

GERIATRICIAN ITEMS 141, 143, 145 AND 147

COMPREHENSIVE ASSESSMENT AND MANAGEMENT PLAN FOR PATIENTS 65+ YEARS

Questions and Answers for GPs

Q: What are the Geriatrician items?

A: Four Geriatrician items (items 141, 143, 145 and 147), providing higher Medicare benefits for long and comprehensive assessments by consultant physicians or specialists in geriatric medicine where the patient is at least 65 years old, are available on the Medicare Benefits Schedule from 1 November 2007.

Item 141

- An initial attendance of more than 60 minutes duration at consulting rooms or hospital to undertake a comprehensive assessment of the patient and develop a management plan.
- The schedule fee for this item is \$408.80.

Item 143

- A subsequent attendance of more than 30 minutes duration at consulting rooms or hospital to review the initial management plan prepared under item 141 or item 145 and to revise the management plan (if necessary).
- The schedule fee for this item is \$255.50.

Item 145

- An initial attendance of more than 60 minutes duration at a place other than consulting rooms or hospital to undertake a comprehensive assessment of the patient and develop a management plan.
- The schedule fee for this item is \$495.65.

Item 147

- A subsequent attendance of more than 30 minutes duration at a place other than consulting rooms or hospital to review the initial management plan prepared under item 141 or item 145 and to revise the management plan (if necessary).
- The schedule fee for this item is \$309.80.

Q: Who can use these items?

A: Items 141, 143, 145 and 147 apply only to services provided by a consultant physician or specialist in the specialty of Geriatric Medicine who has completed the additional requirements of the Royal Australasian College of Physicians for recognition in the subspecialty of geriatric medicine.

Q: Who is eligible for treatment under items 141, 143, 145 and 147?

A: Items 141 - 147 are intended for the comprehensive assessment and management of frail older patients, older than 65, with complex, often interacting, medical, physical and psychological problems, who are at significant risk of poor health outcomes. This includes but is not limited to, patients being managed by their GP with a GP Management Plan (GPMP) or Team Care Arrangements (TCA). It is expected that the Geriatrician management plan will augment the GPMP or TCA.

Q: Does the patient need to be referred to the Geriatrician?

A: Yes. The patient should be referred by a general practitioner. In the event that a specialist of another discipline wishes to refer a patient for these items, the referral should take place through the GP. The need to develop a management plan should be based on the Geriatrician's clinical judgement.

Items 143 and 147 are available in instances where the GP initiates a review of the management plan provided under items 141 and 145, usually where the current plan is not achieving the anticipated outcome.

Q: Can a Geriatrician refer a patient for allied health services?

A: To be eligible for Medicare benefits for allied health services, the patient must be managed by their GP using a GP Management Plan and Team Care Arrangements (TCA) and referred to eligible services by their GP.

A Geriatrician can refer a patient to an allied health professional, but the allied health service will not be eligible for a Medicare rebate on the basis of this referral.

A Geriatrician can identify the need for allied health services in the preparation of the management plan. The GP would then need to review the TCA to incorporate that recommendation and make a referral that meets the Medicare requirements for allied health services.

Q: What should the referral to a Geriatrician involve?

A: The referral from the medical practitioner to the consultant physician should include: the patient's history, relevant pathology results, details of medications and interactions, with particular focus on presenting symptoms and current difficulties. Assessments by other health professionals, including GPs and specialists, relevant care plans and health assessments should also be noted.

Q. What is the Geriatrician expected to provide to the referring medical practitioner?

A. A written report of the assessment, including the management plan, should be provided to the general practitioner within a maximum of two weeks of the assessment. More prompt verbal communication may be appropriate.

Q: What happens to care plans already developed by the GP?

A: As a general principle, the creation of multiple care plans should be avoided. Where a patient is already being managed by their GP with a GP Management Plan (GPMP) or Team Care Arrangements (TCA) and is referred to a Geriatrician for further assessment, the Geriatrician management plan should augment the GPMP or TCA for that patient. The GP may choose to review the GPMP or TCA to incorporate the Geriatrician's management plan.

Further information

More detailed information regarding the claiming requirement of items can be obtained by calling the Medicare Provider Hotline on 132 150 (for practitioners) or 131 011 (for patients).

The item descriptors and explanatory notes can be downloaded from the MBS online website at: www.mbsonline.gov.au