

## Medicare services available for residents of Aged Care Homes

### Standard Aged Care Home Item Numbers

**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.

(NB: 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

### Comprehensive Medical Assessment (CMA)

**Item 712 Eligibility:** Available for all permanent residents of Aged Care Facilities including both high & low care.

### Residential Medication Management Review (RMMR)

**Item 903:** Available for permanent residents of Aged Care Facilities

<b>100 % rebate &amp; MBS Fee</b>	\$187.65
<b>115% DVA</b>	\$215.80◆

<b>100 % rebate &amp; MBS Fee</b>	\$91.85
<b>115% DVA</b>	\$105.65

### Enhanced Primary Care (EPC) Multidisciplinary Care Items Eligibility:

Does the resident have:

- one or more chronic medical conditions (that have been present or are likely to be present for six months) or a terminal condition
- and** complex care needs \* requiring multidisciplinary care from a team of (at least 2) health and care providers, plus the residents' GP (with each team member providing a different kind of care or service to the patient)

If yes, the residents' GP can **contribute** to the care plan (item 730) and either **organise or participate** in a case conference to facilitate care coordination.

### Contribution to a Care Plan Item 731 #

<b>100 % rebate MBS Fee</b>	\$43.40
<b>115% DVA</b>	\$49.95

If the resident's GP has contributed to the care plan (Item 730) the resident may be eligible to access up to five allied health and three dental care services per year.

### Allied Health Items

<b>MBS items</b>	10950; 10952; 10954 10956; 10958; 10960
<b>MBS Fee \$52.85</b>	10962; 10964; 10966
<b>85% \$44.95</b>	10968; 10970; 10951
<b>Full</b>	\$55.05
<b>85%</b>	\$46.80

### Dental Care Items

<b>MBS items</b>	10975, 10976, 10977
<b>MBS Fee</b>	\$91.70
<b>85%</b>	\$77.95

### Case Conference

#### Organise & Coordinate a Case Conference

Time	15-30 min	30-45 min	>45 min
<b>In Aged Care Facility</b>	Item 734	Item 736	Item 738
<b>100 % rebate &amp; MBS Fee</b>	\$3.75	\$125.65	\$167.45
<b>115% DVA</b>	\$96.35	\$144.50	\$192.60

#### Participate in a Case Conference

Time	15-30 min	30-45 min	>45 min
<b>In Aged Care Facility</b>	Item 775	Item 778	Item 779
<b>100 % rebate &amp; MBS Fee</b>	\$59.80	\$95.70	\$131.55
<b>115% DVA</b>	\$68.80	\$110.10	\$151.30

- \* Examples of complex care needs, where routine management is compounded by one of the following:
  - Unstable or deteriorating condition
  - Increasing frailty or dependence
  - Development of complications including falls or incontinence
  - Co-morbidities
  - 2 or more hospital admissions in the past six months
- # In an aged care setting, the GP's contribution to a Care Plan (MBS item 730) 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 \$5 or \$7.50 bulk billing incentive for eligible patients

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## Comprehensive Medical Assessments

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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 CMA is a voluntary service for residents of aged care facilities and must include:

- A detailed medical history
- A comprehensive medical examination
- Developing a list of diagnoses and/ or problems
- A written summary

The CMA (**Item 712**) can be claimed once in a twelve-month period. A **practice nurse** can assist the GP in obtaining information relevant to the CMA for the GP's consideration e.g., liaising with the RACF and gathering together information that the facility has collected. However the nurse 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 facility. 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. Note also that GPs may wish to review and incorporate into the CMA any relevant assessment or information about the resident that is available from the facility. The CMA can provide the GP with useful information to contribute to an eligible resident's care plan and RMMR. (Contact the Division for further information and resources on CMA's)

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## Care Plans

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The resident's 'usual' GP can make a **contribution** to a care plan upon the request of the residential aged care facility as a member of a multidisciplinary care plan team (**Item 730**). The patient's informal or family carer may also be included as an additional formal member of the team. Contribution to a care plan Item 730 can be used up to four times in a 12-month period for both **contributing** to a care plan or **contributing to the review** of a care plan in an aged care facility. Residents with a Care Plan may be eligible for up to five **Allied Health** services & three **Dental** services (where the dental condition is significantly impacting on their chronic medical condition) per year on referral from their GP. **Allied Health services already funded through DVA or other sources are not eligible for these rebates. The services to be referred to MUST BE listed in the Care Plan – if not, a review may be necessary to incorporate the required service.** (Refer to the BSDGP Information Sheet 'CARE PLANS – An Overview')

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## Case Conferences

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In addition to multidisciplinary care planning, the resident's GP can be involved in case conferencing activities with the multidisciplinary team (although both items cannot be claimed on the same day). The eligibility for accessing these items is 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. A GP can organise or participate in a case conference, in a Residential Aged Care Facility. It is expected that a patient would not require more than five case conferences in a twelve month period. *For best practice guidelines for the use of EPC items refer to RACGP practical guide to EPC at the College website; [www.enhancedprimarycare.org.au/](http://www.enhancedprimarycare.org.au/)*

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## Residential Medication Management Review (RMMR)

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From November 1 2004, **MBS Item 903** was released for participation by a GP in a collaborative review of medication management. This item is available for permanent residents of a Residential Aged Care Facility for whom quality use of medicines may be an issue. Designed to complement the other MBS items as above,

**NOTE: Refer also to the relevant Explanatory Notes of the Medicare Benefits Schedule Book of 1 November, 2004**

benefits are payable for one RMMR service for residents on admission and for continuing residents on an as required basis, with a maximum of one per year except where there has been a significant change in their condition or medication regimen.

**Fee: \$88.20      Benefit 85%=\$75.00**

Refer also: <http://www7.health.gov.au/pubs/mbs/mbsnov04>  
GP Contribution to Resident's Care Plans Item 731

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## GP Contribution to Resident's Care

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### 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 GP's 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 GP's 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 GP's 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-medicareconsumers-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, Chiropracist, 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.)