

**Standard Aged Care Home Item Numbers  $\Delta$**

**Items 20 35 43 51** Items refer to the usual (VR) GP attendance to a resident of aged care homes and are used in place of standard consultation items (level 'A', 'B', 'C', & 'D').

**Items 92 93 95 96** Items refer to the usual (non-VR) GP attendance to a resident of an aged care home. (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 $\Delta$**

**Item 712 Eligibility:** For new residents and for existing residents as required.

**Residential Medication Management Review (RMMR) $\Delta$**

**Item 903 Eligibility:** Available for all permanent residents of aged care homes including both high & low care.

<b>100% rebate &amp; MBS Fee</b>	\$187.65
<b>115% DVA</b>	\$215.79

<b>100% rebate &amp; MBS Fee</b>	\$91.85
<b>115% DVA</b>	\$104.47

**Contribution to a Care Plan/Review Item 731# $\Delta$**

**Item 731 Eligibility:** 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.

<b>100% rebate &amp; MBS Fee</b>	\$43.40
<b>115% DVA</b>	\$49.90

**Case Conference $\Delta$**

**Eligibility:** Must involve at least 2 other health care providers and the residents GP.

**Organize & Coordinate a Case Conference**

Time	15-30 min	30-45 min	>45 min
In Aged Care Homes	Item 734	Item 736	Item 738
<b>100% rebate &amp; MBS Fee</b>	\$83.75	\$125.65	\$167.45
<b>115% DVA</b>	\$96.31	\$144.49	\$192.56

**Allied Health & Dental Care Item 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 and three dental care services per year.

**Allied Health Items**

MBS items for use by Allied Health Professionals	10950 10951 10952 10954 10956 10958 10960 10962 10964 10966 10968 10970
MBS Fee	\$55.05
85%	\$46.80

**Participate in a Case Conference**

Time	15-30 min	30-45 min	>45 min
In Aged Care Homes	Item 775	Item 778	Item 779
<b>100% rebate &amp; MBS Fee</b>	\$59.80	\$95.70	\$131.55
<b>115% DVA</b>	\$68.77	\$110.05	\$151.28

**Dental Care Items**

MBS items for use by Dentists	10975, 10976, 10977
MBS Fee	\$91.70
85%	\$77.95

# 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.

$\Delta$  If the service is bulk-billed, the GP is able to claim the \$6.20 item 10990 or \$9.40 item 10991 bulk billing incentive for eligible patients.

This flow chart has been produced by General Practice Divisions Victoria. The aim is to provide an introduction to the MBS Items, it should not be used instead of the Medicare Benefits schedule. It is recommended that GPs refer to the MBS explanatory notes A.20, A.21, & A.22 for a definitive guide.

## 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](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 and can also complement the RMMR.

## Residential Medication Management Review (RMMR) Item 903

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

## 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.

For more information about the Allied Health & Dental care visits under Medicare visit DoHA website: <http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/health-medicare-consumers-booklet4.htm>

### Allied Health & Dental Care Items

When a resident's GP has contributed to their care plan and claimed Item 731, the resident may access Medicare rebates for a maximum of 5 allied health services and 3 dental visits a year when referred by their GP to a HIC registered Allied Health Providers or Dentists.

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. The Item 731 must be successfully claimed prior to the service being received.
3. *EPC Program Referral form for Allied Health Services or Dental Care under Medicare* must be completed by the GP.

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 use one *EPC Program Referral form for Allied Health Services or Dental Care under Medicare* for each Allied Health Service or Dental Care 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 (for example, the aged care home funding usually covers a basic physio assessment but not ongoing treatment.)

## 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 patient's history
- Identify patient's multi-disciplinary care needs
- Identify outcomes to be achieved by members of the case conference team giving care to the patient
- Identify tasks that need to be undertaken in order to achieve outcomes and allocate tasks to team members
- Assess whether previously identified outcomes have been achieved.

The GP can 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 and team members. The GP is required to give a record of the conference to the Aged Care Home, place a copy in the resident's medical records, and offer a copy to the patient and to the resident's carer, if appropriate, with the resident's agreement.

It is expected that a patient would not require more than five case conferences in a twelve month period.

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

\*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.

▲ Obtaining patient or carer's consent (where appropriate) is a requirement for all MBS Items. In undertaking EPC Multidisciplinary activity, the GP is required to inform the patient of who will be involved in the care plan; that their medical history, diagnosis and care preferences will be discussed with other providers, and provide an opportunity for them to specify what may be conveyed or withheld from others. Patients should be informed that they may incur a charge for the EPC service, for which a Medicare rebate will be payable.