Medicare services available for residents of Aged Care Homes

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Standard Aged Care Home Item Numbers ⌂

Items 20 35 43 51 Items refer to the usual (VR) GP attendance to a resident of aged care homes and are used in place of standard consultation items (level 'A', 'B', 'C', & 'D').

Items 92 93 95 96 Items refer to the usual (non-VR) GP attendance to a resident of an aged care home. (nb: All of these items do not apply to patients living in self contained units within a RACF complex, use normal attendance items for surgery attendance or home visit.)

Comprehensive Medical Assessment (CMA) Item 712⌂

Eligibility:

For new residents and for existing residents as required.

100% rebate & MBS Fee	$180.20
115% DVA	$207.23

Residential Medication Management Review (RMMR)⌂

Item 903 Eligibility: Available for all eligible permanent residents of aged care homes including both high & low care.

100% rebate & MBS Fee	$88.20
115% DVA	$101.43

Chronic Disease Management Care Plan Eligibility

- Patients with one or more chronic medical conditions (present or likely to be present for six months) or a terminal condition,
- **and** complex care needs† requiring multidisciplinary care from a team of (at least 2) health and care providers, plus the resident's GP (with each team member providing a different kind of care or service to the patient)

Contribution to a Care Plan/Review Item 731#⌂

100% rebate & MBS Fee	$41.65
115% DVA	$47.90

Allied Health & Dental Care Item Eligibility

If the resident's GP has contributed to the care plan (Item 731) the resident may be eligible to access up to five allied health and three dental care services per year.

Allied Health Items

MBS items	10950 10951 10952 10954 10956 10958 10960 10962 10964 10966 10968 10970
MBS Fee	$52.85
85%	$44.95

Dental Care Items

MBS items	10975, 10976, 10977
MBS Fee	$88.05
85%	$74.85

Case Conference⌂

Organise & Coordinate a Case Conference

Time	**15-30 min**	**30-45 min**	**>45 min**
In Aged Care Homes	Item **734**	Item **736**	Item **738**
100% rebate & MBS Fee	$80.45	$120.65	$160.80
115% DVA	$92.52	$138.75	$184.92

Participate in a Case Conference

Time	**15-30 min**	**30-45 min**	**>45 min**
In Aged Care Homes	Item **775**	Item **778**	Item **779**
100% rebate & MBS Fee	$57.40	$91.90	$126.30
115% DVA	$66.01	$105.69	$145.24

† Examples of complex care needs, where routine management is compounded by one of the following:

- Unstable or deteriorating condition
- Increasing frailty or dependence
- Development of complications including falls or incontinence
- Co-morbidities
- 2 or more hospital admissions in the past six months

In an aged care setting, the GP's contribution to a Care Plan (MBS item 731) is a requirement for accessing the Allied Health and Dental Care services.

⌂ If the service is bulk-billed, the GP is able to claim the $5.10 or $7.65 bulk billing incentive for eligible patients

Flow chart developed by General Practice Divisions—Victoria July '05 Based on PASS at Knox Division '02 EPC flow chart.

Comprehensive Medical Assessments (CMA)

A comprehensive medical assessment (CMA) is available to all permanent residents of aged care homes. A GP can provide a CMA to new residents on admission to an Aged Care Home (recommended within first six weeks) and to existing residents on an as required basis. A maximum of one Medicare rebate is payable for a CMA for a resident in any 12 month period.

A CMA is a voluntary service for residents of aged care homes and must include:

- A detailed medical history
- A comprehensive medical examination
- Developing a list of diagnosis and/problems
- A written summary to aid the facility

Role of the Practice Nurse

A practice nurse can assist the GP in obtaining information relevant to the CMA for the GP's consideration, in taking the resident's history and in the examination, but cannot replace the GP's involvement in these components of the CMA. The CMA must include a personal attendance by the GP to the aged care resident, usually in the aged care home. Unlike the home visit component of an EPC health assessment, there is no specific component of a CMA that can be undertaken wholly by a nurse, in place of the GP.

The GP may wish to review and incorporate into the CMA any relevant assessment or information about the resident that is available from the aged care home. The CMA can provide the GP with useful information to contribute to an eligible resident's care plan and can also complement the RMMR.

Residential Medication Management Review (RMMR)

RMMRs are collaborative services available to new permanent residents or existing residents where required, who are likely to benefit from such a review, including residents for whom quality use of medicines may be an issue or who are at risk of medication misadventure because of a significant change in their condition.

The RMMR (item 903) can be claimed once in a twelve-month period, except where there has been significant change in medical condition or medication regimen requiring a new RMMR.

Chronic Disease Management Care Plans

Contribution to a Care Plan/Review Item 731#

Residents who have one or more chronic medical conditions (that have been present or are likely to be present for six months) or a terminal illness, **and** complex care needs can access Medicare item 731, so that their GP can contribute to their individual care plan.

The resident's 'usual' GP or another GP from the same practice can make a contribution to a care plan upon the request of the residential aged care home as a member of a multidisciplinary care plan team*. The GP can also contribute to a discharge plan of a resident when leaving hospital and is returning back to the aged care home. The chronic disease care plan contribution item requires a multidisciplinary approach to care planning involving collaboration between the GP and at least two other health care providers. The patient's informal or family carer may also be included as an additional formal member of the team but does not count as one of the minimum three members.

In preparing a contribution to the care plan or care plan review the GP is required to obtain consent▲ from the resident or carer where appropriate.

Contribution to a care plan Item 731 can be used up to four times in a 12-month period for both contributing to a care plan or contributing to the review of a care plan in an aged care facility. The GPs contribution should be recorded on the care plan and on the resident's medical record.

The GPs contribution involves the GP 'collaborating with the person preparing the plan to set goals and specify treatment/services to be provided by the GP'.The GP's contribution should be made preferably face to face or by telephone, or where this is not practicable, by fax, email, or written correspondence. The aged care home should provide the medical practitioner with a copy of the plan, or the part of the plan where applicable to services he/she will provide. Members of the team do not have to be communicating at the one time for a GP to claim item 731 (as they do for a *case conference*)

Allied Health & Dental Care items

Since 1 July 2004, people with chronic medical conditions and complex care needs who are being managed through an EPC multidisciplinary care plan have had access to Medicare rebates for a maximum of 5 allied health services and 3 dental visits a year when referred by their GP to HIC registered allied health providers and dentists.

Medicare item 731—GP contribution to a care plan in a Residential Aged Care Facility, **must** be claimed through Medicare for the resident to be eligible to access the new allied health & Dental Care Items.

Allied health providers who may be eligible for a Medicare provider number and to provide services to residents are; Aboriginal Health Worker, Audiologist, Diabetes Educator, Dietician, Mental Health Worker, OT, Physiotherapist, Podiatrist, Chiropodist, Chiropractor, Osteopath, Psychologist, & Speech Pathologist.

To access the allied health or dental care items the GP is required to use **one** EPC allied health referral form for **each** allied health service/dental care referral and provide an original signature on each of the photocopies. The referral form can be photo copied by the AHP/Dentist should multiple services be requested. Once the service has been provided to the patient the allied health professional completes the referral form including their HIC provider number and their original signature on each referral form. The completed referral form then accompanies the Medicare claim form in order access this rebate.

Allied health funded by other Commonwealth or State Government funded programs such as DVA & hospital outpatients, are not eligible for Medicare rebates. An exemption has been granted to Aboriginal Community Controlled Health Services, where the Allied Health Item numbers can be claimed by either salaried or contracted eligible Allied Health providers. These services are to be bulkbilled and all requirements still have to be met including HIC registration of AHPs and dentists. For more information visit HIC website: **http://www.hic.gov.au/providers/**

Case Conferences

In addition to multidisciplinary care planning, the resident's GP can be involved in case conferencing activities with the multi-disciplinary team (although both items cannot be claimed in respect of the same service). The eligibility for accessing these items are the same as care planning. A case conference is a discussion where members of the team must be communicating at the one time for the whole of the conference, either face-to-face, by telephone, video link, or a combination. During the case conference the team will:

- Discuss patient's history
- Identify patient's multi-disciplinary care needs
- Identify outcomes to be achieved by members of the case conference team giving care to the patient
- Identify tasks that need to be undertaken in order to achieve outcomes and allocate tasks to team members

Assess whether previously identified outcomes have been achieved.

A GP can organise or participate in a case conference, in an aged care home. The GP is required to obtain and record patient consent▲ when organising or participating in a case conference.

When organising or participating in a case conference the GP is required to: record day, times, names of participants, matters discussed (history, care needs, outcomes, tasks etc); and provide a summary to patient and team members. The GP is required to give a record of the conference to the aged care home, place a copy in the resident's medical records, and offer a copy to the patient and to the resident's carer, if appropriate, with the resident's agreement.

It is expected that a patient would not require more than five case conferences in a twelve month period.

For best practice guidelines for the use of EPC items refer to RACGP practical guide to EPC at the College website; www.enhancedprimarycare.org.au/

**The multidisciplinary care team may include allied health professionals such as: dentists, diabetes educators, personal care worker, occupational therapist, pharmacist, podiatrist, psychologist, registered nurse, speech pathologists.*

▲ Obtaining patient or carer's consent (where appropriate) is a requirement for all MBS Items. In undertaking EPC Multidisciplinary activity, the GP is required to inform the patient of who will be involved in the care plan; that their medical history, diagnosis and care preferences will be discussed with other providers, and provide an opportunity for them to specify what may be conveyed or withheld from others. Patients should be informed that they may incur a charge for the EPC service, for which a Medicare rebate will be payable.

The purpose of this flow chart is to provide an overview or introduction to the MBS Items, it should not be used instead of the Medicare Benefits schedule. It is recommended that GPs refer to the MBS explanatory notes A.20, A.21, & A.22 for a definitive guide.