Hunter Rural Division of General Practice
Growing with the needs of General Practice

DESKTOP GUIDE TO ITEM NUMBERS

Effective November 2010

For a comprehensive explanation of each MBS Item number refer to the Medicare Benefits Schedule Book or go to www.health.gov.au/mbsonline

Item	Name	$	Description / Recommended Frequency
3	Level A	$16.00	Short - see MBS for complexity of care requirements
23	Level B	$34.40	<20 min - see MBS for complexity of care requirements
36	Level C	$67.65	≥20 min - see MBS for complexity of care requirements
44	Level D	$99.55	≥40 min - see MBS for complexity of care requirements
10991	Bulk Billing item	$10.25	DVA, under 16's and Commonwealth Concession Card holders. Can be claimed concurrently for eligible patients.
Health Assessments and Health Checks			
Item	**Name**	**$**	**Description / Recommended Frequency**
701	Brief Health Assessment	$56.00	< 30 minutes – see MBS for complexity of care requirements
703	Standard Health Assessment	$130.10	30 – 45 minutes – see MBS for complexity of care requirements
705	Long Health Assessment	$179.49	45 – 60 minutes – see MBS for complexity of care requirements
707	Prolonged Health Assessment	$253.60	> 60 minutes – see MBS for complexity of care requirements
Chronic Disease Management			
Item	**Name**	**$**	**Description / Recommended Frequency**
721	GP Management Plan (GPMP)	$136.05	Management plan for patients with a chronic or terminal condition - not more than once yearly
723	Team Care Arrangement (TCA)	$107.80	Management plan for patients with a chronic or terminal condition who require ongoing care from a team including the GP and at least 2 other health or care providers. Enables referral for 5 rebated allied health services - not more than once yearly
732	Review of GP Management Plan and/or Team Care Arrangement	$68.00	Recommended 6 monthly, must be performed at least once over the life of the plan
729	GP Contribution to, or review of, Multidisciplinary Care Plan	$66.35	Contribution to, or review of, a multidisciplinary care plan prepared by another provider (e.g. community, home or allied health providers, specialists), for patients with a chronic or terminal condition and complex needs requiring ongoing care from a team including the GP and at least 2 other health or care providers. Not more than once every 3 months
731	GP Contribution to Care Plan by RACF	$66.35	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 2 other health or care providers. Not more than once every 3 months

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Medication Management and Cycles of Care			
Item	**Name**	**$**	**Description / Recommended Frequency**
900	Home Medicine Review (HMR)	$146.00	Review of medications in collaboration with a pharmacist for patients at risk of medication related misadventure - once every 12 months
903	Residential Medication Management Review (RMMR)	$99.95	For permanent residents of Residential Aged Care Facilities who are at risk of medication related misadventure. Performed in collaboration with the resident's pharmacist - not more than once yearly
2521	Diabetes Annual Cycle of Care Level C + SIP	$67.65 + $40 = $107.65	For accredited practices. Used in place of usual attendance item when completing Diabetes Annual Cycle of Care - once every 11- 13 months
2552	Asthma Cycle of Care Level C + SIP	$67.65 + $100 = $167.65	For accredited practices. Used in place of usual attendance item when completing the Asthma Cycle of Care for patients with moderate to severe asthma - not more than once yearly
11506	Spirometry	$19.75	Measurement of respiratory function involving a permanently recorded tracing performed before and after inhalation of bronchodilator
Practice Nurse Item Numbers			
Item	**Name**	**$**	**Description / Recommended Frequency**
10986	Health Assessment – Healthy Kids Check by Nurse	$56.00	Once only health check for children who have received or are receiving the 4 year old immunisation
10987	Follow up Health Services for Indigenous people	$23.10	Follow up services for an Indigenous person who has received a Health Assessment, not an admitted patient of a hospital. Maximum of 10 service per patient, per calendar year
10993	Immunisation	$11.55	Immunisation provided by a Practice Nurse
10994	Pap Smear and Preventative Check	$23.10	Nurse must be appropriately trained and qualified. See services provided by Practice Nurse Summary for details
10996	Wound Care	$11.55	Nurse must be appropriately trained and qualified. See Services Provided by Practice Nurse Summary for details
10997	Chronic Disease Management	$11.55	Monitoring and support for patients being managed under a GPMP or TCA – not more than 5, per patient, per year.
Mental Health			
Item	**Name**	**$**	**Description / Recommended Frequency**
2702	GP Mental Health Treatment Plan	$128.20	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
2710	GP Mental Health Treatment Plan	$163.35	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 Care Plan	$108.90	Plan should be reviewed after 1 - 6 months
2713	Mental Health Consultation	$71.85	Consult ≥ 20 min, for the ongoing management of a patient with mental disorder. No restriction on the number of these consultations per year

Hunter Rural Division of General Practice
Growing with the needs of General Practice

SERVICES PROVIDED BY PRACTICE NURSES

Effective November 2010

For a comprehensive explanation of each MBS Item number refer to the Medicare Benefits Schedule Book or go to www.health.gov.au/mbsonline

The following services are provided on behalf of, and under the supervision of the GP:

Item	Name	$	Description / Recommended Frequency
10986	Health Assessment – Healthy Kids Check by Nurse	$56.00	Once only heath check for children who have received or are receiving the 4 year old immunisation
10987	Follow up Health Services for Indigenous people	$23.10	Follow up services for an Indigenous person who has received a Health Assessment, not an admitted patient of a hospital. Maximum of 10 services per patient, per calendar year
10993	Immunisation	$11.55	Nurse must be appropriately trained and qualified. See over page for details
10994	Pap Smear and Preventative Check	$23.10	Pap smear and at least one preventative check performed. Nurse must be appropriately trained and qualified. See over page for details
10995	Pap Smear and Preventative Check	$23.10	Same as item 10994 + the patient is 20 – 69 years inclusive and has not had a Pap smear for the past 4 years and at least one preventative check performed
10996	Wound Care	$11.55	Nurse must be appropriately trained and qualified. See over page for details
10997	Chronic Disease Management	$11.55	Monitoring and support for patients being managed under a GPMP or TCA. Maximum of 5 services per patient, per calendar year
10998	Pap Smear	$11.55	Nurse must be appropriately trained and qualified. See over page for details
10999	Pap Smear	$11.55	Same as item 10998 + the patient is 20 – 69 years inclusive and has not had a Pap smear for the past 4 years

COURSES FOR REGISTERED AND ENROLLED NURSES

- Immunisation courses for RNs contact The College of Nursing on 02 9745 7500
- Wound Care courses visit the Australian Practice Nurses Association website: http://www.apna.asn.au or the Wound Care Association NSW website: http://www.wcansw.com.au
- Well Women's Screening courses (Pap Smear), contact Family Planning NSW on 02 8752 4328 or visit the website: http://www.fpnsw.org.au
- Medication Administration courses for ENs, contact The College of Nursing on 02 9745 7500 or visit the TAFE NSW website: http://www.tafensw.edu.au

Hunter Rural Division of General Practice
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SERVICES PROVIDED BY PRACTICE NURSES

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Practice Nurses performing Wound Care

Practices Nurses can only perform wound care if they are appropriately trained and qualified i.e. have completed an accredited training course.

Practice Nurses performing Immunisations

Registered Nurses (RNs) can vaccinate with a written doctor's order. RNs who have completed the College of Nursing Immunisation course, and have maintained their competence can vaccinate without a doctor's order.

Enrolled Nurses (ENs) cannot administer vaccinations unless they have completed an Endorsed Medication Administration course, and then can only immunise with written doctor's order and under the supervision of an RN employed by the practice.

Practice Nurses performing Pap Smears

Practices Nurses can only perform pap smears if they are appropriately trained and qualified i.e. have completed an accredited training course.

Items 10994 and 10995: For undertaking at least one preventive check in addition to Pap Smear when the service is reasonably necessary and appropriate - preventative checks include:

- Checks for Sexually Transmitted Infections
- Taking of a sexual and reproductive history
- Advice on contraception
- Breast awareness education
- Advice on post natal issues
- Continence advice and education

May also include:

- Behavioural risk factor assessment e.g. smoking, nutrition, alcohol and physical activity
- Taking of Blood Pressure

Items 10995 and 10999: For accredited practices, an additional PIP payment of $35 per patient is made for women 20 – 69 years (inclusive) not screened in the past 4 years.

Practice Nurses assisting with Chronic Disease Management Items

Item 10997: For ongoing monitoring and support of a patient where a CDM item (721, 723, 732, 729, 731) has been claimed in the last 12 months - some examples include:

- Checks on clinical progress
- Collection of information to support GP reviews of care plans
- Self management advice
- Monitoring medication compliance

For general assistance, there is no set list of activities that a Practice Nurse is permitted to undertake in assisting the GP, but should be within their professional competencies – some examples include:

- Assessing the patient
- Preparing or reviewing a GPMP or TCA
- Identifying the patient's needs
- Making arrangements for services

The GP must review and confirm all assessments and elements of the service and must see the patient as part of the service.

Hunter Rural Division of General Practice

Growing with the needs of General Practice

PAP SMEAR ITEM NUMBERS

Effective November 2010

For a comprehensive explanation of each MBS Item number refer to the Medicare Benefits Schedule Book or go to www.health.gov.au/mbsonline

Item	Name	Description / Recommended Frequency
3	Level A	Brief – see MBS for complexity of care requirements
23	Level B	< 20 min standard consultation – see MBS for complexity of care requirements
36	Level C	≥ 20 min standard consultation – see MBS for complexity of care requirements
44	Level D	≥ 40 min standard consultation – see MBS for complexity of care requirements
2497	PIP Level A Pap Smear	Short 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
2501	PIP 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
2503	PIP Level B Pap Smear	Out of surgery – 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	PIP 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 4 years
2506	PIP Level C Pap Smear	Out of surgery – 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
2507	PIP 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 4 years
2509	PIP Level D Pap Smear	Out of surgery – 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
10994	Practice Nurse performing Pap Smear and Preventative Check	Pap smear and at least one preventative check performed. Nurse must be appropriately trained and qualified. See over page for details
10995	PIP Practice Nurse performing Pap Smear and Preventative Check	Same as item 10994 + the patient is 20-69 years inclusive and has not had a pap smear for the past 4 years and at least one preventative check performed
10998	Practice Nurse performing Pap Smear	Nurse must be appropriately trained and qualified. See over page for details
10999	PIP Practice Nurse performing Pap Smear	Same as item 10998 + the patient is 20-69 years inclusive and has not had a pap smear for the past 4 years

Hunter Rural Division of General Practice
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PAP SMEAR ITEM NUMBERS

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Accredited Practices		Non-accredited Practices	
Patients who **have** not had a pap smear in the past 4 years use **one of** the standard items:	23, 36, 44 10994 or 10998	For all patients, regardless of time since last pap smear, use **one of** the standard items:	23, 36, 44, 10994 or 10998
Patients who **have not** had a pap smear in the past 4 years use **one of** the PIP items:	2497, 2501, 2503, 2504, 2506, 2507, 2509, 10995 or 10999		

Practice Nurses performing Pap Smears

Practice Nurses can only perform pap smears if they are appropriately trained and qualified i.e. have completed an accredited training course.

Course for Registered and Enrolled Nurses – Well Women's Screening (Pap Smear) courses, contact Family Planning NSW on 02 8752 4328 or visit the website: http://www.fpnsw.org.au

Items 10995 and 10999: For accredited practices, a PIP payment applies. A payment of $35 per patient is made for woman 20-69 years inclusive not screened in the past 4 years.

A further $0.75 per patient, per quarter is paid to practices who reach 50% of female patients aged 20-69 years inclusive, screened in the past 30 months. To reach 50%, female patients need to have had a cervical screening pathology item claimed by a pathology company, in the last 30 months.

Items 10994 and 10995: For undertaking at least one preventative check in addition to Pap Smear when the service is reasonably necessary and appropriate – preventative checks include:

- Checks for Sexually Transmitted Infections
- Taking of a sexual and reproductive history
- Advice on contraception
- Breast awareness education
- Advice on post natal issues
- Continence advice and education

May also include:

- Behavioural risk factor assessment e.g. smoking, nutrition, alcohol and physical activity
- Taking of Blood Pressure

Unscreened of Significantly Under-Screened Populations

Women from the following groups are more likely than the general population to be unscreened or significantly under-screened: Low socioeconomic status, culturally and linguistically diverse (CALD) backgrounds, Indigenous communities, women living in rural or remote areas and older women.

Hunter Rural Division of General Practice
Growing with the needs of General Practice

PATIENTS WITH RISK FACTORS OR CHRONIC CONDITIONS

Effective November 2010

For a comprehensive explanation of each MBS Item number refer to the Medicare Benefits Schedule Book or go to www.health.gov.au/mbsonline

Chronic Disease Management			
Item	**Name**	**$**	**Description / Recommended Frequency**
721	GP Management Plan (GPMP)	$136.05	Management plan for patients with a chronic or terminal condition - not more than once yearly
723	Team Care Arrangement (TCA)	$107.80	Management plan for patients with a chronic or terminal condition who require ongoing care from a team including the GP and at least 2 other health or care providers. Enables referral for 5 rebated allied health services - not more than once yearly
732	Review of GP Management Plan and/or Team Care Arrangement	$68.00	Recommended 6 monthly. Must be performed at least once over the life of the plan
729	GP Contribution to, or Review of, Multidisciplinary Care Plan	$66.35	Contribution to, or review of, a multidisciplinary care plan prepared by another provider (e.g. community, home or allied health providers, specialists), for patients with a chronic or terminal condition and complex needs requiring ongoing care from a team including the GP and at least 2 other health or care providers. Not more than once every 3 months
731	GP Contribution to, or Review of, Multidisciplinary Care Plan prepared by RACF	$66.35	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 2 other health or care providers. Not more than once every 3 months
10997	Chronic Disease Management by Nurse	$11.55	Monitoring and support for patients being managed under a GPMP or TCA – not more than 5, per patient, per year. Can be claimed concurrently with other GP item numbers.
Diabetes and Asthma Cycles of Care			
Item	**Name**	**$**	**Description / Recommended Frequency**
2521	Diabetes Annual Cycle of Care Level C + SIP	$67.45 + $40 = $107.45	For accredited practices. Used in place of usual attendance item when completing Diabetes Annual Cycle of Care - once every 11- 13 months
2552	Asthma Cycle of Care Level C + SIP	$67.45 +$100 = $167.45	For accredited practices. Used in place of usual attendance item when completing the Asthma Cycle of Care for patients with moderate to severe asthma - not more than once yearly
11506	Spirometry	$19.75	Measurement of respiratory function before and after inhalation of bronchodilator
Medication Management			
Item	**Name**	**$**	**Description / Recommended Frequency**
900	Home Medicine Review (HMR)	$146.00	Review of medications in collaboration with a pharmacist for patients at risk of medication related misadventure - once every 12 months

Hunter Rural Division of General Practice
Growing with the needs of General Practice

PATIENTS WITH RISK FACTORS OR CHRONIC CONDITIONS

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ALLIED HEALTH SERVICES

Allied Health Services for Chronic Conditions Requiring Team Care 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**
10950	Aboriginal Health Worker Services	5 Allied Health services per calendar year Can be 5 sessions with one provider or a combination e.g. 3 Dietician and 2 Diabetes education sessions Medicare EPC Referral Form for each provider Allied Health Provider must be Medicare registered
10951	Diabetes Educator Services	
10952	Audiologist Services	
10953	Exercise Physiologist Services	
10954	Dietitian Services	
10958	Occupational Therapist Services	
10960	Physiotherapist Services	
10962	Podiatrist Services	
10964	Chiropractor Services	
10966	Osteopath Services	
10970	Speech Pathologist Services	
10956	Mental Health Worker Services	Use Better Access Mental Health Care items for mental health conditions – 12 sessions and GPMP and TCA for chronic medical conditions – 5 sessions
10968	Psychologist Services	

DENTAL SERVICES

Dental Services for Chronic Conditions Requiring Team Care GP must have completed and claimed 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**
85011-87777	Dentist, Dental Specialist or Dental Prosthetics Services	Range of services – see MBS	Up to $4250 over 2 consecutive calendar years Patient's oral health must be impacting on, or likely to impact on their general health Medicare Dental Referral Form Dentist must be Medicare registered

Hunter Rural Division of General Practice
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PATIENTS WITH RISK FACTORS OR CHRONIC CONDITIONS

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ALLIED HEALTH GROUP SERVICES FOR PATIENTS WITH TYPE 2 DIABETES

Assessment and Provision of Group Services GP must have completed and claimed a GP Management Plan (721), or reviewed an existing GPMP (725), or contributed to, or reviewed, a care plan in a Residential Aged Care Facility (731)			
Item	**Name**	**$**	**Description / Recommended Frequency**
81100	Assessment for Group Services by Diabetes Educator	$76.80	One assessment session only by either Diabetes Educator, Exercise Physiologist or Dietitian, per calendar year Medicare Allied Health Group Services for Type 2 Diabetes Referral Form
81110	Assessment for Group Services by Exercise Physiologist	$76.80	
81120	Assessment for Group Services by Dietitian	$76.80	
81105	Diabetes Education Group Services	$19.15	8 group services per calendar year, can be 8 sessions with one provider or a combination e.g. 3 diabetes education, 3 dietitian and 2 exercise physiology sessions. Medicare Allied Health Group Services for Type 2 Diabetes Referral Form
81115	Exercise Physiology Group Services	$19.15	
81125	Dietetics Group Service	$19.15	

Visit the professional associations' websites to search for local providers offering Medicare rebated group services:
Diabetes Educators - www.adea.com.au
Dieticians - www.daa.asn.au
Exercise Physiologists - www.aaess.com.au

GP MULTIDISCIPLINARY CASE CONFERENCES

Item	**Name**	**$**	**Description / Recommended Frequency**
735	Organise & coordinate a case conference	$66.00	15 – 20 minutes. GP organises and coordinates case conference in RACF or community on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs
739	Organise & coordinate a case conference	$114.10	20 – 40 minutes. GP organises and coordinates case conference in RACF or community on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs
743	Organise & coordinate a case conference	$190.20	> 40 minutes. GP organises and coordinates case conference 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	$83.90	30 – 40 minutes. GP participates in a case conference in RACF or community or on discharge. For patients with a chronic or terminal condition complex, and multidisciplinary care needs
758	Participate in a case conference	$139.80	> 40 minutes. GP participates in a case conference in RACF or community or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs

Hunter Rural Division of General Practice
Growing with the needs of General Practice

HEALTH ASSESSMENTS

Effective November 2010

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Item	Name	$	Description / Recommended Frequency
701	Brief Health Assessment	$56.00	**< 30 minutes** a) Collection of relevant information, including taking a patient history; b) A basic physical examination; c) Initiating interventions and referrals as indicated; and d) Providing the patient with preventive health care advice and information. Incorporating: **Health Assessment - Healthy Kids Check** Once only health check, by GP, for children who have received or are receiving the 4 year old immunisation **Health Assessment - 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 3 years **Health Assessment - 45 - 49 Year Old** Once only health assessment for patients 45-49 years who are at risk of developing a chronic disease **Health Assessment - 75 Years and Older** Health assessment for patients aged 75 years and older. Once every 12 months **Health Assessment - Comprehensive Medical Assessment** Comprehensive Medical Assessment for permanent residents of Residential Aged Care Facilities. Available for new and existing residents. Not more than once yearly **Health Assessment for patient with an Intellectual Disability** Health assessment for patient with an Intellectual Disability. Not more than once yearly **Health Assessment 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). A desktop guide - Caring for Refugee Patients in General Practice is available on the RACGP website www.racgp.org.au
703	Standard Health Assessment	$130.10	**30 - 45 minutes** a) Detailed information collection, including taking a patient history; b) An extensive physical examination; c) Initiating interventions and referrals as indicated; and d) Providing a preventive health care strategy for the patient. Incorporating the Health Assessment categories listed in 701

Hunter Rural Division of General Practice
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HEALTH ASSESSMENTS

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705	Long Health Assessment	$179.45	**45 - 60 minutes** a) Comprehensive information collection, including taking a patient history; b) An extensive examination of the patient's medical condition and physical function; c) Initiating interventions and referrals as indicated; and d) Providing a basic preventive health care strategy for the patient. Incorporating the Health Assessment categories listed in 701
707	Prolonged Health Assessment	$253.60	**>60 minutes** a) Comprehensive information collection, including taking a patient history; b) An extensive examination of the patient's medical condition, and physical, psychological and social function; c) Initiating interventions and referrals as indicated; and d) Providing a comprehensive preventative health care management plan for the patient. Incorporating the Health Assessment categories listed in 701
715	ATSI Health Assessment	$200.20	**No designated time or complexity requirements** Incorporating: **ATSI Child Health Assessment** Health Assessment for ATSI patients 0 – 14 years old. Not available to in-patients of a hospital or RACF. Not more than once every 9 months **ATSI Adult Health Assessment** Health Assessment for ATSI patients 15 – 54 years old. Not available to in-patients of a hospital or RACF. Not more than once every 9 months **ATSI Health Assessment for an Older Person** Health Assessment for ATSI patients 55 years and over. Not available to in-patients of a hospital or RACF. Not more than once every 9 months
10986	Health Assessment – Healthy Kids Check by Nurse	$56.00	Once only health check for children who have received or are receiving the 4 year old immunisation

Hunter Rural Division of General Practice
Growing with the needs of General Practice

GP MENTAL HEALTH ITEM NUMBERS

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Mental Health			
Item	**Name**	**$**	**Description / Recommended Frequency**
2702	GP Mental Health Treatment Plan	$128.20	Prepared by a 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
2710	GP Mental Health Treatment Plan	$163.35	Prepared by a 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	$108.90	Plan should be reviewed after 1 – 6 months
2713	GP Mental Health Consultation	$71.85	Consult ≥ 20 mins for the ongoing management of a patient with mental disorder. No restriction on the number of these consultation per year
2721	GP Focussed Psychological Strategies	$87.50	30-40 mins. Provision of focussed psychological strategies by an appropriately rained and registered GP working in an accredited practice
2723	GP Focussed Psychological Strategies	$87.50 +$24.50 / no of pts seen – max 6	Out of surgery consultation. 30-40 mins. Provision of focussed psychological strategies by an appropriately trained and registered GP working in an accredited practice
2725	GP Focussed Psychological Strategies	$125.20	> 40 mins. Provision of focussed psychological strategies by an appropriately trained and register GP working in an accredited practice
2727	GP Focussed Psychological Strategies	$125.20 + $24.50 / no of pts seen – max 6	Out of surgery consultation. > 40 mins. Provision of focussed psychological strategies by an appropriately trained and registered GP working in an accredited practice
2702 / 2710	Access to Allied Psychological Services (ATAPS)	-	Free psychological services for: youth, health care card holders, low income earners, patients experiencing financial difficulties, patients with perinatal depression (antenatal and postnatal), culturally and linguistically diverse patients, Aboriginal and Torres Strait Islander patients and patients who are, or are at risk of homelessness. All GPs eligible to refer for 6 sessions + more if require. Complete and claim a GP Mental Health Treatment Plan (2702/2710) + ATAPS Referral Form

GP Support and Service Directories	
Don Stewart, Mental Health Nurse (Upper Hunter)	Contact Don Stewart at HRDGP on 02 4933 3824
Karen Harmon, Mental Health Nurse (Cessnock LGA)	Contact Karen Harmon at HRDGP on 02 4933 3824
GP Psych Support	Non-urgent psychiatric advice – www.psychsupport.com.au
Psychiatric Liaison Model	Non-urgent psychiatric advice – www.racgp.org.au/psychiatristdatabase

Hunter Rural Division of General Practice
Growing with the needs of General Practice

RESIDENTIAL AGED CARE FACILITY ITEM NUMBERS

Effective November 2010

For a comprehensive explanation of each MBS Item number please refer to the Medicare Benefits Schedule book or go to www.health.gov.au/mbsonline

Item	Name	$	Description / Recommended Frequency
701	Brief Health Assessment	$56.00	< 30 minutes - see MBS for complexity of care requirements Incorporating: **Health Assessment - Comprehensive Medical Assessment** Comprehensive Medical Assessment (CMA) for permanent residents of Residential Aged Care Facilities. Available for new and existing residents. Not more than once yearly
703	Standard Health Assessment	$130.10	30 - 45 minutes - see MBS for complexity of care requirements. Incorporating: **Health Assessment – CMA**
705	Long Health Assessment	$179.49	45 - 60 minutes - see MBS for complexity of care requirements. Incorporating: **Health Assessment – CMA**
707	Prolonged Health Assessment	$253.60	> 60 minutes - see MBS for complexity of care requirements. Incorporating: **Health Assessment – CMA**
731	GP Contribution to, or Review of, Multidisciplinary Care Plan prepared by RACF	$66.35	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 2 other health or care providers. Not more than once every 3 months
735	Organise and coordinate a case conference	$66.00	15 - 20 minutes. GP organises and coordinates 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	$114.10	20 - 40 minutes. GP organises and coordinates 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	$190.20	> 40 minutes. GP organises and coordinates 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	$48.95	15 - 20 minutes. GP participates in a case conference 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	$83.90	30 - 40 minutes. GP participates in a case conference 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	$139.80	> 40 minutes. GP participates in a case conference 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)	$99.95	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

RESIDENTIAL AGED CARE FACILITY ITEM NUMBERS

Effective November 2010

For a comprehensive explanation of each MBS Item number please refer to the Medicare Benefits Schedule book or go to www.health.gov.au/mbsonline

Health Assessment – Comprehensive Medical Assessment (CMA)
Item 701 / 703 / 705 / 707

A full systems review of a permanent resident in a Residential Aged Care Facility (RACF).

Activities:

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

CMA requires assessment of the resident's health and physical and psychological function, and must include:

- Obtain and record resident's consent
- Information collection, including taking patient history and undertaking or arranging examinations and investigations as required
- Making an overall assessment of the patient
- Recommending appropriate interventions
- Providing advice and information to the patient
- Keeping a record of the Health Assessment – CMA, and offering the patient a written report about the health assessment, with recommendations about matters covered by the Health Assessment – CMA
- Providing a written summary of the outcomes of the Health Assessment – CMA for the resident's records and to inform the provision of care for the resident by the RACF, and assist in the provision of Medical Management Review services for the resident.

GP Contribution to, or Review of, a Multidisciplinary Care Plan prepared by a Residential Aged Care Facility
Item 731

For patients in RACFs with a chronic or terminal condition and complex care needs requiring ongoing care from a team including the GP and at least 2 other health or care providers.

Involves GP contributing to, or reviewing, a Multidisciplinary Care Plan prepared by the RACF, at the request of the facility. The Plan must describe, at least, treatment and services to be provided to the patient by the collaborating providers.

Item number 731 enables Commonwealth funded patients who are classified as low care residents to receive 5 rebated allied health services per calendar year. The need for allied health services must be identified in the Care Plan.

Activities:

- Obtain and record the resident's consent
- Prepare part of the plan or amendments to the plan and add a copy to the patient's medical records; or
- Give advice to a person (e.g. Nursing staff in RACF) who prepares or reviews the plan, and record in writing, on the patient's medical records, any advice provided.

GP Multidisciplinary Case Conferences
Items 735 – 758

For patients in RACFs or the community or on discharge from hospital, with a chronic or terminal condition and complex care needs requiring ongoing care from a multidisciplinary case conference team including the GP and at least 2 other health or care providers. A carer can be included as a formal member of the team, but does not count towards the minimum 3 providers.

Activities:

Time based items 735 – 743 Organise and Coordinate requires:

- Obtain and record resident's consent
- Record meeting details including date, start and end time, location, participants names, all matters discussed and identified by team
- Discuss outcomes with patient and carer and offer a summary of the conference to them and team members
- Keep record in the patient's medical file

Time based items 747 – 758 Participation requires:

- Above activities excluding discussion of outcomes with patient/carer and offering summary to patient/carer and team members.

Residential Medication Management Review (RMMR)
Item 903

For permanent residents (new or existing) of RACFs. A RMMR is a review of medications, in collaboration with pharmacist, for patients at risk of medication related misadventure or for whom quality use of medicines may be an issue.

Activities:

- Obtain and record resident's consent
- Collaborate with reviewing pharmacist
- Provide input from the resident's CMA or relevant clinical information for RMMR and resident's records
- Participate in post-review discussion with pharmacist (unless exceptions apply) regarding the findings, medication management strategies, issues, implementation, follow up and outcomes
- Develop and/or revise Medication Management Plan and finalise plan after discussion with resident
- Offer copy of Medication Management Plan to resident/carer, provide copy for resident's records and for Nursing staff of RACF, discuss plan with Nursing staff, if necessary.

DIABETES ANNUAL CYCLE OF CARE - SIP FLOW CHART

Effective November 2010

For a comprehensive explanation of each MBS Item number refer to the Medicare Benefits Schedule Book or go to www.health.gov.au/mbsonline

Ensure Practice Eligibility

Only accredited and PIP registered practices may claim the SIP

Care Requirements

This item certifies that the minimum requirements of the annual cycle of care have been completed.

Claim SIP item in place of usual attendance item

Eligibility Criteria

No age restrictions for patients

Patients with established Diabetes Mellitus

For patients in the community and in Residential Aged Care Facilities

Essential Clinical Documentation Requirements

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

Essential Requirements

6 Monthly:

Measure height, weight and calculate BMI

Measure BP

Examine feet

Yearly:

Measure HbA1c, 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 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 surg.***	***Out surg.***	***SIP***	***Rebate***
Diabetes SIP - Standard Consult (Level B)	11-13 monthly	2517	2518	$40.00	+ Level B
Diabetes SIP - Long Consult (Level C)	11-13 monthly	2521	2522	$40.00	+ Level C
Diabetes SIP - Prolonged Consult (Level D)	11-13 monthly	2525	2526	$40.00	+ Level D

MBS item 10991 (Bulk Billing Incentive) may also be claimed for eligible patients

ASTHMA ANNUAL CYCLE OF CARE - SIP FLOW CHART

Effective November 2010

For a comprehensive explanation of each MBS Item number refer to the Medicare Benefits Schedule Book or go to www.health.gov.au/mbsonline

Ensure Practice Eligibility

Only accredited and PIP registered practices may claim the SIP

Note: A specialist consultation does not constitute one of the two visits – both must be with the same GP or in exceptional circumstances with another GP from the same practice

Claim SIP item in place of usual attendance item

Eligibility Criteria

No age restrictions for patients

Patients with moderate to severe asthma

Available to patients in the community and in Residential Aged Care Facilities

Essential Requirements

At least 2 asthma consultations within 12 months

One of the consultations must be for a Review

Review must be planned during previous consultation

Clinical Content

Explain Cycle of Care process and gain patient's consent

Diagnosis and assessment of level of asthma control and severity

Review us of and access to asthma-related medication and devices

Give patient 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)

Provide patient self-management education

Review of written or documented Asthma Action Plan

Essential Documentation Requirements

Record patient's consent to Cycle of Care

Document diagnosis and assessment of level of asthma control and severity

Include documentation of the above requirements and clinical content in the patient file, including clinical content of the patient-held written Asthma Action Plan

Claiming

Available to GPs in accredited practices, registered for the Asthma SIP

All elements of the service must be completed to claim

Only paid once every 12 months

		MBS Item			
Name	***Frequency***	***In surg.***	***Out surg.***	***SIP***	***Rebate***
Asthma SIP - Standard Consult (Level B)	12 monthly	2546	2547	$100.00	+ Level B
Asthma SIP - Long Consult (Level C)	12 monthly	2552	2553	$100.00	+ Level C
Asthma SIP - Prolonged Consult (Level D)	12 monthly	2558	2559	$100.00	+ Level D

MBS item 10991 (Bulk Billing Incentive) may also be claimed for eligible patients

HEALTH ASSESSMENT – 75 Years and Older

Item 701 / 703 / 705 / 707

Effective November 2010

For a comprehensive explanation of each MBS Item number refer to the Medicare Benefits Schedule Book or go to www.health.gov.au/mbsonline

Establish a patient register and recall when due for assessment

↓

Perform Health Assessment

Allow 45-90 minutes

Nurse may collect information. GP must see patient

↓

Complete Documentation

↓

Claim MBS Item

Eligibility Criteria

Patients aged 75 years and older

Patient 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, 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 the 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 element of the service must be completed to claim

Requires personal attendance by GP with patient

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

MBS item 10991 (Bulk Billing Incentive) may also be claimed for eligible patients

HEALTH ASSESSMENT – HEALTHY KIDS CHECK

Items 701 / 703 / 705 / 707 & 10986

Effective November 2010

For a comprehensive explanation of each MBS Item number refer to the Medicare Benefits Schedule Book or go to www.health.gov.au/mbsonline

Ensure eligibility & obtain patient consent

Perform Health Check

Document Relevant Information

Identify health concerns & arrange referrals

Claim MBS Item

Eligibility Criteria

Children at least 3 and less than 5 years

Children who have not previously had a health assessment

Children who are receiving their 4 year old immunisation

Clinical Content

Mandatory:

Explain Health Assessment process and gain parent's/carer's consent

Information collection – take patient history and undertake or arrange examinations and investigations as required

Overall assessment of patient

Recommend appropriate interventions

Provide advice and information e.g. 'Get Set 4 Life' booklet

Physical examinations and assessment: height and weight (plot and interpret growth curve/calculate BMI), eyesight, hearing, oral health (teeth and gums), toileting and allergies

Non-Mandatory:

Discuss: eating habits, physical activity, speech and language development, fine and gross motor skills, behaviour and mood

Other examinations considered necessary by GP/Practice Nurse

Essential Documentation Requirements

Record parent's/carer's consent to Health Assessment

Record that 4 year old immunisation was given

Record whether 'Get Set 4 Life' booklet was provided

Record the Health Assessment and offer the parent/carer a copy

Update parent-held child health record

Claiming

All elements of the service must be completed to claim 701/703/705/707 (GP) or 10986 (PN)

Can claim item 10993 (PN immunisation) on the same day as 701/703/705/707 (GP) or 10986 (PN)

MBS Item	*Name*	*Aged Range*	*Recommended Frequency*
701/703/705/707	Health Assessment – Healthy Kids Check by GP	3-4 years	Once only
10986	Health Assessment – Healthy Kids Check by PN	3-4 years	Once only

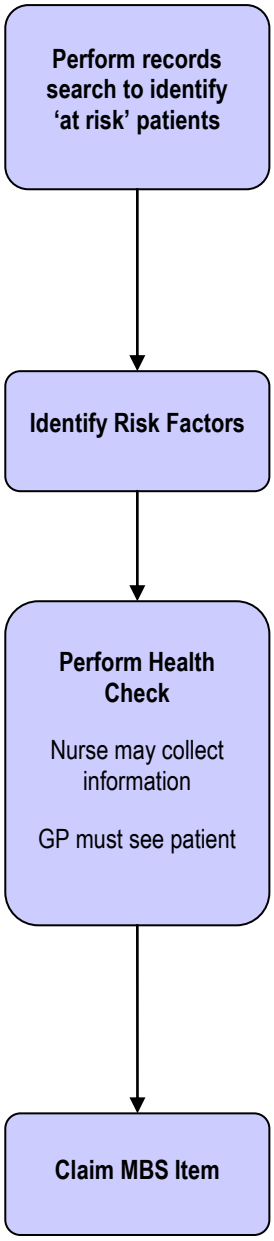
MBS item 10991 (Bulk Billing Incentive) may also be claimed for eligible patients

HEALTH ASSESSMENT – TYPE 2 DIABETES RISK EVALUATION

Items 701 / 703 / 705 / 707

Effective November 2010

For a comprehensive explanation of each MBS Item number refer to the Medicare Benefits Schedule Book or go to www.health.gov.au/mbsonline



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 the 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, including referral to the subsidised Lifestyle Modification Program and follow-up relating to the management of any risk factors identified

Providing 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

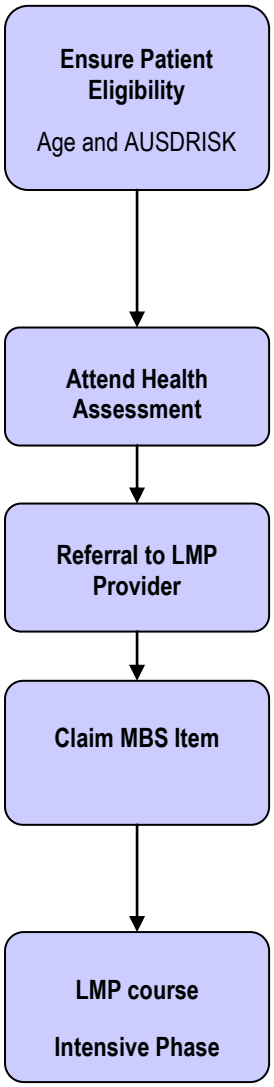
MBS Item	*Name*	*Age Range*	*Recommended Frequency*
701/703/705/707	Health Assessment – Type 2 Diabetes Risk Evaluation	40-49 years	Once every 3 years

MBS item 10991 (Bulk Billing Incentive) may also be claimed for eligible patients

SUBSIDISED LIFESTYLE MODIFICATION PROGRAM TO REDUCE THE RISK OF TYPE 2 DIABETES

Effective November 2010

For a comprehensive explanation of each MBS Item number refer to the Medicare Benefits Schedule Book or go to www.health.gov.au/mbsonline



Eligibility Criteria

Non – ATSI patients aged 40 to 49 years inclusive – MBS item 701, 703, 705 or 707

ATSI patients aged 15 to 54 years inclusive – MBS item 715

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

GP must exclude diabetes

Patient should be able to tolerate moderate physical activity

Referral

Gain patient consent and fax completed Lifestyle Modification Program (LMP) GP Referral Form to LMP Provider

LMP provider will contact the patient to advise of next available course

Patient makes co-payment of $50 (waived for health care and concession card holders)

Patient Participates in LMP

Course provided by accredited allied health professional (e.g. Diabetes Educator, Exercise Physiologist, Physiotherapist, Dietician) over 4 months

LMP course covers: education regarding the risks of diabetes, nutrition and exercise, goal setting and staying motivated; and includes an individualised exercise plan

Follow-up and Reporting

Two months after completion of intensive phase, a follow-up session is conducted

LMP provider will report patient outcome data to GPs on completion of the LMP

MBS Item	*Name*	*Age Range*	*Recommended Frequency*
715	Aboriginal / Torres Strait Islander Adult Health Check	15-54 yrs	Minimum 9monthly
701/703/705/707	Health Assessments (annotated Type 2 Diabetes Risk Evaluation)	40-49 yrs	Once every 3 years
701/703/705/707	Health Assessments (annotated 45-49yr old heath assessment for people at risk of chronic disease)	40-49 yrs	Once only
23	Consulting at consultation room Level B (If referral not taken up within 2 months by the patient – must be annotated with the original item number claimed when the original referral was written)		

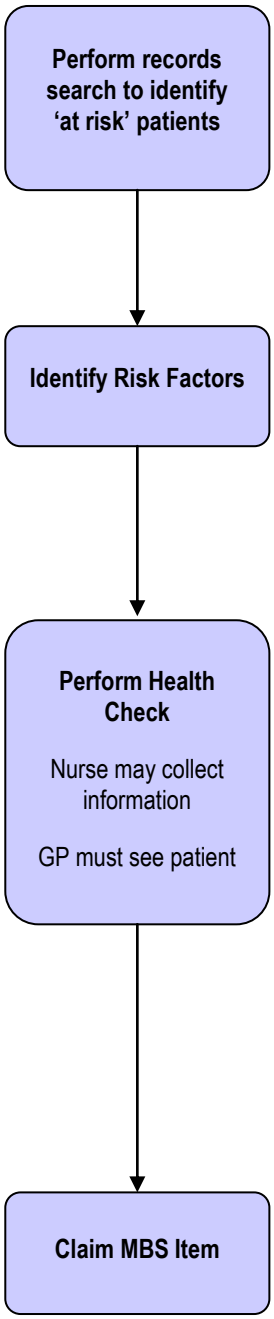
MBS item 10991 (Bulk Billing Incentive) may also be claimed for eligible patients

HEALTH ASSESSMENT – 45 – 49 Year Old

Items 701 / 703 / 705 / 707

Effective November 2010

For a comprehensive explanation of each MBS Item number refer to the Medicare Benefits Schedule Book or go to www.health.gov.au/mbsonline



Eligibility Criteria

Patients aged 45 to 49 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, 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, 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

Requires personal attendance by GP with patient

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

MBS item 10991 (Bulk Billing Incentive) may also be claimed for eligible patients

GP MENTAL HEALTH TREATMENT PLAN & REVIEW

Item 2702 / 2710 & 2712

Effective November 2010

For a comprehensive explanation of each MBS Item number refer to the Medicare Benefits Schedule Book or go to www.health.gov.au/mbsonline

2702 – Prepared by a GP who has not undertaken Mental Health Skills Training

2710 – Prepared by a GP who has undertaken Mental Health Skills Training

Ensure Patient Eligibility

Eligibility Criteria

- No age restrictions for patients
- Patients with a mental disorder, excluding dementia, delirium, tobacco use disorder and mental retardation
- Patients who will benefit from a structured approach to their treatment
- Not for patients in a hospital or a Residential Aged Care Facility

Develop Plan

Only a specialist Mental Health Nurse may assist in the development of the plan

Clinical Content

- Explain steps involved, possible out of pocket costs and gain patient's consent
- Relevant history – biological, psychological, social and presenting complaint
- Mental state examination, assessment of risk and co-morbidity, diagnosis of mental disorder and/or formulation
- Outcome measurement tool score (e.g. K10), unless clinically inappropriate
- Provide 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

Complete Documentation

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

Claim MBS Item

Claiming

- All elements of the service must be completed to claim
- Requires personal attendance by GP with patient
- Review using 2712 at least once during the life of the plan
- Claiming a 2702 / 2710 enables patients to receive 12 rebated individual and 12 group psychology services per calendar year

MBS Item	*Name*	*Recommended Frequency*
2702 / 2710	GP Mental Health Treatment Plan	Not more than once yearly

GP MENTAL HEALTH TREATMENT PLAN & REVIEW

Item 2702 / 2710 & 2712

Effective May 2010

For a comprehensive explanation of each MBS Item number refer to the Medicare Benefits Schedule Book or go to www.health.gov.au/mbsonline

2712 – Review of a GP Mental Health Treatment Plan

Reviewing the Plan

Only a specialist Mental Health Nurse may assist in the reviewing of the plan

Clinical Content

- Explain steps involved, possible out of pocket costs and gain patient's consent
- Review patient's progress against goals outlined in the GP Mental Health Treatment Plan
- Check, reinforce and expand psycho-education
- Plan for crisis intervention and/or relapse prevention, if appropriate and if not previously provided
- Re-administer the outcome measurement tool used when developing the GP Mental Health Treatment Plan (item 2702/2710), except where considered clinically inappropriate

Complete Documentation

Essential Documentation Requirements

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

Claim MBS Item

Claiming

- All elements of the service must be completed to claim
- Requires personal attendance by GP with patient
- Item 2712 should be claimed at least once over the life of the GP Mental Health Treatment Plan
- Claiming a 2712 enables patients to receive a second set of 6 rebated individual and group psychology services
- A review can be claimed 1-6 months after completion of the GP Mental Health Treatment Plan
- If required, and additional review can be performed 3 months after the first review

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

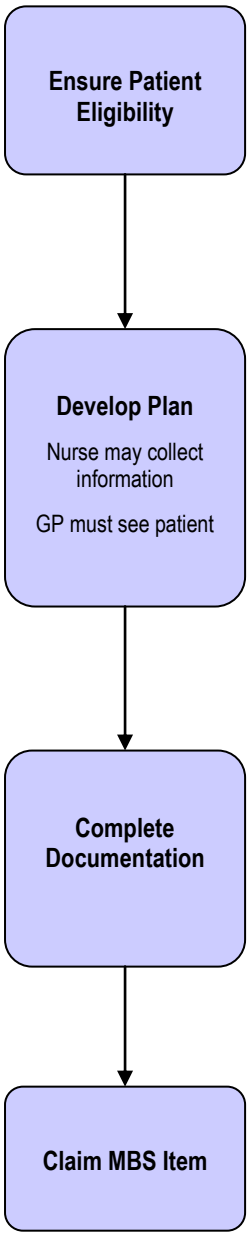
MBS item 10991 (Bulk Billing Incentive) may also be claimed for eligible patients

GP MANAGEMENT PLANS, TEAM CARE ARRANGEMENTS AND REVIEWS

Effective November 2010

For a comprehensive explanation of each MBS Item number refer to the Medicare Benefits Schedule Book or go to www.health.gov.au/mbsonline

GP MANAGEMENT PLAN (GPMP) – ITEM 721



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 2702 / 2710) 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 action to be taken by the patient
- Identify treatments and services required
- Arrangements for providing the treatments and services
- Review using item 732 at least once over the life of the plan

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, keep copy in patient file (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

MBS item	*Name*	*Recommended Frequency*
721	GP Management Plan	2 Yearly (Min. 12 Monthly)

MBS item 10991 (Bulk Billing Incentive) may also be claimed for eligible patients

GP MANAGEMENT PLANS, TEAM CARE ARRANGEMENTS AND REVIEWS

Effective November 2009

For a comprehensive explanation of each MBS Item number refer to the Medicare Benefits Schedule Book or go to www.health.gov.au/mbsonline

TEAM CARE ARRANGEMENT (TCA) – ITEM 723

Ensure Patient Eligibility

Develop TCA

Nurse may collect information and collaborate with providers.

GP must see patient

Complete Documentation

Claim MBS Item

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

Collaborate with 2 collaborating providers and obtain feedback on treatments/services they will provide to achieve patient goals

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 GPMP and TCA enables patients to receive 5 rebated services from allied health and a range of dental services over 2 consecutive calendar years

MBS item	*Name*	*Recommended Frequency*
723	Team Care Arrangement	2 Yearly (Min. 12 Monthly)

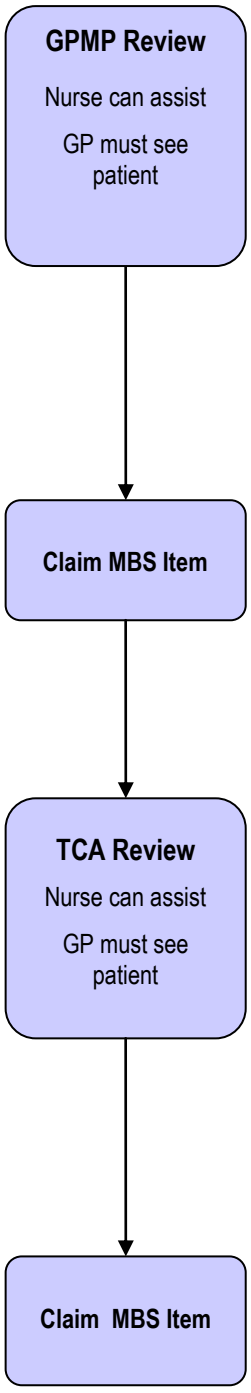
MBS item 10991 (Bulk Billing Incentive) may also be claimed for eligible patients

GP MANAGEMENT PLANS, TEAM CARE ARRANGEMENTS AND REVIEWS

Effective May 2010

For a comprehensive explanation of each MBS Item number refer to the Medicare Benefits Schedule Book or go to www.health.gov.au/mbsonline

REVIEWING A GP MANAGEMENT PLAN (GPMP) AND/OR TEAM CARE ARRANGEMENT (TCA) – ITEM 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 the 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 2 collaborating providers to review all matters in plan

Essential 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 the 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 (min. 3 monthly)

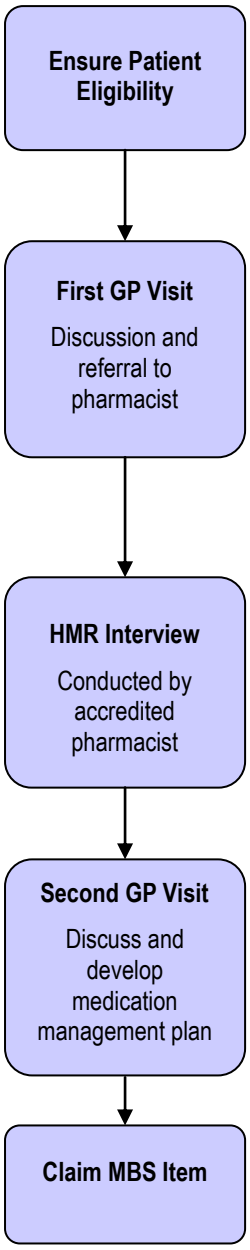
MBS item 10991 (Bulk Billing Incentive) may also be claimed for eligible patients

HOME MEDICINES REVIEW (HMR) – ITEM 900

Also known as Domiciliary Medication Management Review (DMMR)

Effective November 2010

For a comprehensive explanation of each MBS Item number refer to the Medicare Benefits Schedule Book or go to www.health.gov.au/mbsonline



Eligibility Criteria

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

Not for patients in a hospital or Residential Aged Care Facility

Initial VisitK

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

Gain and record patient's consent to HMR

Patient must choose pharmacy

Inform patient of need to return for second visit

Complete HMR referral and sent to patient's preferred pharmacy

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 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

MBS item	*Name*	*Recommended Frequency*
900	Home Medicine Review	Once every 12 months

MBS item 10991 (Bulk Billing Incentive) may also be claimed for eligible patients

Hunter Rural Division of General Practice
Growing with the needs of General Practice

HOME MEDICINES REVIEW (HMR) – ITEM 900

Also known as Domiciliary Medication Management Review (DMMR)

Effective November 2010

For a comprehensive explanation of each MBS Item number refer to the Medicare Benefits Schedule Book or go to www.health.gov.au/mbsonline

An HMR should generally be undertaken by the medical practitioner, or a medical practitioner working in the medical practice, that has provided the majority of services to the patient over the previous 12 months and /or will provide the majority of services to the patient over the coming 12 months.

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

A medical practitioner must assess that a DMMR is clinically necessary to ensure quality use of medicines or address patient's needs. Examples of risk factors known to predispose people to medication related adverse events are:

- Currently taking 5 or more regular medications
- Taking more than 12 doses of medication per day
- Significant changes made to medication treatment regimen in the last 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 difference doctors, both general practitioners and specialists
- Recent discharge from a facility/hospital (in the last 4 weeks)

The process of referral to a community pharmacy includes:

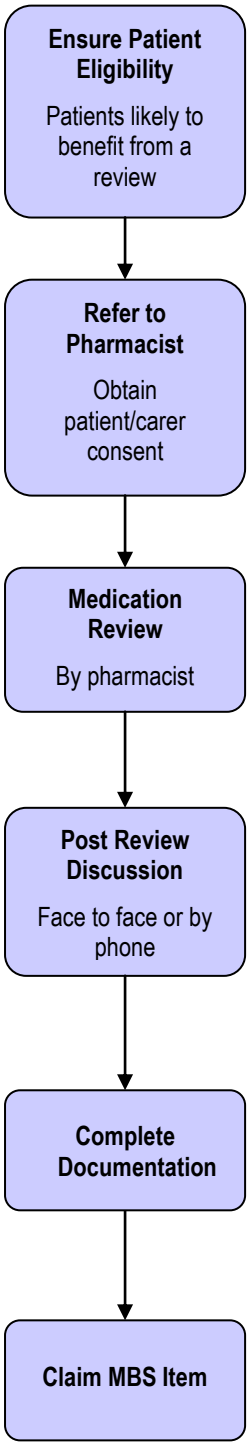
- Obtaining consent from the patient, consistent with normal clinical practice, for a pharmacist to undertake the MMR and for a charge to be incurred for the service for which a Medicare rebate is payable. The patient must be clearly informed of the purpose and possible outcomes of the DMMR, the process involved (including that the pharmacist will visit the patient at home, unless the patient prefers another location or other exceptional circumstances apply), what information will be provided to the pharmacist as part of the DMMR, and any additional costs that may be incurred
- Provision to the patient's preferred community pharmacy, of relevant clinical information, by the medical practitioner for each individual patient, covering the patient's diagnosis, relevant rest results and medication history, and current prescribed medications
- A DMMR referral form is available for this purpose, if this form is not used the medical practitioner must provide patient details and relevant clinical information to the patient's preferred community pharmacy

The discussion of the review findings and report including suggested medication management strategies with the reviewing pharmacist includes receiving a written report from the reviewing pharmacists, discussing the relevant findings and suggested management strategies with the pharmacist (either by phone or face to face) and developing a summary of the relevant review findings as part of the draft medication management plan.

RESIDENTIAL MEDICATION MANAGEMENT REVIEW (RMMR) – Item 903

Effective November 2010

For a comprehensive explanation of each MBS Item number refer to the Medicare Benefits Schedule Book or go to www.health.gov.au/mbsonline



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 respite 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 arrangement do not apply to RMMRs

MBS item	*Name*	*Recommended Frequency*
903	Residential Medication Management Review	As required (min. 12 months)

MBS item 10991 (Bulk Billing Incentive) may also be claimed for eligible patients

Hunter Rural Division of General Practice
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SYSTEMATIC CARE CLAIMING RULES

Effective November 2010

For a comprehensive explanation of each MBS Item number refer to the Medicare Benefits Schedule Book or go to www.health.gov.au/mbsonline

Legend MBS Item Numbers

	No claiming restrictions		
721	GP Management Plan (GPMP)	**2517**	Diabetes Annual Cycle of Care SIP
723	Team Care Arrangement (TCA)	**2546**	Asthma Cycle of Care SIP
732	Review of GPMP and/or TCA	**2702 / 2710**	GP Mental Health Treatment Plan
900	Home Medication Review	**2712**	Review of GP Mental Health Treatment Plan

MONTHS UNTIL NEXT CLAIM FOR SERVICE

*721	24		6			12		
*723		24	6					
**732	6	6	6		3	3		
900				12				
†2517			3		11-13			
††2546	12		3			12		
2702/2710							12	1
§2712							1	3
MBS Item Numbers	*721	*723	**732	900	†2517	††2546	2702/ 2710	§2712

Additional Claiming Rules

***721 & 723** Recommend claiming period 24 months, minimum claiming period 12 months

****732** Recommended claiming period 6 months, minimum claiming period 3 months. Can be claimed twice on the same day if review of both GPMP and TCA are completed, in this case the patient invoice and Medicare claim should be annotated

†2517 Recommended not to be claimed within 3 months of Review Item 732, as services overlap

††2546 Recommended not to be claimed within 12 months of claiming Item 721 alone, as services significantly overlap. Can be claimed on the same day if both 721 and 723 are completed, as the patient has multidisciplinary care needs. Recommended not to be claimed within 3 months of Review Item 732, as services overlap

§2712 Review recommended 1 month – 6 months after 2702 / 2710, with not more than 2 reviews in a 12 month period

Notes Where a service is provided earlier than minimum claiming periods the patient invoice and Medicare claim should be annotated. For example; clinically indicated/required, hospital discharge, exceptional circumstances, significant change.

Standard consultations, health assessments, care plans and medication reviews should not be claimed on the same day. If provided on the same day the patient invoice and Medicare claim should be annotated, for example; clinically indicated/required, separate service

PRACTICE INCENTIVE PAYMENTS (PIP) AND SERVICE INCENTIVE PAYMENTS (SIP) SUMMARY

Effective November 2010

ITEM	ACTIVITY	ITEM NUMBER & TYPE OF CONSULT	PIP ($ per SWPE)	SIP ($ per patient)	Notes	PIP ENQUIRY LINE: 1800 222032
DIABETES	Patient register and recall / reminder system	N/A	$1.00 (Approx. $1,000 per FTE GP)		One-off payment only. Practice must be registered for PIP. Incentive payable with quarterly PIP payments.	
	Annual cycle of care for patients with Diabetes	Level B – 2517 or 2518 Level C – 2521 or 2522 Level D – 2525 or 2526		$40 per Diabetic patient	These item numbers should be used in place of the usual attendance items, when a consultation completes the minimum annual requirements of care.	
	Outcomes payment	N/A	$20 per Diabetic patient, per annum		Payment only made to practices that have a **min. of 2%** of their patient population as diagnosed diabetics. Payment made practices where **20%** of diabetes patients have a completed Annual Cycle of Care.	
ASTHMA	Sign-on payment	N/A	$0.25 (Approx. $250 per FTE GP)		One-off payment only. Practice must be registered for PIP. Incentive payable with quarterly PIP payments.	
	Asthma Cycle of Care	Level B – 2546 or 2547 Level C – 2552 or 2553 Level D – 2558 or 2559		$100 per patient, per annum 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.	
CERVICAL SCREENING	Sign-on payment	N/A	$0.25 (Approx. $250 per FTE GP)		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 4 years	Level A – 2497 Level B – 2501 or 2503 Level C – 2504 or 2506 Level D – 2507 or 2509 PN – 10995 or 10999		$35 per patient	These MBS items must be used instead of the standard consultation items, in order to be eligible for this payment. PN – Practice Nurse item numbers	
	Outcomes payment	N/A	$3.00 per female WPE aged between 20 and 69, per annum		Payment is made to the practices where a minimum of 50% of women aged between 20 and 69 yrs inclusive have been screened in the past 30 months *(paid on a quarterly basis)*.	
IMMUNISATION	Completing an age-appropriate immunisation schedule	N/A		$6.00 ACIR Information Payment	A Notification Payment of $6 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	
	Outcomes payment	N/A	$3.50 per WPE		$3.50 for age-appropriate immunisation rate 90% and over. Practices must register with the General Practice Immunisation Incentive (GPII) Program. **GPII Enquiry Line:** 1800 246101 or www.medicareaustralia.gov.au/gpii	

PRACTICE INCENTIVE PAYMENTS (PIP) AND SERVICE INCENTIVE PAYMENTS (SIP) SUMMARY

Effective November 2010

ITEM	ACTIVITY	PIP ($ per SWPE)	Notes	PIP ENQUIRY LINE: 1800 222032
e-HEALTH	**Requirement 1:** Secure messaging capability	$6.50 per SWPE, per annum	To qualify practices must meet **each** of the requirements: **Requirement 1:** Practices must have a secure messaging capability. The eligible secure messaging suppliers list is available at the National e-Health Transition Authority (NEHTA) website www.nehta.gov.au/pip-vendors	
	Requirement 2: PKI location / site certificates for the practice and an individual PKI certificate for each practitioner working at the practice		**Requirement 2:** Each practice must have a location / site Public Key Infrastructure (PKI) certificate **and** each medical practitioner working at the practice must have an individual PKI certificate. Application forms are available at the Medicare website www.medicareaustralia.gov.au/pkiforms	
	Requirement 3: Access to key electronic clinical resources		**Requirement 3:** At least **one** key electronic clinical resource from **each** of the categories in table 1 of the e-Health Incentive Guidelines and at least **three** electronic resources from **any** of the categories in table 2. Please refer to the e-Health Incentive Guidelines released by the Practice Incentives Program of visit the PIP website www.medicareaustralia.gov.au/pip	
AFTER HOURS CARE	**Tier 1:** Ensuring patients have access to 24-hour care, including access to out-of-hours visits (at home, in a residential aged care facility and in hospital).	$2.00 per SWPE, per annum	'After Hours' refers to any time outside 8am to 6pm weekdays and 8am to 12noon on Saturday.	
	Tier 2: Practices with 2,000 SWPEs or less must cover at least 10 hours per week of their after-hours care arrangements. Practices with more than 2,000 SWPEs must cover at least 15 hours per week of their after-hours care arrangements.		Practices must meet 'Tier 1' requirements. This is in **addition** to 'Tier 1' payment. This arrangement must be for **all** patients. This may include participation in a co-operative roster system to provide after-hours care with other practitioners in the practice area.	
	Tier 3: The practice provides 24-hour, 7 day a week care from within the practice including out-of-hours visits (at home, in a residential aged care facility and in hospital).		**All** after hours care must be provided to **all** patients from **within** the practice. The use of a deputising service of participation in a co-operative roster system does not count towards this tier. General Practices participation in co-operative arrangements are not eligible for Tier 3 as practice GPs are not usually providing after-hours cover for the patients for the **entire** after-hours period. This is in **addition** to 'Tier 1 & 2 payments.	
QUALITY PRESCRIBING	Practice participation in quality use of medicines programs, endorsed by the National Prescribing Service.	$1.00 per SWPE	This incentive is to assist practices in keeping up to date with information on the quality use of medicines. Payment will only be made if the **practice** meets a minimum participation level, set at an average of three activities per FTE GP per year.	
PRACTICE NURSE	Practice employs or retains the services of a practice nurse and are located in an urban area of workforce shortage	RRMA's 1-2: $8.00 RRMA's 3-7: $7.00 per SWPE	Contact the Division for further information, including which suburbs are eligible for the payment. The Practice Nurse is required to work a minimum number of sessions per week depending on the SWPE of the practice.	
TEACHING	Teaching of medical students	$100.00 per session	Payments are made to practices that host university medical student placements. Maximum 2 sessions per day.	

PRACTICE INCENTIVE PAYMENTS (PIP) AND SERVICE INCENTIVE PAYMENTS (SIP) SUMMARY

Effective November 2010

ITEM	ACTIVITY	PIP ($ per SWPE)	Notes	PIP ENQUIRY LINE: 1800 222032
RURAL LOADING	Practices participating in the PIP with a main practice location situated outside capital cities and other major metropolitan centres are automatically paid a rural loading. The rural loading recognises the difficulties of providing care, often with little professional support, in rural and remote areas. The PIP rural loading is higher for practices in more remote areas, in recognition of the added difficulties of providing medical care.	Calculated by multiplying the practice's PIP payments by a percentage loading. The loading is not applied to SIPs or payments through the GPII	No application necessary. The rural loading is automatically applied by Medicare Australia to the PIP payments of rural practices. To be eligible for the PIP rural loading the practice must participate in the PIP and the main practice location must be in an eligible rural or remote area i.e. RRMA 3-7 To query your practice RRMA classification, email pip@medicareaustralia.gov.au or phone 1800 222 032	
DOMESTIC VIOLENCE	Aims to encourage general practices in rural and remote areas to act as a referral point for people experiencing domestic violence. **Requirements:** Registered Nurses (RN), Enrolled Nurses (EN) or Aboriginal Health Workers (AHW) who have completed the certified training from Lifeline and are currently working in a general practice that fits the criteria as being in RRMA 3-7	Payment of $1 per SWPE per annum, capped at $4000 per annum. Payments are made by Medicare Australia to eligible practices as part of each quarterly PIP payment	Contact the division for further information, including which suburbs are eligible for the payment. The PN, EN or AHW is required to work a minimum number of sessions per week depending on the SWPE of the practice. To enquire about Domestic Violence training contact Lifeline Australia on 6215 9400 or email national@lifeline.org.au	
PROCEDURAL GP PAYMENT	**Tier 1:** A GP must provide at least one procedural service as follows: Obstetric delivery, General anaesthetic, major regional blocks or Abdominal surgery, gynaecological surgery requiring general anaesthetic, endoscopy	$2,000 per annum	Practice must participate in the PIP. At least one GP from the practice must provide one or more of the procedural services as described in the definition of a procedural GP. The main practice location must be in an eligible rural or remote area (RRMA) 3-7. A rural loading, which varied according to the location of the practice, is automatically applied to the procedural payments.	
	Tier 2: A GP must meet Tier 1 requirements and provide after hours procedural services on a regular rostered basis	$4,000 per annum		
	Tier 3: A GP must meet the Tier 2 requirements and provide 50 or more eligible surgical and / or anaesthetic and / or obstetric services per year	$10,000 per annum		
	Tier 4: A GP must meet the Tier 2 requirements and deliver 20 or more babies a year. Exceptional circumstances apply	$17,000 per annum		

PRACTICE INCENTIVE PAYMENTS (PIP) AND SERVICE INCENTIVE PAYMENTS (SIP) SUMMARY

Effective November 2010

ITEM	ACTIVITY	PIP	SIP	Notes	PIP ENQUIRY LINE: 1800 222032
AGED CARE ACCESS INITIATIVE	**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		$1,000	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. Maximum payment a GP can receive in one financial year is $2500.	
	Tier 2: GP completes the QSL 2 – 140 MBS services in RACF claimed in a financial year		$1,500		
INDIGENOUS HEALTH	Provision of better health care for Indigenous patients, including best practice management of chronic disease. Sign on payment	$1000		One-off payment only. Practice must be registered for PIP. Practice: - Seeks consent to register their Aboriginal and/or Torres Strait Islander (ATSI) 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 ATSI 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 - Undertakes cultural awareness training within 12 months of joining incentive - Annotates PBS prescriptions for eligible ATSI patient for the PBS Co-payment	
	Annual patient registration payments	$250 per registered ATSI patient, per calendar year		Practice registers their eligible ATSI patients with Medicare for the PIP Indigenous Health Incentive or PBS Co-payment Measure. Practice must actively plan and manage care of their ATSI patients with chronic disease for a calendar year. Payment made to practice for each ATSI patient who: - Is aged 15 years or over - Has a chronic disease - Has had (or has been offered) the 715 ATSI Health Assessment - Has provided informed consent to be registered for the PIP Indigenous Health Incentive The patient's 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	$100 per registered patient, per calendar year		Payment made to practice that (in a calendar year): 1. Develop a 721 GPMP or 723 TCA for the patient and undertake at least one 732 Review of the GPMP or TCA, or 2. Undertake two 732 Reviews of GPMP or TCA, or 3. Complete 732 contribute to, or review, a care plan for a patient in a RACF, on two occasions	
	Tier 2 Outcomes payment: Total Patient Care	$150 per registered patient, per calendar year		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	

SWPE = Standardised Whole Patient Equivalent

Source: Medicare Australia www.medicareaustralia.gov.au/pip

DATA CLEANING –

PATIENT HEALTH INFORMATION MANAGEMENT

Archive patient health information for patients who have not attended the practice for more than three (3) years.
In your clinical software package these patients are marked in-active and can be re-activated or accessed if required.

Patients who are deceased, and the practice has been notified, can be archived.

The patient health record is still stored for at least seven (7) years.

In your clinical software package these patients are marked 'deceased' and can be viewed or 'revived' if required.

Destruction of Medical Records:

Cull patient health records of patients who have not been seen for more than seven (7) years.

In your clinical software package these patients remain inactive and can be accessed if required.

The Privacy Act requires personal health information to be destroyed or permanently de-identified once it is no longer needed for any authorised use or disclosure under the legislation. In the case of patient health information collected for the purpose of providing medical advice or treatment, it may be appropriate to retain this information indefinitely so that it is available, if necessary, to assist with the patient's future diagnosis and treatment.

At the very least, it is recommended that individual patient health records be retained for a minimum of seven (7) years from the date of last contact, or until the patient has reached the age of 25 years, whichever is the longer.

The practice must also ensure that inactive patient health information/records are kept and stored securely. An inactive patient health record is a record of a patient who has not attended the practice for more than two (2) years.

It is acceptable to store such records in the main filing system where space permits, although culling may be recommended for efficient management of information. It is recommended that inactive patient health records are retained by the practice indefinitely, or as stipulated by relevant state or territory legislation.

** RACGP Standards for General Practice 3rd Edition*

Hunter Rural Division of General Practice
Growing with the needs of General Practice

IMMUNISATION REMINDERS

RECALLS & REMINDERS WORK FOR GP PRACTICES & THE COMMUNITY

Successful immunisation programs have a positive impact on the health of our community.

Sending out reminder letters to your patients due for immunisation can improve your immunisation rates and increase your GPII outcome bonus payments.

The outcomes bonus payment is earned every quarter if your coverage rate is at least 90%, and your WPE is at least 10. It is calculated by multiplying the WPE by $3.50.

To register for GPII call 1800 222 032

GP/Nurse puts patient reminder on clinical system

↓

Staff generate reminder list using clinical systems recall tool eg once per month

↓

Staff generate mail merge using immunisation reminder letter template

↓

Reminder letters posted out

NSW Immunisation Schedule from 1 July 2007

CHILDHOOD VACCINES

Birth (Maternity Units)	Hepatitis B	H-B-VAX II
2 Months	Diphtheria, Tetanus, Pertussis, Haemophilus influenza type B (Hib) Hep B, Polio,	INFANRIX HEXA
	Pneumococcal	PREVENAR
	Rotavirus	ROTARIX
	(Children born on/after 1 May 2007)	
4 Months	Diphtheria, Tetanus, Pertussis, Haemophilus influenza type B (Hib) Hep B, Polio,	INFANRIX HEXA
	Pneumococcal	PREVENAR
	Rotavirus	ROTARIX
	(Children born on/after 1 May 2007)	
6 Months	Diphtheria, Tetanus, Pertussis, Haemophilus influenza type B (Hib) Hep B, Polio,	INFANRIX HEXA
	Pneumococcal	PREVENAR
***12 Months**	Measles, Mumps, Rubella	PRIORIX
	Haemophilus influenza type B (Hib)	HIBERIX
	Meningococcal C	MENINGITEC
18 Months	Varicella (Chicken pox)	VARILRIX
***4 years**	Diphtheria, Tetanus, Pertussis, Polio	INFANRIX-IPV
	Measles, Mumps, Rubella	PRIORIX

ADOLESCENT VACCINES

12 years	Hepatitis B	H-B-VAX II
	Varicella (Chicken Pox) (School based	VARILRIX
	Human Papillomavirus Program)	GARDISIL
15 years	Diphtheria, Tetanus, Pertussis	BOOSTRIX

ADULT VACCINES

50 years and over (Aboriginal only)	Influenza	INFLUENZA
	Pneumococcal	PNEUMOVAX 23
65 years and over	Influenza	INFLUENZA
	Pneumococcal	PNEUMOVAX 23

*Refer to the current edition of The Australian Immunisation Handbook for vaccination of children with underlying conditions.

2011 WorkCover Rates for General Practitioners

WorkCover Payment Classification System Information – Professional Medical Services

Payment Classification Code	Type of Service	Service Description	Fee
AA010	Level A Consultation	AMA codes must be used for all consultations and medical services. The rate for consultation fee applies for services on or after 1 January 2011. GST should not be charged on the consultation fee. For further information on the criteria for Level A, B, C & D services, please consult the AMA *List of Medical Services and Fees*. Out-of-hours fees are only payable for emergency attendance of a worker at a time when the practice is not usually open.	$ 32.50
AA020	Level B Consultation		$ 66.00
AA030	Level C Consultation		$ 122.00
AA040	Level D Consultation		$ 186.00
WCO001	Medical Certificate	Initial medical certificate only One certification fee may be charged for the initial certificate only. No fee is payable for subsequent certificates. To order medical certificates phone: *WorkCover Publications Hotline* **13 10 50**	$20.00 (plus GST)
WCO002	Case Conference	Time based fee paid to medical practitioner for additional workers compensation services, such as discussions with insurers, injury management consultants, rehabilitation providers or employers. This rate can also be used when requested by an insurer to prepare a report on an injured worker with respect to injury management. Reports will not be prepaid in whole or part. Reports are to be provided within 10 working days unless a different timeframe has been agreed upon between the parties. Doctors should maintain records of conferences, including the person spoken to, details of discussions and duration of the discussion. Discussions with treating physiotherapists or surgeons etc are not to be invoiced as additional items, as these are considered part of normal medical practice.	$19.50/ 5 minutes (plus GST) *($234.00 per hour plus GST)*
WCO004	Other Medical Items	The cost of all bandages and dressings etc.	Cost price
PHS001	Pharmaceutical Services	Payments for pharmaceutical services e.g. vaccinations.	Cost price
WCO005	Medical Records	Fee for providing copies of medical records (including treating general practitioner or specialist notes and reports)	$30 (for 33 pages or less). An additional $1.00 per page if more than 33 pages.

Hunter Rural Division of General Practice
Growing with the needs of General Practice

DESKTOP GUIDE TO PROCEDURAL ITEM NUMBERS

Effective November 2010

For a comprehensive explanation of each MBS Item number refer to the Medicare Benefits Schedule Book or go to www.health.gov.au/mbsonline

MBS	SERVICE OR PROCEDURE	MEDICARE BENEFIT SCHEDULE		
		100% GOV.	85% REBATE	75% HOSP.
	DISLOCATIONS			
47018	ELBOW, treatment of dislocation of, by closed reduction	$190.10	$161.60	$142.60
47036	INTERPHALANGEAL JOINT, treatment of dislocation of, by closed reduction	$81.55	$69.35	$61.20
47000	MANDIBLE, treatment of dislocation of, by closed reduction	$68.00	$57.80	$51.00
47042	METACARPOPHALANGEAL JOINT, treatment of dislocation of, by closed reduction	$108.60	$92.35	$81.45
47057	PATELLA, treatment of dislocation of, by closed reduction	$122.20	$103.90	$91.65
47024	RADIOULNAR JOINT, DISTAL or PROXIMAL, treatment of dislocation of, by closed reduction, not being a service associated with fracture or dislocation in the same region	$190.10	$161.60	$142.60
47015	SHOULDER, treatment of dislocation of, not requiring general anaesthesia	$81.55	$69.35	$61.20
47069	TOE, treatment of dislocation of, by closed reduction	$68.00	$57.80	$51.00
	FRACTURES			
47354	CARPAL SCAPHOID, treatment of fracture of, not being a service to which item 47357 applies	$163.10	$138.65	$122.35
47348	CARPUS (excluding scaphoid), treatment of fracture of, not being a service to which item 47351 applies	$90.45	$76.90	$67.85
47462	CLAVICLE, treatment of fracture of, not being a service to which item 47465 applies	$108.60	$92.35	$81.45
47516	FEMUR, treatment of fracture of, by closed reduction or traction	$416.55	$354.10	$312.45
47576	FIBULA, treatment of fracture of	$108.60	$92.35	$81.45
47444	HUMERUS, shaft of, treatment of fracture of, not being a service to which item 47447 or 47450 applies	$217.45	$184.85	$163.10

DESKTOP GUIDE TO PROCEDURAL ITEM NUMBERS

Effective November 2010

For a comprehensive explanation of each MBS Item number refer to the Medicare Benefits Schedule Book or go to www.health.gov.au/mbsonline

47336	METACARPAL, treatment of fracture of, by closed reduction	$163.10	$138.65	$122.35
47339	METACARPAL, treatment of intra-articular fracture of, by closed reduction	$190.10	$161.60	$142.60
47633	METATARSAL, 1 of, treatment of fracture of	$108.60	$92.35	$81.45
47636	METATARSAL, 1 of, treatment of fracture of, by closed reduction	$163.10	$138.65	$122.35
47579	PATELLA, treatment of fracture of, not being a service to which item 47582 or 47585 applies	$153.95	$130.90	$115.50
47324	PROXIMAL PHALANX OF FINGER OR THUMB, treatment of fracture of, by closed reduction	$163.10	$138.65	$122.35
47312	MIDDLE PHALANX of FINGER, treatment of fracture of, by closed reduction	$122.20	$103.90	$91.65
47300	DISTAL PHALANX of FINGER or THUMB, treatment of fracture of, by closed reduction, including percutaneous fixation where used	$81.55	$69.35	$61.20
47663	PHALANX OF GREAT TOE, treatment of fracture of, by closed reduction	$135.90	$115.55	$101.95
47369	RADIUS, distal end of, treatment of Colles', Smith's or Barton's fracture of, by cast immobilisation, not being a service to which item 47372 or 47375 applies	$163.10	$138.65	$122.35
47372	RADIUS, distal end of, treatment of Colles', Smith's or Barton's fracture, by closed reduction	$271.65	$230.95	$203.75
47360	RADIUS OR ULNA, distal end of, treatment of fracture of, by cast immobilisation, not being a service to which item 47363 or 47366 applies	$126.85	$107.85	$95.15
47363	RADIUS OR ULNA, distal end of, treatment of fracture of, by closed reduction	$190.10	$161.60	$142.60
47543	TIBIA, plateau of, treatment of medial or lateral fracture of, not being a service to which item 47546 or 47549 applies	$217.45	$184.85	$163.10
47546	TIBIA, plateau of, treatment of medial or lateral fracture of, by closed reduction	$326.05	$277.15	$244.55
47561	TIBIA, shaft of, treatment of fracture of, by cast immobilisation, not being a service to which item 47564, 47567, 47570 or 47573 applies	$262.60	$223.25	$196.95

47564	TIBIA, shaft of, treatment of fracture of, by closed reduction, with or without treatment of fibular fracture	$394.00	$334.90	$295.50
	OBSTETRICS			
16500	ANTENATAL ATTENDANCE	$45.35	$38.55	$34.05
16508	PREGNANCY COMPLICATED BY acute intercurrent infection, intrauterine growth retardation, threatened premature labour with ruptured membranes or threatened premature labour treated by intravenous therapy, requiring admission to hospital - each attendance that is not a routine antenatal attendance, to a maximum of 1 visit per day	$45.35	$38.55	$34.05
16504	TREATMENT OF HABITUAL MISCARRIAGE by injection of hormones each injection up to a maximum of 12 injections, where the injection is not administered during a routine antenatal attendance	$45.35	$38.55	$34.05
16502	POLYHYDRAMNIOS, UNSTABLE LIE, MULTIPLE PREGNANCY, PREGNANCY COMPLICATED BY DIABETES OR ANAEMIA, THREATENED PREMATURE LABOUR treated by bed rest only or oral medication, requiring admission to hospital each attendance that is not a routine antenatal attendance, to a maximum of 1 visit per day	$45.35	$38.55	$34.05
16509	PREECLAMPSIA, ECLAMPSIA OR ANTEPARTUM HAEMORRHAGE, treatment of each attendance that is not a routine antenatal attendance	$45.35	$38.55	$34.05
16505	THREATENED ABORTION, THREATENED MISCARRIAGE OR HYPEREMESIS GRAVIDARUM, requiring admission to hospital, treatment of each attendance that is not a routine antenatal attendance	$43.35	$38.55	$34.05
16519	MANAGEMENT OF LABOUR and delivery by any means (including Caesarean section) including post-partum care for 5 days	$667.65	$596.45	$500.75

16522	MANAGEMENT OF LABOUR AND DELIVERY, or delivery alone, (including Caesarean section), where in the course of antenatal supervision or intrapartum management 1 or more of the following conditions is present, including postnatal care for 7 days: - multiple pregnancy; - recurrent antepartum haemorrhage from 20 weeks gestation; - grades 2, 3 or 4 placenta praevia; - baby with a birth weight less than or equal to 2500gm; - pre-existing diabetes mellitus dependent on medication, or gestational diabetes requiring at least daily blood glucose monitoring; - trial of vaginal delivery in a patient with uterine scar, or trial of vaginal breech delivery; 140/90mm Hg associated with at least 1+ proteinuria on urinalysis; - prolonged labour greater than 12 hours with partogram evidence of abnormal cervimetric progress; - fetal distress defined by significant cardiotocograph or scalp pH abnormalities requiring immediate delivery; OR - conditions that pose a significant risk of maternal death.	$1,567.60	$1,496.40	$1,175.70
16518	MANAGEMENT OF LABOUR, incomplete, where the patient's care has been transferred to another medical practitioner for completion of the delivery	$433.60	$368.60	$325.20
16515	MANAGEMENT OF VAGINAL DELIVERY as an independent procedure where the patient's care has been transferred by another medical practitioner for management of the delivery and the attending medical practitioner has not provided antenatal care to the patient, including all attendances related to the delivery	$433.60	$368.60	$325.20
16564	EVACUATION OF RETAINED PRODUCTS OF CONCEPTION (placenta, membranes or mole) as a complication of confinement, with or without curettage of the uterus, as an independent procedure	$209.75	$178.30	$157.35
16567	MANAGEMENT OF POSTPARTUM HAEMORRHAGE by special measures such as packing of uterus, as an independent procedure	$306.70	$260.70	$230.05

16573	THIRD DEGREE TEAR, involving anal sphincter muscles and rectal mucosa, repair of, as an independent procedure	$249.95	$212.50	$187.50
	OPERATIONS			
30219	HAEMATOMA, FURUNCLE, SMALL ABSCESS OR SIMILAR LESION not requiring admission to a hospital - INCISION WITH DRAINAGE OF (excluding aftercare)	$26.30	$22.40	$19.75
32142	ANAL SKIN TAGS or ANAL POLYPS, excision of 1 or more of	$64.95	$55.25	$48.75
51300	Assistance at any operation identified by the word "Assist." for which the fee does not exceed $537.15 or at a series or combination of operations identified by the word "Assist." where the fee for the series or combination of operations identified by the word "Assist." does not exceed $537.15	$83.05	$70.60	$62.30
51306	Assistance at a delivery involving Caesarean section	$119.95	$102.00	$90.00
30074	DIAGNOSTIC BIOPSY OF LYMPH GLAND, MUSCLE OR OTHER DEEP TISSUE OR ORGAN, as an independent procedure, where the biopsy specimen is sent for pathological examination	$113.10	$96.15	$84.85
30071	DIAGNOSTIC BIOPSY OF SKIN OR MUCOUS MEMBRANE, as an independent procedure, where the biopsy specimen is sent for pathological examination	$50.25	$42.75	$37.70
30653	CIRCUMCISION of a male UNDER 6 MONTHS of age	$44.75	$38.05	$33.60
30656	CIRCUMCISION of a male UNDER 10 YEARS of age but not less than 6 months of age	$104.05	$88.45	$78.85
30659	CIRCUMCISION of a male 10 YEARS OF AGE OR OVER	$144.05	$122.45	$108.05
46513	DIGITAL NAIL OF FINGER OR THUMB, removal of, not being a service to which item 46516 applies	$54.35	$46.20	$40.80
47904	DIGITAL NAIL OF TOE, removal of, not being a service to which item 47906 applies	$54.35	$46.20	$40.80
46420	EXTENSOR TENDON OF HAND OR WRIST, primary repair of, each tendon	$196.85	$167.35	$147.65
30067	FOREIGN BODY IN MUSCLE, TENDON OR OTHER DEEP TISSUE, removal of, as an independent procedure	$215.15	$182.90	$161.40

DESKTOP GUIDE TO PROCEDURAL ITEM NUMBERS

Effective November 2010

For a comprehensive explanation of each MBS Item number refer to the Medicare Benefits Schedule Book or go to www.health.gov.au/mbsonline

41500	EAR, foreign body (other than ventilating tube) in, removal of, other than by simple syringing	$79.35	$67.45	$59.55
41659	NOSE, removal of FOREIGN BODY IN, other than by simple probing	$74.60	$63.45	$55.95
30064	SUBCUTANEOUS FOREIGN BODY, removal of, requiring incision and exploration, including closure of wound if performed, as an independent procedure	$105.75	$89.90	$79.35
30061	SUPERFICIAL FOREIGN BODY, REMOVAL OF, (including from cornea or sclera), as an independent procedure	$22.60	$19.25	$16.95
30052	FULL THICKNESS LACERATION OF EAR, EYELID, NOSE OR LIP, repair of, with accurate apposition of each layer of tissue	$244.35	$207.70	$183.30
30216	HAEMATOMA, aspiration of	$26.30	$22.40	$19.75
32135	HAEMORRHOIDS OR RECTAL PROLAPSE rubber band ligation of, with or without sclerotherapy, cryotherapy or infra-red therapy for	$64.95	$55.25	$48.75
47915	INGROWING NAIL OF TOE, wedge resection for, including removal of segment of nail, ungual fold and portion of the nail bed	$163.10	$138.65	$122.35
42575	TARSAL CYST, extirpation of	$79.60	$67.70	$59.70
46513	DIGITAL NAIL OF FINGER OR THUMB, removal of, not being a service to which item 46516 applies	$54.35	$46.20	$40.80
47904	DIGITAL NAIL OF TOE, removal of, not being a service to which item 47906 applies	$54.35	$46.20	$40.80
30195	BENIGN NEOPLASM OF SKIN, other than viral verrucae (common warts) seborrheic keratosis, cysts and skin tags, treatment by electrosurgical destruction, simple curettage or shave excision, or laser photocoagulation, not being a service to which item 30196, 30197, 30202, 30203 or 30205 applies (1 or more lesions)	$60.10	$51.95	$45.85
32147	PERIANAL THROMBOSIS, incision of	$43.40	$36.90	$32.55
30186	PALMAR OR PLANTAR WARTS (less than 10), definitive removal of, excluding ablative methods alone, not being a service to which item 30185 or 30187 applies	$45.65	$38.85	$34.25
30099	SINUS, excision of, involving superficial tissue only	$86.55	$73.60	$64.95

DESKTOP GUIDE TO PROCEDURAL ITEM NUMBERS

Effective November 2010

For a comprehensive explanation of each MBS Item number refer to the Medicare Benefits Schedule Book or go to www.health.gov.au/mbsonline

45400	FREE GRAFTING (split skin) of a granulating area, small	$196.95	$167.45	$147.75
45200	SINGLE STAGE LOCAL FLAP, where indicated to repair 1 defect, simple and small, excluding flap for male pattern baldness and excluding H-flap or double advancement flap	$273.60	$232.60	$205.20
30219	HAEMATOMA, FURUNCLE, SMALL ABSCESS OR SIMILAR LESION not requiring admission to a hospital - INCISION WITH DRAINAGE OF (excluding aftercare)	$26.30	$22.40	$19.75
30213	TELANGIECTASES OR STARBURST VESSELS on the head or neck where lesions are visible from 4 metres, diathermy or sclerosant injection of, including associated consultation - limited to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - for a session of at least 20 minutes duration	$105.65	$89.85	$79.25
47915	INGROWING NAIL OF TOE, wedge resection for, including removal of segment of nail, ungual fold and portion of the nail bed	$163.10	$138.65	$122.35
	PATHOLOGY OR DIAGNOSTIC TESTS			
13839	ARTERIAL PUNCTURE and collection of blood for diagnostic purposes	$22.15	$18.85	$16.65
11700	TWELVE-LEAD ELECTROCARDIOGRAPHY, tracing and report	$30.05	$25.55	$22.55
73806	Pregnancy test by 1 or more immunochemical methods	$10.20	$8.70	$7.65
12000	SKIN SENSITIVITY TESTING for allergens, USING 1 TO 20 ALLERGENS, not being a service associated with a service to which item 12012, 12015, 12018 or 12021 applies	$37.45	$31.85	$28.10
11506	MEASUREMENT OF RESPIRATORY FUNCTION involving a permanently recorded tracing performed before and after inhalation of bronchodilator - each occasion at which 1 or more such tests are performed	$19.75	$16.80	$14.85
73805	Microscopy of urine, whether stained or not, or catalase test	$4.60	$3.95	$6.45

Hunter Rural Division of General Practice
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DESKTOP GUIDE TO PROCEDURAL ITEM NUMBERS

Effective November 2010

For a comprehensive explanation of each MBS Item number refer to the Medicare Benefits Schedule Book or go to www.health.gov.au/mbsonline

	PROCEDURES			
36800	BLADDER, catheterisation of, where no other procedure is performed	$26.55	$22.60	$19.95
13706	ADMINISTRATION OF BLOOD or bone marrow already collected	$80.20	$68.20	$60.15
30003	LOCALISED BURNS, dressing of, (not involving grafting) each attendance at which the procedure is performed, including any associated consultation	$34.90	$29.70	$26.20
30006	EXTENSIVE BURNS, dressing of, without anaesthesia (not involving grafting) each attendance at which the procedure is performed, including any associated consultation	$44.75	$38.05	$33.60
14200	GASTRIC LAVAGE in the treatment of ingested poison	$57.55	$48.95	$43.20
14206	HORMONE OR LIVING TISSUE IMPLANTATION by cannula	$34.25	$29.15	$25.70
14203	HORMONE OR LIVING TISSUE IMPLANTATION, by direct implantation involving incision and suture	$49.20	$41.85	$36.90
30628	HYDROCELE, tapping of	$34.25	$29.15	$25.70
35503	INTRAUTERINE CONTRACEPTIVE DEVICE, INTRODUCTION OF, not being a service associated with a service to which another item in this Group applies	$51.50	$43.80	$38.65
37415	PENIS, injection of, for the investigation and treatment of impotence - 2 services only in a period of 36 consecutive months	$44.85	$38.15	$33.65
32072	SIGMOIDOSCOPIC EXAMINATION (with rigid sigmoid scope), with or without biopsy	$46.05	$39.15	$34.55
30207	SKIN LESIONS, multiple injections with hydrocortisone or similar preparations	$42.90	$36.50	$32.20

DESKTOP GUIDE TO PROCEDURAL ITEM NUMBERS

Effective November 2010

For a comprehensive explanation of each MBS Item number refer to the Medicare Benefits Schedule Book or go to www.health.gov.au/mbsonline

	SUTURES			
30026	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, small (NOT MORE THAN 7 CM LONG), superficial, not being a service to which another item in Group T4 applies	$50.25	$42.75	$37.70
30029	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, small (NOT MORE THAN 7 CM LONG), involving deeper tissue, not being a service to which another item in Group T4 applies	$86.55	$73.60	$64.95
30038	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, large (MORE THAN 7 CM LONG), superficial, not being a service to which another item in Group T4 applies	$86.55	$73.60	$64.95
30041	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, large (MORE THAN 7 CM LONG), involving deeper tissue, not being a service to which another item in Group T4 applies	$138.55	$117.80	$103.95
30032	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, small (NOT MORE THAN 7 CM LONG), superficial	$79.35	$67.45	$59.55
30035	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, small (NOT MORE THAN 7 CM LONG), involving deeper tissue	$113.10	$96.15	$84.85
30045	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, large (MORE THAN 7 CM LONG), superficial	$113.10	$96.15	$84.85
30048	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, large (MORE THAN 7 CM LONG), involving deeper tissue	$144.05	$122.45	$108.05

DESKTOP GUIDE TO PROCEDURAL ITEM NUMBERS

Effective November 2010

For a comprehensive explanation of each MBS Item number refer to the Medicare Benefits Schedule Book or go to www.health.gov.au/mbsonline

	SKIN LESIONS / BUMPS / LUMPS			
31255	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from nose, eyelid, lip, ear, digit or genitalia, tumour size up to and including 10mm in diameter -** where removal is by therapeutic **surgical excision (other than by shave excision) and suture and *where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination***	$212.95	$181.05	$159.75
31250	GIANT HAIRY or COMPOUND NAEVUS, excision of an area at least 1 percent of body surface ***where the specimen excised is sent for histological confirmation of diagnosis***	$355.00	$301.75	$266.25
31285	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from areas of the body not covered by items *31260* and *31270*, tumour size more than 10mm and up to and including 20mm in diameter** and where removal is by therapeutic **surgical excision (other than by shave excision) and suture, *where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination***	$204.90	$174.20	$153.70
31270	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from face, neck, (anterior to the sternomastoid muscles) or lower leg (mid-calf to ankle), tumour size more than 10mm and up to and including 20mm in diameter** and where removal is by therapeutic **surgical excision (other than by shave excision) and suture, *where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination***	$248.50	$211.25	$186.40
31275	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from face, neck (anterior to the sternomastoid muscles) or lower leg (mid-calf to ankle), tumour size more than 20mm in diameter** and where removal is by **therapeutic surgical excision (other than by shave excision) and suture, *where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination***	$287.90	$244.75	$215.85

DESKTOP GUIDE TO PROCEDURAL ITEM NUMBERS

Effective November 2010

For a comprehensive explanation of each MBS Item number refer to the Medicare Benefits Schedule Book or go to www.health.gov.au/mbsonline

31280	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from areas of the body not covered by items *31255* and *31265*, tumour size up to and including 10mm in diameter** and where removal is by therapeutic **surgical excision (other than by shave excision) and suture, *where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination***	$149.95	$127.50	$112.50
31285	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from areas of the body not covered by items *31260* and *31270*, tumour size more than 10mm and up to and including 20mm in diameter** and where removal is by therapeutic **surgical excision (other than by shave excision) and suture, *where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination***	$204.90	$194.20	$153.70
31290	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from areas of the body not covered by items *31260* and *31275*, tumour size more than 20mm in diameter** and where removal is by **therapeutic surgical excision (other than by shave excision) and suture, *where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination***	$236.55	$201.10	$177.45
31350	BENIGN TUMOUR of SOFT TISSUE, excluding tumours of skin, cartilage, and bone, simple lipomas covered by item 31345 and lipomata, removal of by **surgical excision**, ***where the specimen excised is sent for histological confirmation of diagnosis***, not being a service to which another item in this Group applies	$416.90	$354.40	$312.70
30106	GANGLION OR SMALL BURSA, excision of, not being a service associated with a service to which another item in this Group applies	$149.50	$127.10	$112.15
31345	LIPOMA, removal of by surgical excision or liposuction, where lesion is subcutaneous and **50mm or more in diameter**, or is sub-fascial, ***where the specimen is sent for histological confirmation of diagnosis***	$202.95	$172.55	$152.25

31200	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach to an operation), **removal by surgical excision (other than shave excision) and suture from cutaneous or subcutaneous tissue or from mucous membrane,** not being a service associated with a service to which item 45200, 45203 or 45206 applies and not being a service to which another item in this Group applies	$32.70	$27.80	$24.55
31205	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), **lesion size up to and including 10mm in diameter**, **removal by surgical excision (other than by shave excision) and suture from cutaneous or subcutaneous tissue or from mucous membrane, *including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335, ***where the specimen excised is sent for histological examination*** (not being a service to which item 30195 applies)	$91.80	$78.05	$68.85
31310	MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from face, neck (anterior to sternomastoid muscles) or lower leg (mid - calf to ankle) tumour size up to and including 10mm in diameter** and where removal is by **definitive surgical excision (as defined above and in the explanatory notes to this category) and suture, *where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained***	$268.10	$227.90	$201.10
31215	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), **lesion size more than 20mm in diameter, removal by surgical excision (other than by shave excision) and suture from cutaneous or subcutaneous tissue or from mucous membrane, *including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335, ***where the specimen excised is sent for histological examination*** (not being a service to which item 30195 applies)	$138.10	$117.40	$103.60

31320	MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from face, neck (anterior to sternomastoid muscles) or lower leg (mid calf to ankle) tumour size more than 20mm in diameter** and where removal is by **definitive surgical excision (as defined above and in the explanatory notes to this category) and suture, *where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained***	$378.60	$321.85	$283.95
31325	MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from areas of the body not covered by items *31300* and *31310* - tumour size up to and including 10mm in diameter** and where removal is by **definitive surgical excision (as defined above and in the explanatory notes to this category) and suture, *where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained***	$260.30	$221.30	$195.25
31330	MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from areas of the body not covered by items *31305* and *31310* - tumour size more than 10mm and up to and including 20mm in diameter** and where removal is by **definitive surgical excision (as defined above and in the explanatory notes to this category) and suture, *where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained***	$307.80	$261.65	$230.85
31335	MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from areas of the body not covered by items *31305* and *31320* - tumour size more than 20mm in diameter** and where removal is by **definitive surgical excision (as defined above and in the explanatory notes to this category) and suture, *where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained***	$355.00	$301.75	$266.25
30185	PALMAR OR PLANTAR WARTS (10 or more), definitive removal of, excluding ablative methods alone, not being a service to which item 30186 or 30187 applies	$175.60	$131.70	$149.30

31205	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), **lesion size up to and including 10mm in diameter**, **removal by surgical excision (other than by shave excision) and suture from cutaneous or subcutaneous tissue or from mucous membrane, *including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335, ***where the specimen excised is sent for histological examination*** (not being a service to which item 30195 applies)	$91.80	$78.05	$68.85
31210	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), **lesion size more than 10mm and up to and including 20mm in diameter, removal by surgical excision (other than by shave excision) and suture from cutaneous or subcutaneous tissue or from mucous membrane, *including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335, ***where the specimen excised is sent for histological examination*** (not being a service to which item 30195 applies)	$118.45	$100.70	$88.85
31215	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), **lesion size more than 20mm in diameter, removal by surgical excision (other than by shave excision) and suture from cutaneous or subcutaneous tissue or from mucous membrane, *including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335, ***where the specimen excised is sent for histological examination*** (not being a service to which item 30195 applies)	$138.10	$117.40	$103.60
31230	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), **removal by surgical excision (other than by shave excision) and suture from nose, eyelid, lip, ear, digit or genitalia, *including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335 - ***where the specimen excised is sent for histological examination*** (not being a service to which item 30195 applies)	$161.65	$137.45	$121.25

31235	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), **removal by surgical excision (other than by shave excision) and suture from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), *including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335, **lesion size up to and including 10mm in diameter** - ***where the specimen excised is sent for histological examination*** (not being a service to which item 30195 applies)	$138.10	$117.40	$103.60
31240	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), **removal by surgical excision (other than by shave excision) and suture from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), *including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335, **lesion size more than 10mm in diameter** - ***where the specimen excised is sent for histological examination*** (not being a service to which item 30195 applies)	$161.65	$137.45	$121.25