ADDRESS LETTERS TO
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Billing Medicare

Dear Editor

The excellent article 'Fitting disability into practice' (*AFP* December 2007) was very informative and practical in helping GPs manage the care of complex patients in our daily work, and be rewarded fairly for the time and difficulty of the work.

The case study of 'George' showed how to bill Medicare for attendance items and EPC items on the same day on several occasions. I wish to alert other GPs that Medicare will only remunerate us if we endorse our claim forms correctly.

For example, we can bill GPMP and then item 44 if noted as 'exceptional circumstances clinically indicated' (ie. UTI) and then claim item 723 (TCA) on the same day if:

- TCA is faxed to other service providers, and their agreement is confirmed, and
- the claim form states 'both services completed same day'.

Review items 725 and 727 can be claimed at 3 months, usually more than 6 months, if 'exceptional circumstances clinically indicated' are again recorded.

I hope this reduces the frustration of GPs who are tired of being refused payments due to Medicare technicalities.

Terry Ahern
Coburg, Vic

Management of dementia

Dear Editor

The article by Fiona Millard[1] on GP management of dementia gives some misleading information on cognitive testing and ability to prescribe cholinesterase inhibitors (*AFP* January/February 2008). Prescribing based on Mini Mental State Examination (MMSE) score can occur when the score falls between 10 and 24. For patients whose MMSE is <10, cholinesterase inhibitors can still be prescribed if the specialist feels there is a factor other than their dementia contributing to the low score (eg. language skills, limited education). Where the MMSE is >24, but there is evidence of Alzheimer disease causing significant impairment, further testing with the Alzheimer's Disease Assessment Scale-Cognitive Subscale (ADAS-Cog) also allows cholinesterase inhibitors to be prescribed. The information in the article may add to the impression that treatment is difficult to obtain and not worthwhile. In addition, the article did not mention the benefit to patients and carers of making a diagnosis of the type of dementia. I would encourage GPs who identify cognitive problems in their patients to consider specialist referral.

Vanessa Harrington, Staff Geriatrician
Nambour Hospital, Qld

Reference

1. Millard F. GP management of dementia – a consumer perspective. Aust Fam Physician 2008;37:89–92.

Reply

Dear Editor

Thank you for your pertinent comments on MMSE score and eligibility for acetylcholinesterase inhibitors. Fortunately, access to this medication has become easier but at the time of the study, this medication was new and patients received conflicting advice from GPs and pharmacists, who were their first contact for discussion of the treatment. There was no local geriatrician, which is still the case in most regional areas of North Queensland, and GPs decided who should be referred for assessment, either to a general physician or psychiatrist. The diagnosis of type of dementia can still be problematic when there is no local dementia specialist, but with education, GPs are becoming more resourceful in making the diagnosis and arranging appropriate referrals.

Fiona Millard
Mackay, Qld