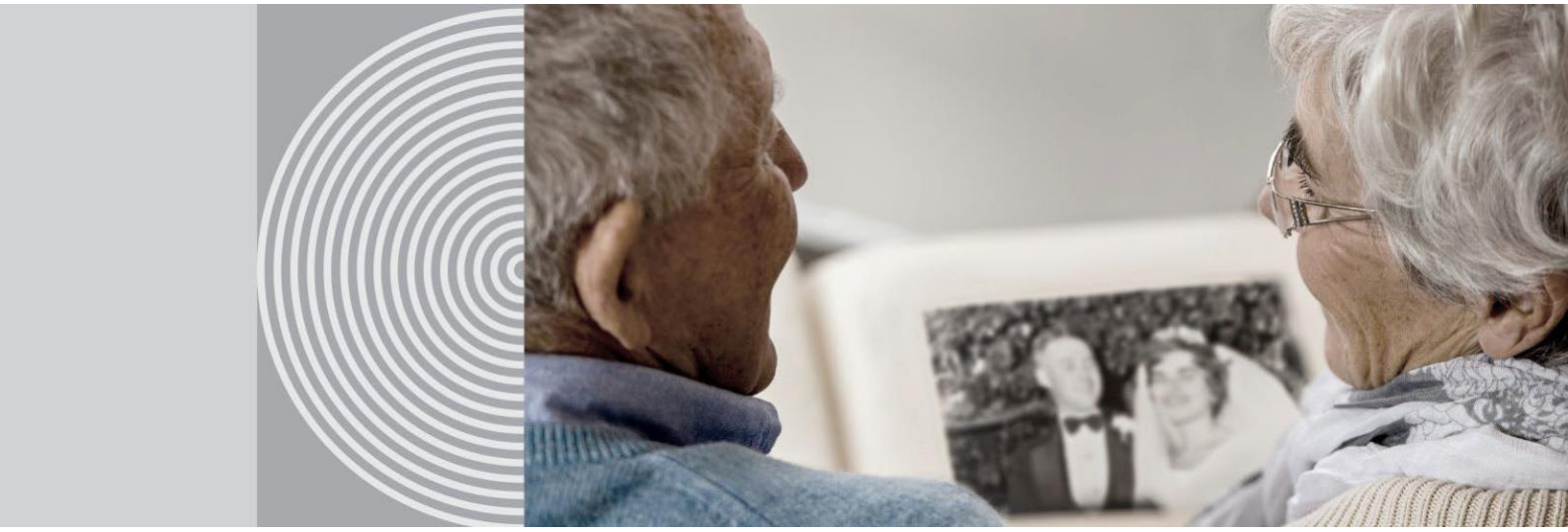
RACGP
Royal Australian College *of* General Practitioners

RACGP aged care clinical guide (Silver Book)

5th edition

Part B. Medicare Benefits Schedule item numbers



General principles

- Consult the Department of Health's MBS Online resource to be familiar with the appropriate Medicare Benefits Schedule (MBS) item numbers.
- Residential aged care facility (RACF) consultation MBS item numbers are unique and are based on clinic levels A, B, C and D.
- Chronic care item numbers for contributing to a care plan and comprehensive health assessments are specific to RACFs.
- Case conferences are useful in RACF settings, and should be used if appropriate.
- Residential medication management reviews have an allocated MBS item number.
- After-hours MBS item numbers are available for RACF consultations during after-hours periods.

Introduction

When billing Medicare, it is vital to be familiar and aware of the criteria relating to the Medicare Benefits Schedule (MBS) item number being billed. The Department of Health's MBS Online is the source of all information and should be consulted for further knowledge.

This chapter provides descriptions of MBS item numbers that would be useful in residential aged care facilities (RACFs). Other MBS item numbers can certainly be used, and are the same as those that would be used in a regular general practice setting.

Consults

In 2019, the MBS item numbers for consults in RACFs have changed. The consult numbers are based on levels A, B, C and D, and are similar to those that apply in a regular general practice setting. However, there is a 'flag fall' MBS item number that provides an incentive for general practitioners (GPs) to visit RACFs. It is important to note that the flag fall MBS item number is for the 'initial attendance by a general practitioner at one RACF, on one occasion, applicable only to the first patient seen on the RACF visit'.

The first consult is billed as Level A, B, C or D and the flag fall MBS item number (refer to Table 1 for more information).

Table 1. Consult MBS item numbers (correct April 2019)

Description	Item number
Level A	90020
Level B	90035
Level C	90043
Level D	90051
Flag fall	90001

Home visits

When visiting older people who are not in an accredited RACF, the MBS item numbers for out-of-office consults apply (refer to Table 2 for more information). These numbers are associated with a 'ready reckoner', which is a payment made for the attendance divided by the number of patients seen.

Table 2. Home visit MBS item numbers (correct April 2019)

Description	Item number
Level A	4
Level B	24
Level C	37
Level D	47

Care plans

In RACFs, the care plan that GPs establish or implement is considered a 'contribution to the care plan' prepared by the staff at the RACF. The contribution to a care plan provides an excellent opportunity to review proactive care and consider issues that may arise every three months (eg routine bloods, discussion about weight loss, diet, medication and clinical review). The contribution to a care plan can be billed with a consultation item number (refer to Table 3 for more information).

The standard care plan and team care arrangement MBS item numbers are not available to residents in an RACF.

Medicare requirements

Medicare requirements for a GP contribution to an RACF care plan:

- Resident has at least one chronic medical condition.
- Ongoing management by at least three collaborating healthcare providers who offer different services. The GP is going to be one, the registered nurse will generally be the other, and in most instances there is also going to be an occupational therapist, podiatrist or physiotherapist involved.

Table 3. Contribution to the care plan MBS item number (correct April 2019)

Description	Item number
Contribution to a care plan	731

Comprehensive medical assessment

A comprehensive medical assessment (CMA) is one of the health assessments that can be billed to Medicare. The criteria for performing a CMA are less stringent than the health assessment for those aged ≥75 years, but no less important. It is suggested that the CMA should be performed within six weeks of admission to the RACF, and annually after that (refer to Table 4 for more information).

Records from the previous treating GP should be obtained for medical and medication history as well as immunisation status. The annual assessment is an opportunity to thoroughly reassess the patient and note any changes in their condition. The CMA documentation is given to the RACF and the patient (if relevant), and a copy is kept in the GP's electronic medical record (refer to Part B. Medical records at residential aged care facilities).

CMA criteria and MBS requirements

CMA criteria:

- Obtain and record patient consent.
- Take a patient history.
- Review medical conditions.
- Review physical, psychological and social function.
- Initiate interventions and referrals as indicated.
- Provide a comprehensive preventive healthcare management plan for the patient.

CMAs must include a:

- written summary of the CMA
- list of diagnoses and medical problems
- copy of the summary that must be provided to the RACF
- copy of the summary that must be offered to the resident or guardian.

Table 4. CMA MBS item numbers (correct April 2019)

Description	Item number
Health assessment – Shorter than 30 minutes	701
Health assessment – Between 30 and 45 minutes	703
Health assessment – Between 45 and 60 minutes	705
Health assessment – Longer than 60 minutes	707

Case conferences

Case conferences are useful in RACFs; arranging a case conference with the staff at the RACF and inviting the resident's family allows for good communication and setting goals and plans for the resident (refer to Table 5 for more information).

There are two types of case conferences:

- Arranged by the GP
- GP attends the case conference arranged by someone else

Patient eligibility for case conferences

Patient eligibility:

- Have a chronic medical condition for six months or one that is terminal
- Require ongoing care from a multidisciplinary team (refer to Part B. Collaboration and multidisciplinary team-based care)

Case conference criteria and MBS requirements

Case conference criteria:

- Explain and record the patient's consent and agreement.
- Three health professionals must attend the meeting, including the GP.
- Record the date and time the meeting starts and ends.
- Record the names of the participants.
- Offer the patient a summary of the case conference.
- Provide this summary to other team members.
- Discuss the outcomes of the conference with the patient and the patient's carer.
- Document all matters discussed and put a copy of this in the patient's medical record.

Tips for case conferences

Case conferences require two healthcare professionals who are responsible for the care of the resident, as well as the GP. Family members are not considered one of those people; however, at the RACF, nurses, carers, physiotherapists, pharmacists and other members of the healthcare team do count.

If a general practice registrar is involved, the supervisor and registrar are able to bill Medicare as the registrar can bill 'arrange' and the GP can bill 'attend' since both registrar and supervisor are part of the medical team.

Table 5. Case conference MBS item numbers (correct April 2019)

Description	Item number
Arrange a case conference	
15–20 minutes	735
20–40 minutes	739
>40 minutes	743
Participate in a case conference	
15–20 minutes	747
20–40 minutes	750
>40 minutes	758

Residential medication management review

As of April 2020, there is no longer an MBS item for follow-up reviews available for GPs.

Medication reviews are an important part of patient care, especially for older people (refer to Part A. Medication management). A Residential Medication Management Review (RMMR) is a good opportunity to collaborate with the pharmacist and get a second opinion on the resident's medications (refer to Table 6 for more information). The pharmacist is normally contracted by the RACF.

It is recommended that every resident gets an RMMR on admission to the RACF, and annually if there are significant changes to the condition or the medications they are taking.

Inviting the pharmacist to the case conference allows for greater communication and collaboration, and they become another member of the treatment team.

MBS requirements

MBS requirements for an RMMR:

- Obtain and record consent from the patient.
- Collaborate with pharmacist providing CMA or clinical information; a referral letter is often adequate.
- If changes are recommended in the RMMR, there should be a conversation with the pharmacist (face to face or by telephone).
- Post-review discussion is **not** necessary when:
  - there are no recommended changes
  - there are only minor changes
  - issues require a case conference.
- Document findings, strategies, actions of implementation and follow up, develop or review medication plan.
- Finalise plan with patient and offer them a copy of the plan.
- Ensure there is a copy of the plan in the patient's medical record.
- Discuss the plan with nursing staff at the RACF.

Table 6. RMMR MBS item number (correct April 2019)

Description	Item number
RMMR	903

After-hours attendances

After-hours attendances are considered different under the MBS, and are differentiated as urgent or non-urgent attendances (refer to Table 7 for more information). This section is only a summary of the MBS item numbers available for after-hours attendances; refer to Part B. Provision of after-hours general practice services in aged care for more information.

Urgent after-hours attendances

Urgent after-hours attendances are for residents who require an urgent assessment that cannot wait until the next day. Only one urgent patient can be seen. If multiple patients are seen, then non-urgent numbers must be used.

Urgent after-hours numbers are used:

- between 6.00 pm and 8.00 am on weekdays
- before 8.00 am and after 12.00 pm on Saturdays
- all day on Sundays
- on public holidays.

Unsociable hours fall within these times and are defined and billed from 11.00 pm to 7.00 am every day.

Non-urgent attendances

Non-urgent attendances are considered as normal Level A, B, C and D consults, but in after-hours time. These can be billed:

- between 6.00 pm and 8.00 am on weekdays
- before 8.00 am and after 12.00 pm on Saturdays
- all day on Sundays
- on public holidays.

The billing for a non-urgent, after-hours attendance includes the ready reckoner. The ready reckoner is dependent on the number of patients seen during the non-urgent after-hours visit. It is the consult fee (ie Level B) plus $46.70 then divided by the number of patients seen, up to a maximum of six patients. For seven or more patients, the fee is the item number plus $3.30 per patient (dollar amounts correct as of April 2019).

Table 7. After-hours attendances MBS item numbers (correct April 2019)

Description	Item number
Urgent-after hours	
After-hours time	584
Unsociable hours	599
Non-urgent after hours	
Level A	5010
Level B	5028
Level C	5049
Level D	5067