Chronic Disease Management Guide

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Wentworth Healthcare Limited (ABN 88 155 904 975) provider of the Nepean Blue Mountains PHN. 23/01/2024

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INTRODUCTION:

This Guide is intended as a resource to assist General Practice staff to effectively coordinate care for their patients with chronic conditions. It provides comprehensive information regarding the MBS items relevant to the management of chronic diseases and other conditions commonly treated in general practice. For current and comprehensive information about each MBS item number, please refer to the Medicare Benefits Schedule at MBS Online. MBS Online is frequently updated as changes to the MBS occur.

FEEDBACK/COMMENTS:

If you have any enquiries or would like to provide feedback or comments regarding information provided in this Guide, please contact the Primary Care Engagement Team: 02 4708 8100

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

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Chronic Disease Overview

Chronic Disease Management (CDM) is an integrated care approach to managing illness which includes screenings, check-ups, monitoring and coordinating treatment, and patient education.

The Australian Institute of Health and Welfare (AIHW) define chronic disease as “long lasting conditions with persistent effects”.[1] Meaning, conditions that have been, or are likely to be present for at least 6 months and include but not limited to:

- Arthritis
- Asthma
- Cancer
- Cardiovascular Disease
- Chronic Kidney Disease
- COPD
- Diabetes Mellitus
- Mental Health.

Chronic Disease in the Nepean Blue Mountains (NBM) Region

The NBM region covers almost 9179 square kilometres and aligns with the Nepean Blue Mountains Local Health District. The region encompasses 4 Local Government Areas (LGAs) and has a total population of 385,944 (2021) The population is projected to grow by 16% by 2041.

An estimated 14.6% of people within the region are smokers, 35.9% of adults are overweight and a further 28.5% are obese, and approximately 50% of the population do not get enough exercise.

These risk factors can result in a compromised state of health and wellbeing in relation to chronic disease, especially among vulnerable population groups and mitigating these risk factors is critical to further support general health and wellbeing within the NBM region.

Specific hospital admissions potentially could be prevented by timely and adequate health care in the community and particularly in General Practice.

Chronic Disease Management (CDM) services have been established to assist eligible medical practitioners (MPs) such as general practitioners (GPs) and non-vocationally recognised medical practitioners (non-VR MPs) support their patients with chronic medical conditions. Care plans must be developed by the patients ‘usual medical practitioner’. Where a ‘usual medical practitioner’:

- has provided a majority of services to the patient in the past 12 months
- will provide the majority of services in the following 12 months.

If your patient has a chronic disease, they may be eligible for services under:

- Preparation of a General Practice Management Plan (GPMP)
- Coordination of Team Care Arrangement (TCA)
- Review of a GPMP and/or TCA
- Contribution to a Multidisciplinary Case Conference

Preparation of a GP Chronic Disease Management Plan

Item 721 GP Management Plan

Recommended Frequency: Once every two years (min 12 monthly)

The Chronic Disease Management (CDM) Medicare items are for General Practitioners (GPs) to manage the health care of people with chronic or terminal medical conditions. This includes those requiring multidisciplinary, team-based care from a GP and at least two other health care providers. Click here for more information.

Ensure patient eligibility

Eligibility Criteria

- No age restrictions for patients
- Patients with a chronic (present for or likely to persist 6 months or more) 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 2702/2710) is suggested for patients with a mental health disorder only

Develop Plan

Nurse/Aboriginal Health Worker or Health Practitioner may collect information

GP must see patient

Clinical Content

- Explain steps involved in GPMP, possible out of pocket costs and gain patient's consent
- Assess health care needs, health problems, relevant history, and conditions
- Agree on management and patient goals with the patient
- Identify treatments and services required
- Arrangements for providing the treatments and services
- Arrangements for review using item 732 at least once over the life of the plan (12-24 months)

Complete relevant activities and documentation

Essential Documentation Requirements

- Record patient's consent to GPMP
- Patients' needs and goals, patient actions and treatments/services required
- Set review date
- Offer copy to patient or carer, keep a copy in patient records

Claim MBS item

Claiming

- All elements of the service must be completed to claim
- Requires personal attendance by GP
- Review using item 732 at least once during the life of the plan (8 reviews over 24 months, more if clinically indicated

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Coordination of Team Care Arrangement (TCA) if 721 in place

Item 723 Team Care Arrangements

Recommended Frequency:
Once every two years (min 12 monthly)

Ensure patient eligibility

Develop Plan

Nurse/Aboriginal Health Worker or Health Practitioner may collect information

GP must see patient

Your practice nurse does not count as one of the 2 or more providers

Complete relevant activities and documentation

Claim MBS item

Eligibility Criteria

- Item 721 must be in place
- 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 PN, and at least two other healthcare providers
- Not for patients in a hospital or patients in a Residential Aged Care Facility

Clinical Content

- Explain steps involved in TCA, possible out of pocket costs, gain and document patient's consent
- Treatment and service goals for the patient and actions to be taken by the patient
- Discuss with patient which two providers the GP will collaborate with and the treatment/services the two providers will deliver
- 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 collaborating providers (**at least 2**) agreements to participate
- Which is essential before billing item 723
- Obtain feedback on treatments/services two collaborating providers will administer to achieve patient goals

Essential Documentation Requirements

- 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 be collaborating providers and copy of providers agreement returned and note in patents clinical notes
- Offer copy to patient and/or carers, keep copy in patient record

Claiming

- **All elements of the service must be completed to claim**
- Required personal attendance by GP with patient (can be face to face or via telehealth)
- Review using item 732 at least once during the life of the plan

- Claiming a GPMP and TCA enables patients to receive five rebated services from an allied health provider (AHP) during one calendar year
- NB – Indigenous patients, are also eligible for additional AHP services under item 715

Reviewing a GPMP and/or TCA

Item 732 Reviewing a Chronic Disease Management Plan (GPMP)

Recommended Frequency: Bi-annually (minimum three (3 monthly)

GPMP Review

Nurse/Aboriginal health Worker or Health Practitioner may collect information

GP must see patient

Clinical Content

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

Essential Documentation Requirements

- Record patient's agreement to review
- Make any required amendments to plan
- Set new review date
- Offer copy to patient and/or carers
- Keep copy in patient record

Claim MBS item

Reviewing a Team Care Arrangement (TCA)

Clinical Content

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

Essential Documentation Requirements

- Record patient's agreement to review
- Make any required amendments to plan
- Set new review date
- Offer copy to patient and/or carers
- Keep copy in patient record
- Send copy of relevant amendments of TCA to collaborating providers

TCA Review

Nurse/Aboriginal Health Worker or Health Practitioner may collect information

GP must see patient

Claiming of GPMP and TCA Review

- 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 three months of a GPMP (721) except where there are exceptional circumstances arising from a significant change in the patient's clinical condition, in this case the Medicare claim should be annotated as to why the service was required earlier
- Item 732 can be claimed twice on the same day is review of both GPMP and TCA are completed. Medicare claim

Claim MBS item

should be annotated "Review of GPMP" for one item number and "Review of TCA" for the other item number and noted in billing.

Individual Allied Health Services Under Medicare

Summary

- A Medicare rebate is available for a maximum of five services per patient each calendar year. Additional services are not possible under any circumstances.
- If a provider accepts the Medicare benefit as full payment for the services, there will be no out-of-pocket cost. If not, the patient will have to pay the difference between the fee charged and the Medicare rebate.
- **Patients must have a GP Management Plan and Team Care Arrangement prepared by their GP or be residents of a Residential Aged Care Facility who are managed under a multidisciplinary care plan.**
- Referrals to allied health providers must be from GPs.
- Allied health providers must report back to the referring GP.

Eligible Patients

Community-based patients may be eligible if they have a chronic (or terminal) medical condition, and their GP has provided the following Chronic Disease Management (CDM) services:

- A GP Management Plan (GPMP) **item 721**
- Team Care Arrangements (TCA) **item 723**

Residents of a Residential Aged Care Facility may be eligible if their GP has contributed to a multidisciplinary care plan prepared for them by the aged care facility or to a review of the multidisciplinary care plan (item 731).

Item	Name	Recommended Frequency
10950	Aboriginal Health Worker Services	Five allied health services per calendar year. Can be five sessions with one provider or a combination (e.g., three dietician and two diabetes education sessions). Referral for allied health services under Medicare form for each provider. Allied health provider must be Medicare registered.
10951	Diabetes Educator Services	
10952	Audiologist Services	
10953	Exercise Physiologist	
10954	Dietician Services	
10958	Occupational Therapist Services	
10960	Physiotherapist Services	
10962	Podiatrist Services	
10964	Chiropractor Services	
10966	Osteopath Services	
10970	Speech Pathologist Services	
10956	Mental Health Worker Services	• Better access to metal health care items: ten sessions • GPMP and TCA for chronic medical conditions: five sessions
10968	Psychologist Services	

Prescribing / Home Medicines Review

Domiciliary Medication Management Review (DMMR)

Targeted at patients living in the community who are likely to benefit from a review and may be at risk of medication misadventure because of risk factors such as:

- Co-morbidities
- Age or social circumstances
- Characteristics of their medicines
- Complexity of their medication regime
- Lack of skills or knowledge to use medicines to their best effect

Examples of risk factors include:

- Currently taking five or more medications
- Taking more than 12 doses of medication per day
- Medications with a narrow therapeutic index or medications requiring therapeutic monitoring
- Significant changes to medication treatment in the last three months
- Suspended non-compliance
- Difficulty managing medication dues to literacy difficulties, cognitive difficulties, or physical difficulties
- Recent discharge from a facility/hospital (in the last four weeks)

In conducting a DMMR, a medical practitioner must:

- Assess a patients medication management need
- Following that assessment, refer the patient to a community pharmacy or an accredited pharmacist for DMMR
- With the patient's consent, provide relevant clinical information required for the review
- Discuss with the reviewing pharmacist the results of that review, including suggested medication management strategies
- Develop a written medication management plan following discussion with the patient

Domiciliary Medication Management Review (DMMR)

Item 900 Domiciliary Medication Management Review

Once every 12 months (unless the medical practitioner believes there has been a significant change to a patient's condition or medicine regimen)

Ensure patient eligibility

First GP Visit

Discussion and referral to pharmacist

DMMR review

Conducted by accredited pharmacist

Claim MBS item

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 Residential Aged Care Facility

GP Initiates Service

- Explain purpose, possible outcomes, process, information sharing with pharmacist
- Gain and record patient's consent to DMMR
- Inform patient of need to return for second visit
- Complete DMMR referral and send to a pharmacy or an accredited pharmacist

DMMR Interview

- Pharmacist holds review in patient's home unless prior approval is sought by the pharmacist
- 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 Visit

- Develop summary of findings as part of draft Medication Management Plan
- Discuss draft plan with patient and offer copy of complete plan
- Send copy of completed, agreed plan to pharmacist

Claiming

- All elements of the service must be completed to claim
- Patient must be seen by the GP at the time of claiming

Health Assessments - Preventative Health and Screening

Preventive healthcare is an important activity in general practice, and a core aspect of many consultations. It includes the prevention of illness, screening activities for the early detection of specific disease, and the promotion and maintenance of health and wellbeing.

How to Make Health Assessments Work for Your Practice

Take a systematic approach to health care in your practice. Designate the task of setting up the health assessment process within the practice:

- Obtain a list of appropriate patients (database search) that have been seen by the GP over the last 12 months
- Ensure all patients are eligible for a Health Assessment
- Set up a process for contacting patients (phone, SMS or mail)
- Ensure adequate time is allowed for each assessment
- Identify and discuss the benefits of a Health Assessment with each patient
- Obtain patient consent
- Findings and outcomes must be discussed with the patient (and carer where appropriate)
- The GP prepares a written summary which that patient signs, including outcomes and recommendations – a copy should be offered to the patient
- Keep a copy of each assessment in patient's records
- Ensure your Practice Nurse is available to help conduct the assessments

If a third person is undertaking the information collection component, the GP must ensure that this person has suitable skills, experience, and qualifications.

Health Assessment Target Groups

Medical practitioners may select one of the MBS Health Assessment items to provide a Health Assessment service to a member of any of the target groups listed. The Health Assessment item that is selected will depend on time taken to complete the Health Assessment service. This is determined by the complexity of the patient's presentation and the specific requirements that have been established for each target group eligible for Health Assessments.

45-49-year-old

Once only Health Assessment for patients 45-49 years who are at risk of developing chronic disease.

Type 2 Diabetes Risk Evaluation

Provision of lifestyle modification advice and interventions for patients aged 40-49 years who score > 12 on AUSDRISK. Once every three years.

75 Years and Older

Health Assessment for patients aged 75 years and older. Once every 12 months.

Comprehensive Medical Assessment

Comprehensive Medical Assessment for permanent residents of Residential Aged Care Facilitates. Available for new and existing residents. Not more than once a year.

Heart Health Check item number 699.

For Patient with an Intellectual Disability

Health Assessment for patients with an intellectual disability. Not more than once a year.

For Refugees and Other Humanitarian Entrants

Once only health assessment for new refugees and other humanitarian entrants, as soon as possible after their arrival (within 12 months of arrival).

For former serving members of the ADF

Health Assessment for 45 – 49-Year-Olds

Item 701/703/705/707 Health assessment for 45-49yrs

Recommended Frequency: Only Once

Perform record search to identify ‘at risk’ patients

Identify risk factors

Perform Health Check

Nurse may collect information

GP must see patient

Claim MBS item

Eligibility Criteria

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

Risk Factors

- Lifestyle: smoking, physical inactivity, poor nutrition, alcohol use
- Biomedical: high cholesterol, high BP, excess weight, impaired glucose metabolism
- Family history of chronic disease

Clinical Content
Mandatory

- Explain Health Assessment process and gain consent
- Information collection - take patient history, examinations and investigations as clinically required
- Overall assessment of patient’s health, including their readiness to make lifestyle changes
- Initiate interventions and referrals as clinically indicated
- Advice and information about Lifestyle Modification Program and strategies to achieve lifestyle and behavior changes

Non-mandatory

- Written patient information resources are recommended

Essential Documentation Requirements

- Record parent’s consent to Health Assessment
- Record the Health Assessment and offer the parent a copy

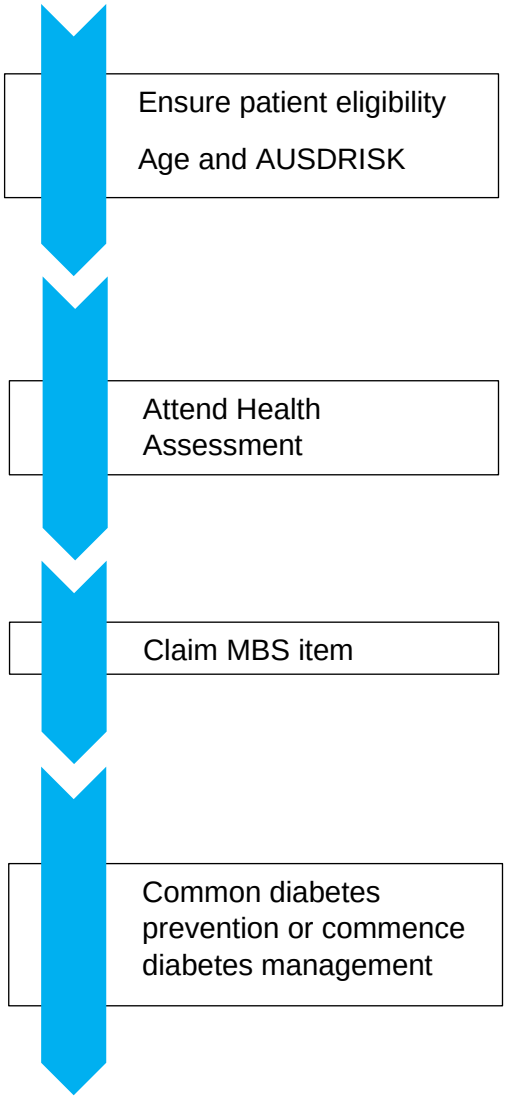
Claiming

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

Health Assessment Type 2 Diabetes Risk 40 – 49 Years

Item 701/703/705/707 Health Assessment: Type 2 Diabetes Risk Evaluation

To reduce the risk of Type 2 Diabetes



Recommended Frequency: Once every 3 years

Eligibility Criteria

- Non-Indigenous patients aged 40 – 49 years inclusive
- Patients must score > 12 point on Australian Type 2 Diabetes Risk Assessment Tool (AUSDRISK)
- GP must exclude diabetes via glucose tolerance test
- Document outcomes
- Determine if diabetes prevention/lifestyle modification or diabetes management is required based on the outcomes of glucose tolerance test

Health Assessment for 75-Years and Older

Item 701/703/705/707
Health Assessment: 75 years and older

Recommended Frequency: Once every 12 Months

Establish a patient register and recall when due for assessment

Perform Health Check

Allow 45 – 90 minutes

Nurse may collect information

GP must see patient

Claim MBS item

Eligibility Criteria

- Patients aged 75 years and older
- Patients seen in consulting rooms and/or at home
- Not for patients in hospital or a Residential Aged Care Facility

Clinical Content
Mandatory

- Explain Health Assessment process and gain patient's/carer's consent
- Information collection - take patient history, examinations and investigations as clinically required
- Measurement of BP, pulse rate and rhythm
- Assessment of medication, continence, immunisation status for influenza, tetanus, and pneumococcus
- Assessment of physical function including activities of daily living and falls in the last three months
- Assessment of psychological function including cognition and mood
- Assessment of 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 the patient

Non-mandatory

- Consider the need for community services, social isolation, oral health and dentition, and nutrition status
- Additional matters as relevant to the patient

Claiming

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

Heart Health Assessment

Item 699 **Recommended Frequency : Annually**

Perform records search to identify ‘at risk’ patients

Identify risk factors

Perform Health Check

Nurse may collect information. GP must see patient.

Claim MBS item

Eligibility Criteria

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

Risk Factors

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

Clinical Content

Mandatory

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

Non-mandatory

- Written patient information is 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

Health Assessment for Aboriginal and/or Torres Strait Islander People

Item 715

Ensure patients eligibility

Note

It may take several shorter sessions to complete the full Health Assessment with an Aboriginal and/or Torres Strait Islanders Patient. **The Practice cannot claim the 715 until all components are completed**

Complete documentation

Claim MBS item

Recommended Frequency : Every 9 months

Eligibility Criteria

- An Aboriginal or Torres Strait Islander child who is less than 15 years
- An Aboriginal or Torres Strait Islander person who is aged between 15 years and 54 years
- An Aboriginal or Torres Strait Islander older person who is aged 55 years and over

Clinical Content
Mandatory

- Explain Health Assessment process and gain parents'/carers consent
- Information collection - taking patient history and undertake or arrange examinations and investigations as required
- Overall assessment of patient
- Recommended appropriate interventions
- Provide advice and information
- Keep a record of the health assessment and offer a copy of the assessment with recommendations about matters covered to the patient and/or carer

.

Non-mandatory

- Discuss eating habits, physical activity, speech and language development, fine and gross mottos skills, behavior, and mood
- Oher examinations considered necessary by GP/Practice Nurse

Essential Documentation Requirements

- Record parent's/carer's consent to Health Assessment
- Record the Health Assessment and offer the parent/carer a copy
- Update parent held child record for children under 5 years of age
- Record immunisations provided. All elements of the service must be completed to claim
- May be completed over several sessions but do not claim 715 until all components are complete NB: Once the patient has had a 715 Health Assessment, they are eligible for ten follow ups by the practice nurse (item number 10987) and five "at risk" allied health visits (separate/additional to the five allied health visits under TCA if the patient is diagnosed with a chronic disease) Referral form for follow-up allied health services

Health Assessments for Government Humanitarian Program

Items 701, 703, 705 and 707 may be used to undertake a Health Assessment for refugees and other humanitarian entrants.

The purpose of this Health Assessment is to introduce new refugees and other humanitarian entrants to the Australian primary health care system as soon as possible after their arrival in Australia (within 12 months of arrival).

In addition to general requirements for Health Assessments, the assessments must include development of a management plan addressing the patient's health care needs, health problems and relevant conditions.

The Health Assessment applied to humanitarian entrants who are residents in Australian with access to Medicare services. This includes refugees, Special Humanitarian Program and Protection Program entrants.

Patients should be asked to provide proof of their visa status and date of arrival in Australia. Alternatively, medical practitioners may telephone Medicare Australia on 132 011, with the patient present, to check eligibility.

The medical practitioner and patient can use the service translator by accessing the Commonwealth Government's Translating and Interpreting Service (TIS) on 131 450.

A Health Assessment for refugees and other humanitarian entrants may only be claimed once by an eligible patient.

Health Assessments for People with an Intellectual Disability

Items 701, 703, 705 and 707 may be used to undertake a Health Assessment for people with an intellectual disability.

A person is considered to have an intellectual disability if they have significantly sub-average general intellectual functioning (two standard deviations below the average intelligence quotient and would benefit from assistance with daily living activities. Where medical practitioners wish to confirm intellectual disability and a patient's need for assistance with activities of daily living, they may seek verification from a paediatrician registered to a practice in Australia or from a government-provided or funded disability service that has assessed the patient's intellectual function.

The Health Assessment provides a structured clinical framework for medical practitioners to comprehensively assess the physical, psychological, and social function of a patient with intellectual disability and to identify any medical intervention and preventive health care required.

A Health Assessment for people with an intellectual disability may be claimed once every 12 months.

Health Assessments for Former Serving Member of the ADF

Items 701, 703, 705 and 707 may be used to undertake a Health Assessment for a former serving member of the Australian Defence Force, including a former member of permanent and reserve forces.

The health assessment can be performed at any point after the patient's discharge from the ADF. The assessment is available to all former ADF members, whether or not they are a DVA client.

The Former Serving Member of the ADF Health Assessment is intended to promote the early detection and intervention of potential mental or physical health concerns in the veteran population, assisting with access to primary health care, facilitating the establishment of ongoing care with a general practitioner striving to achieve better health outcomes for veterans during their transition to civilian life.

This health assessment must include a personal attendance by a medical practitioner taking the patient's history, including the following:

- Service with the ADF – service type, years of service, field of work, deployments, and reason for discharge
- Social history – relationship status, number of children, current occupation
- Current medical conditions

The health assessment should also cover a range of other health domains where these are applicable.

Practice nurses and Aboriginal and Torres Strait Islander health practitioners may assist medical practitioners in performing the health assessment.

Patients should be provided with an explanation of the health assessment process and its likely benefits. Consent to perform the assessment should be obtained and noted in patients' records. Patients should be assured that the information they provide will be treated as confidential.

The health assessment can be performed at any point after the patient's discharge from the ADF. and can only be performed once at a single point in time.

Residential Aged Care Facilities

Health Assessment Provided as a Comprehensive Medical Assessment for Residents of Residential Aged Care Facilities

Items 701, 703, 705 and 707 may be used to undertake a Comprehensive Medical Assessment (CMA) of a resident of a Residential Aged Care Facility.

This requires an assessment of the resident's health and physical and psychological functioning, and must include:

- Making a written summary of the CMA.
- Developing a list of diagnoses and medical problems based on the medical history and examination.
- Providing a copy of the summary to the Residential Aged Care Facility.
- Offering the resident, a copy of the summary.

A Residential Aged Care Facility is a facility in which residential care services, as defined in the Aged Care Act 1997, are provided. This includes facilities that were formerly known as Nursing Homes and Hostels. A person is a resident of a Residential Aged Care Facility if they have been admitted as a permanent resident of that facility.

This Health Assessment is available to new residents on admission. 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.

A Health Assessment for the purpose of a CMA of a resident of a Residential Aged Care Facility may be claimed for an eligible patient:

- On admission to a Residential Aged Care Facility, provided that a CMA has not already been provided in another Residential Aged Care Facility within the previous 12 months.
- At 12-month intervals thereafter.

Can a GP Charge for a Consultation as well as the CMA?

Medical practitioners should not conduct a separate consultation for any other health-related issue in conjunction with a Health Assessment unless it is clinically necessary (i.e., the patient has an acute problem that needs to be managed separately from the assessment).

The only exceptions are:

- The CMA, where, if this Health Assessment is undertaken during the course of a consultation for another purpose, the Health Assessment item and the relevant item for the other consultation may both be claimed.
- Use of a specific form to record the results of the CMA is not mandatory. A Health Assessment provided as a CMA may be claimed annually to an eligible patient.

Arrangements for GP RACF Services

New Items for Doctor's RACF Services

On 1 March 2019, the Government introduced new MBS items for professional services provided by a general practitioner (GP) or medical practitioner at a RACF. The new items include a call-out fee to cover doctors' costs of travel to a RACF (MBS items 90001 and 90002), and new (standard level A to D) attendance items.

The new items simplify claims for RACF services and replace the derived fee payment model.

Call-Out Fee

The call-out items apply to a doctor's initial attendance at a RACF and are billable only for the first patient seen on a RACF visit. Once a call-out item is billed, doctors may then bill an applicable attendance item for each of the RACF patients they see. The fees for the call-out items are $57.25 for GPs.

Item number	Fee
90001	$57.25
90020	$17.90
90035	$39.10
90043	$75.75
90051	$111.50

Billing

The RACF items are only for Medicare-eligible GP and other medical practitioners providing primary care services in RACFs. Doctors employed by RACFs cannot claim the items, nor can specialists, consultant physicians, nurses and other allied health professionals.

Item Restrictions

In general, the call-out fee is intended as a one-off payment to help reimburse travel expenses, but if a doctor must return to a RACF, on the same day and the attendances are not a continuation of an earlier episode of treatment, another call-out fee would apply per subsequent RACF visit.

Residential Medication Management Review (RMMR)

Item 903

Ensure patient eligibility

First GP Visit

Discussion and referral to pharmacist

RMMR review

Conducted by accredited pharmacist

Claim MBS item

Recommended Frequency: As required (payable once in a 12-month period – unless the medical practitioner believes there has been a significant change to a patient's condition or medicine regimen

Eligibility Criteria

- New residents on admission into a RACF
- Existing residents on an 'as required' basis every 12-months or if there has been a significant change in medical condition or medication regimen
- Not for respite patients in a RACF (eligible for Domiciliary Medicines Review when they are living in the community setting)

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 regime
- Finalise plan after discussion with resident
- Offer copy of plan to resident/carer
- Provide copy for resident's records, discuss plan with nursing staff if necessary

Claiming

- All elements of the service must be completed to claim
- Derived fee arrangement does not apply to RMM

Veterans' Care

Coordinated Veterans' Care Program (CVC)

About the CVC Program

The Department of Veterans' Affairs (DVA) new Coordinated Veterans' Care Program commenced on 1 May 2011. The CVC Program:

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

Eligibility

The program is aimed at veterans who are at risk of unplanned admission to the hospital and hold either:

- A Veteran Gold Card and have a chronic health condition
- A Veteran White Card and have a DVA-accepted mental health condition

A DVA-accepted mental health condition means DVA has accepted it as being related to a veteran's military service.

GPs can enrol participants in the program if they:

- Pass an eligibility assessment
- Give their informed consent to be involved in the program

Payments for GPs

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

- Initial assessment and program enrolment (UP01 or UP02)
- Quarterly Care Payments for ongoing care (UP03 or UP04)

Guide for General Practice

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

Multidisciplinary Case Conferences

Patients with a chronic or terminal medication condition and complex care needs requiring care or services from their usual GP and at least two other health or care providers are eligible for a case conference service. There is no list of eligible conditions, however, the CDM items are designed for patients who require a structured approach and to enable GPs to plan and coordinate the care of patients with complex conditions requiring ongoing care from a multidisciplinary team.

Case conferences can be undertaken for patients in the community, for patients being discharge into the community from hospital and for people living in Residential Aged Care Facilitates.

When are patients most likely to benefit from a Case Conference?

- When there is a need to develop immediate solutions in response to a recent change in the patient's condition or circumstances, e.g., death of a carer or unexpected event such as a stroke.
- To facilitate ongoing management such as sharing of information to develop or communicate goals for patient care or define relevant provider contributions to care.

How can a GP be involved in a Case Conference?

Prepare and co-ordinate a case conference

- For patients living in the community
- For private patients on discharge from hospital
- For patients in a Residential Aged Care Facility; not those receiving nursing home level care

Participate in a case conference

- For patients living in the community
- For public or private patients on discharge from hospital
- For patients in a Residential Aged Care Facility; not those receiving nursing home level care

A case conference can occur face-to-face, by phone or by video conference, or through a combination of these. A minimum of three care providers (including the GP) must be in communication with each other throughout the conference. Examples of persons who may be included in a multidisciplinary care team are:

- Allied health professionals.
- Home and community service providers.
- Care organizers such as education providers, "meals on wheels" providers, personal care workers and probation officers.

MBS item numbers for Case Conferences	GP Prepares and Co-ordinates			GP Participates		
Community Case Conference	15-20 mins	20-40 mins	>40 mins	15-20 mins	20-40 mins	>40 mins
	735	739	743	747	750	758
Discharge Case Conference (At the invitation of the hospital)	For Private Patients			For Public and Private Patients		
	735	739	743	747	750	758
RACF Case Conference	735	739	743	747	750	758

Cancer Screening

Cervical Screening

Human Papillomavirus (HPV) is a common infection that can cause cervical cell changes that may lead to cervical cancer. Cervical cancer is one of the most preventable cancer types therefore, routine cervical screening is the best protection against cervical cancer. Previously, the Pap test was used to detect cell changes in the cervix.

In December 2017, this was replaced with the Cervical Screening Test (CST).

CST is more effective than the Pap Test at preventing cervical cancer because it detects the HPV, whereas the Pap Test looked for cell changes in the cervix which may take a longer period to discover. The new test is only required to be completed every five years rather than every two and is expected to protect up to 30% more women (Department of Health and Aged Care, 2022).

Patient Eligibility

- Women aged between 25 and 74
- 'Under screened' women who have not had a cervical smear in the last four years

Self-Collection

Self-collection of a sample for screening is available for women between the ages of 30 and 74 years of age who are overdue for screening by two or more years (i.e., being 4 years since their last Pap Test). Self-collection should only be offered to an eligible person who refuses to have their sample collected by their requesting practitioner.

Cervical Screening Resources

Resource Details	Publication Details
Various Information resources	NSW Cervical Screening Program P: 131 556
National Cancer Screening register	National Cervical Screening Program P: 1800 627 701

Mental Health

MBS Better Access Initiative

The Better Access to psychiatrists, psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access) initiative aims to improve access and outcomes for people with a clinically diagnosed mental illness through a structured and evidence-based approach to treatment.

Under this initiative, Medicare rebates are available to patients for selected mental health services provided by General Practitioners (GPs), psychiatrists, psychologists (clinical and registered) and eligible social workers and occupational therapists.

Better Access Initiative **(**Aust Govt - Dept of Health and Aged Care**)**

What Medicare Services can be Provided Under the Better Access Initiative?

Medicare rebates are available for up to ten individual and ten group allied mental health services per calendar year to patients with an assessed mental disorder who are referred by:

- A GP managing the patient under a GP Mental Health Treatment Plan
- Under a referred psychiatrist's assessment and management plan
- A psychiatrist or paediatrician

Short Term Psychological Therapies

- **Short term psychological therapies** provided to people who have mild to moderate mental illness, or are at risk of suicide or self-harm
- **Group therapy programs** for people with mild to moderate mental illness who would benefit from group therapy. Available groups include, Perinatal depression, Dialectical Behavioral Therapy for young people and adults and Hoarding Disorder treatment.

  From **1 November 2022**, group therapy Medicare Benefits Schedule (MBS) items under the Better Access initiative will include:

- 16 new MBS items for group therapy sessions lasting at least 90 minutes or 120 minutes
- amendments to 8 existing MBS items to reduce the minimum number of patients required to hold a group therapy session from 6 to 4
- allowing all group therapy MBS items to be claimed with only 3 patients, if 4 patients were scheduled to attend but one patient does not attend (for example, due to unforeseen circumstances).

  More information on **Group Therapy MBS Changes** can be found on MBS online

Preparation of a Mental Health Treatment Plan

Items 2700, 2701, 2715 and 2717

Preparation of a GP Mental Health Treatment Plan involves both assessing the patient and preparing the GP Mental Health Treatment Plan document.

What must be Included in the Assessment?

Assessment of a patient for the GP Mental Health Treatment Plan must include:

- Recording the patient's agreement for the GP Mental Health Treatment Plan service
- Taking relevant history (biological, psychological, social) including the presenting complaint
- Conducting a mental state examination
- Assessing associated risk and any co-morbidity
- Making a diagnosis and/or formulation
- Administering an outcome measurement tool, except where it is considered clinically inappropriate

A formulation is important for the development of a GP Mental Health Treatment Plan and includes an assessment of the biological, psychological, and social factors predisposing, precipitating and/or protecting against a mental health problem.

Where the patient has a carer, the GP may find it useful to have the carer present for the assessment or components thereof (subject to patient agreement). The assessment can be part of the same consultation in which the GP Mental Health Treatment Plan is developed, or they can be undertaken in different visits.

Where separate visits are undertaken for the purpose of assessing the patient and developing the GP Mental Health Treatment Plan, they are part of the GP Mental Health Treatment Plan service and are included in items 2700, 2701. 2715 or 2717.

See Medicare Benefits Schedule - Note AN.0.56 GP Mental Health Treatment Items

What must a GP Mental Health Treatment Plan Include?

The development of a mental health plan must include:

- Discussion of the assessment with the patient, including the mental health formulation and/or diagnosis
- Identifying and discussing referral and treatment options with the patient, including appropriate support services
- Agreeing goals with the patient – what should be achieved by the treatment – and any actions the patient will take
- Provision of psychoeducation
- A plan for crisis intervention and/or for relapse prevention, if appropriate at this stage
- Making arrangements for required referrals, treatment, appropriate support services, review and follow up
- Documenting this in the patient's GP Mental Health Treatment Plan
- Offering a copy of the written GP Mental Health Treatment Plan to the patient and/or carer (with patient's agreement)

A GP Mental Health Treatment Plan sample template for the Better Access Program can be accessed here.

Review of a Mental Health Treatment Plan

Item 2712

The review is the key component for assessing and managing the patient's progress once a GP Mental Health Treatment Plan has been prepared, along with ongoing management through the GP Mental Health Consultation item and/or standard consultation items. A patient's GP Mental Health Treatment Plan should be reviewed at least once.

What must the Review Include?

The review stage must include:

- Recording the patient's agreement for the service
- Reviewing the patient's progress against the goals outlined in the GP Mental Health Treatment Plan
- Modifying the plan, if required
- Checking, reinforcing, and expanding education
- A plan for crisis intervention and/or relapse prevention, if appropriate and if not previously provided
- Re-administration of the outcome measurement tool used in the assessment stage, except where considered clinically inappropriate.

Note: This review is a formal review point only and it is expected that in most cases there will be other consultations between the patient and the GP as part of the ongoing management.

When should a Review of the GP Mental Health Care Plan be Done?

The initial review should take place a minimum of four weeks and a maximum of six months after the completion of a GP Mental Health Treatment Plan. If required, an additional review three months after the first review is allowed within a 12-month period.

GP Mental Health Care Consultation

Item 2713

When can I use the GP Mental Health Care Consultation Item?

The GP Mental Health Care Consultation item applies to in surgery consultations, which are of at least 20 minutes duration and where the primary treating problem is related to a mental disorder.

This item is for the ongoing management of patients with a mental disorder, including patients being managed under a GP Mental Health Treatment Plan, however, it can be used whether or not a patient has a Mental Health Treatment Plan. This item should not be used for the patient assessment or preparation of a GP Mental Health Treatment Plan. There are no restrictions on how often this item can be used.

What must a GP Mental Health Care Consultation Include?

- Taking relevant history and identifying the patients presenting problem(s) if not previously documented
- Providing treatment, advice and/or referral for other services or treatment
- Documenting the outcomes of the consultation in the patient's medical records and other relevant mental health plan (where applicable)

A patient may be referred from a GP Mental Health Care Consultation for other treatment and services as per normal GP referral arrangements. This does not include referral for Medicare rebate-able services by focused psychological services, clinical psychology, or other allied mental health services, unless the patient is being managed by the GP under a GP Mental Health Treatment Plan or under a referred psychiatrist assessment and management plan (item 291).

Practice Nurses and Chronic Disease Management

An appropriately skilled practice nurse can deliver some Chronic Disease Management services under the supervision of and on behalf of the GP.

Services include:

- Preparation of a GPMP (MBS item 721 or 229) or TCA (MBS item 723 or 230)

  A nurse may assist a GP in preparing a GP Management Plan (GPMP) or Team Care Arrangement (TCA). The 'usual' GP co-ordinates the plan for a patient with chronic diseases and ensures that each member of the multidisciplinary team has contributed to the plan's development or review. The nurse can collect history, identify needs, goals, and the actions, and make arrangements with services.

  The GP must review the plan with the patient before claiming the relevant item/s.

  Items 721, 723 and 732 apply.

  Patients being managed under a GPMP/TCA may receive ongoing support and monitoring from Practice Nurses, up to five times per year, on behalf of the GP who prepared the plan.

  MBS nurse item 10997 applies.

- Preparation of a Health Assessment

A suitably qualified nurse can assist the GP conduct a chronic disease 45–49-year-old check, a 40–49-year-old diabetes evaluation, a Heart Health Assessment ,an annual Health Assessment for a patient over 75 years or a Comprehensive Medical Assessment (CMA) for a patient in residential aged care. The nurse can collect information for the patient assessment, provide lifestyle advice and education, as well as facilitate appropriate referral pathways inclusive of a multidisciplinary team. Such assistance must be provided in accordance with accepted medical practice and under the supervision of the GP. The GP must meet all regulatory requirements, personally attend the patient, review, and confirm all elements of assistance provided on their behalf before claiming the relevant item/s.

Practice Nurse Item numbers

Chronic disease monitoring and support (MBS item 10997)

Patients being managed under a GPMP, TCA or a Multidisciplinary Care Plan may receive ongoing support and monitoring from practice nurses between structured reviews of the care plan by the patient's usual medical practitioner.

This item can be claimed up to 5 times per patient per calendar year, and as part of the service, the nurse can check on clinical progress, monitor medication compliance, provide advice and collect information to support the review of the care plan.

Health Assessment follow-up (MBS Item 10987)

This service can be claimed by the practice nurse for a health assessment follow up on Aboriginal and Torres Strait Islander People, including MBS items 228 or 715. This item can be claimed up to 10 times per patient per calendar year and includes patient assessment, identification of patient needs and making arrangements for services.

Note: The Practice Nurse item number income estimator (reproduced in this Guide - see Appendix D) provides information regarding the financial contribution Practice Nurses can make when involved in providing care for patients with common chronic conditions.

APPENDIX A

Health Assessment Item Numbers

Item	Name	Description/Recommended Frequency
699	Heart Health Check	≥ 20 mins a. Collection of relevant information, including taking a patient history that is aimed at identifying cardiovascular disease risk factors, including diabetes status, alcohol intake, smoking status, and blood glucose. b. A physical examination, which must include recording of blood pressure and cholesterol status. c. Initiating interventions and referrals to address the identified risk factors. d. Implementing a management plan for appropriate treatment of identified risk factors. e. Providing the patient with preventative health care advice and information, including modifiable lifestyle factors.
701	Brief Health Assessment	< 30 mins a. Collection of relevant information, including taking a patient history. b. A basic physical examination. c. Initiating interventions and referral as indicated. d. Providing the patient with preventative health care advice and information.
703	Standard Health Assessment	30 – 45 mins a. Detailed information collection, including taking a patient history. b. An extensive physical examination. c. Initiating interventions and referrals as indicated. d. Providing a preventative health strategy for the patient.
705	Long Health Assessment	45 – 60 mins a. Comprehensive information collection, including taking a patient history. b. An extensive examination of the patient's medical condition and physical function. c. Providing a basic preventative health care strategy for the patient.
707	Prolonged Health Assessment	> 60 mins a. Comprehensive information collection, including taking a patient history. b. An extensive examination of the patient's medical condition and physical and social function. c. Initiating interventions and referrals as indicated. d. Providing a comprehensive preventative health care management plan for the patient.
715	Aboriginal and Torres Strait Islander Health Assessment	No designated time or complexity requirements **Aboriginal and/or Torres Strait Islander Child** For patients 0-14 years old. Not available to inpatients of a hospital or RACF. Not more than once every nine months. **Aboriginal and/or Torres Strait Islander Adult** For patients 15-54 years old. Not available to inpatients of a hospital or RACF. Not more than once every nine months. **Aboriginal and/or Torres Strait Islander Older Peoples** For patients 55 years and over. Not available to inpatients of a hospital or RACF. Not more than once every nine months.

APPENDIX B

Systematic Care Claiming Rules

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

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

Restrictions of Co-claiming of Chronic Disease and General Consultation Items
Co-claiming of GP consultation items 3, 4, 23, 24, 36, 37, 44, 47, 52, 54, 57, 58, 59, 60, 63, 65, 597, 598, 599, 600, 5000, 5003, 5020, 5023, 5040, 5043, 5060, 5063, 5200, 5203, 5207, 5208, 5220, 5223, 5227, and 5228 with chronic disease management items 721, 723, or 732 **is not permitted for the same patient on the same day.**

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

APPENDIX C

Mental Health Item Numbers

Item	Name	Description/Recommended Frequency
2700	GP Mental Health Treatment Plan (prepared by a GP who has not undertaken Mental Health Skills Training)	Assessment of patient taking at least 20 minutes. Not more than once yearly
2701		Assessment of patient taking at least 40 minutes. Not more than once yearly
2715	GP Mental Health Treatment Plan (prepared by GP who has undertaken Mental Health Skills Training)	Assessment of patient taking between 20-39 minutes. Not more than once yearly
2717		Assessment of patient taking at least 40 minutes. Not more than once yearly
2712	Review of GP Mental Health Treatment Plan	Plan should be reviewed everyone – six months
2713	GP Mental Health Consultation	Consult > 20 minutes for the ongoing management of a patient with a mental disorder. No restrictions on the number of these consultations per year
2721	GP focused Psychological Strategies (provision of focused psychological strategies by an appropriately trained and registered GP working in an accredited practice)	30-40 minutes
2723		Out of surgery consultation. 30 – 40 minutes
2725		> 40 minutes
2727		Out of surgery consultation. > 40 minutes

Checklist for GP Mental Health Treatment Plan

Assessment (As part of a GP Mental Health Treatment Plan)	• Patient's agreement for the GP Mental Health Treatment Plan service • Relevant History • Mental state examination • Assess risk and co-morbidity • A diagnosis and/or formulation • Administer outcome measurement tool (unless clinically inappropriate)
Plan	• Discussion of the assessment with the patient, including the mental health formulation and/or diagnosis • Identifying and discussing referral and treatment options with the patient • Agreeing on goals with the patient • Provision of psychoeducation • Crisis intervention and/or relapse prevention plan if appropriate • Referrals, treatment, appropriate support services, review, and follow-up • Documenting results in the patient's GP Mental Health Treatment Plan • Offer a copy of the plan to the patient
Review	• Recording the patient's agreement for this service • Review patient's progress against the goals outlined in the GP Mental Health Treatment Plan • Modify GP Mental Health Treatment Plan if required • Check, reinforce and expand education • Crisis intervention and/or relapse prevention plan if appropriate and if not previously provided • Re-administration of the outcome measurement tool (unless clinically inappropriate) **The Review is conducted one month to six months from when the GP Mental Health Treatment Plan was prepared**
Consultation	• Taking relevant history and identifying the patient's presenting problem(s) (if not previously documented) • Providing treatment, advice and/or referral for other services of treatment • Documenting the outcomes of the consultation in the patient's medical records and other relevant mental health plan (where applicable)

Mental State Examination	
Appearance and General Behaviour	**Mood** (Depressed/Labile)
Thinking (Content/Rate/Disturbances)	**Affect** (Flat/Blunted)
Perception (Hallucinations etc.)	**Appetite** (Disturbed eating patterns)
Cognition (Level of consciousness/Delirium/Intelligence)	**Sleep** (Initial insomnia/Early morning wakening)
Attention/Concentration	**Motivation/Energy**
Memory (Short and long term)	**Judgement** (Ability to make rational decisions)
Insight (Capacity to organise and understand problem, symptom, or illness)	**Anxiety Symptoms** (Physical and emotional
Orientation (Time/Place/Person)	**Speech** (Volume/Rate/Content)

APPENDIX D

Practice Nurse Item Number Income Estimator

PRACTICE NURSE ITEM NUMBER CALCULATOR

phn NEPEAN BLUE MOUNTAINS
An Australian Government Initiative

Item	Activity	MBS No.	No. of Services	MBS Fee	Income Generated
Health Assessmnets	Diabetes Risk (40-49 year olds)	701 (brief)		$62.75	$0.00
		703 (standard)		$145.80	$0.00
		705 (long)		$201.15	$0.00
		707 (prolonged)		$284.20	$0.00
	45 - 49 Year Old Health Check	701 (brief)		$62.75	$0.00
		703 (standard)		$145.80	$0.00
		705 (long)		$201.15	$0.00
		707 (prolonged)		$284.20	$0.00
	75 + Years	701 (brief)		$62.75	$0.00
		703 (standard)		$145.80	$0.00
		705 (long)		$201.15	$0.00
		707 (prolonged)		$284.20	$0.00
	Indigneous Health Assessment	715		$224.40	$0.00
	ATSI Follow Up with Nurse	10987		$25.35	$0.00
	Heart Health Assessment	699		$76.95	$0.00
Chronic Disese Management	GP Management Plan	721		$152.50	$0.00
	Team Care Arrangement	723		$120.85	$0.00
	GPMP Review	732		$76.15	$0.00
	TCA Review	732		$76.15	$0.00
	Nurse Contribution to GPMP/TCA	10997		$12.70	$0.00
	DMMR	900		$163.70	$0.00
Mental Health	GPMHP without Mental Health Skill Trainin	2700 (20-39 min)		$75.80	$0.00
		2701 (> 40 min)		$111.60	$0.00
	GPMHP with Mental Health Skill Training	2715 (20-39 min)		$96.25	$0.00
		2717 (> 40 min)		$141.80	$0.00
	GPMHP Review	2712		$75.80	$0.00
	Mental Health Consult > 20 minutes	2713		$75.80	$0.00
Eating Disorders	EDTP without Mental Health Skill Training	90250 (20-39 min)		$75.80	$0.00
		90251 (> 40 min)		$111.60	$0.00
	EDTP with Mental Health Skill Training	90252 (20-39 min)		$96.25	$0.00
		90243 (> 40 min)		$141.80	$0.00
	EDTP Review	90264		$75.80	$0.00
Women's Health	Antenatal Attendance	16500		$49.85	$0.00
	Administration of hormone implant	14206		$37.65	$0.00
	Removal of hormone implant	30062		$64.20	$0.00
	Insertion of IUD	35503		$84.75	$0.00
	Urine pregnancy test	73806		$10.15	$0.00
	Cervical Screen not done in 4 years	2497		$17.90	$0.00
Other Serivces	ECG	11707		$19.45	$0.00
	Spirometry - Diagnosis	11505		$43.50	$0.00
	Spirometry - Monitor	11506		$21.75	$0.00
				Total	$0.00

APPENDIX E

Information and Resources for Health Professionals

- Chronic disease Management GP Management Plans and Team Care Arrangements by Services Australia
- Practice Nurse Items
- Medicare Benefits Schedule item descriptors and explanatory notes at MBS Online
- The Guidelines for Preventive Activities in General Practice (9th Edition)
- Putting Prevention into Practice (Third Edition) have been developed to support evidence based preventative activities in primary care
- Mental Health and Suicide Prevention Aust Govt / Department of Health and Aged Care
- Nepean Blue Mountains PHN HealthPathways
- Notes for CVC Program Providers Aust Govt/ Department of Veterans' Affairs
- CVC Toolbox.dva.gov.au