

Changes to Medicare Primary Care Items

Health Assessments

The structure of health assessment items will be changed and Medicare fees will be rationalised. Ten health assessment items will be replaced by **four new time-based items**. The following health assessments will be undertaken under four new items:

| New item numbers | New item names |
|------------------|---|
| 701 | Brief Health Assessment of less than 30 minutes duration |
| 703 | Standard Health Assessment lasting more than 30 minutes but less than 45 minutes |
| 705 | Long Health Assessment lasting more than 45 minutes but less than sixty minutes |
| 707 | Prolonged Health Assessment lasting more than 60 minutes |
| 715 | Aboriginal and Torres Strait Islander people's health assessment |
| 10986 | Healthy Kids Check provided by a Practice Nurse or registered Aboriginal Health Worker |

| Target Groups | Frequency of Service |
|---|---|
| Healthy Kids Check - 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 |
| Type 2 diabetes risk evaluation - 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 |
| 45 -49 year old health assessments - 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 **Aboriginal and Torres Strait Islander people's health assessment** items will be collapsed into one health assessment item with no designated time or complexity requirements, and with no distinction between an assessment provided in or out of the consulting rooms. The length of the health assessment will be at the medical practitioner's discretion. This health assessment will be an annual service. The minimum time allowed between services will be nine 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.

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.

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.

Two Chronic Disease Management (CDM) items for the review of CDM plans (items 725 and 727) will be **combined into one new item number (732)** that can be used *either* to review a GP Management Plan (GPMP, item 721) *or* to coordinate a review of Team Care Arrangements (TCAs, item 723):

| Old items | | New item | |
|-------------|--|-------------|--|
| Item number | Item name | Item number | Item name |
| 725 | Review a GP Management Plan | 732 | Review a GP Management Plan <i>or</i> Coordinate a Review of Team Care Arrangements/ Multidisciplinary Community Care Plan/ Multidisciplinary Discharge Plan |
| 727 | Coordinate a Review of Team Care Arrangements/ Multidisciplinary Community Care or Discharge Plan | | |

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. 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 descriptor and explanatory notes, they can be claimed on the same day.

A Guide to Chronic Disease Management

The Chronic Disease Management (CDM) items are for:

- Preparation by a GP of a GP Management Plan (GPMP);
- Coordination by a GP of Team Care Arrangements (TCA);
- Review by a GP of a GP Management Plan;
- Coordination by a GP of a review of Team Care Arrangements;
- Contribution to a multidisciplinary care plan or contribution to a review of a multidisciplinary care plan (for patients who are not residents of aged care facilities); and
- Contribution to a multidisciplinary care plan or contribution to a review of a multidisciplinary care plan (for residents of aged care facilities).

Patients with a chronic or terminal medical condition are eligible for a GP Management Plan item. Patients who also have complex needs requiring care from a multidisciplinary team are also eligible for a Team Care Arrangements item.

The recommended frequency for these services, allowing for variation in patients' needs, is once every two years, with regular reviews (recommended six monthly) of the patient's progress against the plan. This is recommended as an average frequency but should be applied with regard to the patient's requirements - in general, a new GPMP and/or TCA should not be prepared unless and until required by the patient's condition needs and circumstances. The review items are the key components for assessing and managing the patient's progress once a GPMP or TCA have been prepared.

While a GP Management Plan and Team Care Arrangements are able to be provided independently, it is expected that in most cases a patient with complex needs would have both services. It is not mandatory, however, to follow the preparation of a GP Management Plan with the coordination of Team Care Arrangements or to prepare a GP Management Plan before coordinating Team Care Arrangements.

Patients may be eligible to be referred for:

- Allied health services and/or Dental services where they are being managed by a GP under **both** a GP Management Plan and a Team Care Arrangements.
- Residents of aged care facilities may also be eligible to be referred for allied health and/or dental services where their GP has contributed to, or contributed to a review of, a care plan prepared for them by the facility or discharging hospital.

Healthy Kids Check

The purpose of the Healthy Kids Check is to ensure that every four year old child in Australia has a basic health check to see if they are healthy, fit and ready to learn when they start school. The Healthy Kids Check will promote early detection of lifestyle risk factors, delayed development and illness, and introduce guidance for healthy lifestyles and early intervention strategies. The Check will provide an opportunity to:

- Issue parents/guardians with information and advice on healthy habits for life for children;
- Link parents/guardians and children to the primary health care system;
- Assist General Practitioners (GPs) and Practice Nurses and registered Aboriginal Health Workers to identify any health issues for children prior to starting school; and
- Enable GPs to provide treatment or referral for any conditions identified as a result of the check.

The GP or Practice Nurse, or registered Aboriginal Health Worker is also required to note that the four year-old immunisation has been given (including evidence provided).

Aboriginal and Torres Strait Islander Health Checks

The purpose of these health check is to ensure that Aboriginal and Torres Strait Islander people receive the optimum level of health care by encouraging early detection, diagnosis and intervention for common and treatable conditions that cause considerable morbidity and early mortality.

An Aboriginal and Torres Strait Islander Adult Health Check means the assessment of an Aboriginal and/or Torres Strait Islander patient's health and physical, psychological and social function, and whether preventive health care, education and other assistance should be offered to that patient, to improve the patient's health and physical, psychological or social function.

For the purposes of this item a person is an Aboriginal and/or Torres Strait Islander person if the person identifies himself or herself as being of Aboriginal and/or Torres Strait Islander descent. Patients should be asked to self-identify their Aboriginal and/or Torres Strait Islander status and their age for the purpose of these items, either verbally or by completing a form.

The Aboriginal and Torres Strait Islander health checks should generally be undertaken by the patient's 'usual doctor', that is the medical practitioner, or a practitioner working in the medical practice or health service, who has provided the majority of services to the patient in the past twelve months, or who is likely to provide the majority of services in the following twelve months.

Practice Nurses, Aboriginal Health Workers and other health professionals may assist GPs in performing the health check, in accordance with accepted medical practice and under the supervision of the GP.

It is recommended that practitioners establish a register of their patients seeking a health check and remind registered patients when their next health check is due.

Type 2 Diabetes Risk Evaluation

The purpose of this item is to support general practitioners (GPs) to address the health needs of patients aged 40 to 49 years of age who are at '*high risk*' of developing type 2 diabetes. The '*high risk*' score will be determined following the patient's completion of the Australian Type 2 Diabetes Risk Assessment Tool. The aim of this item is to review the factors underlying the '*high risk*' score identified by the Australian Type 2 Diabetes Risk Assessment Tool to instigate early interventions, such as lifestyle modification programs, to assist with the prevention of type 2 diabetes.

The Australian Type 2 Diabetes Risk Assessment Tool can be obtained from www.health.gov.au/epc.

The completion of the Australian Type 2 Diabetes Risk Assessment Tool is mandatory for patient access to the Type 2 Diabetes Risk Evaluation item. The tool can be completed either by the patient or with the assistance of a health professional or practice staff. Patients with a '*high*' score result are eligible to attend a Type 2 Diabetes Risk Evaluation by their GP, and subsequent referral to lifestyle modification programs if appropriate.

45 Year Old Health Check

The health check is targeted at people who are between 45 and 49 years of age (inclusive) who are at risk of developing a chronic disease.

A patient must be at risk of developing a chronic disease. A chronic disease or condition is one that has been or is likely to be present for at least six months, including but not limited to asthma, cancer, cardiovascular illness, diabetes mellitus, mental health conditions, arthritis and musculoskeletal conditions.

The decision about whether an individual is at risk of developing a chronic disease rests with the clinical judgement of the GP, but a specific risk factor must be identified. Factors that the GP may consider include, but are not limited to:

- Lifestyle risk factors, such as smoking, physical inactivity, poor nutrition or alcohol misuse;
- Biomedical risk factors, such as high cholesterol, high blood pressure, impaired glucose metabolism or excess weight; or
- Family history of a chronic disease.

Medicare Dental Items For Patients With Chronic Conditions AND Complex Care Needs - Services Provided by a Dental Practitioner on Referral From a GP [Items 85011-87777]

The items can be provided by dentists, dental specialists and dental prosthetists registered with Medicare Australia. Eligible patients can receive up to \$4,250 in Medicare benefits (including Extended Medicare Safety Net benefits where applicable) for dental services provided **over two consecutive calendar years** under items 85011-87777.

The two-year period is counted from the calendar year of the patient's first eligible dental service. For example, if the patient's first dental service is on 15 November 2007, the applicable two-year period will be the 2007 and 2008 calendar years.

When referring patients for dental services, GPs should inform patients that the services will not necessarily be bulk billed. Dental practitioners are free to set their own fees for services and, in some instances, **patients may incur out-of-pocket costs**. To assist patients in understanding the cost of dental treatment, dental practitioners will be required to provide patients with a proposed treatment plan following an examination and assessment including any diagnostic tests. The plan must include an itemised quotation of proposed charges for future work.

Eligible patients. The dental items are targeted at patients with chronic medical conditions and complex care needs. The patient's oral health must also be impacting on, or likely to impact on, their general health.

In practice this means that, **before a patient can access dental services under Medicare**, the patient must have received the following services from a GP within the previous two years:

- GP Management Plan **and** Team Care Arrangements; **or**
- For residents of an aged care facility, their GP must have contributed to or reviewed a multidisciplinary care plan prepared for the resident by the facility.

Reporting by the dental practitioner to the GP. The dental practitioner must provide a copy or summary of the patient's treatment plan to the referring GP at the commencement of the course of treatment (ie following an examination and assessment of the patient, including any diagnostic tests).

Domiciliary Medication Management Review (DMMR) also known as Home Medicines Review (Item 900)

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

Examples of risk factors known to predispose people to medication related adverse events are:

- Currently taking 5 or more regular medications;
- Taking more than 12 doses of medication per day;
- Significant changes made to medication treatment regimen in the last 3 months;
- Medication with a narrow therapeutic index or medications requiring therapeutic monitoring;
- Symptoms suggestive of an adverse drug reaction;
- Sub-optimal response to treatment with medicines;
- Suspected non-compliance or inability to manage medication related therapeutic devices;
- Patients having difficulty managing their own medicines because of literacy or language difficulties, dexterity
- Problems or impaired sight, confusion/dementia or other cognitive difficulties;
- Patients attending a number of different doctors, both general practitioners and specialists; and
- Recent discharge from a facility / hospital (in the last 4 weeks).

Benefits for a DMMR service under this item are payable only once in each 12 month period, except where there has been a significant change in the patient's condition or medication regimen requiring a new DMMR. In such cases the patient's invoice or Medicare voucher should be annotated to indicate that the DMMR service was required to be provided within 12 months of another DMMR service.

Comprehensive Medical Assessments for Residents of Aged Care Facilities

A CMA is available to **new residents** on admission into a RACF. Generally, it is recommended that new residents should receive a CMA as soon as possible after admission, preferably within six weeks following admission into a RACF.

A CMA is available for **existing residents** where it is required in the opinion of the resident's medical practitioner, for instance, because of a significant change in medical condition, physical and/or psychological function, associated with, for example (but not limited to):

- Discharge from an acute care facility in the previous 4 weeks;
- Significant changes to medication regimen in the last 3 months;
- Change in medical condition or abilities;
- Falls in the last three months;
- Change in cognitive abilities and function;
- Change in physical function including Activities of Daily Living.

Annual Health Assessment for People with an Intellectual Disability (Items 718 and 719)

The purpose of the health assessment is to support general practitioners (GPs) to identify and address the specific clinical needs of patients who have an intellectual disability. If an assessment identifies that a patient has a chronic medical condition and complex care needs, it may be appropriate to involve other health professionals in the patient's care using the Enhanced Primary Care (EPC) Chronic Disease Management (CDM) items for GP Management Plans and Team Care Arrangements.

Practitioners should establish a register of their patients seeking annual health assessments and remind registered patients when their next health assessment is due.