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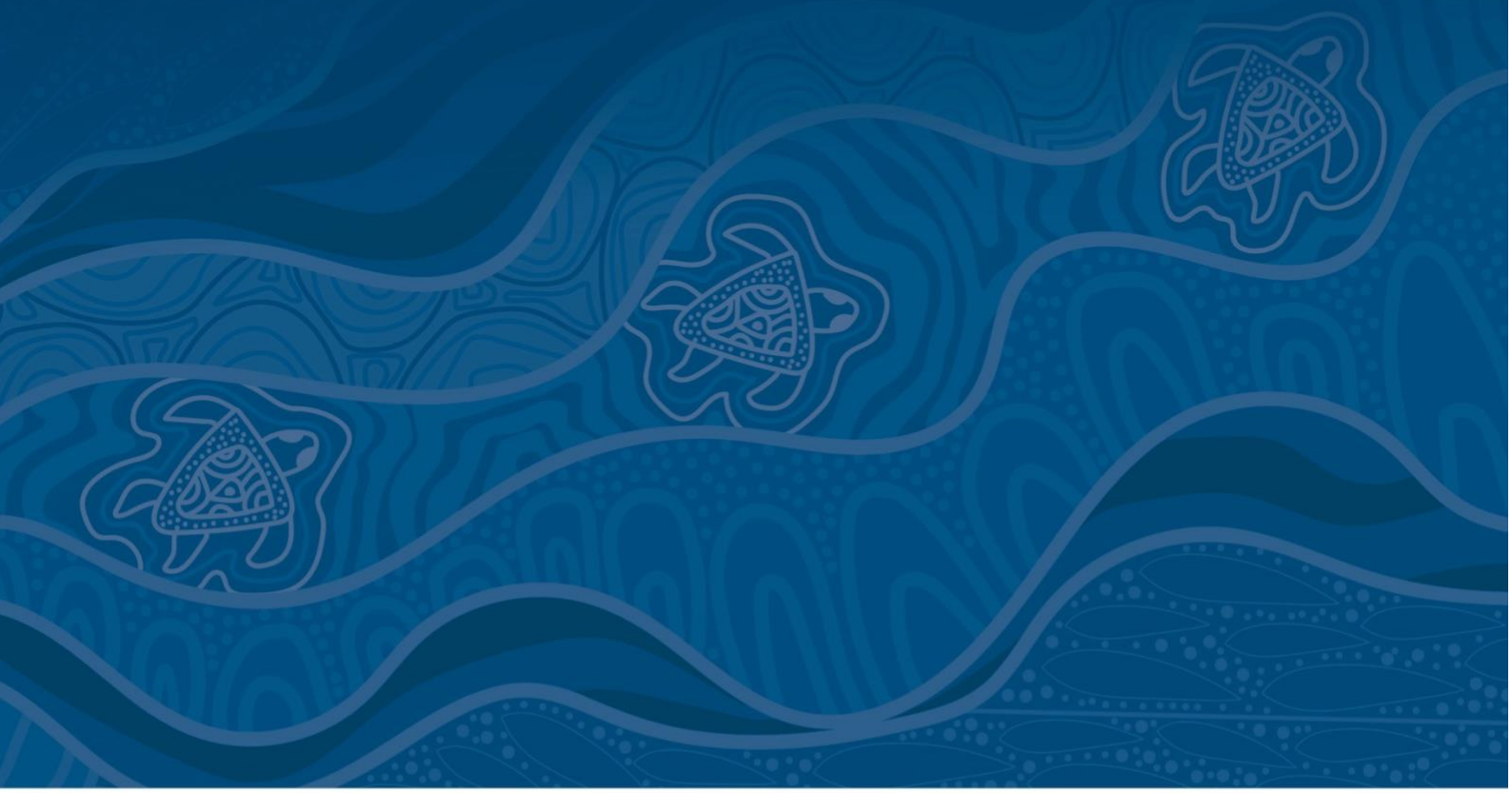
An Australian Government Initiative

DESKTOP GUIDE TO MBS ITEM NUMBERS

Funding pathways for general practices and Aboriginal Community Controlled Health Organisations

September 2024



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Introduction

This guide outlines the most used MBS item numbers in primary care and aims to assist with the correct use when claiming MBS item numbers. Each item number in this guide contains a link which provides item number criteria and fact sheets. Also included is an outline of practice incentive payments and useful flow charts.

Quick links

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

For a comprehensive explanation of each MBS Item number, refer to Medicare Benefits Schedule online: www.health.gov.au/mbsonline

For an Excel spreadsheet to calculate MBS Item numbers, go to the Murray PHN calculator:
Murray PHN MBS item number calculator

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Table of contents

Consultation item numbers

Item	Name	Benefit	Description / recommended frequency
3	Level A	$19.60	Short - see MBS for complexity of care requirements.
23	Level B	$42.85	<6min - <20 min - see MBS for complexity of care requirements.
36	Level C	$82.90	≥20 min - see MBS for complexity of care requirements.
44	Level D	$118.00	≥40 min - see MBS for complexity of care requirements.
123	Level E	$197.90	≥60 min - see MBS for complexity of care requirements.
160	Prolonged Consult	$252.40	Professional attendance by a general practitioner, for a period of not less than 1 hour but less than 2 hours on a patient in imminent danger of death.
161	Prolonged Consult	$420.55	Professional attendance by a general practitioner, for a period of not less than 2 hours but less than 3 hours on a patient in imminent danger of death.

After hours item numbers

Item	Name	Benefit	Description / recommended frequency
5000	Level A - short	$33.00	Professional attendance by a general practitioner, before 8am, after 8pm on any day. After 1pm Saturday, all day Sunday and Public Holidays.
5020	Level B - >6min and <20min	$55.80	Professional attendance by a general practitioner, before 8am, after 8pm on any day. After 1pm Saturday, all day Sunday and Public Holidays.
5040	Level C - >20mins and <40mins	$95.70	Professional attendance by a general practitioner, before 8am, after 8pm on any day. After 1pm Saturday, all day Sunday and Public Holidays.
5060	Level D - <40 and <60mins	$134.20	Professional attendance by a general practitioner, before 8am, after 8pm on any day. After 1pm Saturday, all day Sunday and Public Holidays.
5071	Level E- >60mins	$227.95	Professional attendance by a general practitioner, before 8am, after 8pm on any day. After 1pm Saturday, all day Sunday and Public Holidays.

Home visits

Item	Name	Benefit	Description / recommended frequency
24	Home Visit - Level B	$72.85	Professional attendance by a general practitioner, lasting at least 6 minutes and less than 20 minutes in a home or hospital.
37	Home Visit - Level C	$112.90	Professional attendance by a general practitioner, lasting at least 20 minutes and less than 40 minutes in a home or hospital.
47	Home Visit - Level D	$152.15	Professional attendance by a general practitioner, lasting at least 40 minutes and less than 60 minutes in a home or hospital.
124	Home Visit - Level E	$227.90	Professional attendance by a general practitioner, lasting at least 60 minutes in a home or hospital.

Residential aged care home item numbers

Item	Name	Benefit	Description / recommended frequency
90001	Flag fall for call out to RACH	$62.65	Call out fee for the first patient attended during one attendance by a general practitioner at one residential aged care facility on one occasion.
90005	Flag fall for administering or Covid-19 vaccines at RACH	$127.30	A flag fall service to which item 93644, 93645, 93646, 93647, 93653, 93654, 93655, 93656, 93660 or 93661
90020	Level A - short	$19.60	Professional attendance at a residential aged care facility lasting <6 minutes.
90035	Level B - >6min and <20min	$42.85	Professional attendance at a residential aged care facility lasting at least 6 minutes and less than 20 minutes.
90043	Level C - >20mins and <40mins	$82.90	Professional attendance at a residential aged care facility lasting at least 20 minutes and less than 40 minutes.
90051	Level D - <40 and <60mins	$122.15	Professional attendance at a residential aged care facility lasting at least 40 minutes and less than 60 minutes.
90054	Level E - >60mins	$197.90	Professional attendance at a residential aged care facility lasting at least 60 minutes.

Residential aged care after hours

Item	Name	Benefit	Description / recommended frequency
5028	After hours RACH Visit - Level B	$109.05	Professional attendance by a general practitioner on care recipients in a residential aged care facility, lasting at least 6 minutes and less than 20 minutes.
5049	After hours RACH Visit - Level C	$148.95	Professional attendance by a general practitioner on care recipients in a residential aged care facility, lasting at least 20 minutes and less than 40 minutes.
5067	After hours RACH Visit - Level D	$187.45	Professional attendance by a general practitioner on care recipients in a residential aged care facility, lasting at least 40 minutes and less than 60 minutes.
5077	After hours RACH Visit - Level E	$281.20	Professional attendance by a general practitioner on care recipients in a residential aged care facility, lasting at least 60 minutes.

Other common item numbers

Item	Name	Benefit	Description / recommended frequency
11505	Spirometry (Diagnosis)	$39.90	To confirm diagnosis of Asthma, COPD or another cause of airflow limitation – once in a 12-month period.
11506	Spirometry Monitoring	$19.95	Measurement of spirometry before and after inhalation of bronchodilator to confirm diagnosis of Asthma, COPD other causes.
11309	Audiometry	$25.50	Audiogram, air conduction.
11707	ECG	$17.85	12 lead electrocardiography, tracing only by medical practitioner.
11610	Ankle Brachial Index (ankle and wrist can both be billed)	$61.70	Measurement of posterior tibial and dorsalis pedis (or toe) and brachial arterial pressures bilaterally using Doppler or plethysmography techniques, for the evaluation of lower extremity arterial disease, examination, hard copy trace and report.
11607	24-hour Blood pressure monitoring	$99.75	Continuous ambulatory blood pressure recording for 24 hours or more for a patient.

Item	Name	Benefit	Description / recommended frequency
14206	Implant (Implanon)	$34.50	Hormone or living tissue implant (implanon) by cannula.
14203	Implant (Implanon) - if sutured	$49.55	Hormone or living tissue implant (implanon) by cannula involving incision and suture.
30062	Implant (Implanon) removal	$58.85	Removal of Etonogestrel subcutaneous implant (e.g. implanon).
35503	Insertion of IUD/Mirena	$77.65	Introduction of an intra-uterine device for abnormal uterine bleeding or contraception or for endometrial protection during oestrogen replacement therapy.
73806	Pregnancy test	$8.65	Pregnancy test by one or more immunochemical methods.
16500	Antenatal attendance	$45.65	Antenatal attendance.
16591	Planning and management of a pregnancy	$138.15	Planning and management of a pregnancy if the pregnancy has progressed beyond 28 weeks, the service includes a mental health assessment. Only once per pregnancy.
16407	Postnatal attendance	$69.45	Postnatal attendance between 4-8 weeks after birth lasting at least 20 minutes and includes Mental health assessment.
4001	Nondirective pregnancy counselling	$87.25	Professional attendance of at least 20 minutes in duration for the purpose of providing non-directive pregnancy support counselling to a patient who is either currently pregnant of has been in the preceding 12 months.
13757	Venesection	$70.65	Therapeutic Venesection for the management of haemochromatosis.
41677	Nasal Cauterisaiton	$87.20	Nasal haemorrhage, arrest of during an episode of epistaxis by cauterization or nasal cavity packing, or both.
30219	Drainage of abscess, Haematoma	$26.50	Haematoma, furuncle, small abscess or similar lesion- incision with drainage.
32147	Incision of Perianal Abscess	$43.65	Perianal Thrombosis, incision of [multiple option]
42644	Removal of foreign body - imbedded	$69.90	Cornea or Sclera, complete removal of embedded foreign body.
30064	Removal of foreign body - Subcut	$106.45	Subcutaneous foreign body, removal of requiring incision and exploration, including closure of wound.
36800	Bladder Catheterisation	$26.70	Bladder, Catheterisation of where no other procedure is performed.
30003	Burns dressing	$35.20	Burns, involving >1% but <3% of total body surface.
30202	Cryotherapy	$46.80	Removal of confirmed malignant neoplasm of skin by liquid nitrogen.

Common minor surgical item numbers - sutures and skin lesion removal

Item	Name	Benefit	Description / recommended frequency
47915	Wedge Resection	$164.15	Wedge resection of ingrowing nail of toe involving removal of nail segment.
30071	Biopsy	$50.60	Diagnostic biopsy of skin sent for pathological examination.

Removal of lesion from tough site (nose, eyelid, eyebrow, lip, ear, digit or genitalia)

Item	Name	Benefit	Description / recommended frequency
31357	Excision of lesion	$106.20	Benign <6mm
31360	Excision of lesion	$162.70	Benign >6mm
31356	Excision of lesion	$214.35	Malignant (BCC/SCC) <6mm
31358	Excision of lesion	$262.35	Malignant (BCC/SCC) >6mm
31371	Excision of lesion	$345.70	Nasty (Melanoma) all sizes

Removal of lesion from Intermediate site (face, neck, scalp, nipple, knee and below, wrist and below)

Item	Name	Benefit	Description / recommended frequency
31362	Excision of lesion	$129.75	Benign <14mm
31364	Excision of lesion	$167.20	Benign >14mm
31361	Excision of lesion	$180.80	Malignant (BCC/SCC) <14mm
31363	Excision of lesion	$236.55	Malignant (BCC/SCC) >14mm
31372	Excision of lesion	$298.95	Nasty (Melanoma) <14mm
31373	Excision of lesion	$345.55	Nasty (Melanoma) >14mm

Removal of lesion from any other site

Item	Name	Benefit	Description / recommended frequency
31366	Excision of lesion	$92.50	Benign <15mm
31368	Excision of lesion	$121.60	Benign >15-30mm
31370	Excision of lesion	$139.10	Benign <30mm
31365	Excision of lesion	$153.30	Malignant (BCC/SCC) <14mm
31367	Excision of lesion	$206.85	Malignant (BCC/SCC) >14mm
31369	Excision of lesion	$238.15	Malignant (BCC/SCC) >14mm
31374	Excision of lesion	$273.00	Nasty (Melanoma) <15mm
31375	Excision of lesion	$293.80	Nasty (Melanoma) >15-30mm
31376	Excision of lesion	$340.55	Nasty (Melanoma)>30mm

Covid vaccination item numbers

Item	Name	Benefit	Description / recommended frequency
93645	Administer Covid Vaccine Business hours	$41.50	Professional attendance by a general practitioner for the purpose of assessing a patient's suitability for a COVID-19 vaccine.
93654	Administer Covid Vaccine After hours	$54.90	Professional attendance by a general practitioner for the purpose of assessing a patient's suitability for a COVID-19 vaccine.
10660	Covid vaccine suitability assessment	$42.80	Profession attendance lasting more than 10 minutes in duration, to provide in-depth clinical advice on the individual risks and benefits associated with receiving a COVID-19 vaccine.

Sutures (items can be used for tissue adhesive resin)

Item	Name	Benefit	Description / recommended frequency
30026	Sutures to skin and subcut tissue	$50.60	Suture <7cm Superficial
30029	Sutures to skin and subcut tissue	$87.20	Suture <7cm Deep
30035	Sutures to skin and subcut tissue	$113.90	Suture <7cm Face or Neck Deep
30032	Sutures to skin and subcut tissue	$79.90	Suture <7cm Face or Neck Superficial
30038	Sutures to skin and subcut tissue	$87.20	Suture >7cm Superficial

Treatment of fractures

Item	Name	Benefit	Description / recommended frequency
47354	Treatment of fracture	$164.15	Fracture Scaphoid by cast immobilisation
47361	Treatment of fracture	$127.65	Distal end or radius or ulna (or both) by cast immobilisation
47462	Treatment of fracture	$109.30	Clavicle, treatment of
47471	Treatment of fracture	$41.65	Ribs one or more
47561	Treatment of fracture	$264.35	Tibia Shaft of
47546	Treatment of fracture	$328.10	Tibia Plateau medial or lateral
47595	Treatment of fracture	$156.05	Ankle Joint, hindfoot, metatarsals or toes

Clinically suspected melanoma surgical item numbers

Item	Name	Benefit	Description / recommended frequency
31377	Clinically suspected Melanoma	$106.20	Nose/eyelid/eyebrow/ear/digit/genitalia <6mm
31378	Clinically suspected Melanoma	$162.70	Nose/eyelid/eyebrow/ear/digit/genitalia >6mm
31379	Clinically suspected Melanoma	$129.75	Face/neck/scalp/nipple/distal lower and upper limb <14mm
31380	Clinically suspected Melanoma	$162.70	Face/neck/scalp/nipple/distal lower and upper limb >14mm
31381	Clinically suspected Melanoma	$92.50	Any other site <15mm
31382	Clinically suspected Melanoma	$121.60	Any other site >15mm
31383	Clinically suspected Melanoma	$139.10	Any other site >30mm

Bulk billing items

Item	Name	Benefit	Description / recommended frequency
75870	Bulk Billing Item MMM1	$21.35	For patients U16 years or a concessional beneficiary for services provided where not admitted to hospital and service is bulk billed. This item can be claimed with face-to-face level B, C, D and E general attendance items, and level B telehealth and telephone general attendance items. **This is a general overview, please click on the link to assess eligibility.*
75871	Bulk Billing Item MMM2	$32.50	For patients U16 years or a concessional beneficiary for services provided where not admitted to hospital and service is bulk billed. This item can be claimed with face-to-face level B, C, D and E general attendance items, and level B telehealth and telephone general attendance items. **This is a general overview, please click on the link to assess eligibility.*
75872	Bulk Billing Item MMM2, 3, 4, 5, 6 and 7	$32.50	For patients U16 years or a concessional beneficiary for services provided where not admitted to hospital and service is bulk billed. **This is a general overview, please click on the link to assess eligibility.*
75873	Bulk Billing Item MMM3 and 4	$34.50	For patients U16 years or a concessional beneficiary for services provided where not admitted to hospital and service is bulk billed. This item can be claimed with face-to-face level B, C, D and E general attendance items, and level B telehealth and telephone general attendance items. **This is a general overview, please click on the link to assess eligibility.*
75874	Bulk Billing Item MMM5	$36.65	For patients U16 years or a concessional beneficiary for services provided where not admitted to hospital and service is bulk billed. This item can be claimed with face-to-face level B, C, D and E general attendance items, and level B telehealth and telephone general attendance items. **This is a general overview, please click on the link to assess eligibility.*
75875	Bulk Billing Item MMM6	$38.70	For patients U16 years or a concessional beneficiary for services provided where not admitted to hospital and service is bulk billed. This item can be claimed with face-to-face level B, C, D and E general attendance items, and level B telehealth and telephone general attendance items. **This is a general overview, please click on the link to assess eligibility.*
75876	Bulk Billing Item MMM7	$41.10	For patients U16 years or a concessional beneficiary for services provided where not admitted to hospital and service is bulk billed. This item can be claimed with face-to-face level B, C, D and E general attendance items, and level B telehealth and telephone general attendance items. **This is a general overview, please click on the link to assess eligibility.*
75880	Bulk Billing Item MMM1 MyMedicare	$21.35	**MyMedicare** service is provided to MyMedicare enrolled patients. For patients U16 years or a concessional beneficiary for services provided where not admitted to hospital and service is bulk billed. This item can be claimed with level C, D, and E telehealth general attendance items, and level C and D telephone general attendance items, where the patient is registered with MyMedicare. **This is a general overview, please click on the link to assess eligibility.*
75881	Bulk Billing Item MMM2 MyMedicare	$32.50	**MyMedicare** service is provided to MyMedicare enrolled patients. For patients U16 years or a concessional beneficiary for services provided where not admitted to hospital and service is bulk billed. This item can be claimed with level C, D, and E telehealth general attendance items, and level C and D telephone general attendance items, where the patient is registered with MyMedicare. **This is a general overview, please click on the link to assess eligibility.*

Item	Name	Benefit	Description / recommended frequency
75882	Bulk Billing Item MMM3 and 4 MyMedicare	$34.50	**MyMedicare** service is provided to MyMedicare enrolled patients. For patients U16 years or a concessional beneficiary for services provided where not admitted to hospital and service is bulk billed. This item can be claimed with level C, D, and E telehealth general attendance items, and level C and D telephone general attendance items, where the patient is registered with MyMedicare. **This is a general overview, please click on the link to assess eligibility.*
75883	Bulk Billing Item MMM5 MyMedicare	$36.65	**MyMedicare** service is provided. For patients U16 years or a concessional beneficiary for services provided where not admitted to hospital and service is bulk billed. This item can be claimed with level C, D, and E telehealth general attendance items, and level C and D telephone general attendance items, where the patient is registered with MyMedicare. **This is a general overview, please click on the link to assess eligibility.*
75884	Bulk Billing Item MMM6 MyMedicare	$38.70	**MyMedicare service** is provided, if: (a) the attendance service is provided to a patient: (i) who is enrolled in MyMedicare at the general practice through which the attendance service is provided; and (ii) who is under the age of 16 or who is a concessional beneficiary; and (b) the patient is not an admitted patient of a hospital; and (c) the attendance service is bulk-billed. This item can be claimed with level C, D, and E telehealth general attendance items, and level C and D telephone general attendance items, where the patient is registered with MyMedicare. **This is a general overview, please click on the link to assess eligibility.*
75885	Bulk Billing Item MMM7 MyMedicare	$41.10	Professional attendance at which a **MyMedicare** service is provided, practice location in a **Modified Monash 7 area;** other than an attendance service associated with a service to which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75870, 75871, 75872, 75873, 75874, 75875, 75876, 75880, 75881, 75882, 75883 or 75884 applies. This item can be claimed with level C, D, and E telehealth general attendance items, and level C and D telephone general attendance items, where the patient is registered with MyMedicare. **This is a general overview, please click on the link to assess eligibility.*

Video consultation and telehealth services

Item	Name	Benefit	Description / recommended frequency
91790	Short Consultation video	$19.60	Telehealth attendance by a general practitioner requiring a short patient history and limited management. Must have an established clinical relationship with patient.
91800	Standard Consultation video	$42.85	Telehealth attendance by general practitioner lasting less than 20 mins. Must have an established clinical relationship with patient.
91801	Long Consultation video	$82.90	Telehealth attendance by general practitioner lasting longer than 20 mins. Must have an established clinical relationship with patient.
91802	Extended video consultation	$122.15	Telehealth attendance by a general practitioner lasting at least 40 minutes. Must have an established clinical relationship with patient.
91920	Video attendance by a general practitioner, lasting at least 60 minutes	$197.90	Telehealth attendance by a general practitioner to a patient registered under MyMedicare with the billing practice, lasting at least 60 minutes and includes any of the following that are clinically relevant: short patient history, investigations, implementing a management plan and appropriate preventative health.
91890	Short Consultation Telephone	$19.60	Phone attendance by a general practitioner lasting less than 6 minutes requiring a short patient history and if required limited management. Must have an established clinical relationship.
91891	Standard Consultation Telephone ≥ 6 minutes	$42.85	Phone attendance lasting at least 6 minutes and includes any of the following that are clinically relevant: short patient history, investigations, implementing a management plan and appropriate preventative health.
91900	Long Consultation Telephone *Must be enrolled with MyMedicare	$82.90	Phone attendance by a general practitioner to a patient registered under MyMedicare with the billing practice, lasting at least 20 minutes and includes any of the following that are clinically relevant: short patient history, investigations, implementing a management plan and appropriate preventative health.
91910	Extended Telephone consultation *Must be enrolled with MyMedicare	$122.15	Phone attendance by a general practitioner to a patient registered under MyMedicare with the billing practice, lasting at least 40 minutes and includes any of the following that are clinically relevant: short patient history, investigations, implementing a management plan and appropriate preventative health.
92004	Health Assessment for Aboriginal and or Torres Strait Islander people via videoconference	$241.85	92004 is the videoconference equivalent of existing face to face item 715.
92024	Preparation of GP Management Plan via videoconference	$164.35	92024 is the videoconference equivalent of existing face to face item 721.
92025	Coordination of Team Care Arrangement via videoconference	$130.25	92025 is the videoconference equivalent of existing face to face item 721.
92026	Care Plan via videoconference	$80.20	Contribution to a Care Plan or to a review of Care Plan prepared by another provider or a review prepared by another provider. 92026 is the videoconference equivalent of existing face to face item 729.
92027	Care Plan for RACF patient via videoconference	$80.40	Contribution to a Care Plan or to a review of Care plan for a patient being discharged from hospital or in a residential aged care facility. Service must be performed by pts usual GP. 92026 is the videoconference equivalent of existing face to face item 731.
92028	Review or coordinate a review of GPMP or TCA via videoconference	$82.10	Attendance by the GP to review or coordinate a review of GPMP or TCA Must be performed by the patient's usual GP.
92142	Management Plan for patient with a disability <13 yrs via videoconference	$153.25	Assessment, diagnosis and preparation of treatment and management plan, applicable only once. 92142 is the equivalent existing face to face item 139.

Item	Name	Benefit	Description / recommended frequency
92136	Non-directive pregnancy support >20mins via videoconference	$87.25	92136 is the videoconference equivalent of existing face to face item 4001 GP required to meet credentialing requirements for this item.
92138	Non-directive pregnancy support >20mins via telephone	$87.25	92138 is the telehealth equivalent of existing face to face item 4001 GP required to meet credentialing requirements for this item.
92731	Professional attendance <5 minutes for sexual or reproductive health check via telephone	$19.60	Consultation for the provision of services related to blood borne virus, sexual or reproductive health by a GP less than 5 minutes. Note assisted reproductive technology and antenatal care are outside these items.
92715	Consultation <5 minutes for sexual or reproductive health check via videoconference	$19.60	Consultation for the provision of services related to blood borne virus, sexual or reproductive health by a GP less than 5 minutes. Note assisted reproductive technology and antenatal care are outside these items.
92734	Consultation 5-20 minutes for sexual or reproductive health check via telephone	$42.85	Consultation for the provision of services related to blood borne virus, sexual or reproductive health by a GP between 5-20 minutes. Note assisted reproductive technology and antenatal care are outside these items.
92718	Consultation 5-20 minutes for sexual or reproductive health check via videoconference	$42.85	Consultation for the provision of services related to blood borne virus, sexual or reproductive health by a GP between 5-20 minutes. Note assisted reproductive technology and antenatal care are outside these items.
92737	Consultation 21-40 minutes for sexual or reproductive health check via telephone	$82.90	Consultation for the provision of services related to blood borne virus, sexual or reproductive health by a GP between 20-40 minutes. Note assisted reproductive technology and antenatal care are outside these items.
92721	Consultation 21-40 minutes for sexual or reproductive health check via videoconference	$82.90	Consultation for the provision of services related to blood borne virus, sexual or reproductive health by a GP between 20-40 minutes. Note assisted reproductive technology and antenatal care are outside these items.
92740	Consultation ≥40 minutes for sexual or reproductive health check via telephone	$122.15	Consultation for the provision of services related to blood borne virus, sexual or reproductive health by a GP for at least 40 minutes. Note assisted reproductive technology and antenatal care are outside these items.
92724	Consultation ≥40 minutes for sexual or reproductive health check via videoconference	$122.15	Consultation for the provision of services related to blood borne virus, sexual or reproductive health by a GP for at least 40 minutes. Note assisted reproductive technology and antenatal care are outside these items.

NEW video consultations and telehealth services

Bulk billing incentives for eligible patients from 1 November 2023 – Modified Monash 1 (Metropolitan Area) (Refer to criteria on page 14)

Applicable BBI item	10990	75870	75880 (MyMedicare enrolled patients only)
Standard hours consultations			
In consulting rooms	3	23, 36, 44, 123	
Out of consulting rooms	4	24, 37, 47, 124	
Residential aged care facility	90020	90035, 90043, 90051, 90054	
Telehealth			
Video	91790 (all) 91801, 91802, 91920 if not MyMedicare enrolled	91800	91801, 91802, 91920
Phone	91890	91891	91900, 91910
After hours consultations			
In consulting rooms	5000	5020, 5040, 5060, 5071	
Out of consulting rooms	5003[4]	5023[5], 5043[5], 5063[5], 5076[5]	
Residential aged care facility	5010[4]	5028[5], 5049[5], 5067[5], 5077[5]	
Other	All other “unreferred services”[6], including but not limited to chronic disease management items, Better Access mental health items, health assessments, minor procedures etc.		

Bulk billing incentives for eligible patients from 1 November 2023 – Modified Monash 2 (Regional Centre) (Refer to criteria on page 14)

Applicable BBI item	10991	75871	75881 (MyMedicare enrolled patients only)
Standard hours consultations			
In consulting rooms	3	23, 36, 44, 123	
Out of consulting rooms	4	24, 37, 47, 124	
Residential aged care facility	90020	90035, 90043, 90051, 90054	
Telehealth			
Video	91790 (all) 91801, 91802, 91920 if not MyMedicare enrolled	91800	91801, 91802, 91920
Phone	91890	91891	91900, 91910
After hours consultations			
In consulting rooms	5000	5020, 5040, 5060, 5071	
Out of consulting rooms	5003	5023, 5043, 5063, 5076	
Residential Aged Care Facility	5010	5028, 5049, 5067, 5077	
Other	All other “unreferred services”[4], including but not limited to: chronic disease management items, Better Access mental health items, health assessments, minor procedures etc.		

Bulk billing incentives for eligible patients from 1 November 2023 – Modified Monash 3 and 4 (Medium and Large Rural Towns) (Refer to criteria on page 14)

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

Bulk billing incentives for eligible patients from 1 November 2023 – Modified Monash 5 (Small Rural Towns) (Refer to criteria on page 14)

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

Bulk billing incentives for eligible patients from 1 November 2023 – Modified Monash 6 (Remote Communities) (Refer to criteria on page 14)

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

Bulk billing incentives for eligible patients from 1 November 2023 – Modified Monash 7 (Very Remote Communities) (Refer to criteria on page 14)

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

Page 8

1 *Includes all medical practitioners eligible to claim MBS GP items i.e. fellows of the RACGP or ACRRM, medical practitioners undertaking a training placement approved by the RACGP or ACRRM or a training placement under the Remote Vocational Training Scheme, practitioners listed on the Vocational Register of General Practitioners, a medical practitioner who has successfully completed the requirements of the Medicare Plus for Other Medical Practitioners Program or is providing services under that program, or a medical practitioner providing services in accordance with the Other Medical Practitioners Extension Program*

2 *Bulk billing incentives can be claimed you bulk bill a child under 16 or a Commonwealth Concession Card holder www.servicesaustralia.gov.au/concession-and-health-care-cards*

3 *Practice located in Modified Monash area www.health.gov.au/resources/apps-and-tools/health-workforce-locator/app*

4 *If service is provided in an MM 2- 7 area by a GP whose practice is located in an MM 1 area, then BBI item number 10992 is claimed*

5 *If service is provided in an MM 2-7 area by a GP whose practice is located in an MM1 area, then BBI item number 75872 is claimed*

6 *Bulk billing incentives cannot be claimed for the provision of COVID vaccine support services*

Pages 9-13

1 *Includes all medical practitioners eligible to claim MBS GP items i.e. fellows of the RACGP or ACRRM, medical practitioners undertaking a training placement approved by the RACGP or ACRRM or a training placement under the Remote Vocational Training Scheme, practitioners listed on the Vocational Register of General Practitioners, a medical practitioner who has successfully completed the requirements of the Medicare Plus for Other Medical Practitioners Program or is providing services under that program, or a medical practitioner providing services in accordance with the Other Medical Practitioners Extension Program*

2 *Bulk billing incentives can be claimed you bulk bill a child under 16 or a Commonwealth Concession Card holder www.servicesaustralia.gov.au/concession-and-health-care-cards*

Chronic disease management

Item	Name	Benefit	Description / recommended frequency
721	GP Management Plan (GPMP)	$164.35	Management plan for patients with a chronic or terminal condition. Not more than once yearly unless clinically required, e.g. patient unable to meet the goals set due to chronic condition or hospital stay. GP needs to indicate in the clinical notes on the Medicare Bulk Bill form prior to billing the service.
723	Team Care Arrangement (TCA)	$130.25	Management plan 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. Enables referral for 5 rebated allied health services. Not more than once yearly unless clinically required. e.g. patient unable to meet the goals set due to chronic condition or hospital stay. GP needs to indicate in the clinical notes on the Medicare Bulk Bill form prior to billing the service.
732	Review of GP Management Plan and/or Team Care Arrangement	$82.10	The recommended frequency is every 6 months. The minimum claiming period is 3 months. If a GPMP and TCA are both reviewed on the same date item 732 can be claimed twice on the same day.
729	GP Contribution to, or Review of, Multidisciplinary Care Plan	$80.40	Contribution by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), to a multidisciplinary care plan prepared by another provider or a review of a multidisciplinary care plan prepared by another provider (other than a service associated with a service to which any of items 735 to 758 apply). Not more than once every 3 months.
731	GP Contribution to, or Review of, Multidisciplinary Care Plan prepared by RACF	$80.20	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 (other than a service associated with a service to which items 735 to 758 apply).

Health assessments

Item	Name	Benefit	Description / recommended frequency
699	Heart Health Assessment	$82.90	30 + years Lasting at least 20 minutes – see MBS for complexity of care req.*
701	Brief Health Assessment	$67.60	Brief health assessment, lasting not more than 30 minutes.
703	Standard Health Assessment	$157.10	>30 - 45 minutes - see MBS for complexity of care requirements.
705	Long Health Assessment	$216.80	>45 - <60 minutes - see MBS for complexity of care requirements.
707	Prolonged Health Assessment	$306.25	> 60 minutes - see MBS for complexity of care requirements.
715	Aboriginal and Torres Strait Islander Health Assessment	$241.85	Not timed – Frequency 9-12 months.

Medication management

Item	Name	Benefit	Description / recommended frequency
900	Domiciliary Medication Management Review (DMMR)	$176.40	Intended to maximise an individual patient's benefit from their medication regimen, and prevent medication-related problems through a team approach, once every 12 months except if there has been a significant change in the patient's condition or medication regimen requiring a new DMMR.
903	Residential Medication Management Review (RMMR)	$120.80	For permanent residents of residential aged care facilities who are at risk of medication related misadventure. Performed in collaboration with the resident's pharmacist. Once every 12 months.

Practice nurse/Aboriginal and Torres Strait Islander health practitioners (ATSIHP)* Item numbers as of July 2024

Item	Name	Benefit	Description / recommended frequency
10987	Follow Up Health Services for Indigenous people	$27.30	Follow-up services provided by Practice Nurse or Aboriginal and Torres Strait Islander Health Practitioner for an Indigenous person who has received a Health Assessment (715), not an admitted patient of a hospital. Maximum of 10 services per patient, per calendar year.
10988	Immunisation	$13.65	Immunisation provided to a person on behalf of the medical practitioner by an Aboriginal and Torres Strait Islander Health Practitioner. Claimed once per patient visit even if multiple vaccines given.
10989	Wound Treatment	$13.65	Treatment of wound (other than normal after care) provided by an Aboriginal and Torres Strait Islander Health Practitioner if the treatment is provided on behalf of, and under supervision of, a medical practitioner and the person is not admitted to hospital
10997	Chronic Disease Management	$13.65	Monitoring and support for patients being managed under a GPMP or TCA. Not more than 5, per patient, per calendar year.

**From 1 July 2023, restrictions preventing First Nations people claiming a heart health assessment service within 12 months of an Aboriginal and Torres Strait Islander Peoples health assessment service was removed.*

**A practice nurse means a registered or enrolled nurse or nurse practitioner who is employed by, or whose services are otherwise retained by a general practice on behalf of and under supervision of Medical Practitioner.*

Mental health numbers

Item	Name	Benefit	Description / recommended frequency
2700	GP Mental Health Treatment Plan	$81.70	Professional attendance by a general practitioner (including a general practitioner who has **not** undertaken mental health skills training) of at least **20 minutes but less than 40 minutes** in duration for the preparation of a GP.
2701	GP Mental Health Treatment Plan	$120.25	Professional attendance by a general practitioner (including a general practitioner who has **not** undertaken mental health skills training) of **at least 40 minutes** in duration for the preparation of a GP mental health treatment plan for a patient*.
2715	GP Mental Health Treatment Plan	$103.70	Professional attendance by a general practitioner (including a general practitioner who has undertaken mental health skills training of **at least 20 minutes but less than 40 minutes** in duration for the preparation of a GP mental health treatment plan for a patient*.

2717	GP Mental Health Treatment Plan	$152.80	Professional attendance by a general practitioner (including a general practitioner who has undertaken mental health skills training) of at least 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient.
2712	Review of GP Mental Health Treatment Plan	$81.70	Professional attendance by a general practitioner to review a GP mental health treatment plan which he or she, or an associated general practitioner has prepared, or to review a Psychiatrist Assessment and Management Plan.
2713	Mental Health Consultation	$81.70	Professional attendance by a general practitioner in relation to a mental disorder and of at least 20 minutes in duration, involving taking relevant history and identifying the presenting problem (to the extent not previously recorded), providing treatment and advice and, if appropriate, referral for other services or treatments, and documenting the outcomes of the consultation
2721	GP Focused Psychological Strategies	$105.65	Professional attendance at consulting rooms by a general practitioner, for providing focused psychological strategies for assessed mental disorders by a general practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 30 minutes, but less than 40 minutes.
92112	GP Mental Health Treatment Plan	$81.70	**Telehealth attendance**, by a general practitioner who **has not** undertaken mental health skills training (and not including a specialist or consultant physician), of at **least 20 minutes but less than 40 minutes** in duration for the preparation of a GP mental health treatment plan for a patient.
92113	GP Mental Health Treatment Plan	$120.25	**Telehealth attendance**, by a general practitioner who **has not** undertaken mental health skills training (and not including a specialist or consultant physician), of at **least 20 minutes but less than 40 minutes** in duration for the preparation of a GP mental health treatment plan for a patient.
92116	GP Mental Health Treatment Plan	$103.70	**Telehealth attendance** by a general practitioner (including a general practitioner **who has undertaken** mental health skills training of **at least 20 minutes but less than 40 minutes** in duration for the preparation of a GP mental health treatment plan for a patient *
92117	GP Mental Health Treatment Plan	$152.80	**Telehealth attendance** by a general practitioner (including a general practitioner **who has undertaken** mental health skills training) **of at least 40 minutes** in duration for the preparation of a GP mental health treatment plan for a patient.
92114	Review of GP Mental Health Treatment Plan-Telehealth	$81.70	Telephone or Telehealth attendance by a general practitioner to review a GP mental health treatment plan which he or she, or an associated general practitioner has prepared, or to review a Psychiatrist Assessment and Management Plan.
92126	Review of GP Mental Health Treatment Plan -Telephone		
92115	Mental Health Consultation - Telehealth	$81.70	Telephone or Telehealth attendance by a general practitioner in relation to a mental disorder and of at least 20 minutes in duration, involving taking relevant history and identifying the presenting problem (to the extent not previously recorded), providing treatment and advice and, if appropriate, referral for other services or treatments, and documenting the outcomes of the consultation.
92127	Mental Health Consultation - Telephone		

Eating disorder treatment plans

Item	Name	Benefit	Description / recommended frequency
90250	Eating Disorder Treatment Plan	$81.70	Professional attendance by a general practitioner to prepare an eating disorder treatment and management plan, lasting at least 20 minutes but less than 40 minutes where the practitioner **has not successfully completed** mental health skills training.
92146	Eating Disorder Treatment Plan - Telehealth		
90251	Eating Disorder Treatment Plan	$120.25	Professional attendance by a general practitioner to prepare an eating disorder treatment and management plan, lasting at least 40 minutes, where the practitioner **has not successfully completed** mental health skills training.
92147	Eating Disorder Treatment Plan - Telehealth		
90252	Eating Disorder Treatment Plan	$103.70	Professional attendance by a general practitioner to prepare an eating disorder treatment and management plan, lasting at least 20 minutes but less than 40 minutes, if the practitioner **has successfully completed** mental health skills training.
92148	Eating Disorder Treatment Plan - Telehealth		
90253	Eating Disorder Treatment Plan	$152.80	Professional attendance by a general practitioner to prepare an eating disorder treatment and management plan, lasting at least 40 minutes if the practitioner **has successfully completed** mental health skills training.
92149	Eating Disorder Treatment Plan - Telehealth		
90264	Review of Eating Disorder Treatment Plan	$81.70	Professional attendance by a general practitioner to review an eating disorder treatment and management plan.
92170	Review of Eating Disorder Treatment Plan-Telehealth		
92176	Review of Eating Disorder Treatment Plan-Telephone		
723	Team Care Arrangement for Mental Health	$130.25	Manage mental health conditions by coordinating the development or review of TCAs. They apply for a patient who is being treated under the Better Access initiative or has an EDTMP.

*Many patients will not require a new plan after their initial plan has been prepared. A new plan should not be prepared unless clinically indicated, and generally not within 12 months of a previous plan. Ongoing management can be provided through the GP Mental Health Treatment Consultation and standard consultation items, as required, and reviews of progress through the GP Mental Health Treatment Plan Review item. A rebate for preparation of a GP Mental Health Treatment Plan will not be paid within 12 months of a previous claim for the patient for the same or another Mental Health Treatment Plan item or within three months following a claim for a GP Mental Health Treatment Review (item 2712 or former item 2719), other than in exceptional circumstances.

The recommended frequency for the review service, allowing for variation in patients' needs, is:

- an initial review, which should occur between four weeks to six months after the completion of a GP Mental Health Treatment Plan; and
- if required, a further review can occur three months after the first review.
- In general, most patients should not require more than two reviews in a 12-month period, with ongoing management through the GP Mental Health Treatment Consultation and standard consultation items, as required.

Fact sheets

- Mental health case conferencing fact sheet
- Allied health case conferencing fact sheet

Allied health services for chronic conditions requiring team care

GP must have completed a GP Management Plan (721) and Team Care Arrangement (723), or contributed to a Multidisciplinary Care Plan in a Residential Aged Care Facility (731) or have had a Review of a GPMP and TCA item 732 and completed a referral containing all components of form which can be found **HERE**. Patient must have a chronic or terminal medical condition and complex care needs requiring care from a multidisciplinary team consisting of their GP and at least two other health or care providers.

Item	Name	Description / recommended frequency
10950	Aboriginal and Torres Strait Health Workers (ATSIHW) or Aboriginal and Torres Strait Islander Health Practitioner (ATSIHP) Services	ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH SERVICE Aboriginal or Torres Strait Islander health service provided to a person by an eligible Aboriginal health worker or eligible Aboriginal and Torres Strait Islander health practitioner. **$60.35** Aboriginal and Torres Strait Health Workers (ATSIHW) or Aboriginal and Torres Strait Islander Health Practitioner (ATSIHP) Services and Allied Health Providers must have a Medicare Provider number. Maximum of five services (including any services to which items 10950 to 10970, 93000, 93013, 93501 to 93513 and 93524 to 93538 apply) in a calendar year. Can be 5 sessions with one provider or a combination, e.g., 3 dietitians' and 2 diabetes educators' sessions. GP refers to allied health professional using 'Referral Form for Chronic Disease Allied Health (Individual) Services under Medicare' or a referral form containing all components. One for each provider. Allied health professionals must report back to the referring GP after first and last visit.
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	For mental health conditions use Better Access Mental Health Care items – 10 sessions. For chronic physical conditions use GPMP and TCA - 5 sessions >20mins per calendar year Better access and GPMP can be used for the same patient where eligible.
10968	Psychologist	For mental health conditions, use Better Access Mental Health Care items – 10 sessions. For chronic physical conditions, use GPMP and TCA – 5 sessions per calendar year Better Access and GPMP can be used for the same patient, where eligible.

Follow-up allied health services for Aboriginal and Torres Strait Islander Peoples who have had a health assessment

A person who is of Aboriginal or Torres Strait Islander descent may be referred by their GP for follow-up allied health services under items 81300 to 81360 when the GP has undertaken a health assessment (Items 701, 703, 705, 707 or 715) and identified a need for follow-up allied health services.

These items provide an alternative pathway for Aboriginal or Torres Strait Islander peoples to access allied health services. If a patient meets the eligibility criteria for individual allied health services under the Chronic Disease Management items (10950 to 10970) and for follow-up allied health services, they can access both sets of services and are eligible for up to ten allied health services under Medicare per calendar year.

Item	Name	Description / recommended frequency
81300	Aboriginal and Torres Strait Health Worker or Aboriginal and Torres Strait Islander Health Practitioner Services	Aboriginal and Torres Strait Health Workers, or Aboriginal and Torres Strait Islander Health Practitioners and Allied Health Providers must have a current Medicare Provider number for each location in which they practice. **$60.35** Maximum of 5 allied health services per patient each calendar year (in addition to the 5 services eligible from TCA 10950- 10970). Services must be of at least 20min duration and medical notes need to reflect same. GP refers to allied health professionals using a 'Referral form for follow-up allied health services under Medicare for People of Aboriginal or Torres Strait Islander descent' or a referral form containing all components. One for each provider. Allied health professionals must report back to the referring GP after the first and last services. This also includes health professionals using the same clinical software, an internal process of feedback must be in place for the GP to review the medical notes and enter if any further action is required e.g., recall patient, as they did not attend service or further action not required, recall patient for health assessment in 9-12months.
81305	Diabetes Education	
81310	Audiology	
81315	Exercise Physiology	
81320	Dietetics	
81325	Mental Health	
81330	Occupational Therapy	
81335	Physiotherapy	
81340	Podiatry	
81345	Chiropractic	
81350	Osteopathy	
81355	Psychology	
81360	Speech Pathology	

Allied health group services for patients with type 2 diabetes

GP must have completed a GP Management Plan (721), or reviewed an existing GPMP (732), or contributed to, or reviewed a Multidisciplinary Care Plan in a Residential Aged Care Facility (731) and completed a referral containing all components of form. For more information click here

Item	Name	Description / Recommended Frequency
81100	Assessment for Group Services by Diabetes Educator	One assessment session only by either Diabetes Educator, Exercise Physiologist or Dietitian, per calendar year. Medicare Allied Health Group Services for Type 2 Diabetes Referral Form. A report is required to be provided to the referring GP that identifies if the patient would benefit from Group Services, before the group services are provided to the patient. **$77.40**
81110	Assessment for Group Services by Exercise Physiologist	
81120	Assessment for Group Services by Dietitian	
81105	Diabetes Education Group Services	8 group per calendar year, can be 8 sessions with one provider or a combination e.g. 3 diabetes education, 3 dietitians and 2 exercise physiology sessions. Medicare Allied Health Group Services for Type 2 Diabetes Referral Form. Ensure all participants sign the Medicare Assignment of Benefits form after the group sessions. A report back to the referring GP is required at the completion of the group services and all providers who provided Group Services must contribute to this report. **$19.30**

GP multidisciplinary care conferences

Item	Name	Description / recommended frequency
735	Organise and coordinate a case conference	>15 -<20 minutes. GP organise and coordinates case conference with at least 2 other members, each of whom provide a different kind of care or service to the patient and is not a family carer of the patient, and 1 of whom may be another medical practitioner in RACF or community, or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs. **$80.55**
739	Organise and coordinate a case conference	>20 - <40 minutes. GP organise and coordinates case conference in RACF or community, or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs. **$137.65**
743	Organise and coordinate a case conference	> 40 minutes. GP organise and coordinates case conference in RACF or community, or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs. **$229.65**
747	Participate in a case conference	>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. **$59.20**
750	Participate in a case conference	>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. **$101.45**
758	Participate in a case conference	>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. **$168.80**

GP mental health case conferencing

Item	Name	Description / recommended frequency
930	Organise and coordinate a case conference 15-20 minutes **$80.55**	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate a mental health case conference, if the conference lasts for at least 15 minutes, but for less than 20 minutes.
933	Organise and coordinate a case conference 20-40 minutes **$137.75**	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate a mental health case conference, if the conference lasts for at least 20 minutes, but for less than 40 minutes.
935	Organise and coordinate a case conference >40 mins **$229.65**	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate a mental health case conference, if the conference lasts for at least 40 minutes.
937	Participate in a case conference 15-20 minutes **$59.20**	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to participate in a mental health case conference, if the conference lasts for at least 15 minutes, but for less than 20 minutes.
943	Participate in a case conference 20-40 minutes **$101.45**	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to participate in a mental health case conference, if the conference lasts for at least 20 minutes, but for less than 40 minutes.
945	Participate in a case conference >40 minutes **$168.80**	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to participate in a mental health case conference, if the conference lasts for at least 40 minutes.

Click here for allied health case conferencing fact sheet

Health assessment target groups

Pages 30 to 36 will provide a more comprehensive overview of each target group and the health assessment criteria, clinical content, essential documentation and claiming requirements. The table below provides an overview of the Health Assessment target groups and frequency of assessments.

Target group	Frequency
Patient aged 30 years and over can have a Heart Health Assessment lasting at least 20 minutes (item 699)	Once annually
People aged 45- 49 years (inclusive) who are at risk of developing a chronic disease. Patients may also receive a type 2 diabetes risk evaluation if they are at high risk of developing type 2 diabetes and meet the relevant eligibility criteria.	Once only
People aged 40-49 years (inclusive) or 15-54 years (inclusive) for Aboriginal and Torres Strait Islander people with a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool (AUSDRISK)	Once every 3 years only
People aged 75 years and older.	Provided annually
Comprehensive medical assessment for permanent residents of a Residential Aged Care Facility (new and existing)	Provided annually
People who have an intellectual disability	Provided annually
This health assessment is for refugees and other humanitarian entrants who arrive in Australia with complex and unusual medical conditions resulting from their area of origin or previous living conditions. This assessment is separate from, and in addition to, a medical assessment specifically for the grant of a Refugee or Humanitarian visa.	Voluntary, one-off service and must be provided within twelve months of the person's arrival in Australia or grant of visa
Health assessment for patients that have identified as Aboriginal and/or Torres Strait Islander	Once every 9-12 Months
Former serving members of the Australian Defence Force including former members of permanent and reserve Forces (discharged before 30 June 2019)	Once only
Former serving members of the Australian Defence Force including former members of permanent and reserve Forces (discharged after 1 July 2019)	Annually for 5 years

Further information

- https://www1.health.gov.au/internet/main/publishing.nsf/Content/mha_resource_kit
- A health assessment should generally be undertaken by the patient's 'usual doctor', that is, the medical practitioner (or medical practitioner in the same practice) who has provided the majority of services to the patient in the past 12 months, and/or is likely to provide the majority of services in the following 12 months. Should a medical practitioner other than the patient's 'usual doctor' or practice nurse undertake the health assessment, a copy of the health assessment record should be forwarded to the patient's 'usual doctor' or practice, subject to the agreement of the patient or their parent/guardian.
- Items 701,703,705 and 707 may be used to undertake a health assessment. Item 699 used for heart health assessment
- Item 10990 or 10991 (bulk billing incentives) can be claimed in conjunction with any health assessment, provided the conditions of item 10990 and 10991 are satisfied.
- Medical practitioners should establish a register of patients who require annual health assessments and remind these patients when their next health assessment is due. If an assessment identifies that a patient has a chronic medical complex care needs, it may be appropriate for the GP to involve other health professionals in the patient's care using the MBS Chronic Disease Management items.

Health assessment item numbers

Item	Name	Description / recommended frequency
701	Brief Health Assessment <30mins	Professional attendance by a general practitioner to perform: • Collection of relevant information, including taking a patient history and A basic physical examination • initiating interventions and referrals as indicated and • providing the patient with preventive health care advice and information.
703	Standard Health Assessment 30-44 minutes	Professional attendance by a general practitioner to perform: • Detailed information collection, including taking a patient history and an extensive physical examination • initiating interventions and referrals as indicated and • Providing a preventive health care strategy for the patient.
705	Long Health Assessment 45-59 minutes	Professional attendance by a general practitioner to perform: • Comprehensive information collection, including taking a patient history • An extensive examination of the patient's medical condition physical function • Initiating interventions and referrals as indicated; and providing a basic preventive health care management plan for the patient.
707	Prolonged Health Assessment Lasting at least 60 minutes	Professional attendance by a general practitioner to perform: • Comprehensive information collection, including taking a patient history • Extensive examination of the patient's medical condition, and physical, psychological, • social function and Initiating interventions and referrals as indicated • Providing a comprehensive preventive health care management plan for the patient.
715	Aboriginal and Torres Strait Islander Peoples Health Assessment No designated time / complexity requirements	Professional attendance by a general practitioner at consulting rooms or in another place other than a hospital or residential aged care facility to perform: • For children aged 0-14 years old. • Adults between 15-54 years of age • Older people over 55 years Must include the following: • Information collection, including taking a patient history and undertaking examinations and investigations as required • Making an overall assessment of the patient; • Recommending appropriate interventions; • Providing advice and information to the patient; and • Keeping a record of the health assessment, and offering the patient, and/or patient's carer, a written report about the health assessment with recommendations about matters covered by the health assessment; and • Offering the patient's carer (if any, and if the general practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report relevant to the carer.

Residential aged care facility item numbers

Item	Name	Description / recommended frequency
731	GP Contribution or review of a Multidisciplinary Care Plan	Contribution by a general practitioner to: • a multidisciplinary care plan for a patient in a residential aged care facility, prepared by that facility, or to a review of such a plan prepared by such a facility; or • a multidisciplinary care plan prepared for a patient by another provider before the patient is discharged from a hospital, or to a review of such a plan prepared by another provider
701-707	Health Assessment	Comprehensive medical assessment for permanent residents of a Residential Aged Care Facility (new and existing)
• Health assessments are not available to people who are in-patients of a hospital or care recipients in a residential aged care facility (with the exception of a comprehensive medical assessment provided to a permanent resident of a residential aged care facility). • Before a health assessment is commenced, the patient (and/or the patient's parent(s), carer or representative, as appropriate) must be given an explanation of the health assessment process and its likely benefits. The patient must be asked whether they consent to the health assessment being performed. In cases where the patient is not capable of giving consent, consent must be given by the patient's parent(s), carer or representative. Consent to the health assessment must be noted in the patient's records. • A health assessment may only be claimed by a general practitioner.		
A health assessment must include the following elements: a. information collection, including taking a patient history and undertaking or arranging examinations and investigations as required. b. making an overall assessment of the patient. c. recommending appropriate interventions. d. providing advice and information to the patient. e. keeping a record of the health assessment, and offering the patient a written report about the health assessment, with recommendations about matters covered by the health assessment; and f. offering the patient's carer (if any, and if the general practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report relevant to the carer.		
903	Residential Medication Management Reviews	Available new residents on admission and existing permanent residents on a "as required" basis to people who are likely to benefit from such a review. This includes residents for whom quality use of medicines may be an issue or residents who are at risk of medication misadventure because of a significant change in their condition or medication regimen.
735	Organise and coordinate a case conference 15-19 minutes	GP to organise and coordinate, or participate in, multidisciplinary case conferences for patients in the community or patients being discharged into the community from hospital or people living in residential aged care facilities.
739	Organise and coordinate a case conference 20-39 minutes.	GP to organise and coordinate, or participate in, multidisciplinary case conferences for patients in the community or patients being discharged into the community from hospital or people living in residential aged care facilities.

Item	Name	Description / recommended frequency
743	Organise and coordinate a case conference At least 40 minutes.	GP to organise and coordinate, or participate in, multidisciplinary case conferences for patients in the community or patients being discharged into the community from hospital or people living in residential aged care facilities.
747	Participate in a case conference 15-19 minutes.	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to participate in: a community case conference or a multidisciplinary case conference in a residential aged care facility or a multidisciplinary discharge case conference.
750	Participate in a case conference 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 >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.

- Items 735-758 are for patients who have at least one medical condition that has been (or likely to be) present for at least 6 months, is terminal and require ongoing care from a multidisciplinary case conference team who includes a medical practitioner and at least two other members, each providing a different kind of care and is not a family carer of the patient.
- Should generally be undertaken by the patient's usual general practitioner that has provided the majority of services to the patient over the previous 12 months and/or will be providing the majority of services to the patient over the coming 12 months.
- May include allied health professionals such as, but not limited to: Aboriginal health care workers; asthma educators; audiologists; dental therapists; dentists; diabetes educators; dietitians; mental health workers; occupational therapists; optometrists; orthoptists; orthotists or prosthetists; pharmacists; physiotherapists; podiatrists; psychologists; registered nurses; social workers; speech pathologists.
- A team may also include home and community service providers, or care organisers, such as: education providers; "meals on wheels" providers; personal care workers (workers who are paid to provide care services); probation officers.
- The patient's informal or family carer may be included as a formal member of the team in addition to the minimum of three health or care providers. The patient and the informal or family carer do not count towards the minimum of three.
- Organisation and coordination of a multidisciplinary discharge case conference (items 735, 739 and 743) may be provided for private in-patients being discharged into the community from hospital.

Drug and alcohol items

In November 2016, 15 items were introduced for addiction medicine supporting addiction medicine specialists to provide care (see MBS Online items 6018- 6042). No specific addiction medicine MBS items are available for general practice at this time. In order to ensure that patients receive the necessary care, GPs may consider optimising the following items to better support their patients with alcohol and other drugs of addiction. Addiction issues may be considered a mental health issue and many AOD clients have concurrent chronic diseases.

General consultation items			
Item	**Name**	**$**	**Description / recommended frequency**
3	Consultation (Level A)	$19.60	Brief
23	Consultation (Level B)	$42.85	Standard <20 mins
36	Consultation (Level C)	$82.90	Long ≥20 mins
44	Consultation (Level D)	$118.00	Prolonged ≥40 mins
Benefit = 100% on above consultation items			

Chronic disease care plans				
721	GP Management Plan (GPMP)	$164.35 (Benefit 75% = $118.50)		• For use when co-morbid chronic disease present • Co-claiming of GP consultation items (i.e. 3, 4, 23, 24 etc) with CDM items 721, 723 or 732 is not permitted for the same patient on the same day. • 721/723 minimum claim period – 12 months • 729-732 minimum claim period – 3 months
723	Team Care Arrangement (TCA)	$130.25 (Benefit 75% = $93.90)		
732	Review of GPMP/TCA	$82.10 (Benefit 75% = $59.20)		
10997	Service to patient with GPMP/TCA by a PN/AHW/AHP	$13.65 (Benefit 100%)		Not more than 5, per patient, per year
GP mental health treatment items				
2700	Consultation for the completion of GP MH treatment plan 20mins but <40 mins	$81.70 (Benefit 75% = $61.30)		• GPMP/TCA can only be utilised in conjunction with MHTPs where there is an eligible comorbid condition. • May claim separate consultation on the same day only if other condition must be treated immediately
2701	Consultation to complete GP MH treatment plan of at least 40 mins	$120.25 (Benefit 75% = $90.20)		
2712	Review GP MH treatment plan	$81.70 (Benefit 75% = $61.30)	**Telehealth** 92126 $78.55	• Should occur 4 weeks to 6mths after completion of GPMHTP • Minimum 3 months between reviews. Should not require more than two reviews in 12 months. Following up with 'Consultations"
2713	GP Mental Health Treatment consultation ≥20 min	$81.70 (Benefit 100%)	92127 $78.55	For extended consultation, taking history, providing treatment/advice/referral • Unlimited claims per year
2715	GP MHTP consultation by GP with MH skills training 20mins but <40 mins	$103.70 (Benefit 75% = $77.80)	2715 and 2717 can be claimed by GPs who have completed MH training Mental Health Skills Training accreditation	**2715**
2717	GP MHTP consultation by GP with MH skills training at least 40 mins	$152.80 (Benefit 75% = $114.60)		**2717**
2721	GP providing focused psychological strategies 30mins and <40mins	$105.65 (Benefit 100%)	Medical practitioner must be registered with Medicare as meeting credentialing requirements (FPS training)	**2721**

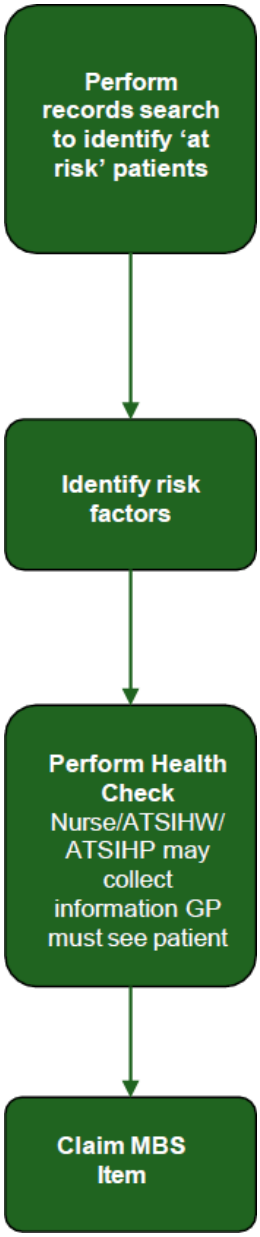
Case conference GP *organises and coordinates*			
Items	Duration	$	• Maximum of 5 conferences per patient in 12 month period
735	15-20 minutes	$80.55	• Requires three or more providers present who provide a service to the patient* • May only claim one item per case conference • Can be conducted face to face, tele/videoconference or a combination **GP role:** • Obtain consent from resident and all participants • Document meeting and outcomes • Provide copies of outcomes to all participants • Read MBS requirements
739	20-40 minutes	$137.75	
743	>40 minutes	$229.65	
Case conference GP *participates*			
747	15-20 minutes	$59.20	
750	20-40 minutes	$101.45	
758	>40 minutes	$168.80	
Benefit = 75% on above case conference items			

Home/ Institution Visits – VR GP			
4	Brief	$47.05	Fee for item 3 ($19.60), plus $30.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 3 ($19.60) plus $2.40 per patient. See below
24	Standard <20 mins	$68.60	The fee for item 23 ($39.75), plus $28.85 divided by the number of patients seen, See below.
37	Long ≥20 minutes	$105.80	The fee for item 36 ($76.95), plus $28.85 divided by the number of patients seen, See below.
47	Prolonged ≥40 minutes	$142.15	The fee for item 44 ($113.30), plus $28.85 divided by the number of patients seen, See below.

*Examples of persons who, for the purposes of care planning and case conferencing may be included in a multidisciplinary care team are allied health professionals such as, but not limited to: Aboriginal health care workers; asthma educators; audiologists; dental therapists; dentists; diabetes educators; dietitians; mental health workers; occupational therapists; optometrists; orthoptists; orthotists or prosthetists; pharmacists; physiotherapists; podiatrists; psychologists; registered nurses; social workers; speech pathologists.

A team may also include home and community service providers, or care organisers, such as: education providers; "meals on wheels" providers; personal care workers (workers who are paid to provide care services); probation officers. The patient's informal or family carer may be included as a formal member of the team in addition to the minimum of three health or care providers. The patient and the informal or family carer do not count towards the minimum of three.

Type 2 diabetes risk evaluation – health assessment - items 701 / 703 / 705 / 707



Eligibility criteria

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

Clinical content

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

Essential documentation requirements

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

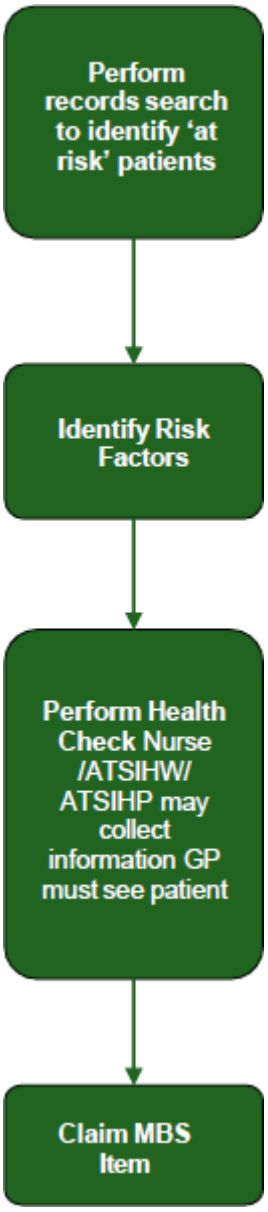
Claiming

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

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

- Department of Health and Aged Care Fact Sheet

45-49-year-old health assessment - items 701 / 703 / 705 / 707



Eligibility criteria

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

Risk factors

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

Clinical content mandatory

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

Non-mandatory

- Written patient information is recommended

Essential documentation requirements

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

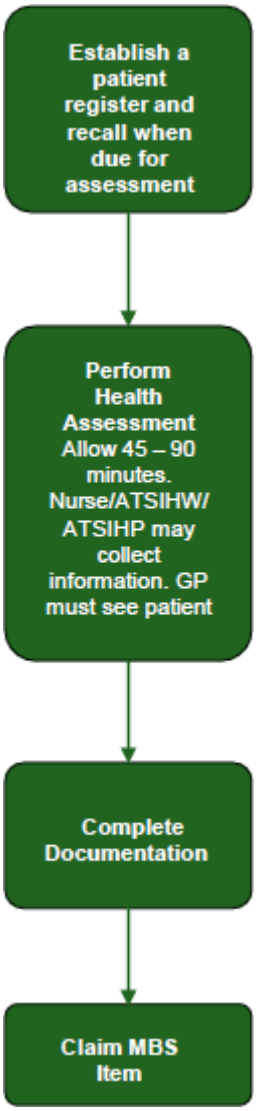
Claiming

- All elements of the service must be completed to claim

MBS item	Name	Age range	Recommended frequency
701 / 703 / 705 / 707	Health Assessment – 45-49	45-49 years	Once only

- Department of Health and Aged Care Fact Sheet

75 years and older – health assessment - items 701 / 703 / 705 / 707



701 / 703 / 705 / 707 - Time based, see MBS for complexity of care requirements of each item

Eligibility criteria

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

Clinical content mandatory

- Explain Health Assessment process and gain patient's/ carer's consent
- Information collection– takes patient history; undertake examinations and investigations as clinically required Measurement of BP, Pulse rate and rhythm
- Assessment of: Medication; Continence; Immunisation status for influenza, tetanus and pneumococcus; Physical function including activities of daily living and falls in the last 3 months; Psychological function including cognition and mood; and Social function including availability and adequacy of paid and unpaid help and the patient's carer responsibilities
- Overall assessment of patient Recommend appropriate interventions
- Provide advice and information
- Discuss outcomes of the assessment and any recommendations with patient

Non-mandatory

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

Essential documentation requirements

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

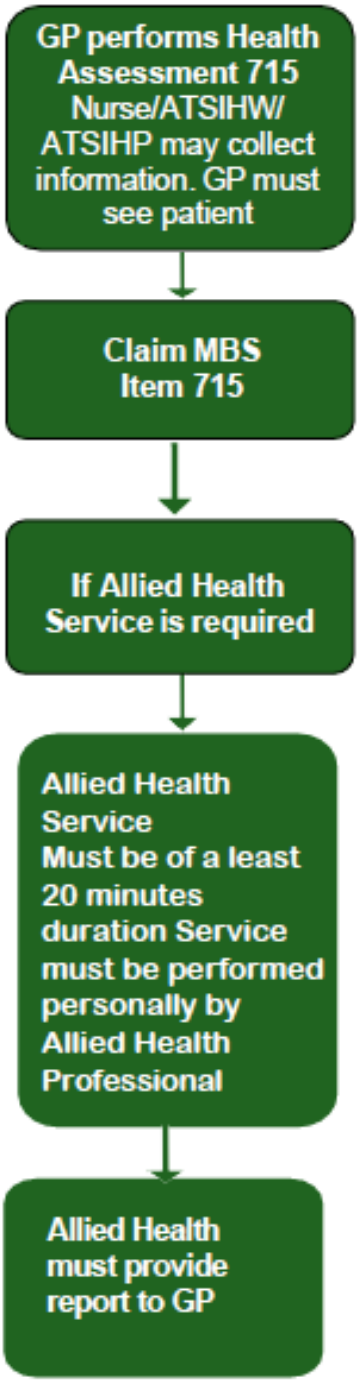
Claiming

- All elements of the service must be completed to claim

MBS item	Name	Age range	Recommended frequency
701 / 703 / 705 / 707	Health Assessment – 75 Years +.	75 years and older	Provided annually

- Department of Health and Aged Care Fact Sheet

Aboriginal and Torres Strait Islander heath assessment - item 715



Item 715

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

Eligibility criteria

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

Mandatory

Health Assessment includes physical, psychological and social wellbeing. It also assesses what preventative health care, education and other assistance that should be offered to improve the patient's health and wellbeing. It must include:

- Information collection of patient history and undertaking examinations and investigations as required. Overall assessment recommending any appropriate intervention provide advice and information
- Recording the health assessment
- Offering the patient, a written report with recommendations about matters cover by the health assessment

Optional

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

Essential documentation requirements

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

Claiming

- All elements of the service must be completed to claim

MBS item	Name	Age range	Recommended frequency
715	Aboriginal and Torres Strait Islander Health Assessment	All Ages	Once in a 9-month period
81300 to 81360	*Allied Health Services	All Ages	Max 5 services per year
10987	Service provided by practice nurse or registered Aboriginal health worker	All Ages	Max 10 services per year

Home medicines review (HMR) – Item 900

Also known as domiciliary medication management review (DMMR)

Eligibility criteria

- Patients at risk of medication related problems or for whom quality use of medicines may be an issue.
- Not for patients in a hospital or a Residential Aged Care Facility.
- DMMRs are targeted at patients who are likely to benefit from such a review: patients for whom quality use of medicines may be an issue or; patients who are at risk of medication misadventure because of factors such as their co-morbidities, age or social circumstances, the characteristics of their medicines, the complexity of their medication treatment regimen, or a lack of knowledge and skills to use medicines to their best effect.

Initial visit with GP

- Explain purpose, possible outcomes, process, information sharing with pharmacist and possible out of pocket costs.
- Gain and record patient's consent to HMR. Inform patient of need to return for second visit.
- Complete HMR referral and send to patient's preferred pharmacy or accredited pharmacist.

HMR interview

- Pharmacists hold a review in a patient's home unless patient prefers another location.
- The pharmacist prepares a report and sends it to the GP covering review findings and suggested medication management strategies.
- The pharmacist and GP discuss findings and suggestions.

Second GP visit

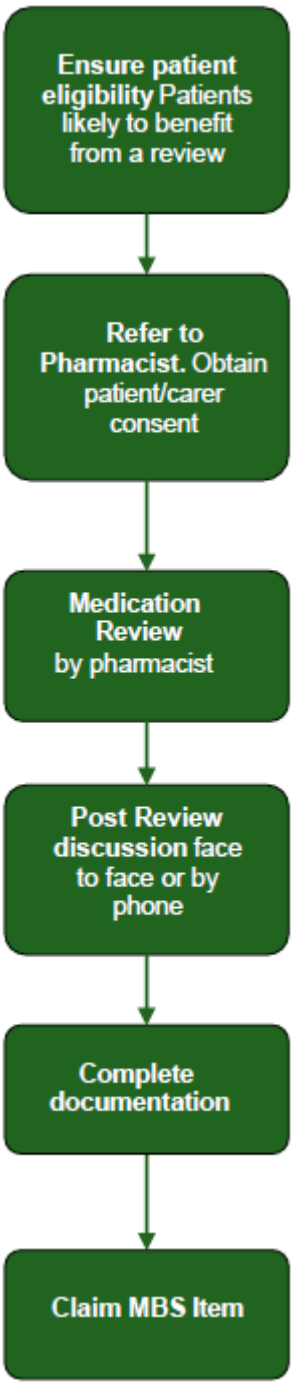
- Develop summary of findings as part of draft medication management plan.
- Discuss draft plan with patient and offer copy of completed plan. Send a copy of plan to pharmacist.

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 Medicines Review	Once every 12 months

Residential medication management review (RMMR) - Item 903



Eligibility criteria

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

GP initiates service

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

Accredited pharmacist component

- Review resident's clinical notes and interview resident.
- Prepare Medication Review report and send it to GP.

GP and pharmacist post review discussion

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

Essential documentation requirements

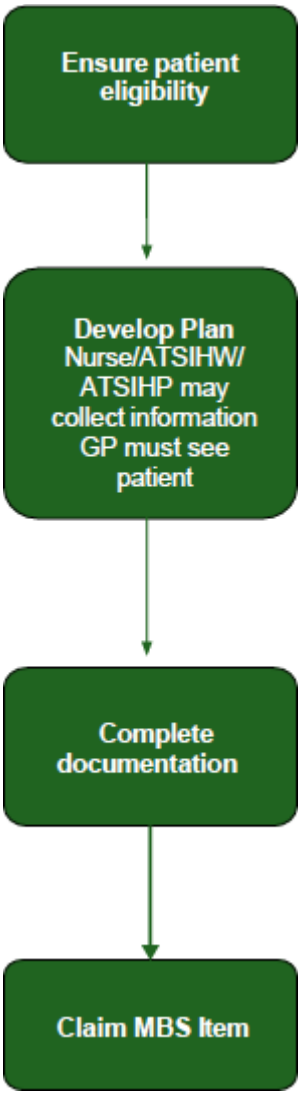
- Record resident's consent to RMMR.
- Develop and/or revise Medication Management Plan which should identify medication management goals and medication regimen.
- Finalise Plan after discussion with resident.
- Offer copy of Plan to resident/carer, provide copy for resident's records and for nursing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

Claiming

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

MBS item	Name	Recommended frequency
903	Residential Medication Management Review	As required (Recommended annually)

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 2700/2701/2715/2717) is suggested for patients with a mental disorder only.

Clinical content

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

Claiming

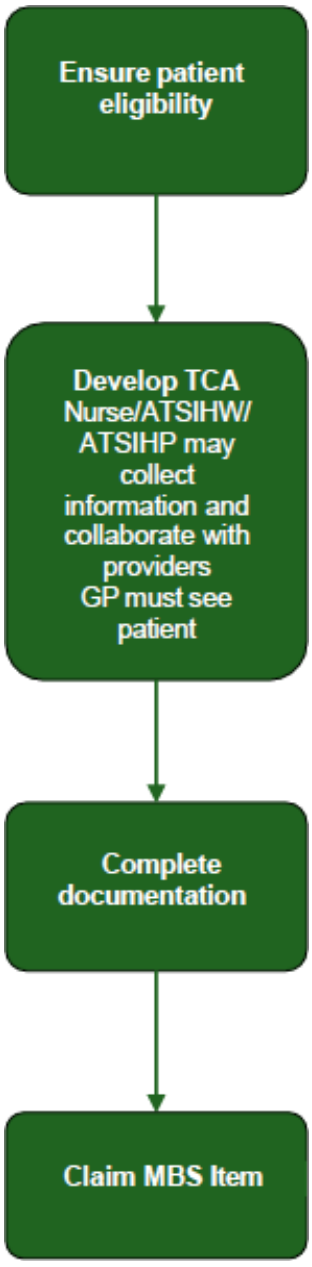
- All elements of the service must be completed to claim.
- Requires personal attendance by GP with patient.
- Review using item 732 at least once during the life of the plan.

MBS item	Name	Recommended frequency
721	GP Management Plan	2 yearly (Minimum 12 monthly) *

*CDM services may be provided more frequently in the exceptional circumstances defined below.

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

Team care arrangement (TCA) – Item 723



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

- Consult with at least two collaborating providers, each of whom will provide a different kind of treatment or service to the patient, and one of whom may be another medical practitioner, when planning for the multidisciplinary care of the patient
- Prepare a document that describes:
  - (i) Treatment and service goals for the patient.
  - (ii) Treatment and services that collaborating providers will provide to the patient.
  - (iii) Actions to be taken by the patient
  - (iv) arrangements to review (i) (ii) and (iii) by a date specified in the document
    Explain steps involved in TCA, possible out of pocket costs, gain consent
    Discuss with patient which 2 providers the GP will collaborate with and the treatment and services the 2 providers will deliver.

Essential documentation requirements

- Record patient's consent to TCA.
- Goals, collaborating providers, treatments/services, actions to be taken by patient
- Set review date.
- Give copies of the relevant parts of the document to the collaborating providers. Offer a copy of the documents to the patient and the patient's carer (if appropriate and patient agrees).
- Add a copy of the document to the patient's medical record.
- Consult with 2 collaborating providers and obtain feedback on treatment/services they will provide to achieve patient goals.
- The document must be retained for 2 years

Claiming

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

MBS item	Name	Recommended frequency
723	Team Care Arrangement	2 yearly (Minimum 12 monthly) *

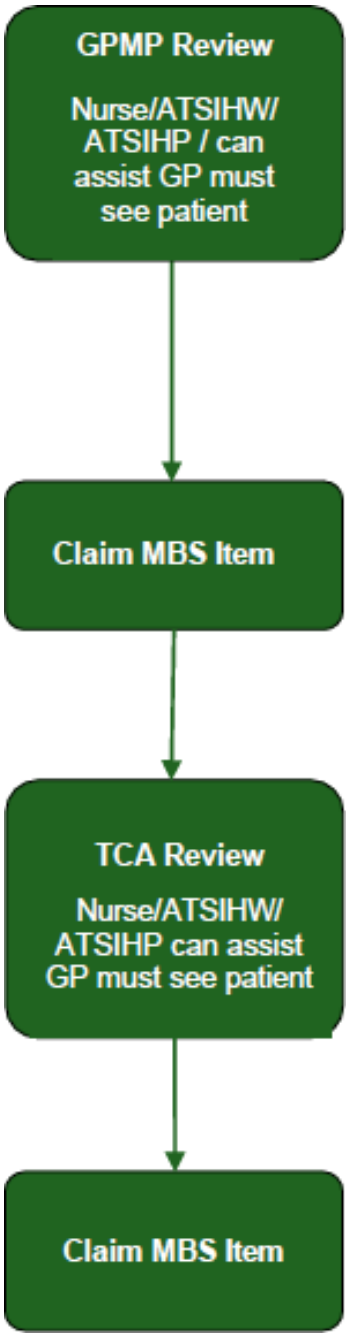
Review using item 732 at least once during the life of the plan.

* CDM services may be provided more frequently in the exceptional circumstances defined below.

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

Review of a GP management plan (GPMP) and/or team care arrangement (TCA) - Item 732

Review of a GP Management Plan (GPMP)



Clinical content

- Explain steps involved in the review and gain consent. Review all matters in relevant plan.
- Essential Documentation Requirements Record patient's agreement to review.
- Make any required amendments to plan. Set new review date.
- Offer copy to patient (with consent, offer to carer). Keep copy in patient file.

Claiming

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

Review of 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 documentation requirements

- Record patient's consent to review. Make any required amendments to the 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

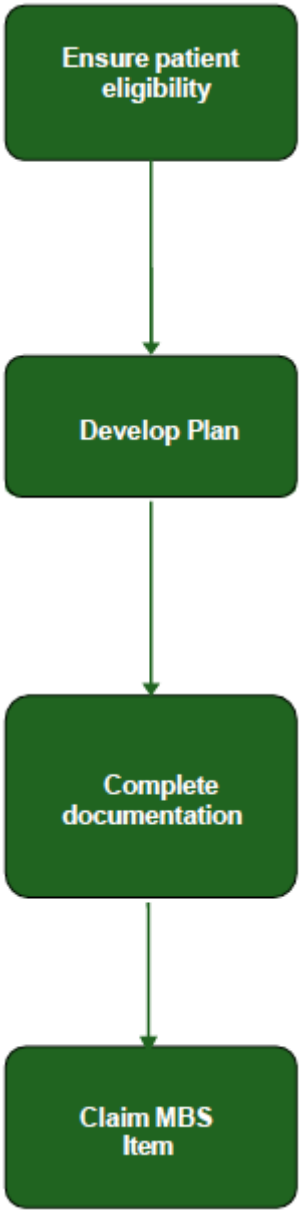
- All elements of the service must be completed to claim.
- Requires personal attendance by a GP with a patient.
- Item 732 should be claimed at least once over the life of the TCA. Cannot be claimed within 3 months of a TCA (item 723).
- Item 732 can be claimed twice on same day if review of both GPMP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

MBS Item	Name	Recommended frequency
732	GP Management Plan and/or Team Care Arrangement	6 months (Minimum 3 months)

Mental health treatment plan – Items 2700/2701/2715/2717

2700/2701- prepared by a GP who **has not** undertaken mental health skills training. A credentialed Mental Health Nurse, Aboriginal and Torres Strait Islander Health Worker or Aboriginal and Torres Strait Islander Practitioner that has completed Mental Health training can also assist the GP.

2715/2717 - prepared by a GP who **has** undertaken mental health skills training. A credentialed Mental Health Nurse, Aboriginal and Torres Strait Islander Health Worker or Aboriginal and Torres Strait Islander Practitioner that has completed Mental Health training can also assist the GP.



Eligibility criteria

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

Clinical content

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

Essential documentation requirements

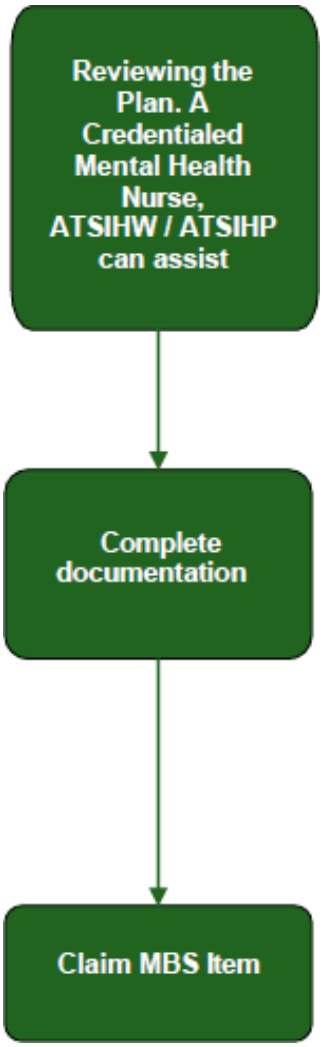
- Record patient's consent to GP Mental Health Treatment Plan.
- Document diagnosis of mental disorder.
- Results of outcome measurement tool.
- Patient needs and goals, patient actions, and treatments/services required
- Set review date.
- Offer copy to patient (with consent, offer to carer), keep copy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

Claiming

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

MBS item	Name	Recommended frequency
2700, 2701, 2715, 2717	GP Mental Health Treatment Plan: **FACT SHEETS** Not more than once a year except in exceptional circumstances	

Review of mental health treatment plan – Item 2712



Clinical content

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

Essential documentation requirements

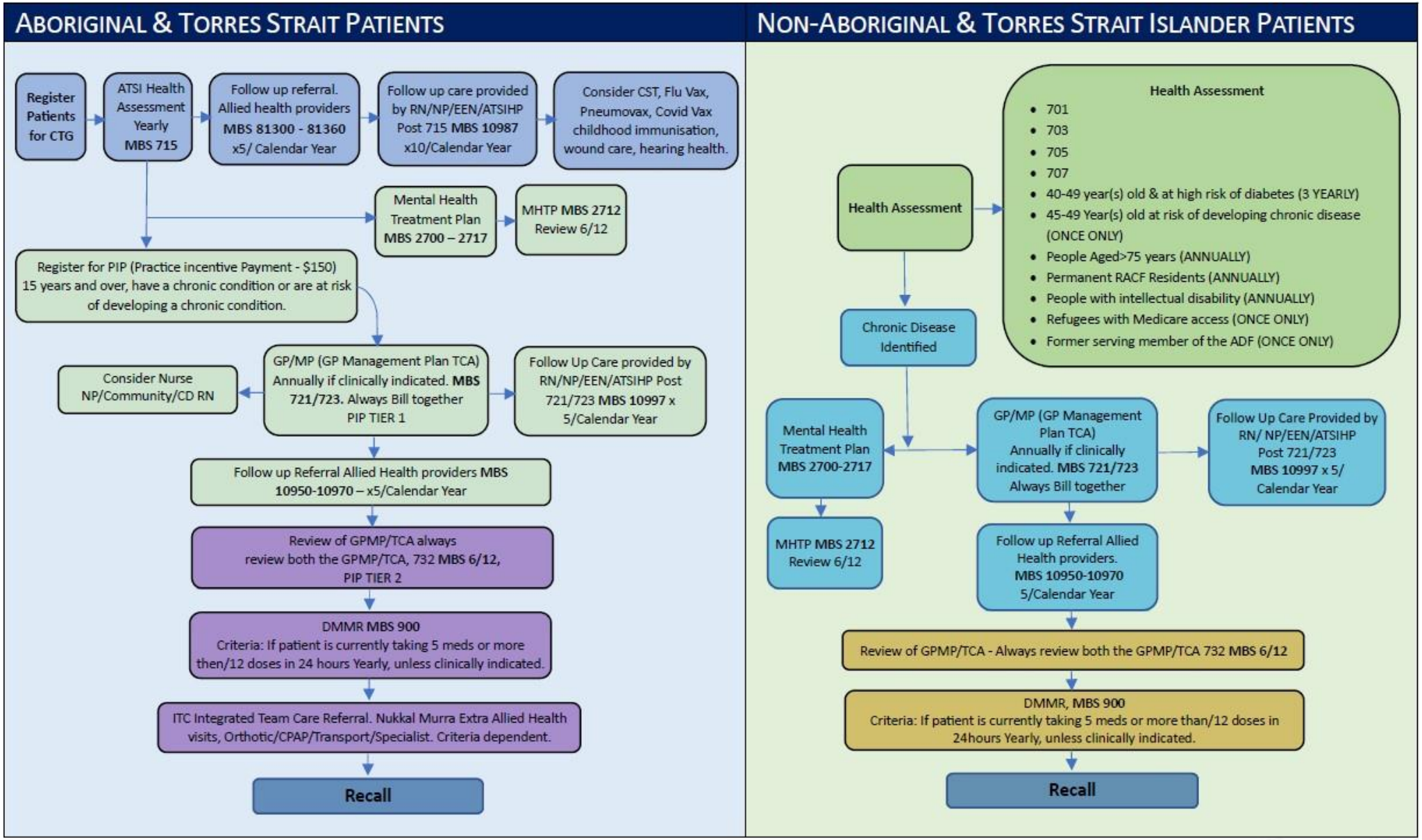
- Record patient's consent to Review.
- Results of re-administered outcome measurement tool document relevant changes to GP Mental Health Treatment Plan.
- Offer copy to patient (with consent, offer to carer). Keep copy in patient file.

Claiming

- All elements of the service must be completed to claim.
- Requires personal attendance by GP with patient.
- Item 2712 should be claimed at least once over the life of the GP Mental Health Treatment Plan.
- According to the FAQs on The Australian Government Department of Health Website (2012), it is not mandatory for the GP to see the patient to do a referral for the further four allied mental health sessions.
- A review can be claimed 1–6 months after completion of the GP Mental Health Treatment Plan. If required, an 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.

PATIENT HEALTH JOURNEY



Non-VR GP (MDRAP and PEP or 19AB exemption) MBS item numbers

Consultation item numbers

Item	Name	Benefit	Description / recommended frequency
179	Level A – Brief Consultation – In Rooms	$15.70	Professional attendance at consulting rooms of **not more than 5 minutes** in duration (other than a service to which any other item applies) - each attendance, by a medical practitioner in an eligible area.
181	Level A – Brief Consultation – Home Visit	*see note	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item in the table applies), **not more than 5 minutes** in duration - an attendance on one or more patients at one place on one occasion - each patient, by a medical practitioner in an eligible area. (**See MBS online for fee calculation**). ** The fee for 179, plus $24.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 179 plus $1.90 per patient.*
90183	Level A – Brief Consultation – RACF Visit	$15.70	Professional attendance (other than a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (that is not accommodation in a self-contained unit) of **not more than 5 minutes** in duration — an attendance on one or more patients at one residential aged care facility on one occasion— each patient, by medical practitioner in an eligible area.
185	Level B – Standard Consultation – In Rooms	$34.25	Professional attendance at consulting rooms of **more than 5 minutes in duration but not more than 25 minutes** (other than a service to which any other item applies) - each attendance, by a medical practitioner in an eligible area.
187	Level B – Standard Consultation – Home Visit	*see note	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item in the table applies) of **more than 5 minutes in duration but not more than 25 minutes**—an attendance on one or more patients at one place on one occasion - each patient, by a medical practitioner in an eligible area. (**See MBS online for fee calculation**). ** The fee for item 185, plus $24.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 185 plus $1.90 per patient.*
90188	Level B – Standard Consultation – RACF Visit	$34.25	Professional attendance (other than a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (that is not accommodation in a self-contained unit) of **more than 5 minutes in duration but not more than 25 minutes** - an attendance on one or more patients at one residential aged care facility on one occasion -

Consultation item numbers

Item	Name	Benefit	Description / recommended frequency
			each patient, by a medical practitioner in an eligible area.
189	Level C – Long Consultation – In Rooms	$66.35	Professional attendance at consulting rooms of **more than 25 minutes in duration but not more than 45 minutes** (other than a service to which any other item applies) - each attendance, by a medical practitioner in an eligible area.

Item	Name	Benefit	Description / recommended frequency
191	Level C – Long Consultation – Home Visit		Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item in the table applies) of **more than 25 minutes in duration but not more than 45 minutes** -an attendance on one or more patients at one place on one occasion - each patient, by a medical practitioner in an eligible area. (**See MBS online for fee calculation**).
90202	Level C – Long Consultation – RACF Visit	$66.35	Professional attendance (other than a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (that is not accommodation in a self-contained unit) of **more than 25 minutes in duration but not more than 45 minutes** - an attendance on one or more patients at one residential aged care facility on one occasion - each patient, by a medical practitioner in an eligible area.
203	Level D – Prolonged Consultation – In Rooms	$97.70	Professional attendance at consulting rooms of **more than 45 minutes** in duration (other than a service to which any other item applies) - each attendance, by a medical practitioner in an eligible area.
206	Level D – Prolonged Consultation – Home Visit	*see note	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item in the table applies) of **more than 45 minute**s in duration - an attendance on one or more patients at one place on one occasion - each patient, by a medical practitioner in an eligible area. (**See MBS online for fee calculation**). **The fee for item 189, plus $24.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 189 plus $1.90 per patient.*
90212	Level D – Prolonged Consultation – RACF Visit	$97.70	Professional attendance (other than a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (that is not accommodation in a self-contained unit) of **more than 45 minutes** in duration - an attendance on one or more patients at one residential aged care facility on one occasion - each patient, by a medical practitioner in an eligible area.
10990	Bulk Billing Item	$7.15	DVA, under 16s and Commonwealth Concession Card holders. Can be claimed concurrently for eligible patients.
10991	Bulk Billing Item	$10.80	DVA, under 16s and Commonwealth Concession Card holders. Region specific. Can be claimed concurrently for eligible patients.
11506	Spirometry	$19.95	Measurement of respiratory function before and after inhalation of bronchodilator.
11707	ECG	$17.85	12 Lead Electrocardiography, tracing only.
11731	Implanted electrocardiogram loop recording	$33.70	Implanted electrocardiogram loop recording, by a medical practitioner, including reprogramming when required; retrieval of stored data, analysis, interpretation and report by a medical practitioner. Applicable once in a 4 week period.

Extended consultation

Item	Name	Benefit	Description / recommended frequency
214	Brief Extended Consultation Imminent danger of death	$201.95	Professional attendance by a medical practitioner for a period of **not less than 1 hour but less than 2 hours** (other than a service to which another item applies) on a patient in imminent danger of death.
215	Standard Extended Consultation Imminent danger of death	$336.50	Professional attendance by a medical practitioner for a period of **not less than 2 hours but less than 3 hours** (other than a service to which another item applies) on a patient in imminent danger of death.
218	Long Extended Consultation Imminent danger of death	$470.80	Professional attendance by a medical practitioner for a period of **not less than 3 hours but less than 4 hours** (other than a service to which another item applies) on a patient in imminent danger of death.
219	Prolonged Extended Consultation Imminent danger of death	$605.70	Professional attendance by a medical practitioner for a period of **not less than 4 hours but less than 5 hours** (other than a service to which another item applies) on a patient in imminent danger of death.
220	Extra Prolonged Extended Consultation Imminent danger of death	$672.95	Professional attendance by a medical practitioner for a period of **5 hours or more** (other than a service to which another item applies) on a patient in imminent danger of death.

Chronic disease management

Item	Name	Benefit	Description / recommended frequency
229	GP Management Plan (GPMP)	$131.50	Attendance by a medical practitioner, for preparation of a GP management plan for a patient (other than a service associated with a service to which any of items 735 to 758 and items 235 to 240 apply).
230	Team Care Arrangement (TCA)	$104.20	Attendance by a medical practitioner, to coordinate the development of team care arrangements for a patient (other than a service associated with a service to which any of items 735 to 758 and items 235 to 240 apply).
231	GP Contribution to, or Review of, Multidisciplinary Care Plan prepared by another Provider	$64.15	Contribution by a medical practitioner, to a multidisciplinary care plan prepared by another provider or a review of a multidisciplinary care plan prepared by another provider (other than a service associated with a service to which any of items 735 to 758 and items 235 to 240 apply).
232	GP Contribution to, or Review of, Multidisciplinary Care Plan prepared by RACF	$64.15	Contribution by a medical practitioner, to:(a) a multidisciplinary care plan for a patient in a residential aged care facility, prepared by that facility, or to a review of such a plan prepared by such a facility; or(b) a multidisciplinary care plan prepared for a patient by another provider before the patient is discharged from a hospital, or to a review of such a plan prepared by another provider(other than a service associated with a service to which items 735 to 758 and items 235 to 240 apply).

GP multidisciplinary case conference

Item	Name	Benefit	Description / recommended frequency
235	Standard Organise and coordinate a case conference	$64.50	Attendance by a medical practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference **lasts for at least 15 minutes, but for less than 20 minutes** (other than a service associated with a service to which items 721 to 732 or items 229 to 233 apply).
236	Long Organise and coordinate a case conference	$110.25	Attendance by a medical practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate:(a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference **lasts for at least 20 minutes, but for less than 40 minutes** (other than a service associated with a service to which items 721 to 732 or items 229 to 233 apply).
237	Prolonged Organise and coordinate a case conference	$183.70	Attendance by a medical practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference **lasts for at least 40 minutes** (other than a service associated with a service to which items 721 to 732 or items 229 to 233 apply).
238	Standard Participate in a case conference	$47.35	Attendance by a medical practitioner, as a member of a multidisciplinary case conference team, to participate in: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference **lasts for at least 15 minutes, but for less than 20 minutes** (other than a service associated with a service to which items 721 to 732 or items 229 to 233 apply).
239	Long Participate in a case conference	$81.15	Attendance by a medical practitioner, as a member of a multidisciplinary case conference team, to participate in: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference **lasts for at least 20 minutes, but for less than 40 minutes** (other than a service associated with a service to which items 721 to 732 or items 229 to 233 apply).
240	Prolonged Participate in a case conference	$135.05	Attendance by a medical practitioner, as a member of a multidisciplinary case conference team, to participate in: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference **lasts for at least 40 minutes** (other than a service associated with a service to which items 721 to 732 or items 229 to 233 apply).

GP multidisciplinary case conference

Item	Name	Benefit	Description / recommended frequency
243	Lead and coordinate a case conference for a patient with Cancer	$63.15	Attendance by a medical practitioner, as a member of a case conference team, to lead and coordinate a multidisciplinary case conference on a patient with cancer to develop a multidisciplinary treatment plan, if the case conference is of **at least 10 minutes**, with a multidisciplinary team of at **least 3 other medical practitioners** from different areas of medical practice (which may include general practice), and, in addition, allied health providers.
244	Lead and coordinate a case conference for a patient with Cancer	$29.45	Attendance by a medical practitioner, as a member of a case conference team, to participate in a multidisciplinary case conference on a patient with cancer to develop a multidisciplinary treatment plan, if the case conference is of **at least 10 minutes**, with a multidisciplinary team of at **least 4 medical practitioners** from different areas of medical practice (which may include general practice), and, in addition, allied health providers.

Medication management review

Item	Name	Benefit	Description / recommended frequency
245	Domiciliary Medication Management Review (DMMR)	$141.10	Participation by a medical practitioner in a Domiciliary Medication Management Review (DMMR) for a patient living in a community setting, in which the medical practitioner, with the patient's consent: (a) assesses the patient as: (i) having a chronic medical condition or a complex medication regimen; and (ii) not having their therapeutic goals met; and (b) following that assessment: (i) refers the patient to a community pharmacy or an accredited pharmacist for the DMMR; and (ii) provides relevant clinical information required for the DMMR; and (c) discusses with the reviewing pharmacist the results of the DMMR including suggested medication management strategies; and (d) develops a written medication management plan following discussion with the patient; and (e) provides the written medication management plan to a community pharmacy chosen by the patient For any particular patient—this item or item 900 is applicable not more than once in each 12 month period, except if there has been a significant change in the patient's condition or medication regimen requiring a new DMMR.
249	Residential Medication Management Review (RMMR)	$96.60	Participation by a medical practitioner in a residential medication management review (RMMR) for a patient who is a permanent resident of a residential aged care facility - other than an RMMR for a resident in relation to whom, in the preceding 12 months, this item or item 903 has applied, unless there has been a significant change in the resident's medical condition or medication management plan requiring a new RMMR.

Health assessments

Item	Name	Benefit	Description / recommended frequency
224	Brief Health Assessment	$54.10	Professional attendance by a medical practitioner to perform a brief health assessment, **lasting not more than 30 minutes** and including: (a) collection of relevant information, including taking a patient history; and (b) a basic physical examination; and (c) initiating interventions and referrals as indicated; and (d) providing the patient with preventive health care advice and information.
225	Standard Health Assessment	$125.70	Professional attendance by a medical practitioner to perform a standard health assessment, **lasting more than 30 minutes but less than 45 minutes**, including: (a) detailed information collection, including taking a patient history; and (b) an extensive physical examination; and (c) initiating interventions and referrals as indicated; and (d) providing a preventive health care strategy for the patient.
226	Long Health Assessment	$173.40	Professional attendance by a medical practitioner to perform a long health assessment, **lasting at least 45 minutes but less than 60 minutes**, including: (a) comprehensive information collection, including taking a patient history; and (b) an extensive examination of the patient's medical condition and physical function; and (c) initiating interventions and referrals as indicated; and (d) providing a basic preventive health care management plan for the patient.
227	Prolonged Health Assessment	$245.00	Professional attendance by a medical practitioner to perform a prolonged health assessment (lasting at least 60 minutes) including: (a) comprehensive information collection, including taking a patient history; and (b) an extensive examination of the patient's medical condition, and physical, psychological and social function; and (c) initiating interventions or referrals as indicated; and (d) providing a comprehensive preventive health care management plan for the patient.
228	Aboriginal and Torres Strait Islander Health Assessment	$193.45	Professional attendance by a medical practitioner at consulting rooms or in another place other than a hospital or residential aged care facility, for a health assessment of a patient who is of Aboriginal or Torres Strait Islander descent—this item or item 715 not more than once in a 9 month period.

Mental health

Item	Name	Benefit	Description / recommended frequency
272	Standard Consultation - GP Mental Health Treatment Plan	$65.35	Professional attendance by a medical practitioner (who **has not** undertaken mental health skills training) of **at least 20 minutes but less than 40 minutes** in duration for the preparation of a GP mental health treatment plan for a patient.
276	Long Consultation - GP Mental Health Treatment Plan	$96.20	Professional attendance by a medical practitioner (who has not undertaken mental health skills training) of at least 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient.
277	Review of GP Mental Health Treatment Plan	$65.35	Professional attendance by a medical practitioner to review a GP mental health treatment plan which he or she, or an associated medical practitioner has prepared, or to review a Psychiatrist Assessment and Management Plan.
279	Standard Consultation - Mental Health Consultation	$65.35	Professional attendance by a medical practitioner in relation to a mental disorder and of **at least 20 minutes** in duration, involving taking relevant history and identifying the presenting problem (to the extent not previously recorded), providing treatment and advice and, if appropriate, referral for other services or treatments, and documenting the outcomes of the consultation.
281	Standard Consultation - GP Mental Health Treatment Plan	$82.95	Professional attendance by a medical practitioner (who **has** undertaken mental health skills training) of **at least 20 minutes but less than 40 minutes** in duration for the preparation of a GP mental health treatment plan for a patient.
282	Long Consultation - GP Mental Health Treatment Plan	$122.25	Professional attendance by a medical practitioner (who **has** undertaken mental health skills training) of **at least 40 minutes** in duration for the preparation of a GP mental health treatment plan for a patient.
283	Standard GP Focused Psychological Strategies – In Rooms	$84.55	Professional attendance at consulting rooms by a medical practitioner, for providing focused psychological strategies for assessed mental disorders by a medical practitioner registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service, and **lasting at least 30 minutes, but less than 40 minutes.**
285	Standard GP Focused Psychological Strategies – Out of Rooms	*see note	Professional attendance at a place other than consulting rooms by a medical practitioner, for providing focused psychological strategies for assessed mental disorders by a medical practitioner registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service, and **lasting at least 30 minutes, but less than 40 minutes**. (**See MBS online for fee calculation**). **The fee for item 283, plus $23.70 divided by the number of patients seen, up to a maximum of six*

Mental health

Item	Name	Benefit	Description / recommended frequency
			patients. For seven or more patients - the fee for item 283 plus $1.85 per patient.

286	Long GP Focused Psychological Strategies – In Rooms	$121.00	Professional attendance at consulting rooms by a medical practitioner, for providing focused psychological strategies for assessed mental disorders by a medical practitioner registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service, and **lasting at least 40 minutes.**
287	Long GP Focused Psychological Strategies – Out of Rooms	*see note	Professional attendance at a place other than consulting rooms by a medical practitioner, for providing focused psychological strategies for assessed mental disorders by a medical practitioner registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service, and **lasting at least 40 minutes**. (**See MBS online for fee calculation**). **The fee for item 286, plus $23.70 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 286 plus $1.85 per patient.*
792	Non-directive pregnancy support counselling	$69.80	Professional attendance of **at least 20 minutes** in duration at consulting rooms by a medical practitioner who is registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service for the purpose of providing non-directive pregnancy support counselling to a person who: (a) is currently pregnant; or (b) has been pregnant in the 12 months preceding the provision of the first service to which this item or items 4001, 81000, 81005 or 81010 applies in relation to that pregnancy.

*Many patients will not require a new plan after their initial plan has been prepared. A new plan should not be prepared unless clinically required, and generally not within 12 months of a previous plan. Ongoing management can be provided through the GP Mental Health Treatment Consultation and standard consultation items, as required, and reviews of progress through the GP Mental Health Treatment Plan Review item. A rebate for preparation of a GP Mental Health Treatment Plan will not be paid within 12 months of a previous claim for the patient for the same or another Mental Health Treatment Plan item or within three months following a claim for a GP Mental Health Treatment Review (item 277), other than in exceptional circumstances.

+The recommended frequency for the review service, allowing for variation in patients' needs, is:

- an initial review, which should occur between four weeks to six months after the completion of a GP Mental Health Treatment Plan; and
- if required, a further review can occur three months after the first review.

In general, most patients should not require more than two reviews in a 12-month period, with ongoing management through the GP Mental Health Treatment Consultation and standard consultation items, as required.

After Hours

<table>
<tr><th colspan="3">Attendance period</th><th>Item number</th><th>Brief guide</th></tr>
<tr><td colspan="3">After Hours – In Rooms</td><td rowspan="2">733 (<5 mins 1 patient) - $26.40
737 (5-25 mins 1 patient) - $44.60
741 (25-45 mins 1 patient) - $76.55
745 (>45 mins 1 patient) - $107.35
761-769 (>1-6 patients)</td><td rowspan="2">These items can only be used for the first patient. If more than one patient is seen on the one occasion, other items apply to a maximum of 6 patients.</td></tr>
<tr><td>Mon-Fri
7am-8am or
6pm-11pm</td><td>Sat
7am-8am or 12noon-
11pm</td><td>Sun and Public Holidays
7am-11pm</td></tr>
<tr><td colspan="3">After Hours at a place other than consulting rooms</td><td>772 (<5 mins >1-6 patient)
776 (5-25 mins >1-6 patient)
788 (25-45 mins >1-6 patient)
789 (>45mins >1-6 patients)</td><td rowspan="3">For consultations at the health centre, if more than one patient is seen on the one occasion, these items apply to a maximum of 6 patients.</td></tr>
<tr><td colspan="3">Mon-Fri
Before 8am or after 6pm</td><td rowspan="2">Sat
Before 8am or After 12pm</td></tr>
<tr><td colspan="3">Sun and Public Holidays
All day</td></tr>
</table>

Nurse practitioner - MBS item numbers

Routine consultations

Item	Name	Benefit	Description / recommended frequency
82200	Brief <5 minutes	$14.20	Professional attendance by a participating nurse practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management.
82205	Standard 5-24 minutes	$31.05	Professional attendance by a participating nurse practitioner lasting less than 20 minutes and including any of the following: a) taking a history; b) undertaking clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; for 1 or more health related issues, with appropriate documentation.
82210	Long 25-44 minutes	$58.85	Professional attendance by a participating nurse practitioner lasting at least 20 minutes and including any of the following: a) taking a detailed history; b) undertaking clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; for 1 or more health related issues, with appropriate documentation.
82215	Prolonged >45 minutes	$86.80	Professional attendance by a participating nurse practitioner lasting at least 40 minutes and including any of the following: a) taking an extensive history; b) undertaking clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; for 1 or more health related issues, with appropriate documentation.

Telehealth

Item	Name	Benefit	Description / recommended frequency
91192	Brief <5 minutes	$14.20	Telehealth attendance by a participating nurse practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited management.
91178	Standard 5-24 minutes	$31.05	Telehealth attendance by a participating nurse practitioner lasting less than 20 minutes if the attendance includes any of the following that are clinically relevant: a) taking a short history; b) arranging any necessary investigation; c) implementing a management plan; d) providing appropriate preventive health care.
91179	Long 25-44 minutes	$58.50	Telehealth attendance by a participating nurse practitioner lasting at least 20 minutes if the attendance includes any of the following that are clinically relevant: a) taking a detailed history; b) arranging any necessary investigation; c) implementing a management plan; d) providing appropriate preventive health care.
91180	Prolonged >45 minutes	$86.80	Telehealth attendance by a participating nurse practitioner lasting at least 40 minutes if the attendance includes any of the following that are clinically relevant: a) taking an extensive history; b) arranging any necessary investigation; c) implementing a management plan; d) providing appropriate preventive health care.

Telephone

Item	Name	Benefit	Description / recommended frequency
91193	Brief <5 minutes	$14.20	Phone attendance by a participating nurse practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited management.
91189	Standard 5-24 minutes	$31.05	Phone attendance by a participating nurse practitioner lasting less than 20 minutes if the attendance includes any of the following that are clinically relevant: a) taking a short history; b) arranging any necessary investigation; c) implementing a management plan; d) providing appropriate preventive health care.

Item	Name	Benefit	Description / recommended frequency
91190	Long 25-44 minutes	$58.50	Phone attendance by a participating nurse practitioner lasting at least 20 minutes if the attendance includes any of the following that are clinically relevant: a) taking a detailed history; b) arranging any necessary investigation; c) implementing a management plan; d) providing appropriate preventive health care.
91191	Prolonged >45 minutes	$86.80	Phone attendance by a participating nurse practitioner lasting at least 40 minutes if the attendance includes any of the following that are clinically relevant: a) taking an extensive history; b) arranging any necessary investigation; c) implementing a management plan; d) providing appropriate preventive health care.

Case conferences

Item	Name	Benefit	Description / recommended frequency
10955	Multidisciplinary case conferencing - at least 20 mins	$47.35	Attendance by an eligible allied health practitioner, as a member of a multidisciplinary case conference team, to participate in: a) a community case conference; or b) a multidisciplinary case conference in a residential aged care facility; if the conference lasts for at least 15 minutes, but for less than 20 minutes (other than a service associated with a service to which another item in this Group applies).
10957	Multidisciplinary case conferencing - 20-40 mins	$81.15	Attendance by an eligible allied health practitioner, as a member of a multidisciplinary case conference team, to participate in: a) a community case conference; or b) a multidisciplinary case conference in a residential aged care facility; if the conference lasts for at least 20 minutes, but for less than 40 minutes (other than a service associated with a service to which another item in this Group applies).
10959	Multidisciplinary case conferencing - at least 40 mins	$135	Attendance by an eligible allied health practitioner, as a member of a multidisciplinary case conference team, to participate in: a) a community case conference; or b) a multidisciplinary case conference in a residential aged care facility; if the conference lasts for at least 40 minutes (other than a service associated with a service to which another item in this Group applies).

Practice incentive payments - summary

Apply for the Practice Incentives Program - Health professionals - Services Australia (in bulk or / individual incentive)

Some PIP payments are based on a measure of the practice size, known as the Standardised Whole Patient Equivalent (SWPE) value. The SWPE value is a calculation of practice size. It is based on Medicare Benefits Schedule (MBS) services all general practitioners and nurse practitioners provide in the practice.

The SWPE value includes Medicare and the Department of Veterans' Affairs (DVA) services provided to patients during the reference period. This is a rolling, historical, 12-month period. It starts 16 months before the payment quarter.

PIP Quality stream

Incentive	Aspect or activity	Payment amount
Indigenous Health Incentive	Sign on payment. This is a once only payment. Practices agree to undertake specified activities to improve the care of their Aboriginal and Torres Strait Islander patients with a chronic disease or mental disorder.	$1000 per practice
	Patient registration payment. This is a payment to practices for each eligible Aboriginal and/or Torres Strait Islander patient aged 15 years or over. (to be removed in 2025). *January 2025, lifetime enrolment to the Indigenous Health Incentive will begin and the need to re-register patients yearly will be removed.	$150 per eligible patient per calendar year
	Outcome payment Tier 1. A payment to practices that meet the requirements of the Tier 1 Outcome payment within a 12-month assessment period.	$100 per eligible patient per 12- month assessment period
	Outcome payment Tier 2. A payment to practices for providing a target level of care for a registered patient within a 12-month assessment period.	$200 per eligible patient per 12- month assessment period (increasing to $300 on 1/1/25)
Quality Improvement Incentive	A payment to practices undertaking continuous quality improvement through the collection and review of practice data.	$5 per SWPE capped at $12,500 per quarter

PIP capacity stream

Incentive	Aspect or Activity	Payment amount
After Hours Incentive	Level 1: Participation payment Practices must meet the requirements of Level 1. This includes having formal arrangements in place to ensure patients have access to care in the complete after-hours period.	$1 per SWPE
	Level 2: Sociable after-hours cooperative coverage Practices must meet the requirements of Level 2. This includes participating in a cooperative arrangement and other formal arrangements. This is to make sure patients have access to care in the sociable and unsociable after-hours periods.	$4 per SWPE
	Level 3: Sociable after-hours practice coverage Practices must meet the requirements of Level 3. This includes providing after hours care directly through the practice and through formal arrangements.	$5.50 per SWPE
	Level 4: Complete after-hours cooperative coverage Practices must meet the requirements of Level 4. This includes participating in a cooperative arrangement. This makes sure patients have access to care throughout the complete after-hours period.	$5.50 per SWPE
	Level 5: Complete after-hours practice coverage Practices must meet the requirements of Level 5. This includes the practice providing after-hours care directly to patients throughout the complete after-hours period.	$11 per SWPE
eHealth Incentive	Practices must meet each of the requirements to qualify for payments through this incentive.	$6.50 per SWPE capped at $12,500 per practice per quarter
TEACHING PAYMENT	Payment to practices for providing teaching sessions to medical students. Practices can claim payment for up to 2 sessions per GP per day.	**$200 PER SESSION**
GENERAL PRACTICE AGED CARE INCENTIVE	Paid as PIP to practice and MyMedicare IP to General practitioners. Both Practice and practitioners must be registered for MyMedicare. Payments are linked to registration, and responsible provider must be nominated.	$300 per person registered with MyMedicare to GP as MyMedicare IP **$130 PER PATIENT TO PRACTICE AS PIP**
	A 'Responsible Provider' is a provider who is responsible for coordinating the delivery of eligible services to the registered patient as part of the General Practice in Aged Care Incentive. This includes services provided by other health professionals at the practice as part of the servicing requirements of the incentive. Responsible Providers will be required to be linked to an eligible patient who is registered in the General Practice in Aged Care Incentive in MyMedicare.	
	To meet the servicing requirements of the General Practice in Aged Care Incentive, providers and practices must deliver at least 10 eligible services, from eligible MBS and Department of Veterans' Affairs (DVA) funded services, over a 12-month period including: • eligible care planning services delivered by the Responsible Provider. • 8 eligible regular services comprising of at least 2 per quarter, each in a separate calendar month.	

Incentive	Aspect or activity	Payment amount
General Practice Aged Care Incentive	Paid as PIP to practice and MyMedicare IP to General practitioners. Both Practice and practitioners must be registered for MyMedicare. Payments are linked to registration, and responsible provider must be nominated.	$300 per person registered with MyMedicare to GP as MyMedicare IP $130 per patient to practice as PIP
	A 'Responsible Provider' is a provider who is responsible for coordinating the delivery of eligible services to the registered patient as part of the General Practice in Aged Care Incentive. This includes services provided by other health professionals at the practice as part of the servicing requirements of the incentive. Responsible Providers will be required to be linked to an eligible patient who is registered in the General Practice in Aged Care Incentive in MyMedicare.	
	To meet the servicing requirements of the General Practice in Aged Care Incentive, providers and practices must deliver at least 10 eligible services, from eligible MBS and Department of Veterans' Affairs (DVA) funded services, over a 12-month period including: • eligible care planning services delivered by the Responsible Provider. • 8 eligible regular services comprising of at least 2 per quarter, each in a separate calendar month.	

PIP rural support stream

Incentive	Aspect or activity	Payment amount
Procedural GP Payment	Tier 1: Payment for a GP in a rural or remote practice who provides at least 1 procedural service in the 6-month reference period. The service must meet the definition of a procedural service.	$1000 per procedural GP per 6-month reference period
	Tier 2: Payment for a GP in a rural or remote practice who meets both: • The Tier 1 requirement provides after-hours procedural services on a regular or rostered basis. • This must be 15 hours per week on average throughout the 6-month reference period.	$2000 per procedural GP per 6-month reference period
	Tier 3: Payment for a GP in a rural or remote practice who both: • meets the Tier 2 requirements. • provides 25 or more eligible surgical, anaesthetic or obstetric services in the 6-month reference period.	$5000 per procedural GP per 6-month reference period
	Tier 4: Payment for a GP in a rural or remote practice who both: • meets the Tier 2 requirements. • delivers 10 or more babies in the 6-month reference period or meets the obstetric needs of the community.	$8500 per procedural GP per 6-month reference period
Rural loading Incentive	Payment for a practice whose main location is outside a metropolitan area, based on the Rural, Remote and Metropolitan Area (RRMA) Classification. Once all incentive payments are added, the rural loading amount is applied.	RRMA 3- 15% loading RRMA 4- 20% loading RRMA 5- 40% loading RRMA 6- 25% loading RRMA 7- 50% loading

What is the workforce incentive program – practice stream (WIP-PS)?

The WIP-PS provides financial incentives for eligible general practices to support multidisciplinary, team-based models of care across Modified Monash (MM) regions 1-7.

Workforce Incentive Program – Practice Stream

https://www.health.gov.au/our-work/workforce-incentive-program/practice-stream

Services Australia

https://www.servicesaustralia.gov.au/apply-for-workforce-incentive-program-wip-practice-stream?context=20

WIP-PS

Guidelines

What are the eligibility requirements for a general practice to participate in WIP-PS?

To be eligible to participate in the WIP-PS, a general practice (including Aboriginal Medical Services and Aboriginal Community Controlled Health Services) must meet all of the following requirements:

- be a general practice as defined by the Royal Australian College of General Practitioners (RACGP)
- be accredited, or registered for accreditation, as a general practice against the RACGP Standards for general practices (the RACGP Standards)
- Noting that a general practice must be accredited (or registered with the aim of becoming accredited within 12 months of registration)
- employ at least one full-time or part-time GP
- engage at least one eligible health professional; and
- maintain at least $10 million in public liability insurance.

Eligible health professionals

Eligible health professional types under the WIP-PS include nurse practitioners, registered nurses, midwives, enrolled nurses, Aboriginal and Torres Strait Islander practitioners and workers. Allied health professional types include audiologists, chiropractors, diabetes educators, dietitians/nutritionists, exercise physiologists, occupational therapists, orthoptists, orthotists/prosthetists, osteopaths, paramedics, pharmacists (non-dispensing role), physiotherapists, podiatrists, psychologists, social workers and speech pathologists. Extra requirements apply for some professional types - refer to the Guidelines.

All health professionals must hold the minimum qualifications set out in the Guidelines and maintain the required level of professional indemnity insurance.

WIP-PS payments

Services Australia calculates and administer the payments for the Department of Health and Aged Care (Health) each quarter in February, May, August and November.
The amount paid to each eligible general practice depends on the following factors:

- Practice size measured in Standardised Whole Patient Equivalent (SWPE);
- practice location;
- type of practice;
- type of eligible health professionals engaged;
- average weekly hours worked by eligible health professionals at the practice over the quarter; and
- loadings applicable (loading by MM region and DVA concession status)

Please note: A 50% increase is applied to the SWPE values of Aboriginal Medical Services and Aboriginal Community Controlled Health Services.

Indicative payment amounts and rural loadings

A practice may be eligible to receive incentive payments of up to $130,000 per year per practice (before rural loadings and indexation are applied). Indexation will be applied each year from 2024-25, starting in August 2024.

Indicative annual incentive amounts based on Standardised Whole Patient Equivalent (SWPE) values

SWPE value	Minimum average number of hours per week for full incentive payment Minimum average number of hours per week for full incentive payment	Annual incentive amount* for combined nurse practitioner, registered nurse, midwife, and allied health professionals	Annual incentive amount* for combined enrolled nurse, Aboriginal and Torres Strait Islander health worker, or Aboriginal and Torres Strait Islander health practitioners
1000	12 hours 40 minutes	$32,500	$16,250
2000	25 hours 20 minutes	$65,000	$32,500
3000	38 hours	$97,500	$48,750
4000	50 hours 40 minutes	$130,000	$65,000

*Indexation will be applied to payments from 2024-25

Rural loadings are available on top of incentive payments as follows:
0% for MM 1 and MM 2;
30% for MM 3;
40% for MM 4 and MM 5; and
60% for MM 6 and MM 7.