ENHANCED PRIMARY CARE MBS ITEMS

RECENT QUESTIONS AND ANSWERS
AS AT 27 AUGUST 2001

1. What involvement does a pharmacist need to have in a care plan to consider them a part of the "team"? For example, is just dispensing medications sufficient, is providing patients with Webster packs sufficient, etc?

For a pharmacist to qualify as a member of a multidisciplinary care team, he/she would need to provide professional advice or assistance to meet the needs of the patient beyond that which would normally be expected as part of the specific dispensing process. Examples of such services might be preparing dosette boxes and explaining their use to the patient, providing advice on inhaler use to asthmatics or advice on interaction between medications.

2. On release from gaol, prisoners often either do not have a Medicare card or are unaware of their Medicare card number. Is there a system in place to fast track the allocation of Medicare card numbers to these people?

Generally, ex-prisoners are considered eligible persons (they are residents of Australia) for the purposes of Medicare. For Medicare purposes, an ex-prisoner will still be enrolled and have a PIN Number and a Medicare number. The PIN Number is a unique identifier which never changes. However, depending on the length of the sentence served, the Medicare card will either be current or expired.

If the Medicare card expires during the term of the prisoner's sentence, he/she could make specific arrangements (through the social worker or welfare agency) at any time while in prison to complete a replacement card form. This should be accompanied by a letter from the social worker explaining the situation and the card can then be provided to the prisoner prior to their release.

Medical services provided to prisoners or those on remand would generally be regarded as services provided under a law of a State and, as a result, Medicare benefits would not be payable. However, this does not mean that a person is not entitled to have a valid Medicare card at all times.

3. Can a GP charge an MBS consultation item for looking at a patient who is receiving wound care treatment by the GP's practice nurse?

A nurse providing wound care may count towards the mandatory membership of a multidisciplinary care team. In such cases, the nurse would be expected to take responsibility and authority for the wound management. The GP would, therefore, not necessarily be required to also check the wound but could do so if he/she considered it professionally appropriate to meet the clinical needs of the patient.

4. Can practitioners access the EPC care planning and case conferencing items when providing obstetric shared care?

As in other situations where multiple medical and health providers may be involved in the care of a patient, there are benefits in coordinating the provision of the services of those practitioners, such as general practitioners, hospital midwives, ultrasound and obstetricians, who are involved in providing normal care directed to the safe delivery of a healthy baby, and a planned approach will assist this. This can be achieved through normal consultation items and supported by a plan for the provision of required services.

EPC multidisciplinary care planning and case conferencing items may be appropriate for the management of patients with complications arising from pregnancies, where the complications generate multidisciplinary care needs and one or more chronic conditions, the treatment of which requires the services of the general practitioner and at least two other health or service providers. The providers involved in the care planning and case conferencing must supply different kinds of care or services to meet the patient's multidisciplinary care needs.

The EPC items are not appropriate for the management of a normal pregnancy, ie where there are no complications generating multidisciplinary needs and a chronic condition. This does not mean that planning for the provision of required services is not appropriate, it means that this can be done through existing consultation items and outside the specific focus of EPC multidisciplinary care planning for people for chronic conditions and multiple care needs.

5. What criteria apply for GPs to be able to utilise the EPC MBS items when providing services to clients of a Multi-Purpose Service?

EPC Medicare Benefits Schedule Items and Multi-Purpose Services (MPS)

Enhanced Primary Care (EPC) Medicare Benefits Schedule (MBS) items for multi-disciplinary care planning and case conferencing in community and hospital-discharge settings, and for health assessments in the community setting, were introduced in November 1999.

In November 2000, amendments to the Medicare Benefits Schedule extended the availability of the EPC MBS items for care planning and case conferencing to all residents of aged care homes. A Residential Aged Care Facility is defined in Section 14.5 of the General Explanatory Notes of the *Medicare Benefits Schedule book 1 November 2000* as:

> a facility in which residential aged care services are provided, as defined in the *Aged Care Act 1997*, including facilities which were formerly known as nursing homes and hostels.

Multi-purpose services (MPS) receive Commonwealth funding under the flexible care provisions of *the Aged Care Act 1997*. Under the Act, flexible care is defined as:

> care provided in a residential or community setting through an aged care service that addresses the needs of care recipients in alternative ways to the care provided through residential care services and community care services.

Under the MPS program, clients may be receiving services within the community, within a hospital setting or within an aged-care residential setting.

The explanatory notes in the current *MBS book* do not separately specify whether EPC MBS services may be provided to clients of an MPS. However, there is no intention to exclude MPS clients from receiving appropriate EPC MBS services.

Whether a GP providing services to a client of an MPS can utilise the EPC MBS items, and, if so, which items may be used, depends on:

- whether the GP is already receiving remuneration for the services provided to the MPS client eg under contractual Visiting Medical Officer (VMO) arrangements; and

- whether the services are being provided in the community, as part of a hospital admission or as an aged care resident.

Where the GP receives remuneration (eg salary, sessional payment or other VMO payment) from the MPS for the services that he/or she provides to the MPS client, the GP cannot also charge against the MBS for these services, including for EPC items.

Where the GP provides services to the MPS client in a fully private capacity, he or she may charge against the MBS for relevant EPC services as follows:

- **For community-based clients of an MPS**:
  - health assessment items (700, 702, 704, 706);
  - community care planning items (720, 724, 726); and
  - community case conferencing items (740, 742, 744, 759, 762, 765).

  Community-based clients are those receiving community aged-care package services or other non-residential services through the MPS.

- **For MBS clients being discharged from hospital to the community setting (including as an MPS client in the community setting)**

– Items for contribution to a discharge care plan or participation in a discharge case conference (728, and 768, 771, 773) – these items are available to public and private patients as out of hospital services and are rebated at 85% of the MBS fee;
– Items for preparing a discharge care plan or organising and coordinating a discharge case conference (722, and 746, 749, 757) – these items are available to private patients only and must be organised by the medical practitioner who is providing in-patient care. These services are professional services provided to the patient in conjunction with hospital treatment, and are rebated at 75% of the MBS fee.

(Note: Similar arrangements apply to the discharge case conferencing items for consulting physicians. Items 813 and 815, participation in a discharge case conference, are available to private and public patients, are out-of-hospital services, and are rebated at 85%. Items 809 and 811, organisation and coordination of a discharge case conference, are available to private patients, are in-hospital services, and are rebated at 75%.)

- **For MPS residents receiving aged-care services in a residential setting :**
  – contribution to a care plan or to review of a care plan in a residential aged care facility item (730); and
  – organisation of, or participation in, a case conference in a residential aged care facility items (734, 736, 738, 775, 778, 779).

6. Can more than 2 GPs be reimbursed for participating in an EPC case conference?

The MBS Explanatory Notes clearly state that case conference teams should include a medical practitioner and at least two other members, each of whom provides a different kind of care or service to the patient and one of whom may be another medical practitioner (normally a specialist or consultant physician).

A second GP can be involved in multidisciplinary care planning or case conferencing, and be remunerated for their contribution to the process, only if that GP provides a significantly different service to the patient. In these circumstances, the care provided by the second GP should be different from that of the usual GP. In submitting a claim, the Medicare form would need to be appropriately annotated.

The reasoning behind this is that each of the members of the multidisciplinary team should be providing a different kind of care or service to the patient. Where multiple GPs are involved in the care of the same patient, it may be important to coordinate the services they provide. However, the EPC items are specifically designed to facilitate the provision of multidisciplinary services to meet the different health and care needs of the patients with chronic conditions.

7. Is it the VMO status of the GP that precludes use of the EPC items? For example, a patient is admitted to hospital under a specialist. The patient's GP has VMO rights but is not looking after this patient's care in hospital in this instance. Can the hospital engage the GP to contribute to the care plan?

There is no restriction on a patient claiming a Medicare rebate in respect of a service provided by a GP who is acting in a purely private capacity, ie outside any VMO agreement with the hospital. If in this case the GP is invited by the hospital to contribute to the discharge care plan and provides his services separately and independently of any VMO arrangement with the hospital then his/her service would attract a Medicare rebate. Note that if the GP were providing his services as part of a VMO arrangement he/she could still contribute to the discharge care plan but the patient would not be eligible for a Medicare rebate for his/her contribution.

8. Question: Should GPs be working only with the health and care providers listed in the RACGP Guidelines and MBS Explanatory Notes as members of multidisciplinary care teams?

The health and care providers listed in the RACGP Guidelines and pro-formas and in the MBS Explanatory Notes are examples only of persons who, for the purposes of care planning and case conferencing may be included in a multidisciplinary care team. These lists are not exclusive or prescriptive. It may be appropriate for health or care providers other than those listed to be members of a multidisciplinary care team, where they are providing a different kind of care or service to meet the health or care needs of the patient.

9. Can a GP use an unregistered nurse, acting under their supervision to collect data for health assessments. In this case the person is qualified as a registered nurse, however hasn't practiced for more than 5 years and therefore isn't registered with the Nurses Board of Victoria.

There are no mandatory qualifications for persons who may be used to assist a GP with the information collection component of a health assessment. It is up to the GP to be satisfied that such persons (referred to as third party service providers) have the necessary skills, expertise and training to collect the information required for the health assessment.

The relevant sections of the MBS Explanatory Notes are:

A.20.3 The information collection component of the assessment may be rendered by a nurse or other assistant in accordance with accepted medical practice, acting under the supervision of the medical practitioner. The other components of the health assessment must include a personal attendance by the medical practitioner.

A.20.4 For the purposes of A20.3, the services of a third party service provider such as a nurse or other assistant may only be used to assist in the information collection component of health assessments where:

(a) use of the third party service provider is initiated by the patient's medical practitioner, after the patient has agreed to a health assessment and to the use of a third party to collect information for the assessment.

(b) the patient is made aware whether information collected about them for the health assessment will be retained by the third party service provider

(c) The third party service provider must act under the supervision of the practitioner. The practitioner should:

- *be satisfied that the third party service provider has the necessary skills, expertise and training to collect the information required for the health assessment,*
- *have established how the information is to be collected and recorded (including any forms used),*
- *set or approve the quality assurance procedures for the information collection,*
- *be consulted on any issues arising during the information collection,*
- *review and analyse the information collected to prepare their report of the health assessment and communicate to the patient their recommendations about matters covered by the health assessment.*

10. Can an EPC health assessment be provided to a person receiving a community aged care package and living in the community?

Yes. A person living in the community setting who is receiving a community aged care package would be eligible for a health assessment. The health assessment items are not available to in-patients of a hospital, day hospital facility or care recipients in residential aged care facilities.

11. Can a GP charge for a standard consultation and a HA or CP or CC on the same day.

Although the HIC has a system 'block' on payment for the provision of two services (ie a consultation, and a HA/CP/CC) on the same day, the HIC operator would override the block if the GP's account for the services is annotated (ie as 'service clinically required on same day' or similar).

If the account is not annotated, it will not be paid. (Note also that there may be situations where eg a new operator processing the claim for payment at the HIC may be unaware of the procedure and simply see the block and reject the account. In such situations the account would need to be resubmitted to HIC for payment.)

See also the following answer to another query on this subject which was distributed to SBOs etc in May 2001:

Question: *Can a GP claim for two distinct services provided to a resident in a residential aged care facility on the same day, ie claim for a usual consultation item as well as for contributing to a care plan or case conference?*

A. *Yes, provided the attendance item relates to a distinct service that was clinically required to be provided to the resident on the same day as the GP contributed to the care plan or participated in the case conference. In such cases the GP should annotate the resident's invoice or Medicare voucher to indicate that the attendance item was clinically required to be provided on the same day.*

12. Can a DON and a Nurse make up two members of a CC for an aged care resident?

Because the case conference is designed to address at least one chronic condition in a multidisciplinary environment, the team needs to reflect the multidisciplinary nature of the service. Each of the members of the team needs to be providing a different kind of care or service to the patient.

A DON and a Nurse could participate in a multidisciplinary case conference team, but would not count as two separate members of the team as they would both be providing the same kind of residential nursing care to the patient. To constitute a multidisciplinary team for payment under the EPC case conferencing items, the team would need to include another health professional (as well as the patient's GP) making a separate and distinct contribution to the care plan or case conference.

13. Can two EPC Items be claimed on the same day?

Rebates are payable for health assessment items and other EPC items - care planning and case conference items - when they are carried out in the same day. The outcomes of the health assessment may legitimately warrant the development of a care plan or the arrangement of a case conference for people with chronic or multidisciplinary care needs. If it is necessary to perform either of the latter two services on the same day it should be undertaken as a distinct consultation to the health assessment item.

It should not be necessary for GP's to claim care planning and case conferencing items on the same day. Rebates are not payable in this instance because some of the activities in carrying out a case conference are included as part of carrying out a care plan.

14. Can an EPC discharge case conference be provided for non-acute patients being discharged from hospital into a transitional care facility; the patients will be in the facility for a maximum of 12 weeks with the aim of getting at least 60% of the patients back into the community after this period?

Assuming the patients being discharged from hospital are eligible for an EPC service (ie have a chronic condition and multidisciplinary needs), than a GP (expected to generally be the patient's usual GP) could contribute to a discharge care plan or participate in a discharge case conference in respect of their post-discharge care (for public patients). For private patients the patient's usual GP, who is providing in-patient care, may also organise a discharge care plan or case conference.

15. Can an EPC case conference be claimed for where one GP has been providing care in the transitional care facility (RACF) and the other GP (the patient's usual GP) will be providing care on the patient's return to the community.

The two GPs involved in this scenario are both providing GP type services to the patient, albeit one in the environment of the care facility and one in the community environment. From the information provided, the services don't appear to be different in nature or type - the patient is presumably receiving similar general practitioner services from both providers.

This would not seem to meet the criteria for exception to the general principle that a multidisciplinary team comprise a minimum of three health or care providers, each of whom must provide a different type of care or service to the patient. A team must include the GP and can comprise one other medical practitioner, normally a specialist or consultant physician. Another GP could be included as a member of the team only where they provide a significantly different service to the patient. The item is not intended to reimburse for coordination of the same or similar services to the patient, but to facilitate multidisciplinary input to the patient's complex care needs.

16. Can a patient with an opiate dependency have an EPC care plan developed between the GP, Drug and Alcohol Nurse and the Methadone Clinic?

If the GP considers that the patient with an opiate dependency has a chronic condition and multidisciplinary needs, then he or she could claim the relevant care planning item, provided they meet the other requirements for that item.

In this case the patient may have a chronic condition due to their opiate dependency and they may have multidisiciplinary needs - this is a matter for the GP to decide. It is not clear, however, that the patient's multidisciplinary needs would be met by a team with the membership as proposed. Are the GP, Drug and Alcohol Nurse and Methadone Clinic actually each providing different kinds of care or service to the patient, or are they all basically providing the same addiction management service? If the GP is satisfied that they are in fact each providing a different kind of care or service then it may be an appropriate situation for EPC care planning.