want from you their GP?
- Review medication devices technique.
- Perform physical examination (including Spirometry).
- Grade asthma severity and level of control.
- Consider 2 weeks of peak expiratory flow rate (PEFR) recording and charting.
- Is a change in medication required?
- Consider if clinically appropriate for Home Medicines Review, write referral.
- Complete Asthma Action Plan for consumer to follow till next visit.
- Identify triggers; consider RAST and skin prick testing.

Visit two should be billed under MBS items in Group A18 or A19 (2546, 2552 or 2558).
Include item 11506 if Spirometry performed.

(optional) Visit 3 – Date Approx. 1 month later

- Review patient and his/her PEFR record.
- Perform Spirometry (if not already done or consider redoing).
- Assess progress, review medication devices and techniques.
- Review and complete written asthma action plan.
- Discuss results of RAST and skin-prick testing.
- Is a change in medication required?
- Check on, reinforce and expand education.
- Answer any questions.
- Place patient on twelve-month recall for Asthma Cycle of Care.
- Complete HMR Medication Management Plan (Finalise MBS Item 900 claim).

Visit three should be billed under normal MBS items (23/36 or 44).
Include item 11506 if Spirometry performed.

ACTION PLANS can be located as below.

In Best Practice:	Enter **patient name**, click **Clinical**, click **Asthma action plan.**
In Best Practice v3:	via **Assessment** or the **respiratory calculator** tool.
In Medical Director:	In Medical Director v3, Enter **patient name**, click **Asthma action plan** via **Assessment** or the **respiratory calculator** (Under TOOLS/ Tool box).

PRACTICE INCENTIVE PAYMENTS AND SERVICE INCENTIVE PAYMENTS SUMMARY

<table>
<tr><th></th><th>Activity</th><th>Item number and type of consult VR</th><th>Item number and type of consult non VR</th><th>PIP</th><th>SIP</th><th>Notes</th></tr>
<tr><td rowspan="3">Diabetes</td><td>Patient register and recall/reminder system</td><td>N/A</td><td>N/A</td><td>S1.00
(per SWPE)</td><td></td><td>• One off sign on payment – Practice must register for Diabetes PIP
• Practice is required to use a Register of patients with diabetes and an active recall/reminder system
• Incentive payable with quarterly PIP</td></tr>
<tr><td>Annual Cycle of Care for patients with diabetes</td><td>General Practitioner Attendance in surgery

2517 – Level B
2521 – Level C
2525 – Level D</td><td>Other Non–referred attendances in surgery

2620 – Standard consultation
2622 – Long consultation
2624 – Prolonged consultation</td><td></td><td>S40.00 per patient (plus consult fee)</td><td>• GPs within a practice that have signed on for the PIP will receive a SIP of $40 per year for each cycle of care completed for a patient with diabetes
• Must meet the minimum requirements for a cycle of care within an 11 to 13 month period
• CANNOT be claimed at the same time as GPMP review item number

<table>
<tr><th colspan="2">Diabetes Annual Cycle of Care</th></tr>
<tr><th>Activity</th><th>Frequency/Description</th></tr>
<tr><td>eGFR</td><td>At least once every year</td></tr>
<tr><td>HbA1c</td><td>At least once every year</td></tr>
<tr><td>Eye examination</td><td>At least once every 2 years</td></tr>
<tr><td>BMI</td><td>At least twice per cycle</td></tr>
<tr><td>BP</td><td>At least twice per cycle</td></tr>
<tr><td>Examine feet</td><td>At least twice per cycle</td></tr>
<tr><td>TC, trigs and HDL</td><td>At least once every year</td></tr>
<tr><td>Microalbuminuria</td><td>At least once every year</td></tr>
<tr><td>Provide self-care education</td><td>Ongoing</td></tr>
<tr><td>Review diet</td><td>Ongoing</td></tr>
<tr><td>Review physical activity</td><td>Ongoing</td></tr>
<tr><td>Smoking status</td><td>As required</td></tr>
<tr><td>Review Medication</td><td>Ongoing</td></tr>
</table></td></tr>
<tr><td>Outcomes payment</td><td>N/A</td><td></td><td>S20.00
(per diabetic SWPE)</td><td></td><td>• Payment made to practices where at least 2% of practice patients are diagnosed with diabetes
• Payment made ONLY to practices where 50% of diabetes patients have completed an Annual Cycle of Care</td></tr>
</table>

	Sign on payment			$0.25 (per SWPE)		• One off payment only • Practice must be registered for PIP • Incentive payable with quarterly PIP payments
Asthma	Asthma Cycle of Care	General Practitioner attendance in surgery 2546 – Level B 2552 – Level C 2558 – Level D	Other non-referred attendances in surgery 2664 – Standard Consultation 2666 – Long consultation 2668 – Prolonged Consultation		$100 per patient (plus consult fee)	• Once per 12 months for patients with moderate to severe asthma • Claim normal consult item on 1st visit, on the 2nd visit claim ONLY the CR or non VR'd asthma item • For patients with **asthma alone**, GPs should choose to use either GPMP CDM Item 721 **or** an Asthma Cycle of Care, **not both**. For those with **asthma and complex needs,** a GP may provide term-based care using items 721 (GPMP) and 723 (TCA) and the Asthma Cycle of Care **Asthma Cycle of Care** • At least 2 asthma related consultations within 12 months for a patient with moderate to severe asthma (at least 1 of which (the review consultation) is a consultation that was planned at a previous consultation) • Documented diagnosis ad assessment of level of asthma control and severity of asthma • Review of the patient's use of and access to asthma-related medication and devices • Provision to the patient of a written asthma action plan (if the patient is unable to use a written asthma action plan – discussion with the patient about an alternative method of providing an asthma action plan, and documentation of the discussion in the patient's medical records) • Provision of asthma self-management education to the patient, and • Review of the written or documented asthma action plan
Cervical Screening	Sign on payment	N/A				• One off payment only • Practice must be registered for PIP • Incentive payable with quarterly PIP payments

	Screening women aged 20-69 years inclusive, who have not been screened in the past four years	Consult in surgery 2497 – Level A 2501 – Level B 2504 – Level C 2507 – Level D	Professional attendance in surgery 2598 – Brief consultation 2600 – Standard consultation 2603 – Long consultation 2606 – Prolonged consultation		$35 per patient (plus consult fee)	These MSB items must be used instead of the standard consultation items. Quote only the VR or non VR'd item number for the cervical screening
	Outcome payment	N/A		$3 per female WPE aged 20 - 69		Payment is made to practices where a minimum of 70% of women aged between 20 and 69 years inclusive have been screened in a 30 month reference period (paid on a quarterly basis)
Immunisation	Completing an age appropriate immunisation schedule	N/A				Notification Payment is given by the Australian Childhood Immunisation Register (ACIR) when a GP makes a notification on the completion of an age appropriate immunisation. GPs must complete a registration form – ACIR Payment Account Details For Immunisation Providers – which is lodged with Medicare Australia. ACIR enquiry line: 1800 653 809 or www.medicareaustralia.gov.au/acir
Digital Health	**Requirement 1:** integrate Healthcare identifiers into Electronic Practice Records.					• Apply to Human Services to obtain a Healthcare Provider Identifier–Organisation (HPI–O) for the practice, and store the HPI–O in a compliant clinical software system; • Ensure that each general practitioner within the practice has their Healthcare Provider Identifier–Individual (HPI–I) stored in a compliant clinical software system; and • Use a compliant clinical software system to access, retrieve and store verified Individual Healthcare Identifiers (IHI) for presenting patients.

	Requirement 2: Secure Messaging Capability					• The practice must have a standards-compliant secure messaging capability to electronically transmit and receive clinical messages to and from other healthcare providers, use it where feasible, and have a written policy to encourage its use in place. • Practice can provide verification that the compliant product has been installed and configured. Retain a copy of the completed checklist from your secure messaging software provider
	Requirement 3: Data Records and Clinical Coding					• Practices must ensure that where clinically relevant, they are working towards recording the majority of diagnoses for active patients electronically, using a medical vocabulary that can be mapped against a nationally recognised disease classification or terminology system. Practices must provide a written policy to this effect to all GPs within the practice.
	Requirement 4: Electronic Transfer of prescriptions					• The practice must ensure that the majority of their prescriptions are sent electronically to a Prescription Exchange Service (PES).
	Requirement 5: My Health Record system					• Use compliant software for accessing the My Health Record system, and creating and posting shared health summaries and event summaries; • Apply to participate in the My Health Record system upon obtaining a HPI–O; and • Upload a shared health summary for a minimum of 0.5% of the practice's standardised whole patient equivalent (SWPE) count of patients per PIP payment quarter.
	For full guideline and further information please refer to Human Services or Digital Health: https://www.humanservices.gov.au/health-professionals/enablers/ehealth-incentive https://www.digitalhealth.gov.au/get-started-with-digital-health/pip-ehealth-incentive					

Practice Nurse	Practice employs or retains the services of a primary health care practice nurse					Payments under the PNIP are calculated quarterly ad are stratified with one incentive equating to: $25,000 per annum, per $1,000 SWPE where a Registered Nurse works at least 12 hours 40 minutes per week; and $12,500 per annum, per 1,000 SWPE where an Enrolled Nurse or Aboriginal Health Worker works at least 12 hours and 20 minutes per week
After Hours	As from 1 July 2015 the After Hours Incentive aims to support general practices to provide their patients with appropriate access to afterhours care					
	Complete after hours period	Level 1 Participation $1 per SWPE				Formal arrangements in place with other providers, including Medical Deputising Services, to ensure access for practice patients.
	Sociable after hours period	Level 2 Sociable after hours cooperative coverage $4 per SWPE				Participating general practice in cooperative arrangement, including minimum hourly participation requirements
	Unsociable after hours period					Participating general practice in cooperative arrangement, including minimum hourly participation requirements
	Sociable after hours period	Level 3 Sociable after hours practice coverage $5.50 per SWPE				Participating general practice
	Unsociable after hours period					Formal arrangements in place with other providers, including Medical Deputising Services, to ensure access for practice patients
	Complete after hours period	Level 4 Complete after hours cooperative coverage $5.50 per SWPE				Participating general practice in cooperative with other general practices, including minimum hourly participation requirements

	Complete after hours period	Level 5 Complete after hours practice coverage $11 per SWPE				Participating general practice
	For further information please refer to MBS online or Human Services: http://www.mbsonline.gov.au/ http://www.humanservices.gov.au/health-professionals/services/practice-incentives-programme/pip-after-hours-incentive#a5					
Quality Prescribing	Complete after hours period					• The incentive is to assist practices in keeping up to date with information on the quality use of medicines. • Each Gp must notify the NPS of their provider and prescriber numbers when undertaking an activity • Contact NPS MedicineWISE on (02) 8217 8700 for further details on suitable activities provided by NPS MedicineWISE (not their correct name can I put NPS MedicineWISE) • Paid annually in May
Teaching	Teaching of medical students					Payments are made to practices that host university medical student placements, Maximum two sessions per GP per day. Minimum 3 hours per session.

Aged Care	Provision of primary care services for patients in Residential Aged Care Facilities (RACFs)	**Tier 1**: GP completes the Qualifying Service Level (QSL) 1 – 60 MBS services in RACF claimed in a financial year	**Tier 2**: GP completes the QSL 2 – 140 MBS services in RACF claimed in a financial year			MBS items that count towards QSLs include attendances in RACF, contributions to multidisciplinary care plans and Residential Medication Management Reviews. GPs need to provide the service using their PIP linked Medicare provider number. GPs do not need to apply to participate in the Incentive. Medicare will request bank details from GPs eligible to receive payments once they have reached the QSL.
Indigenous Health	Provision of better health care for Indigenous patients, including best practice management of chronic disease	Sign on payment				One off payment only. Practice must be registered for PIP **Practice:** • Seeks consent to register their Aboriginal and/or Torres Strait Islander patients (regardless of age) who have, or are at risk of, chronic disease, with Medicare and the practice for chronic disease management in a calendar year • Establishes a mechanism to ensure their patients aged 15 years and over with a chronic disease are followed up e.g. recall/reminder system, to ensure they return for ongoing care • At least two staff members (including a GP) undertakes cultural awareness training within 12 months of joining incentive • Annotates PBS prescriptions for eligible patients for the PBS Co-payment
		Annual patient registration payments				Practice registers their eligible patients with Medicare for the Indigenous Health Incentive or PBS Co-payment Measure. Practice must actively plan and manage care of their patients with chronic disease for a calendar year Payment made to practice for each patient who: • Is aged 15 years or over • Has a chronic disease • Has had (or has been offered) a Health Assessment (Item No 715) • Has provided informed consent to be registered for the PIP Indigenous Health Incentive The patients registration period commences from the date they provide consent to participate in the incentive, and will end on 31 December that year. Practices are required to obtain consent to re-register patients each year

		Tier 1 Outcomes payment: Chronic Disease Management				Payment made to practices that (in a calendar year): 1. Develop a 721 GP Management Plan or 723 Team Care Arrangement for the patient and undertake at least one 732 Review of the GPMP or TCA; or 2. Undertake two 732 Reviews of GPM or TCA; or 3. Complete 731 contribute to, or review, a care plan for a patient in a RACF, on two occasions
		Tier 2 Outcomes payment: Total Patient Care				Payment made to practices that provide the majority (i.e. the highest number) of MBS services for the patient (with a minimum of 5 MBS services) in a calendar year. This may include the MBS services provided to qualify for Tier 1