ENHANCED PRIMARY CARE MBS ITEMS
November 2000

(Excerpt from MBS Schedule)

	GROUP A14 - HEALTH ASSESSMENTS
700	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) **AT CONSULTING ROOMS** for a health assessment - of a patient who is **at least 75 years old** - not being a health assessment of a patient in respect of whom, in the preceding 12 months, a payment has been made under this item or **item 702, 704 or 706** *(See para A.20 of explanatory notes to this Category)* **Fee:** $146.25 **Benefit:** 75% = $109.70, 85% = $124.35
702	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) **NOT BEING AN ATTENDANCE AT CONSULTING ROOMS, A HOSPITAL OR A RESIDENTIAL AGED CARE FACILITY** for a health assessment - of a patient who is **at least 75 years old** - not being a health assessment of a patient in respect of whom, in the preceding 12 months, a payment has been made under this item or **item 700**, **704 or 706** *(See para A.20 of explanatory notes to this Category)* **Fee:** $206.85 **Benefit:** 75% = $155.15, 85% = $175.85
704	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) **AT CONSULTING ROOMS** for a health assessment - of a patient who is **at least 55 years old and of Aboriginal or Torres Strait Islander descent** - not being a health assessment of a patient in respect of whom, in the preceding 12 months, a payment has been made under this item or **item 700, 702 or 706** *(See para A.20 of explanatory notes to this Category)* **Fee:** $146.25 **Benefit:** 75% = $109.70, 85% = $124.35
706	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) **NOT BEING AN ATTENDANCE AT CONSULTING ROOMS, A HOSPITAL OR A RESIDENTIAL AGED CARE FACILITY,** for a health assessment - of a patient who is **at least 55 years old and of Aboriginal or Torres Strait Islander descent** - not being a health assessment of a patient in respect of whom, in the preceding 12 months, a payment has been made under this item or **item 700, 702 or 704** *(See para A.20 of explanatory notes to this Category)* **Fee:** $206.85 **Benefit:** 75% = $155.15, 85% = $175.85

MULTIDISCIPLINARY CARE PLANS	
	GROUP A15 - MULTIDISCIPLINARY CARE PLANS AND CASE CONFERENCES
	SUBGROUP 1 - MULTIDISCIPLINARY CARE PLANS
720	**PREPARATION** by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), in consultation with a multidisciplinary care plan team, of a multidisciplinary **COMMUNITY CARE PLAN** for a patient (not being a service associated with a service to which **items 734 to 779** apply) - payable not more than once in any 6 month period *(See para A.21 of explanatory notes to this Category)* **Fee:** $188.05 **Benefit:** 75% = $141.05, 85% = $159.85
722	**PREPARATION** by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), in consultation with a multidisciplinary care plan team, of a multidisciplinary **CARE PLAN** for a patient (not being a service associated with a service to which **items 734 to 779** apply) - payable not more than once for each HOSPITAL ADMISSION *(See para A.21 of explanatory notes to this Category)* **Fee:** $188.05 **Benefit:** 75% = $141.05, 85% = $159.85
724	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), to **REVIEW** a multidisciplinary **COMMUNITY CARE PLAN** or a **DISCHARGE CARE PLAN** prepared by that medical practitioner for a patient and claimed for under item 720 or 722 (not being a payment for a service to which **items 734 to 779** apply) - payable not more than once in any 3 month period, and not being an attendance in relation to a patient: (a) for whom, in the preceding 3 months, a payment has been made under **item 720**; or (b) for whom, in the preceding month, a payment has been made under **item 722** *(See para A.21 of explanatory notes to this Category)* **Fee:** $94.05 **Benefit:** 75% = $70.55, 85% = $79.95
+726	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a multidisciplinary care plan team, to contribute to a multidisciplinary **COMMUNITY CARE PLAN** or to a **REVIEW** of a multidisciplinary **COMMUNITY CARE PLAN** prepared by another provider (not being a payment for a service to which **items 734 to 779** apply) - not being an attendance in relation to a patient for whom, in the preceding 6 months, a payment has been made under **item 720** *(See para A.21 of explanatory notes to this Category)* **Fee:** $37.90 **Benefit:** 75% = $28.45, 85% = $32.25
728	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a multidisciplinary care plan team, to **CONTRIBUTE** to a multidisciplinary **DISCHARGE CARE PLAN** or to a **REVIEW** of a multidisciplinary **DISCHARGE CARE PLAN** prepared by another provider (not being a service associated with a service to which **items 722**, **740 to 773** apply) *(See para A.21 of explanatory notes to this Category)* **Fee:** $37.90 **Benefit:** 75% = $28.45, 85% = $32.25

730	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a multidisciplinary care plan team, to make a **CONTRIBUTION** to a multidisciplinary **CARE PLAN IN A RESIDENTIAL AGED CARE FACILITY** or to a **REVIEW** of a multidisciplinary **CARE PLAN IN A RESIDENTIAL AGED CARE FACILITY** prepared by the residential aged care facility (not being a payment in respect of a service to which **items 734 to 779** apply) *(See para A.21 of explanatory notes to this Category* **Fee:** $37.90 **Benefit:** 75% = $28.45, 85% = $32.25
	SUBGROUP 2 - CASE CONFERENCES
734	**CASE CONFERENCE - MEDICAL PRACTITIONER (OTHER THAN A SPECIALIST OR CONSULTANT PHYSICIAN)** Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **ORGANISE AND CO-ORDINATE A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY**, where the conference time is at least 15 minutes, but less than 30 minutes (not being a service associated with a service to which **item 730** applies) *(See para A.22 of explanatory notes to this Category* **Fee:** $73.15 **Benefit:** 75% = $54.90, 85% = $62.20
736	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **ORGANISE AND CO-ORDINATE A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY**, where the conference time is at least 30 minutes, but less than 45 minutes (not being a service associated with a service to which **item 730** applies) *(See para A.22 of explanatory notes to this Category* **Fee:** $109.70 **Benefit:** 75% = $82.30, 85% = $93.25

MULTIDISCIPLINARY CARE PLANS - CASE CONFERENCES	
738	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **ORGANISE AND CO-ORDINATE A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY**, where the conference time is at least 45 minutes, (not being a service associated with a service to which **item 730** applies) *(See para A.22 of explanatory notes to this Category* **Fee:** $146.25 **Benefit:** 75% = $109.70, 85% = $124.35
740	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **ORGANISE AND CO-ORDINATE A COMMUNITY CASE CONFERENCE**, where the conference time is at least 15 minutes, but less than 30 minutes (not being a service associated with a service to which **items 720 to 730** apply) *(See para A.22 of explanatory notes to this Category)* **Fee:** $73.15 **Benefit:** 75% = $54.90, 85% = $62.20
742	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **ORGANISE AND CO-ORDINATE A COMMUNITY CASE CONFERENCE**, where the conference time is at least 30 minutes, but less than 45 minutes (not being a service associated with a service to which **items 720 to 730** apply) *(See para A.22 of explanatory notes to this Category)* **Fee:** $109.70 **Benefit:** 75% = $82.30, 85% = $93.25
744	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **ORGANISE AND CO-ORDINATE A COMMUNITY CASE CONFERENCE**, where the conference time is at least 45 minutes (not being a service associated with a service to which **items 720 to 730** apply) *(See para A.22 of explanatory notes to this Category)* **Fee:** $146.25 **Benefit:** 75% = $109.70, 85% = $124.35
746	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **ORGANISE AND CO-ORDINATE A DISCHARGE CASE CONFERENCE**, where the conference time is at least 15 minutes, but less than 30 minutes (not being a service associated with a service to which **items 720 to 730** apply) - payable not more than once for each HOSPITAL ADMISSION *(See para A.22 of explanatory notes to this Category)* **Fee:** $73.15 **Benefit:** 75% = $54.90, 85% = $62.20
749	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **ORGANISE AND CO-ORDINATE A DISCHARGE CASE CONFERENCE**, where the conference time is at least 30 minutes, but less than 45 minutes (not being a service associated with a service to which **items 720 to 730** apply) - payable not more than once for each HOSPITAL ADMISSION *(See para A.22 of explanatory notes to this Category)* **Fee:** $109.70 **Benefit:** 75% = $82.30, 85% = $93.25

757	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **ORGANISE AND CO-ORDINATE A DISCHARGE CASE CONFERENCE**, where the conference time is at least 45 minutes (not being a service associated with a service to which **items 720 to 730** apply) - payable not more than once for each HOSPITAL ADMISSION *(See para A.22 of explanatory notes to this Category)* **Fee:** $146.25 **Benefit:** 75% = $109.70, 85% = $124.35
759	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **PARTICIPATE IN A COMMUNITY CASE CONFERENCE**, (other than to organise and co-ordinate the conference), where the conference time is at least 15 minutes, but less than 30 minutes (not being a service associated with a service to which **items 720 to 730** apply) *(See para A.22 of explanatory notes to this Category)* **Fee:** $52.20 **Benefit:** 75% = $39.15, 85% = $44.40
762	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **PARTICIPATE IN A COMMUNITY CASE CONFERENCE** (other than to organise and co-ordinate the conference), where the conference time is at least 30 minutes, but less than 45 minutes (not being a service associated with a service to which **items 720 to 730** apply) *(See para A.22 of explanatory notes to this Category)* **Fee:** $83.55 **Benefit:** 75% = $62.70, 85% = $71.05
765	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **PARTICIPATE IN A COMMUNITY CASE CONFERENCE** (other than to organise and co-ordinate the conference), where the conference time is at least 45 minutes (not being a service associated with a service to which **items 720 to 730** apply) *(See para A.22 of explanatory notes to this Category)* **Fee:** $114.90 **Benefit:** 75% = $86.20, 85% = $97.70

MULTIDISCIPLINARY CARE PLANS - CASE CONFERENCES	
768	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **PARTICIPATE IN A DISCHARGE CASE CONFERENCE** (other than to organise and co-ordinate the conference), where the conference time is at least 15 minutes, but less than 30 minutes (not being a service associated with a service to which **items 720 to 730** apply) - payable not more than once for each HOSPITAL ADMISSION *(See para A.22 of explanatory notes to this Category)* **Fee:** $52.20 **Benefit:** 75% = $39.15, 85% = $44.40
771	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **PARTICIPATE IN A DISCHARGE CASE CONFERENCE** (other than to organise and co-ordinate the conference), where the conference time is at least 30 minutes, but less than 45 minutes (not being a service associated with a service to which **items 720 to 730** apply) - payable not more than once for each HOSPITAL ADMISSION *(See para A.22 of explanatory notes to this Category)* **Fee:** $83.55 **Benefit:** 75% = $62.70, 85% = $71.05
773	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **PARTICIPATE IN A DISCHARGE CASE CONFERENCE** (other than to organise and co-ordinate the conference), where the conference time is at least 45 minutes (not being a service associated with a service to which **items 720 to 730** apply) - payable not more than once for each HOSPITAL ADMISSION *(See para A.22 of explanatory notes to this Category)* **Fee:** $114.90 **Benefit:** 75% = $86.20, 85% = $97.70
775	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **PARTICIPATE IN A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY**, (other than to organise and co-ordinate the conference), where the conference time is at least 15 minutes, but less than 30 minutes (not being a service associated with a service to which **item 730** applies) *(See para A.22 of explanatory notes to this Category* **Fee:** $52.20 **Benefit:** 75% = $39.15, 85% = $44.40
778	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **PARTICIPATE IN A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY**, (other than to organise and co-ordinate the conference), where the conference time is at least 30 minutes, but less than 45 minutes (not being a service associated with a service to which **item 730** applies) *(See para A.22 of explanatory notes to this Category* **Fee:** $83.55 **Benefit:** 75% = $62.70, 85% = $71.05

779	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **PARTICIPATE IN A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY**, (other than to organise and co-ordinate the conference), where the conference time is at least 45 minutes, (not being a service associated with a service to which **item 730** applies) *(See para A.22 of explanatory notes to this Category* **Fee:** $114.90 **Benefit:** 75% = $86.20, 85% = $97.70
801	**CASE CONFERENCE - CONSULTANT PHYSICIAN** Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to **ORGANISE AND COORDINATE A COMMUNITY CASE CONFERENCE** of at least 30 minutes but less than 60 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines (see note A24.6 on permissible combinations) *(See para A.24 of explanatory notes to this Category)* **Fee:** $183.00 **Benefit:** 75% = $137.25, 85% = $155.55
803	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to **ORGANISE AND COORDINATE A COMMUNITY CASE CONFERENCE** of more than 60 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines (see note A24.6 on permissible combinations) *(See para A.24 of explanatory notes to this Category)* **Fee:** $244.00 **Benefit:** 75% = $183.00, 85% = $207.40
805	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to **PARTICIPATE IN A COMMUNITY CASE CONFERENCE** (other than to organise and to coordinate the conference) of at least 30 minutes but less than 60 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines (see note A24.6 on permissible combinations) *(See para A.24 of explanatory notes to this Category)* **Fee:** $152.00 **Benefit:** 75% = $114.00, 85% = $129.20
807	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to **PARTICIPATE IN A COMMUNITY CASE CONFERENCE** (other than to organise and to coordinate the conference) of more than 60 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines (see note A24.6 on permissible combinations) *(See para A.24 of explanatory notes to this Category)* **Fee:** $202.60 **Benefit:** 75% = $151.95, 85% = $172.25
809	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to **ORGANISE AND COORDINATE A DISCHARGE CASE CONFERENCE** of at least 30 minutes but less than 60 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines (see note A24.6 on permissible combinations) *(See para A.24 of explanatory notes to this Category)* **Fee:** $183.00 **Benefit:** 75% = $137.25, 85% = $155.55

811	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to **ORGANISE AND COORDINATE A DISCHARGE CASE CONFERENCE** of more than 60 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines (see note A24.6 on permissible combinations) *(See para A.24 of explanatory notes to this Category)* **Fee:** $244.00 **Benefit:** 75% = $183.00, 85% = $207.40
813	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to **PARTICIPATE IN A DISCHARGE CASE CONFERENCE** of at least 30 minutes but less than 60 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines (see note A24.6 on permissible combinations) *(See para A.24 of explanatory notes to this Category)* **Fee:** $152.00 **Benefit:** 75% = $114.00, 85% = $129.20
815	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to **PARTICIPATE IN A DISCHARGE CASE CONFERENCE** of more than 60 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines (see note A24.6 on permissible combinations) *(See para A.24 of explanatory notes to this Category)* **Fee:** $202.60 **Benefit:** 75% = $151.95, 85% = $172.25

EXPLANATORY NOTES

A.20 Health Assessments (Items 700 to 706)

A.20.1 These items do not apply to in-patients of a hospital, day hospital facility or care recipients in residential aged care facilities.

A.20.2 A health assessment should generally only be undertaken by the medical practitioner, or a practitioner working in the medical practice, that has provided the majority of services to the patient over the previous 12 months and/or will provide the majority of services to the patient over the coming 12 months.

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 satisified 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.

A.20.5 For items 704 and 706, a person is of Aboriginal or Torres Strait Islander descent if the person identifies himself or herself as being of that descent. Patients should be asked to self-identify their Indigenous status and state their age for the purposes of these items, either verbally or by completing a form. Difficulties may arise in relation to establishing the age of the patient. Knowledge of a person's age or date of birth is sometimes considered irrelevant by Indigenous people and as

such some people may not be able to answer with a high degree of accuracy. The person's Indigenous status and age should be accepted on the basis of their self-identification.

A.20.6 A ***health assessment*** means the assessment of a patient's health and physical, psychological and social function and whether preventative health care and education should be offered to the patient, to improve that patient's health and physical, psychological and social function.

A.20.7 The assessment must include:

(a) measurement of the patient's blood pressure, pulse rate and rhythm; and
(b) an assessment of the patient's medication; and
(c) an assessment of the patient's continence; and
(d) an assessment of the patient's immunisation status for influenza, tetanus and pneumococcus; and
(e) an assessment of the patient's physical function, including the patient's activities of daily living, and whether or not the patient has had a fall in the last 3 months; and
(f) an assessment of the patient's psychological function, including the patient's cognition and mood; and
(g) an assessment of the patient's social function, including the availability and adequacy of paid and unpaid help, and whether the patient is responsible for caring for another person.

A.20.8 The assessment must also include keeping a record of the health assessment, signed by the patient and offering the patient a written report about the health assessment, with recommendations about matters covered by the health assessment.

A.20.9 In circumstances where the patient's usual medical practitioner or practice, as defined in A20.2, does not undertake the health assessment, a copy of the health assessment report should be forwarded to that medical practitioner or practice (subject to the patient's agreement).

A.20.10 The annual health assessment should not take the form of a health screening service, in particular the assessment should not include category 5 (diagnostic imaging) services or category 6 (pathology) services unless the health assessment detects problems that require clinically relevant diagnostic imaging or pathology services. (See General Notes 13.3.)

A.20.11 Practitioners should not conduct a separate consultation in conjunction with a health assessment unless it is clinically indicated that a problem must be treated immediately.

A.20.12 Practitioners should establish a register of their patients seeking annual health assessments and remind registered patients when their next health assessment is due.

A.20.13 Where a component of the health assessment is conducted at consulting rooms and a component is conducted in the patient's home the latter item should be claimed.

A.20.14 The balance between the patient's health and physical, psychological and social function domains is a matter for professional judgement in relation to each patient. Practitioners should consider the following:

Medical:

Medication review

This should include a review of medications taken including OTCs and prescriptions from other doctors; medications prescribed but not taken; interactions; and review of indications. In this age group, side effects and interactions occur more frequently and at lower dosage than in younger adults.

Blood pressure and pulse rate and rhythm

Where the assessment identifies a spot high blood pressure reading or evidence of atrial fibrillation (irregularly irregular pulse), a follow up consultation should be arranged to determine further management.

Continence

Continence problems are under reported and a major cause of reduced quality of life in this age group. They are usually easily detectable by direct questioning, and when first diagnosed are frequently amenable to improved management. If identified, a follow up consultation should be arranged to investigate the underlying pathology and arrange management.

Immunisation status (Influenza, Tetanus, Pneumococcus)

Refer to the current Australian Standard Vaccination Schedule (NHMRC) for appropriate vaccination schedules for individuals in this age group.

Physical function:

Activities of Daily Living

Assessment of activities of daily living is concerned with the interaction between the patient, their impairment (if any) and their environment. As a minimum, the patient's ability to transfer between bed, chair and toilet, bathe, dress, prepare food and eat should be assessed. The assessment should also include whether the patient can: use the telephone; get to the shops or the bank; read books; watch TV; listen to the radio or recorded music; and look after the house (cleaning, minor repairs etc).

Where significant functional impairment is identified, the use of a formal instrument such as the Index of Independence in Activities of Daily Living; the Modified Barthel Index; or the Medical Outcome Study Physical Functioning Measure should be considered.

Falls in last 3 months
The patient should be asked whether they have suffered any falls in the previous three months. A recent fall is the strongest predictor of future fall related injury.

Psychological function:
Cognition
Unrecognised dementia is common in this age group. Detailed diagnosis can often improve quality of life. Cognition can be assessed with a recognised tool such as the Folstein Mini Mental State Examination or the Hodkinson Abbreviated Mental Assessment.

Mood
At a minimum, the assessment should include enquires about depressed affect. If mental symptoms are present (eg abnormal affect or memory loss), the use of a formal depression scale such as the Geriatric Depression Scale should be considered.

Social function:
Availability and adequacy of paid and unpaid help when needed and wanted
This is the central component of an assessment of the patient's social support. People's social networks tend to become smaller as they age, and the role of formal services may need to increase correspondingly.

Caring for another person
Being a carer for another person can significantly affect physical and psychological health and substantially reduce opportunities to maintain social networks. When the person being assessed is a carer, the assessment should include: an evaluation of the effect of this role on health and functioning; and the provision of information about local carer support services, including regular or emergency respite care.

NB: The tools referred to in the preceding explanatory notes should be used at the clinical discretion of the practitioner. Practitioners using such tools should be familiar with their use and if not, should seek appropriate education/training.

A.20.15 In addition, the assessment will usually cover additional matters of particular relevance to the patient. The medical literature and consensus medical opinion support the following additional components: multi-system review; fitness to drive; hearing; vision; oral health; diet and nutritional status; smoking; foot care; sleep; need for community services; home safety; cardiovascular risk factors, including blood pressure; and alcohol use.

A.21 Care Planning (Items 720 to 730)

A.21.1 Items 720, 724 and 726 apply only to a service in relation to a patient who suffers from at least one medical condition that has been (or is likely to be) present for at least 6 months, or that is terminal, and is not an in-patient of a hospital, day hospital facility, or a care recipient in a residential aged care facility.

A.21.2 Items 722 and 728 apply only to a service in relation to a patient who suffers from at least one medical condition that has been (or is likely to be) present for at least 6 months, or that is terminal, and is an in-patient of a hospital or day hospital facility, and is not a care recipient in a residential aged care facility.

A.21.3 Item 730 applies only to a service in relation to a care recipient in a residential aged care facility who suffers from at least one medical condition that has been (or is likely to be) present for at least 6 months, or that is terminal.

A.21.4 For the purposes of items 720 to 730 a medical practitioner should generally be the medical practitioner or a practitioner working in the medical practice that has provided the majority of services to the patient over the previous 12 months and/or will provide the majority of services to the patient over the coming 12 months.

Preparation of a multidisciplinary care plan
A.21.5 For items 720, 722, 724, 726, 728 and 730 preparation of a multidisciplinary care plan means the preparation of a written plan describing the following matters:

(a) an assessment of the patient and their health care needs; and
(b) an assessment of the kinds of treatment, health services and health care that the patient is likely to need; and
(c) an assessment of any other kind of services and care that the patient is likely to need (for example, home and community care services); and
(d) arrangements for giving the treatment, services and care referred to in paragraph (b); and
(e) management goals with which the patient agrees; and
(f) arrangements to review the plan by a day specified in the plan.

A.21.6 Preparation of the plan must also include:
(a) a meeting with the patient to discuss the preparation of the plan; and
(b) telling the patient who will be included in the multidisciplinary care plan team; and
(c) recording the plan and the patient's agreement to the preparation of the plan; and
(d) giving copies of relevant parts of the plan to persons who, under the plan, will give the patient the treatment, service and care mentioned in the plan; and
(e) offering a copy of the plan (and evidence of the contribution made to the plan by members of the team) to the patient; and
(f) if the patient is eligible to be provided with treatment under Part V of the *Veterans' Entitlement Act 1986*, giving a copy of the plan to the Department of Veterans' Affairs.

A.21.7 A multidisciplinary care plan team includes a medical practitioner and at least 2 other members who contribute to the plan, each of whom provides a different kind of care or service to the patient, and 1 of whom may be another medical practitioner (normally a specialist or consultant physician).

Example
Examples of persons who, for the purposes of care planning and case conferencing may be included in a multidisciplinary care team are allied health professions such as, but not limited to: Aboriginal health care workers; audiologists; dental therapists; dentists; dieticians; occupational therapists; optometrists; orthoptists; orthotists or prosthetists; pharmacists; physiotherapists; podiatrists; psychologists; registered nurses; social workers; speech pathologists.

A team may also include home and community service providers, or care organisers, such as: education providers; "meals on wheels" providers; personal care workers; probation officers.

The patient, or his or her informal carer, is not counted toward the minimum of three.

A.21.8 In making arrangements for implementation of the plan, the medical practitioner should specify the type of care to be provided and ascertain the availability of care from other providers. The documentation of the care plan should note the agreement of the other providers specified in the plan. This may be in the form of the medical practitioner's note of a telephone conversation.

A.21.9 While the patient must be present for a needs assessment by the medical practitioner in order to develop the care plan, the patient need not be present while formal documentation is prepared and members of the multidisciplinary care plan team are contacted.

A.21.10 When discussing the preparation of the plan with the patient, practitioners should:

- Inform the patient that his or her medical history, diagnosis and care preferences will be discussed with other care providers; and
- Provide an opportunity for the patient to specify what medical and personal information he or she wants to be conveyed to, or withheld from, the other members of the multidisciplinary care plan team;
- Inform the patient that he or she will incur a charge for the service provided by the practitioner for which a Medicare rebate will be payable;
- Inform the patient of any additional costs he or she will incur.

A.21.11 While no standard format for the care plan is mandated, practitioners should consider a recognised care planning tool, for example those developed by the Royal Australian College of General Practitioners (RACGP).

A.21.12 It is recommended that a community care plan be prepared only once per year. However, a new plan may be prepared if the patient's clinical condition has changed markedly since the previous plan, but not within 6 months of the previous plan. Any changes to the plan required after 3 months of the plan being prepared would attract a benefit under the review item 724 (see paragraphs A.21.16 and A.21.17).

A.21.13 Ongoing implementation and maintenance of the plan by the medical practitioner will be covered under normal consultation items.

Discharge care plans

A.21.14 For items 722 and 728 a multidisciplinary discharge care plan is a multidisciplinary care plan that is prepared for a patient before the patient is discharged from a hospital.

A.21.15 Preparation of a discharge care plan (item 722) may be provided for private in-patients only, and must be prepared by the medical practitioner who is providing in-patient care (in most cases this should be the patient's usual medical practitioner).

Review of care plans

A.21.16 For item 724, review of a multidisciplinary care plan means a process by which the medical practitioner who prepared the care plan:

(a) reviews a community care plan or discharge care plan prepared under item 720 or 722 including reviewing the matters mentioned in A.21.5; and
(b) considers whether the arrangements for treatment, service and care have been carried out; and
(c) consults with other members of the multidisciplinary care plan team to consider whether different arrangements need to be made to achieve the management goals mentioned in the plan; and
(d) if different arrangements need to be made, prepares a revised multidisciplinary care plan, stating those arrangements.

A.21.17 The review of the plan must also include:

(a) discussing the review of the plan with the patient; and
(b) recording the patient's agreement to reviewing the plan; and
(c) offering a copy of relevant parts of the revised multidisciplinary care plan (if any) to the patient, and giving copies to persons who, under the revised plan, will give the patient the treatment, service and care mentioned in the plan; and
(d) if the patient holds an entitlement for treatment under Part V of the *Veterans' Entitlements Act 1986*, giving a copy of the revised multidisciplinary care plan (if any) to the Department of Veterans' Affairs.

Contribution to care plans

A.21.18 For items 726 and 728, a contribution to a care plan must be at the request of the person who prepares the plan, and may include preparation of a part of the plan that relates to the treatment, service or care that the medical practitioner will give to the patient and giving advice to the person who prepares the plan.

A.21.19 Contribution to a care plan does not include preparation of a multidisciplinary ***community*** care plan, a multidisciplinary discharge care plan or a care plan in a residential aged care facility, but can include contribution to a review of a care plan organised by another provider.

A.21.20 A medical practitioner's contribution to a ***community*** care plan, a discharge plan or a care plan in a residential aged care facility can be made by either face-to-face meeting, telephone, fax, e-mail, written correspondence or other means.

A.21.21 The medical practitioner should request a copy of the completed plan, or an extract of the plan relating to the medical practitioner's contribution, for the patient's medical record. The medical practitioner must include a record of his or her contribution in the patient's medical record.

A.21.22 For item 730, a contribution to a care plan in a residential aged care facility must be at the request of the residential aged care facility. It is expected that a medical practitioner would not normally be required to contribute to an individual care plan in a residential aged care facility more than four times in a 12 month period. The medical practitioner's contribution should be documented in the care plan maintained by the residential aged care facility and a record of the contribution included in the care recipient's medical record.

General requirements

A.21.23 In circumstances where the patient's usual medical practitioner, as defined in A21.4, is not a member of the multidiscplinary care team, a copy of the care plan should be forwarded to that medical practitioner (subject to patient's agreement).

A.21.24 Before commencing a care plan, the medical practitioner should ascertain whether the patient currently has another active care plan and if so, should not duplicate that plan.

A.21.25 The benefit is not claimable (and an account should not be rendered) until all components of these items have been provided (see general notes 7.6).

A.22 Case Conferences by medical practitioners (other than specialist or consultant physician) (Items 734 to 779)

A.22.1 Items 740, 742, 744, 759, 762 and 765 apply only to a service in relation to a patient who suffers from at least one medical condition that has been (or is likely to be) present for at least 6 months, or that is terminal, and is not an in-patient of a hospital, day hospital facility or a care recipient in a residential aged care facility.

A.22.2 Items 746, 749, 757, 768, 771 and 773 apply only to a service in relation to a patient who suffers from at least one medical condition that has been (or is likely to be) present for at least 6 months, or that is terminal, and is an in-patient of a hospital or day hospital facility and is not a care recipient in a residential aged care facility.

A.22.3 Items 734, 736, 738, 775, 778 and 779 apply only to a service in relation to a care recipient in a residential aged care facility who suffers from at least one medical condition that has been (or is likely to be) present for at least 6 months, or that is terminal.

A.22.4 A case conference is a process by which a case conference team carries out the following activities:
(a) discussing a patient's history; and
(b) identifying the patient's multidisciplinary care needs; and
(c) identifying outcomes to be achieved by members of the case conference team giving care and service to the patient; and
(d) identifying tasks that need to be undertaken to achieve these outcomes, and allocating those tasks to members of the case conference team; and
(e) assessing whether previously identified outcomes (if any) have been achieved.

A.22.5 For items 746, 749, 757, 768, 771 and 773, a discharge case conference is a case conference carried out in relation to a patient before the patient is discharged from a hospital or day hospital facility.

A.22.6 For the purposes of items 734 to 779 a medical practitioner should generally be the medical practitioner or a practitioner working in the medical practice that has provided the majority of services to the patient over the previous 12 months and/or will provide the majority of services to the patient over the coming 12 months.

A.22.7 A case conference team includes a medical practitioner and at least 2 other members, who participate in the case conference, each of whom provides a different kind of care or service to the patient, and 1 of whom may be another medical practitioner (normally a specialist or consultant physician).

Example
Examples of persons who, for the purposes of care planning and case conferencing may be included in a multidisciplinary care team are allied health professionals such as, but not limited to: Aboriginal health care workers; audiologists; dental therapists; dentists; dieticians; occupational therapists; optometrists; orthoptists; orthotists or prosthetists; pharmacists; physiotherapists; podiatrists; psychologists; registered nurses; social workers; speech pathologists.

A team may also include home and community service providers, or care organisers, such as: education providers; "meals on wheels" providers; personal care workers; probation officers.

The patient, or his or her informal carer, is not counted toward the minimum of three.

Organisation of a case conference
A.22.8 Organise and coordinate a case conference means undertaking the following activities in relation to a case conference:
(a) explaining to the patient the nature of a case conference, and asking the patient whether the patient agrees to the case conference taking place; and
(b) recording the patient's agreement to the case conference; and
(c) recording the day on which the conference was held, and the times at which the conference started and ended; and
(d) recording the names of the participants; and
(e) recording the matters mentioned in A.22.4 and putting a copy of that record in the patient's medical records; and
(f) offering the patient, and giving each other member of the team a summary of the conference; and
(g) discussing the outcomes of the case conference with the patient.

A.22.9 Organisation of a discharge case conference (items 746, 749 and 757), may be provided for private in-patients only, and must be organised by the medical practitioner who is providing in-patient care (in most cases this should be the patient's usual medical practitioner).

Participation in a case conference

A.22.10 Participation in a case conference must be at the request of the person who organises and coordinates the case conference and includes undertaking the following activities when participating in a case conference:

(a) explaining to the patient the nature of a case conference, and asking the patient whether he or she agrees to the medical practitioner participating in the case conference; and
(b) recording the patient's agreement to the medical practitioner participating in the case conference; and
(c) recording the day on which the conference was held, and the times at which the conference started and ended; and
(d) recording the names of the participants; and
(e) recording the matters mentioned in A.22.4 in so far as they relate to the medical practitioner's participation in the case conference, and putting a copy of that record in the patient's medical records; and
(f) offering the patient a summary of the conference.

Case conferences in a residential aged care facility

A.22.11 For items 734, 736, 738, 775, 778 and 779, organising or participating in a case conference in a residential aged care facility means undertaking the relevant activities referred to in A.22.4, A.22.8 and A.22.10. For these items the medical practitioner must give a record of the conference, or a record of the medical practitioner's participation in the conference, to the residential aged care facility, place a copy in the patient's medical records, and offer a copy to the patient.

General requirements

A.22.12 In circumstances where the patient's usual medical practitioner, as defined in A21.4, is not a member of the case conference team, a record of the case conference should be forwarded to that medical practitioner (subject to the patient's agreement).

A.22.13 It is expected that a patient would not normally require more than 5 case conferences in a 12-month period.

A.22.14 The case conference must be arranged in advance within a time frame that allows for all the participants to attend. The minimum three care providers must be present for the whole of the case conference. All participants must be in communication with each other throughout the conference, either face to face, by telephone or by video link, or a combination of these.

A.22.15 In explaining to the patient the nature of a case conference and asking the patient whether he or she agrees to the case conference taking place, the medical practitioner should:

- Inform the patient that his or her medical history, diagnosis and care preferences will be discussed with other care providers;
- Provide an opportunity for the patient to specify what medical and personal information he or she wants to be conveyed to or withheld from the other case conference team members; and
- Inform the patient that he or she will incur a charge for the service provided by the practitioner for which a Medicare rebate will be payable.
- Inform the patient of any additional costs he or she will incur.

A.22.16 The benefit is not claimable (and an account should not be rendered) until all components of these items have been provided. (See General Notes 7.6)

A.24 Case Conferences by consultant physician (Items 801 to 815)

A.24.1 Items 801, 803, 805 and 807 apply to a community case conference (including a case conference conducted in a residential aged care facility) organised to discuss one patient in detail and applies only to a service in relation to a patient who suffers from at least one medical condition that has been (or is likely to be) present for at least 6 months, or that is terminal. Items 801, 803, 805 and 807 do not apply to an in-patient of a hospital or day hospital facility.

A.24.2 For items 809, 811, 813 and 815, a discharge case conference is a case conference carried out in relation to a patient before the patient is discharged from a hospital or day hospital facility. Items 809, 811, 813 and 815 are payable not more than once for each hospital admission.

A.24.3 The purpose of a case conference is to establish and coordinate the management of the care needs of the patient.

A.24.4 A case conference is a process by which a multidisciplinary team carries out the following activities:

- discusses a patient's history;
- identifies the patient's multidisciplinary care needs;
- identifies outcomes to be achieved by members of the case conference team giving care and service to the patient;
- identifies tasks that need to be undertaken to achieve these outcomes, and allocating those tasks to members of the case conference team; and
- assesses whether previously identified outcomes (if any) have been achieved.

A.24.5 For the purposes of these items, a multidisciplinary team requires the involvement of a minimum of four formal care providers from different disciplines. The consultant physician is counted toward the minimum of four. Although they may attend the case conference, neither the patient nor his or her informal carer, or any other medical practitioner (except where the medical practitioner is the patient's usual General Practitioner) can be counted toward the minimum of four.

A.24.6 For the purposes of 1.5 "formal care providers" includes:

- The patient's usual General Practitioner;
- Allied health professionals, being: registered nurse, physiotherapist, occupational therapist, podiatrist, speech pathologist, pharmacist; dietician; psychologist; orthoptist; orthotist and prosthetist, optometrist; audiologist, social worker, Aboriginal health worker, mental health worker; and
- Community service providers being: personal care worker, home and community care service provider, meals on wheels provider, education provider and probation officer.

Organisation of a case conference

A.24.7 For items 801, 803, 809 and 811, organise and coordinate a community case conference means undertaking the following activities in relation to a case conference:

(a) explaining to the patient or the patient's agent the nature of a case conference, and asking the patient or the patient's agent whether he or she agrees to the case conference taking place; and
(b) recording the patient's or agent's agreement to the case conference; and
(c) recording the day on which the conference was held, and the times at which the conference started and ended; and
(d) recording the names of the participants; and
(e) recording the matters mentioned in 1.4 and putting a copy of that record in the patient's medical records; and
(f) giving the patient or the patient's agent, and each other member of the team a summary of the conference; and
(g) giving a copy of the summary of the conference to the patient's usual general practitioner; and
(h) discussing the outcomes of the patient or the patient's agent.

Participation in a case conference

A.24.8 For items 805, 807, 813 and 815, participation in a case conference must be at the request of the person who organises and coordinates the case conference and includes undertaking the following activities when participating in a case conference:

(a) recording the day on which the conference was held, and the times at which the conference started and ended; and
(b) recording the matters mentioned in 1.4 in so far as they relate to the medical practitioner's participation in the case conference, and putting a copy of that record in the patient's medical records.

General requirements

A.24.9 The case conference must be arranged in advance, within a time frame that allows for all the participants to attend. The minimum four care providers must be present for the whole of the case conference. All participants must be in communication with each other throughout the conference, either face to face, by telephone or by video link, or a combination of these.

A.24.10 A record of the case conference which contains: a list of the participants; the times the conference commenced and concluded; a description of the problems, goals and strategies; and a summary of the outcomes must be kept in the patient's record. The notes and summary of outcomes must be provided to all participants and to the patient's usual general practitioner.

A.24.11 Prior informed consent must be obtained from the patient, or the patient's agent. In obtaining informed consent the consultant physician should:

- Inform the patient that his or her medical history, diagnosis and care preferences will be discussed with other case conference participants;
- Provide an opportunity for the patient to specify what medical and personal information he or she wants to be conveyed to, or withheld from, the other care providers;
- Inform the patient that he or she will incur a charge for the service for which a Medicare rebate will be payable.

A.24.12 Medicare benefits are only payable in respect of the service provided by the coordinating consultant physician or the participating consultant physician. Benefits are not payable for participation by other medical practitioners at a case conference, except where a medical practitioner participates in a case conference in accordance with Items 759 to 779.

A.24.13 The benefit is not claimable (and an account should not be rendered) until all components of these items have been provided. See point 7 of the General Explanatory Notes for further details on billing procedures.

A.24.14 It is expected that a patient would not normally require more than 5 case conferences in a 12 month period.

A.24.15 This item does not preclude the claiming of a consultation on the same day if other clinically relevant services are provided.