

10 March 2009

Standard Aged Care Home GP Consultation Item Numbers △

Items 20 35 43 51 Items refer to the usual (VR) GP attendance to a resident of an aged care home and are used in place of standard consultation items (level 'A', 'B', 'C', & 'D'). These items include a 'derived fee' according to the number of patients seen in one visit.

Items 92 93 95 96 Items refer to the usual (non-VR) GP attendance to a resident of an aged care home. Includes 'derived fee' (N.B. All of these items do not apply to patients living in self contained units within a RACF complex, use normal attendance items for surgery attendance or home visit.)

Comprehensive Medical Assessment (CMA) Item 712△

Item 712: For new residents and for existing residents as required. Maximum of 1 in a 12 month period. Completion of CMA will assist facilities with the resident assessment and determining care needs.

100% rebate & MBS Fee	\$196.20
115% DVA	\$225.65

Residential Medication Management Review (RMMR) Item 903△

Pharmacist is contracted to perform 1 RMMR per resident per year and to review findings with the GP and RACF staff.

Item 903: As well, GP may initiate RMMR; available for all permanent residents of aged care homes.

100% rebate & MBS Fee	\$96.00
115% DVA	\$110.40

Contribution to a Care Plan/Review Item 731#△

Item 731: The care plan is initiated by the RACF. All residents of an Aged Care Home are eligible for care plan contribution due to the chronic and complex nature of the medical conditions that have contributed to their need for residential care.

100% rebate & MBS Fee	\$63.75
115% DVA	\$73.35

Case Conference△

Eligibility: Must involve at least 2 other health care providers and the residents GP. Team members must be responsible for different aspects of care. (Resident / family may be involved / present but are not counted as care providers.)

Organize & Coordinate a Case Conference

Time	15-30 min	30-45 min	>45 min
In Aged Care Homes	Item 734	Item 736	Item 738
100% rebate & MBS Fee	\$87.55	\$131.35	\$175.10
115% DVA	\$100.70	\$151.05	\$201.40

Allied Health MBS Items

Eligibility: If the resident's GP has contributed to the care plan AND claimed Item 731 the resident may be eligible to access up to five allied health sessions. GP must formally refer to the allied health practitioner and AH practitioner must comply with defined reporting procedures. Some allied health services for residents in high care places are already funded. Check with the RACF for details.

Item Numbers (profession specific)	10950 To 10970
MBS Fee	\$57.55 (85% rebate—\$48.95)

Participate in a Case Conference

Time	15-30 min	30-45 min	>45 min
In Aged Care Homes	Item 775	Item 778	Item 779
100% rebate & MBS Fee	\$62.50	\$100.05	\$137.55
115% DVA	\$71.90	\$115.10	\$158.20

THIS IS A QUICK REFERENCE ONLY.

FOR A DEFINITIVE GUIDE ON MEDICARE ITEM NUMBERS CHECK THE MBS AT: <http://www.health.gov.au/internet/mbsonline/publishing.nsf/content/medicare-benefits-schedule-mbs-1>

FORTH A COMPLETE LISTING OF DVA MEDICAL BENEFITS GO TO: http://www.dva.gov.au/health/provider_fees/DVA_Fee_Schedule_for_Medical_Services-1Dec2008.pdf

In an aged care setting, the GP's contribution to a Care Plan (MBS item 731) is a requirement for accessing the Allied Health and Dental Care services.
 △ If the service is bulk-billed, the GP is able to claim the \$6.50/\$5.55 item 10990 or \$9.80/\$8.35 item 10991 bulk billing incentive for eligible patients.

This flow chart has been produced by General Practice Victoria. The aim is to provide an introduction to the MBS Items, it should not be used instead of the Medicare Benefits schedule.

MBS Online is available at: <http://www.health.gov.au/internet/mbsonline/publishing.nsf/Content/Medicare-Benefits-Schedule-MBS-1>

Comprehensive Medical Assessments (CMA) Item 712

A Comprehensive Medical Assessment (CMA) is available to all permanent residents of aged care homes. A GP can provide a CMA to new residents on admission to an Aged Care Home (recommended within first six weeks) and to existing residents on an as required basis. A maximum of one Medicare rebate is payable for a CMA for a resident in any 12 month period.

A CMA is an optional service for residents of aged care homes and must include:

- A detailed medical history
- A comprehensive medical examination
- Developing a list of diagnosis and/problems
- A written summary to aid the facility

For more information visit DoHA website: http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-medicare-health_pro-gp-cmarach.htm

Role of the Practice Nurse

A practice nurse can assist the GP in obtaining information relevant to the CMA for the GP's consideration, in taking the resident's history and in the examination, but cannot replace the GP's involvement in these components of the CMA. The CMA must include a personal attendance by the GP to the aged care resident, usually in the Aged Care Home. Unlike the home visit component of an EPC Health Assessment, there is no specific component of a CMA that can be undertaken wholly by a nurse, in place of the GP.

The GP may wish to review and incorporate into the CMA any relevant assessment or information about the resident that is available from the Aged Care Home. The CMA can provide the GP with useful information to contribute to an eligible resident's Care Plan (Item 731) and can also complement the RMMR (Item 903)

Residential Medication Management Review (RMMR) Item 903

GPs may request an RMMR for a resident. RMMRs are collaborative services available to new permanent residents or existing residents, who are likely to benefit from such a review, including residents for whom quality use of medicines may be an issue or who are at risk of medication misadventure because of a significant change in their condition. The RMMR (item 903) can be claimed once in a twelve-month period, except where there has been significant change in medical condition or medication regimen requiring a new RMMR.

From 1 July 2007, Pharmacists are funded to conduct 1 RMMR per resident per year. This is done without a GP referral for the service.

Pharmacists working with aged care facilities MUST have an agreement with the facility (and Medicare Australia) to participate in quality activities related to QUM in aged care facilities.

For more information visit DoHA website: [http://www.health.gov.au/internet/main/publishing.nsf/Content/170DCB543D605A3CCA2573E2000151D/\\$File/agedcarefact.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/170DCB543D605A3CCA2573E2000151D/$File/agedcarefact.pdf)

GP Contribution to Resident's Care Plans Item 731

Contribution to a Care Plan/Review Item 731#

All residents of Aged Care Homes are eligible for a Contribution to a Care Plan (Item 731). This is the only Care Planning item the GP can claim for Aged Care Home residents. GP Management Plans (Item 721) and Team Care Arrangements (Item 723) CANNOT be claimed for residents of Aged Care Homes.

A Care Plan is developed by the Aged Care Home for every resident. This practice recognizes the chronic and complex nature of the medical conditions that have contributed to their need for residential care.

The resident's usual GP or another GP from the same practice can make a contribution to a Care Plan upon the request of the Aged Care Home.

The Item 731 can also be claimed when the GP is involved in Discharge Care Planning for a resident leaving hospital and returning back to the Aged Care Home.

The recommended frequency of Item 731 is once every six months but can be claimed after a minimum of three months. In preparing a contribution to the Care Plan the GP is required to obtain consent▲ from the resident or carer.

The GPs contribution involves the GP collaborating with the Aged Care Home staff to set goals and specify treatment/services to be provided by the GP or provide advice to the person preparing the plan. The GP's contribution should be made preferably face to face or by telephone, or where this is not practicable, by fax, email, or written correspondence.

The GPs contribution should be recorded on the Aged Care Home care plan (this can be done by the Aged Care Home staff member the GP has communicated with) and the GP should make a note on the resident's medical record. The Aged Care Home should offer the GP a copy of the plan, or the part of the plan into which the GPs suggestions have been incorporated.

Item 731 is required for a resident to access additional allied health services under MBS. Eligibility and further details at: <http://www.health.gov.au/internet/main/publishing.nsf/Content/admin-arrangement-for-allied-health>

*The multidisciplinary care team may include allied health professionals such as: dentists, diabetes educators, personal care worker, occupational therapist, pharmacist, podiatrist, psychologist, registered nurse, speech pathologists.

Allied Health & Dental Care Items

When a resident's GP has contributed to their care plan, the resident may access Medicare rebates for a maximum of 5 allied health services a year and dental care when referred by their GP to a HIC registered Allied Health Provider or a General Dentist, Dental Specialist or Dental Prosthetist.

Allied health providers who may be eligible for a Medicare provider number and to provide services to residents are: Aboriginal Health Worker, Audiologist, Diabetes Educator, Dietician, Exercise Physiologists, Mental Health Worker, OT, Physiotherapist, Podiatrist, Chiropodist, Chiropractor, Osteopath, Psychologist, & Speech Pathologist.

To access the Allied Health or Dental Care Items the GP is required to formally refer the patient to the practitioner. For details about the referral process use one *EPC Program Referral form for Allied Health Services or Dental Care under Medicare* for each Allied Health Service provider. Once the service has been provided to the patient the Allied Health professional completes the bottom section of the referral form including their HIC provider number and their original signature. A copy of this form no longer needs to be submitted with the patient's Medicare claim.

Allied health funded by other Commonwealth or State Government funded programs such as DVA & hospital outpatients, are not eligible for Medicare rebates. An exemption has been granted to Aboriginal Community Controlled Health Services where the Allied Health item numbers can be claimed by either salaried or contracted eligible Allied Health providers. These services are to be bulkbilled and all requirements still have to be met including HIC registration of AHPs and dentists.

Note: all Low Care residents are eligible for the Allied Health & Dental Care rebates. However in High Care, residents are only eligible for rebates if the service they are referred for is not already funded by the aged care home.

The following steps must be completed in order for the resident to receive a Medicare rebate on Allied Health or Dental Care services:

1. The GP must include a comment in the Contribution to Care Plan (Item 731) regarding the need for Allied Health or Dental service.
2. *EPC Program Referral form for Allied Health Services or Dental Care under Medicare* must be completed by the GP.

Case Conferences

The resident's GP can be involved in case conferencing activities with the multi-disciplinary team* (at least two other health or care professionals each providing a different kind of care or service to the patient must be present in addition to the GP). The eligibility for accessing these items are the same as care planning. A case conference is a discussion where members of the team must be communicating at the one time for the whole of the conference, either face-to-face, by telephone, video link, or a combination. During the case conference the team will discuss a patient's history, identify multidisciplinary care needs and plans and outcomes for future care.

The GP may organise or participate in a case conference, in an Aged Care Home. The GP is

required to obtain and record patient consent▲ when organising or participating in a case conference. When organising in a case conference the GP is required to: record day, times, names of participants, matters discussed (history, care needs, outcomes, tasks etc); and provide a summary to patient / carer as agreed, the attending team members and the aged care facility. A record should also be kept in the resident's medical record. It is expected that a patient would not require more than five case conferences in a twelve month period.

For more information DoHA website: <http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-epc-caseconf.htm>