

Medicare item numbers for COPD and Prevention

Item number		Service covered by this item
715		Aboriginal and Torres Strait Islander Health Assessment For any indigenous person no designated time or complexity requirements length is at Medical practitioner's discretion.
701 (A Brief)	< 30mins	Health Assessment over 75 Years (Annually) 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	Healthy Kids Check (Once age 4) For a four year old in conjunction with 4year old immunisation. Involves consultation and review "Get set for Life "Resource issued to parent. Comprehensive Medical Assessment (CMA) of a resident of an aged care facility (Annually) An assessment of a person in an aged care facility. Involves clinical information and assessment of daily living activities.
705 (A Long)	45mins-60mins	Diabetes Risk Assessment 40-49 year old (Every three years and not within three years of a 45-49 year old health check) 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. Health Assessment for refugees (Once within 12 months of arrival in Australia) For a newly arrived refugee. Medical component normally performed by those practices undertaking refugee health services.
707 (A Prolonged)	> 60mins	45-49 year old Health Check (Once only and not within three years of a 713) For a person in this age bracket who has a predisposition to a Chronic Disease. Involves clinical information and assessment of daily living activities. Health Assessment on a person with an Intellectual Disability (annually) A comprehensive health assessment (Involving the Carer) of a person with an intellectual disability. Involves clinical information and assessment of daily living activities.
721		Preparation of a GP Management Plan (GPMP) (Every two years) A detailed plan of care for a patient with a chronic disease. Involves goal setting and has a clinical and patient orientated focus.
723		Coordination of a Team Care Arrangement (TCA)(Yearly) A referral method used to refer a person on a GPMP to at least 2 allied health professionals (it 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.
732		Review of a GPMP or Review of a TCA (Every six months) 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 (it 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		Contribution to a review of a multidisplinary care plan for a resident of an aged care facility (Every three months) A review of a previously performed assessment of a person in an aged care facility.
735 (A Brief)	15mins-20mins	Organise and coordinate a case conference in a residential aged care facility (Any time that it is done) 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		Home Medication Review (HMR or DMMR) (Annually) 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		Residential Medication Management Review (RMMR) (Annually) 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.
11506		Spirometry (Any time that it is done)
10993		Immunisation Once per patient visit even if more than one vaccine is administered
11700		ECG(Any time that it is done)
10997(performed by a Nurse or Aboriginal Health Worker)		Service provided to a person with a chronic disease and a GPMP (Five per patient per year) Education of or assistance provided to a patient with a GPMP by a practice nurse.
10987(performed by a Nurse or Aboriginal Health Worker)		Follow up service is provided for an Indigenous person who has received a (maximum of 10 times per patient per calendar year.) includes: <ul style="list-style-type: none"> • Examinations/interventions as indicated by the Health Check; • Education regarding medication compliance and associated monitoring; • Checks on clinical progress and service access; • Education, monitoring and counselling activities and lifestyle advice; • Taking a medical history; and Prevention advice for chronic conditions, and associated follow up.