

Questions and Answers - The Changes to Medicare Primary Care Items from 1 May 2010

Increases in MBS Fees

Which MBS items' fees will increase on 1 May 2010?

Fee increases will apply to level C and D general attendance items including: items 36 and 44; GP acupuncture items 197 and 198; Practice Incentive Payments items 2504, 2507, 2521, 2525, 2552 and 2558; Public Health Physicians items 412 and 413; and non-urgent after-hours items 5040 and 5060.

Will the derived fees for out-of-surgery consultations and after-hours items be increased?

Derived fees for level A and B out-of-surgery and after-hours consultations will not change. Derived fees level C and D out-of-surgery and after-hours consultations will increase proportionately.

What will the fee increases be from 1 May 2010?

Details of the level of fee increases can be found on 'The Changes to Medicare Primary Care Items – A Fact Sheet for General Practitioners' at <http://www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-changes-to-medicare-primary-care-items-for-gps>

Will there be any changes for the general attendance item 23 (Level B)?

There will be no change to the fee for item 23 (Level B). The item descriptor will change to allow GPs to address multiple health issues and provide valuable preventive health care.

Health Assessments

How will I claim for a health assessment?

From 1 May 2010, there will be four time-based health assessment items, consisting of brief, standard, long and prolonged consultations.

- A Brief Health Assessment (MBS Item 701) will be used to undertake simple and straightforward health assessments. The health assessment should take less than 30 minutes to complete.
- A Standard Health Assessment (MBS Item 703) will be used for more complex consultations that last more than 30 minutes but take less than 45 minutes.
- A Long Health Assessment (MBS Item 705) will be used for extensive consultations that last more than 45 minutes but less than one hour.
- A Prolonged Health Assessment (MBS Item 707) will be used for complex consultations that require more than 60 minutes to complete.

Medical practitioners may select one of the MBS health assessment items to provide a health assessment service to a member of any of the target groups listed in the table below. The health assessment item that is selected will depend on the time taken to complete the health assessment service. This will be determined by the complexity of the patient's presentation.

| Target Groups | Frequency of Service |
|---|---|
| Children aged at least 3 years and less than 5 years of age, who have received or who are receiving their 4 year old immunisation | Once only to an eligible patient |
| People aged 40-49 years (inclusive) with a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool | Once every three years to an eligible patient |
| People aged 45-49 years (inclusive) who are at risk of developing chronic disease | Once only to an eligible patient |
| People aged 75 years and older | Provided annually to an eligible patient |
| Permanent residents of Residential Aged Care Facilities | Provided annually to an eligible patient |
| People with an intellectual disability | Provided annually to an eligible patient |
| Refugees and other humanitarian entrants | Once only to an eligible patient |

The requirements for each of these target groups will remain unchanged and will be available in the explanatory notes.

How will I claim a health assessment for Aboriginal and Torres Strait Islander people and what will the time period be between two consecutive health assessments?

The Aboriginal and Torres Strait Islander Persons Health Assessment (MBS item 715) will be available to all people of Aboriginal and Torres Strait Islander descent and should be used for health assessments for the following age categories:

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

This health assessment will be an annual service. The minimum time allowed between services will be nine (9) months. This will allow flexibility for very remote communities, where medical practitioner visits may be less frequent and may make it more difficult to follow a consistent schedule of health assessments.

Will there be any change to the way that GPs charge for their own services and the services of the practice nurse when providing health assessments?

No, there will be no change to the way that GPs charge for their own services and the services of the practice nurse when providing health assessments. Practice nurses and registered Aboriginal health workers may assist medical practitioners in performing the health check, in accordance with accepted medical practice and under the supervision of the medical practitioner. This may include activities associated with:

- information collection; and
- providing patients with information about recommended interventions at the direction of the medical practitioner.

All other components of the health assessment must be undertaken by the medical practitioner and must include a personal attendance by a medical practitioner. The time take by the practice nurse to complete the above components of the health assessment can be included in the total time for GPs to claim these items. The exception is the Healthy Kids Check item (10986) provided by a practice nurse or registered Aboriginal health worker.

The MBS Healthy Kids Check can be provided by either a medical practitioner or a practice nurse/registered Aboriginal health worker. Both items will be claimed by a general practitioner. If the Healthy Kids Check is provided by a practice nurse or registered Aboriginal health worker, it is

undertaken for and on behalf of a medical practitioner. This item was previously MBS item 711. It has been retained but has been allocated a new MBS item number 10986 and the fee will be increased to align with the Brief Health Assessment provided by a GP.

How do I fill in a patient's account/receipt/invoice for the new MBS Health Assessment items 701, 703, 705, 707?

Doctors should annotate their patient's account/receipt/invoice or bulk billing assignment of benefit voucher with a description of the particular MBS health assessment service delivered to the patient, including the time taken (brief, standard, long or prolonged) and the type of health assessment being provided to the patient (for example: Healthy Kids Check; health assessment for people aged 45 to 49 years who are at risk of developing chronic disease; type 2 diabetes risk evaluation; health assessment for people aged 75 years and older etc.).

Health Assessments Proformas

From 1 May 2010, can I still use the proformas for health assessments previously provided on the Department of Health and Ageing's website?

Yes, from 1 May 2010, you may continue to use the proformas which were previously provided by the Department of Health and Ageing to assist health professionals in completing health assessments. These will continue to be available on the Department of Health and Ageing's website at <http://www.health.gov.au/internet/main/publishing.nsf/Content/mha.htm>.

From 1 May 2010, there will be four time-based health assessment items, consisting of brief, standard, long and prolonged consultations. Medical practitioners may select one of the MBS health assessment items to provide a health assessment service to a member of a specific target group.

The health assessment requirements for each target group will not change from previous health assessment items. From 1 May 2010, the explanatory notes will be available on the Department of Health and Ageing's website at <http://www.health.gov.au/mbsonline> and fact sheets for each target group will be available at <http://www.health.gov.au/internet/main/publishing.nsf/Content/mha.htm>.

Referral to a subsidised Lifestyle Modification Program for patients at risk of developing type 2 diabetes

Will there be any changes to the referral process to a Lifestyle Modification Program for patients at risk of developing type 2 diabetes from 1 May 2010?

There will not be any changes to the referral process to a Lifestyle Modification Program for patients at risk of developing type 2 diabetes from 1 May 2010.

Patients aged 40 to 49 years of age who are at high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool (AUSDRISK) and who have undertaken a health assessment provided as a type 2 diabetes risk evaluation, will continue to be eligible for referral by a medical practitioner to a subsidised Lifestyle Modification Program as one of a number of possible intervention strategies.

Patients may also be referred to a subsidised Lifestyle Modification Program following a health assessment provided for people aged 45-49 years who are at risk of developing a chronic disease or following an Aboriginal and Torres Strait Islander Persons Health Assessment if they are found to be at high risk of developing type 2 diabetes as measured by the AUSDRISK.

Chronic Disease Management

How often can item 732 be claimed?

Each service to which item 732 applies (i.e. Review of a GP Management Plan and Review of Team Care Arrangements) may be claimed once in a three-month period, except where there are exceptional circumstances arising from a significant change in the patient's clinical condition or care circumstances that necessitates earlier performance of the service for the patient.

Where a service is provided in exceptional circumstances, the patient's invoice or Medicare voucher should be annotated to indicate the reason why the service was required earlier than the minimum time interval for the relevant item. Payment can then be made.

Can a GP claim item 732 twice on the same day?

Yes. Providing an item 732 for reviewing a GP Management Plan and another 732 for reviewing Team Care Arrangements (TCAs) are both delivered on the same day as per the MBS item descriptors and explanatory notes, they could be claimed on the same day.

After hours MBS items

What MBS item do I bill for an urgent after hours consultation from 1 May 2010?

From 1 May 2010, urgent after hours consultations may be claimed under Medicare items 597, 589, 599 and 600.

Urgent after hours consultations by GPs (item 597) and other medical practitioners (item 598) may be claimed for urgent consultations provided either in consulting rooms or at a place other than consulting rooms in an after hours period. These items will have new starting times of 6pm on weekdays and 12 noon on Saturdays. All other time periods for these after hours items will remain unchanged.

Urgent after hours consultations by GPs (item 599) and other medical practitioners (item 600) may be claimed for consultations provided in consulting rooms or at a place other than consulting rooms between 11pm-7am (unsociable hours) on any day of the week.

These items will require that:

- the attendance be requested by the patient or a responsible person in or not more than two hours before the start of the same unbroken period;
- the patient's medical condition requires urgent treatment; and
- it is necessary for the practitioner to return to and specially open consulting rooms for the attendance, remain unchanged.

Medical practitioners who routinely provide services to patients in the after-hours periods at consulting rooms, or who provide the services (as a contractor, employee, member or otherwise) for a general practice or clinic that routinely provides services to patients in after-hours periods at consulting rooms will not be able to bill urgent after hours items 597, 598, 599 and 600.

Non-urgent after hours MBS items

What MBS items can I bill for non-urgent after hours consultations from 1 May 2010?

From 1 May 2010, the following non-urgent after hours MBS items can be billed : 5000, 5003, 5010, 5020, 5023, 5028, 5040, 5043, 5049, 5060, 5063, 5067, 5200, 5203, 5207, 5208, 5220, 5223, 5227, 5228, 5260, 5263, 5265, 5267.

Non-urgent after hours items for services provided at consulting rooms will continue to apply on Sundays and public holidays, after 1pm on Saturdays and after 8pm on any other day: 5000, 5020, 5040, 5060, 5200, 5203, 5207, 5208.

Non-urgent after hours items for home visits and consultations at institutions (other than a hospital or a residential aged care facility) will be combined into one MBS item at levels A, B, C and D: items 5003, 5023, 5043, 5063, 5220, 5223, 5227, 5228.

MBS items for services provided at residential aged care facilities (RACFs) remain unchanged: 5010, 5028, 5049, 5067, 5260, 5263, 5265, 5267.

All non-urgent after hours services provided at a place other than consulting rooms, outlined above, will apply on Sundays and public holidays, after 12 noon on Saturdays and after 6pm on any other day.