

Questions from RACGP/WAGPN Demystifying Medicare Seminar 24 October 2009

- Why can't you train Doctors about MBS items when you first train GP's (Case scenario)

A: Medicare Australia is working with Regional Training Providers to ensure GP Registrars receive adequate education in relation to MBS items. In addition, a range of online learning modules can be accessed via the Medicare Australia website.

- For annual EPC to enable patient to continue to access same allied health provider when should it be done (1st Jan) and what item number should be used?

A: The 5 rebateable allied health services are claimable every calendar year. Referrals can be written during a normal consultation (i.e. a GPMP/TCA review item should only be rendered if clinically relevant).

When a patient does not use all 5 visits within the calendar year (Jan 1st – Dec 31st), the referral remains in place until all are used. Patients may then have another referral written if further visits are required, however they will only be rebated for a total of 5 visits in that calendar year (e.g. if only 3 visits were rebated in 2009, the patient will still be eligible for a maximum of 5 rebateable visits in 2010)

- How to find out whether I have done Level 1 Mental Health Training?

A: Check with RACGP (they hold records of all accredited training), or local division Mental Health Officer if they were the provider.

- Lots of patients already come interstate – unaware of whether they already have MHT Plan from E.S. GP. How to find out?

A: Contact the Medicare Australia provider enquiry line on 132150 and ask while the patient is in the consultation room with you.

- When do I bill for TCAs?

A: When all requirements of the item are completed including agreements received from 2 of the other care providers. Agreements can be written (email, fax and letter) or verbal (must be documented in patient notes). NB: must have agreement from all provides included in the collaboration. Other providers of care can be listed as providing care but not part of the collaboration. They must be informed that patient has had TCA developed (e.g. Cardiologist listed but

not part of TCA, Exercise physiologist and Dietitian agrees to contribute to TCA).

Please refer to the DoHA CDM Q&A document for further information.

- If I refer and the patient has MBS 721 in place, is there a rebate for the patient for the referral?

A: If patient only has a GPMP (721) in place they are not eligible for Medicare funded allied health services.

- Charge (item number). Driving license assessment – secondary to drink driving charge?

A: General explanatory note G13.1 states that Medicare benefits are payable for age or health related medical examinations to obtain or renew a license to drive a private motor vehicle. This would apply to the scenario described above.

- Commercial Drivers License – someone who is unemployed requires to obtain a commercial drivers license to try to seek work – is this Medicare rebateable?

A: General explanatory note G13.1 states that Medicare benefits are not payable for health screening services. This includes compulsory examinations and tests to obtain a flying, commercial driving or other license.

- Fracture management – If I see a patient following a fall, order an X-Ray, upon review of the X-Ray a scaphoid fracture seen – plaster applied and appointment then made for hospital clinic fracture Clinic, what item number can I bill?

A: If on attendance at the fracture clinic, the patient will be seeing a specialist who will take over care for the fracture, you can only charge a consultation item. If the GP will maintain clinical care of the fracture, they can render the appropriate fracture item.

- CDM compliance – Is Medicare able to provide examples of CDM plans which have been rejected by Medicare and examples of plans/formats which have Medicare requirements?

A: General explanatory note A.33 of the Medicare Benefits Schedule contains information regarding what should be included in a GPMP. Additionally, sample templates are available on the Department of Health & Ageing website, plus some division websites.

- Does Medicare have examples of accepted Chronic Disease Management plan templates?

A: Sample templates are available on the Department of Health & Ageing website, plus some division websites.

- Will a care plan for an obese patient i.e.: hypertension, hypercholesterolaemia and possibly smoking/impair blood glucose hold up in an audit?

A: Questions have asked on whether the following are chronic medical conditions for the purposes of the items: alcohol or other substance abuse; smoking; obesity; unspecified chronic pain; hypertension, hypercholesterolemia, or syndrome X; impaired fasting glucose tolerance or impaired glucose tolerance; pregnancy.

The general position on these 'conditions' is that they have not been regarded as chronic medical conditions for the purpose of the EPC items to date and this remains the case with the CDM items. (Note that in many cases a patient may have complications or co-morbidities, that may be a result of or exacerbated by such conditions or risk factors, that would make them eligible for CDM services.)

In some cases these 'conditions' would not be commonly regarded as chronic medical conditions of themselves, others may more accurately be regarded as risk factors for development of chronic conditions, some possibly relate more to personal choice/behavioral issues and some (pregnancy without complications) could be regarded as a normal part of life.

It is recognised, however, that conditions such as the above can occur across a wide spectrum of severity and in a broad range of circumstances, with, for example, some patients with one (or more) of the above conditions being unable to self-manage or comply with care and treatment, being functionally disabled by their condition etc.

A GP must assess whether a patient is eligible for a CDM service, having reference firstly to the MBS eligibility criteria and the guidance above setting out the general position.

Where a patient's 'condition' would not obviously come within the MBS definition, a GP may still consider that, notwithstanding the above, the patient's condition and circumstances are such that they require the preparation of a GP Management Plan, for example, because of non-compliance, inability to self-manage, functional disability etc.

In these cases, the GP should be satisfied that the GP's peers would regard the provision of a CDM service as appropriate for that patient, given the patient's needs and circumstances.

- Can communication for DMMR 900's be via fax?

A: No. The discussion of the review findings and report including suggested medication management strategies with the reviewing pharmacist includes: Receiving a written report from the reviewing pharmacist; and discussing the relevant findings and suggested management strategies with the pharmacist (either by phone or face to face); and developing a summary of the relevant review findings as part of the draft medication management plan.

- Can nurses organize/refer for DMMR under direction of GP; re: Mr X has discussed with GP, can nurse arrange the logistics of asking pharmacist to review?

A: The potential need for a DMMR may be identified by the medical practitioner or by receipt of advice from the patient, a carer or another health professional including a pharmacist.

A medical practitioner must assess that a DMMR is clinically necessary to ensure quality use of medicines or address patient's needs. Additionally, the medical practitioner must ensure that all other components of the item have been met.

A practice nurse may provide administrative support in relation to the DMMR-related services.

- Can we definitely bulk bill unrelated issues along with a workers comp or MVIT consult, given that W/C and MVIT on another invoice?

A: If separate consultations have occurred for a Medicare rebatable service and a service covered by Workers' Compensation, two separate invoices can be raised. However, the provider would need to ensure that the medical records reflected this by means of clearly indicated separate entries for the Workcover and Medicare rebatable services.

- What is the guidance on patient's signatures on assigning benefits to a clinic that bulk bills electronically?

A: Practices utilizing electronic claiming are not required to retain patient signatures when lodging claims for assigned benefits.

- Does a GPMP have to be in place to claim TCA?

A: No. A TCA can be done without a GPMP. While a GPMP and a TCA are able to be provided independently, it is expected that in most cases a patient with complex needs would have both services. It is not mandatory, however, to follow the preparation of a GP Management Plan with the coordination of TCA or to prepare a GPMP before coordinating TCA. A TCA can be provided to patients who have a current GPMP or to those patients whose care is, in the opinion of the providing GP, appropriately managed at the GP level without a GPMP (Patient notes must reflect this). Note that a patient with only a TCA in place will be unable to access allied Health rebateable items.

- Can a SIP item number be claimed with GPMP or TCA

A: A SIP item number associated with the completion of a cycle of care (e.g. asthma or diabetes) can be rendered in association with item 721 or 723 provided that the item descriptor for both services has been met.

A SIP item number associated with the completion of a cycle of care (e.g. asthma or diabetes) can not be rendered in association with items 725 or 727.

- Are specialists audited?

A: Medicare Australia's Compliance Program involves all health professionals registered with Medicare Australia and members of the public. Medicare Australia's National Compliance Program for 2009-2010 has identified a number of specialist groups of interest including anaesthetists, orthopaedic surgeons, consultant psychiatrists, plastic surgeons, non-specialist surgeons and gastroenterologists.

- Most GP's works as a contractor/employee etc. If Immunisation item cost by Medicare goes to owner, not to GP, and if anything goes wrong, medico legally or mistake in item number etc, where GP stands for? What's your opinion please, any comment?

A: The GP would be responsible for any billing or medico-legal issues that arise.

- When an elderly patient presents for e.g. repeat prescriptions and provides a Drivers medical form often they cannot be "put off" and doing a medical significantly disrupts the day for the Doctor. Is there any chance of Medicare liaising with the driver license body to incorporate in the covering letter work to the effect "please ensure that you inform the receptionist that you require a drivers medical in order for adequate time can be allowed".

A: Given that this is a state issue, we suggest raising it with the AMA (WA) or the local branch of your craft group.

- Why does Medicare/DoHA not communicate recent changes directly to GP?

A: Providers can subscribe to receive MBS updates via email through the MBS Online website (www.mbsonline.gov.au).

- Is “commercial license” MBS rebateable if for volunteer work (e.g. retired bus driver keeps his license to do voluntary work for senior citizens)?

A: General explanatory note G13.1 states that Medicare benefits are not payable for health screening services. This includes compulsory examinations and tests to obtain a flying, commercial driving or other license.

- Medicare often refuses payments for seniors in the aftercare period. Where can I find information on the periods of aftercare for various conditions as often I see patients in this period (before getting letters from specialists of the procedure)?

A: If the GP is aware that patient has had a recent procedure, and is consulting them on an unrelated matter, they should annotate the invoice to indicate that the consultation was not for the purposes of providing aftercare.

If the consultations relate to routine aftercare, a Medicare rebate would not apply unless the original procedure item number excluded the after-care component. Please refer to explanatory note T8.5 for further information.

- The issue of not “usual” GP’s opportunistically doing plans, assessments etc on our regulars, needs to have some form of redress as it is immoral and it is usually greed based – the patients are often unaware and it is unfair to the regular, Dr and Practice.

A: If you believe another provider is engaging in non-compliant or fraudulent behaviour please contact the Australian Government Services Tip-Off Line on 131 524.

- How can we find out when a patient has had a care plan done elsewhere to enable our doctor to do another care plan if needed, especially if done by an opportunist GP?

A: Medical practitioners can contact the Medicare Australia Provider Enquiry Line on 132150 while the patient is present if they have granted permission to do so.

- Without item 723, being triggered, patients can't claim AHP on 721. However this happened in Sept 2009?

A: Patient must have a GPMP (721) and a TCA (723) completed to access rebateable Allied Health services. (i.e. 723 does not need to be billed prior to the AHP consultation however the TCA service must have been provided).

- Must DMMR be sent to usual community pharmacy or so long as patient agrees to whichever?

A: Referral to a community pharmacist should be made to the patient's preferred community pharmacist (see Explanatory note A.39)

- Can 10997 be billed when nurse recalls patient for Fluvax/pneumovac (on care plan) as 10993 as well

A: No. Item 10997 is used to provide: checks on clinical progress; monitoring medication compliance; self management advice, and; collection of information to support GP review within scope of the Care Plan.

- If the patient is sent by an Allied Health Provider for a TCA is this taken as contact and agreement to plan?

A: No. If the patient is eligible for a TCA, collaboration is still needed with each of the agreed providers, even though they may already be receiving ongoing care from this provider.

- If the Allied Health Provider has not seen the patient before the plan initiated how do they agree to the plan?

A: The steps in coordinating a TCA includes contacted the proposed providers and obtaining their agreement to participate, realizing that they may wish to see the patient before they provide input but that they may decide to proceed after considering relevant documentation, including any current GPMP (see explanatory note A.33).

- To get 6 more psychology visits for mental health after the initial 12, don't you have to charge a 2712?

A: Where referrals are provided in exceptional circumstances, both the patient's GP Mental Health Treatment Plan and referral should be annotated to briefly indicate the reason why the service involved was required in excess of the 12 services permitted within a calendar year. Referral for the 6 additional services can be done during a normal consultation or a mental health consultation, or a 2712 review if appropriate.

- Will there be an item number for point of care testing for INRs?

A: There is currently no MBS item number for point of care INR testing. Medicare Australia is unable to comment on whether an item number may be created for this service in the future.

- What course should practice nurses use before doing pap smears?

A: The only provider of PAP training in WA is The Family Planning Association. Please visit their website for course information. www.fpwa.org.au

- If a TCA is initiated, then contact made to providers, does the Dr need to see the patient or can we just bill them the 723?

A: Item 723 can be rendered once all components of the service and item descriptor have been met. The patient does not need to be present when item 723 is rendered.

- When billing item 721 and 723 can you bill a 10997 as well?

A: Medicare benefits are payable for an MBS Item 10997 service rendered on the same day as an item 721, 723, 725, 727, 729 or 731 service if the person has a GP Management Plan (GPMP), Team Care Arrangements (TCA) or Multidisciplinary Care Plan (MCP) in place.

- Are practice nurses putting their registration at risk if there is no written order from GP for vaccines?

A: Yes. A nurse is required to have a written order for any medication they are giving. If a verbal order is given it must be entered into the notes by the GP within 24 hours. See The Medication Management Guidelines for Nurses and Midwives http://www.nmbwa.org.au/2/2217/50/message_to_colleagues.pm

- Aged pensioner driving medicals can you bulk bill this service?

A: General explanatory note G13.1 states that Medicare benefits are payable for age or health related medical examinations to obtain or renew a license to drive a private motor vehicle.

- Documenting consent for vaccines, can this be done by practice nurse?

A: This is a medico-legal question and should be directed to your medical indemnity provider.

- Can you bill 10997 with a health check item number?

A: No. Item 10997 can only be rendered if the patient has a GP Management Plan (GPMP), Team Care Arrangements (TCA) or Multidisciplinary Care Plan (MCP) in place.

- Item 2713 needs to be time based – some general mental health visits last 45 – 60 minutes – item does not reflect the time spent with patient.

A: Level B, C and D consultations may be rendered for the purposes of implementing a management plan. For items 23 to 51 and 5020 to 5067, implementation of a management plan includes counseling services (see explanatory note A.5).

- If audited would it be acceptable to have done 721/723 for IGT and obesity? I don't understand why it needs to be an actual chronic disease, not a risk factor, but multiple risk factors are acceptable?

A: Yes. Questions have asked on whether the following are chronic medical conditions for the purposes of the items: alcohol or other substance abuse; smoking; obesity; unspecified chronic pain; hypertension, hypercholesterolemia, or syndrome X; impaired fasting glucose tolerance or impaired glucose tolerance; pregnancy.

The general position on these 'conditions' is that they have not been regarded as chronic medical conditions for the purpose of the EPC items to date and this remains the case with the CDM items. (Note that in many cases a patient may have complications or co-morbidities, that may be a result of or exacerbated by such conditions or risk factors, that would make them eligible for CDM services.)

In some cases these 'conditions' would not be commonly regarded as chronic medical conditions of themselves, others may more accurately be regarded as risk factors for development of chronic conditions, some possibly relate more to personal choice/behavioral issues and some (pregnancy without complications) could be regarded as a normal part of life.

It is recognised, however, that conditions such as the above can occur across a wide spectrum of severity and in a broad range of circumstances, with, for example, some patients with one (or more) of the above conditions being unable to self-manage or comply with care and treatment, being functionally disabled by their condition etc.

A GP must assess whether a patient is eligible for a CDM service, having reference firstly to the MBS eligibility criteria and the guidance above setting out the general position.

Where a patient's 'condition' would not obviously come within the MBS definition, a GP may still consider that, notwithstanding the above, the patient's condition and circumstances are such that they require the preparation of a GP Management Plan, for example, because of non-compliance, inability to self-manage, functional disability etc.

In these cases, the GP should be satisfied that the GP's peers would regard the provision of a CDM service as appropriate for that patient, given the patient's needs and circumstances.

- How is it determined whether your peers would agree?

A: The peer review process forms part of the Professional Services Review (PSR). Further information regarding the PSR process can be found in General Explanatory note G8.1 or via the PSR website; www.psr.gov.au

- If a patient has had an EPC referral to podiatrist for 3 visits and Physio for 2 visits in Nov 2009, and has seen Physio x 2 in Dec 2009 but only podiatrist x 2, can another referral be done in Jan 2010 for Physio even though not all 5 visits used. (e.g. still has 1 x podiatrist)?

A: Yes another referral could be written for the physiotherapist however another referral could not be written for the podiatrist as the original referral would still be valid.

- Would a fax with a cover sheet stating "Please only contact us if you do not agree with this care" be sufficient proof of collaboration? That is if we haven't heard back from the AHP, we can assume they agree with the care?

A: No. Collaboration means communicating with the other providers to discuss potential treatment or services they will provide. Communication must be two-way - preferably oral communication, or, if not practicable, communication in writing (including by exchange of faxes or email). It should relate to the specific needs and circumstances of the patient. The communication from the collaborating providers must include advice on treatment and management of the patient.

To provide input to the TCA that relates to the specific needs and circumstances of the patient, the participating providers may:

- refer to their existing knowledge of the patient, i.e. where they are an existing patient of that provider;
- provide input based on the information provided by the GP, including the patient's current GP Management Plan (GPMP); or
- on their own judgment, decide that they would prefer to see the patient before they provide input - but note that there is no MBS requirement for the

allied health professional to undertake a consultation with the patient for the purposes of developing the TCA.

While it is not mandatory that the allied health provider must see the patient before contributing to the plan (unless they wish to), they do need to provide input to the TCA on the treatment or services they will provide, based on their understanding of the patient's needs. Note that, in many cases, it is expected that the allied health professional can provide advice about the treatment/services they will provide based on the information provided by the GP, including the patient's current GP Management Plan (GPMP).

On the other hand, it would not be sufficient for a provider to simply say 'I will assess the patient and then I will advise you what treatment I will provide', as this would not constitute discussing or providing advice on potential treatment or services and would leave nothing to be documented in the TCA.

It is not necessary to 'case conference' with the collaborating providers (i.e. talk with all of the providers at the same time).

- Do patients have to sign mental health care plans?

A: The GP must record the patient's agreement for the GP Mental Health Treatment Plan service, but it not necessary for them to sign the plan.

- MBS T8.5 Table re account for fractures, does this apply to account for fractures reduced as inpatient in public or private hospital?

A: Public Hospitals are funded through state government and should provide aftercare for patients. Private hospitals would generate Medicare billing and aftercare periods will apply.

If the GP consultation is unrelated to the original procedure, the invoice should be appropriately annotated (e.g. consultation unrelated to procedure).

- When will Rudd government initiate a streamline Medicare and have fewer item numbers be implemented?

A: Medicare Australia is unable to comment on this question.

- Are there any item numbers to cover phone coaching and follow up of diabetes patients – i.e. – insulin adjustment, review of BGL and for psychological support from credentialed diabetes educator is AHP under TCA?

A: General explanatory note G13.1 states that Medicare benefits are not payable for telephone consultations.

- A 721 has been initiated and a 723 is being negotiated. GP and patient requirements and goals have been identified. If the allied health specialist agree to be part of the TCA with no change to goals, does the patient have to return to sign 723?

A: Item 723 can be rendered once the full item descriptor has been met.

- A 721 and 723 has been initiated. Patient returns for a review. In that time the effectiveness of the 723 is assessed. Patient is responding well to allied health interventions therefore plan not changed. A 725 is claimed. Can the 727 be claimed?

A: Item 725 is for patients who have a current GPMP in place and who would benefit from a review of that GPMP. Item 727 is for patients who have a TCA in place and would benefit from a team based review of the TCA. Provided the full item descriptor for both services have been met, both items could be rendered during the same consultation (see explanatory note A.33)