

## Chronic Disease and Assessment Medicare Item Numbers

Item number		Service covered by this item
<b>VR</b> B 2517 C 2521 D 2525	<b>Non VR</b> 2620 2622 2624	<b>Diabetes Annual Cycle of Care (annually - can be used as goal of a diabetes GPMP)</b> Best practice in diabetes care requires at least 4 visits per year to complete the cycle and bill the item number.
<b>VR</b> B 2546 C 2552 D 2558	<b>Non VR</b> 2664 2666 2668	<b>Asthma Cycle of Care (annually - cannot be used as a goal of an asthma GPMP)</b> Best practice in asthma care for moderate to severe asthmatics. Requires 2 visits per year to complete the cycle and bill the item number.
10986 ( performed by a Nurse or Aboriginal Health Worker)		<b>Healthy Kids Check (once age 4 )</b> For a four year old in conjunction with 4year old immunisation. Involves consultation and review. "Get set for Life "Resource issued to parent.
715		<b>Aboriginal and Torres Strait Islander Health Assessment</b> For any indigenous person. No designated time or complexity requirements. Length is at medical practitioner's discretion.
701 (A Brief)	< 30mins	<b>Health Assessment over 75 Years (annually)</b> A comprehensive health assessment for a person in this age bracket. Involves clinical information and assessment of daily living activities.
703 (A Standard)	30mins-45mins	<b>Healthy Kids Check (once age 4)</b> For a four year old in conjunction with 4year old immunisation. Involves consultation and review. "Get set for Life "Resource issued to parent.  <b>Comprehensive Medical Assessment (CMA) of a resident of a residential aged care facility (annually)</b> An assessment of a person in an aged care facility. Involves clinical information and assessment of daily living activities.
705 (A Long)	45mins-60mins	<b>Diabetes Risk Assessment</b> <b>40-49 year old (Every three years and not within three years of a 45-49 year old health check)</b> For a person in this age bracket who has a high predisposition to Type 2 Diabetes (as determined by: "The Australian Type 2 Diabetes Risk Assessment Tool" questionnaire). Involves clinical information and assessment of daily living activities.  <b>Health Assessment for refugees (once within 12 months of arrival in Australia)</b> For a newly arrived refugee. Medical component normally performed by those practices undertaking refugee health services.  <b>45-49 year old Health Check (once only and not within three years of a 713)</b> For a person in this age bracket who has a predisposition to a Chronic Disease. Involves clinical information and assessment of daily living activities.
707 (A Prolonged)	> 60mins	<b>Health Assessment on a person with an Intellectual Disability (annually)</b> A comprehensive health assessment (involving the Carer) of a person with an intellectual disability. Involves clinical information and assessment of daily living activities.
721		<b>Preparation of a GP Management Plan (GPMP) (every two years)</b> A detailed plan of care for a patient with a chronic disease. Involves goal setting and has a clinical and patient orientated focus.
723		<b>Coordination of a Team Care Arrangement (TCA) ( yearly)</b> A referral method used to refer a person with chronic disease to at least 2 allied health professionals (which requires 2 way communication with the allied health professionals regarding the patient). If the patient also has a GPMP, then they can receive 5 Medicare rebated visits to these professionals in a calendar year.

732		<b>Chronic Disease Management Review (of a GPMP or of a TCA) (every six months)</b> Review of a previously performed detailed plan of care for a patient with a chronic disease. Involves goal setting and has a clinical and patient orientated focus or review of a previously performed referral method used to refer a person on a GPMP to at least 2 allied health professionals. The review requires 2-way communication with the allied health professionals regarding the patient. Patient then receives 5 Medicare rebated visits to these professionals in a calendar year.
731		<b>Contribution to a review of a multidisciplinary care plan for a resident of an aged care facility (every three months)</b> A review of a previously performed assessment of a person in an aged care facility.
735 (A Brief)	15mins-20mins	<b>Organise and coordinate a case conference in a residential aged care facility (any time that it is done)</b> For a patient in an aged care facility. Where the GP organises a case conference about the patient involving several care providers.
739 (A Standard)	20mins-40mins	
743 (A Long)	40mins	
900		<b>Home Medication Review (HMR or DMMR) (annually)</b> An assessment of medications and the way the patient uses the prescribed medication for a person whom has five or more medications or whom it is deemed appropriate. This assessment involves an accredited Pharmacist reviewing the medications and sending a report back to the GP.
903		<b>Residential Medication Management Review (RMMR) (annually)</b> For a patient in an aged care facility. An assessment of medications and the way the patient uses the prescribed medication for a person whom has five or more medications or whom it is deemed appropriate. This assessment involves an accredited Pharmacist reviewing the medications and sending a report back to the GP.
2710 (with accredited Mental Health Skills Training (MHST))		<b>Mental Health Care Plan (annually)</b> A detailed agreed plan of care for a patient with a mental health condition. This involves goal setting and has a clinical and patient orientated focus. It enables a referral pathway for treatment by Psychologists, Psychiatrists and other mental health workers.
2702 (without accredited MHST)		
2712		<b>Review of Mental Health Plan (every six months)</b> Review of a previously performed mental health care plan.
2713		<b>Mental Health Care Consultation (any time that it is done)</b> A consultation of more than 20mins where the primary concern is mental health.
10997 (performed by a Nurse or Aboriginal Health Worker)		<b>Service provided to a person with a chronic disease and a GPMP (five per patient per calendar year)</b> Education of or assistance provided to a patient with a GPMP by a Practice Nurse or Aboriginal Health Worker.
10987 (performed by a Nurse or Aboriginal Health Worker)		<b>Follow up service is provided for an Indigenous person who has received an Aboriginal and Torres Strait Islander Health Assessment (maximum of 10 times per patient per calendar year).</b> includes: <ul style="list-style-type: none"> <li>• Examinations/interventions as indicated by the health check;</li> <li>• Education regarding medication compliance and associated monitoring;</li> <li>• Checks on clinical progress and service access;</li> <li>• Education, monitoring and counselling activities and lifestyle advice;</li> <li>• Taking a medical history; and Prevention advice for chronic conditions, and associated follow up.</li> </ul>

MBS Fees current as at 1<sup>st</sup> May, 2010

More detailed and comprehensive explanatory notes and MBS Item descriptors are available at [www.health.gov.au/mbsonline](http://www.health.gov.au/mbsonline) and at [www.health.gov.au/mbsprimarycareitems](http://www.health.gov.au/mbsprimarycareitems)