



14. Medicare Australia

14.1 General Practice Financing

Medicare Australia's responsibilities include:

- ensuring Medicare benefits are paid to eligible health care consumers for services provided by eligible medical practitioners
- assessing and paying Medicare benefits for a range of medical services, whether provided in or out of hospitals, based on a schedule of fees (the Medicare Benefits Schedule) determined by the Australian Government Department of Health and Ageing in consultation with professional bodies.

The latest MBS information is available at www.health.gov.au/mbsonline

Medicare is available to:

- eligible Australian residents
- New Zealand citizens
- holders of permanent visas
- a number of visitors and temporary residents from countries with reciprocal health care arrangements with Australia are covered in certain circumstances
- people who have applied for a permanent visa – other requirements apply.

Some categories of Australians, such as members of the armed services and veterans, are covered by additional special arrangements, with the remainder eligible for mainstream coverage by Medicare. Some injuries and illnesses are covered by other forms of financing: such as workers' compensation insurance. Motor vehicle accidents may be covered by third party motor vehicle insurance.

In February 2004, for the first time in Australia, MBS items were made available for the work undertaken by general practice nurses. The new items were initially for a practice nurse to provide immunisation and wound management services for and on behalf of a GP. Additional items for Pap smears and Preventive Health Checks and Antenatal Care (November 2006) have since been added to the MBS. A new practice nurse MBS item for chronic disease care was introduced in May 2007. More item numbers for practice nurses are progressively being rolled out.

For more information about Medicare:

- call Medicare Australia Information Service on **132 011**
- write to Medicare Australia at GPO Box 9822 in your capital city
- visit **www.medicareaustralia.gov.au**

14.2 Bulk-billing

Bulk-billing is when a doctor bills Medicare directly, accepting the Medicare rebate as full payment for a service. Under this arrangement the patient signs a Medicare claim form and no additional charges relating to the service can be made. Therefore, there are no 'out of pocket expenses' to the patient. Bulk-billing applies at the doctor's discretion.

On 1 February 2004, new Medicare items were introduced to pay GPs incentive payments for bulk-billed services provided to concession cardholders and children. The items provide an additional incentive payment in urban areas and also incentive payments in rural and remote areas and in all of Tasmania.

The gap

'The gap' is the difference between the fee charged by GPs for their medical services and the recommended Medicare rebate relating to those services. If the doctor's fee is above the Medicare rebate, the patient will pay the remainder of the doctor's fee. This is known as 'the gap'.

14.3 The Pharmaceutical Benefits Scheme

The Commonwealth Government has provided affordable access to a wide range of medicines for all Australians via a subsidy whereby the patient pays less for the medicine. This is known as the Pharmaceutical Benefits Scheme (PBS).

For more information on the PBS Safety Net contact free call **1800 020 613** or visit **www.medicareaustralia.gov.au/provider/pubs/program/pbs.jsp**

14.4 Department of Veterans' Affairs

The Department of Veterans' Affairs funds medical services provided by GPs and specialists who are registered with DVA for eligible veterans, widowers, war widows and their dependents. Eligible veterans are issued with either a gold or white health care. A gold card entitles a veteran to a full range of services funded by DVA, while a white card provides access to the services for service related conditions.

For more information on benefits available to DVA patients, including the Veterans' MATES program visit **www.dva.gov.au**

14.5 Medicare and the Medicare Benefits Schedule

The Australian Government Department of Health and Ageing (DoHA) is responsible for the policy development of Medicare and the Medicare Benefits Schedule.

Medicare Item Numbers

MBS Online contains the Medicare Benefits Schedule (MBS) - a listing of the Medicare services subsidised by the Australian Government.

The Schedule is part of the wider Medicare Benefits Scheme managed by DoHA and administered by Medicare Australia.

MBS Online contains the latest information and is updated as changes to the MBS occur.

Feedback and suggestions from MBS Online users are invited and may be submitted by emailing the MBS Online Team at **mbsonline@health.gov.au**

For current Medicare Item Number information visit

<http://www.health.gov.au/internet/mbsonline/publishing.nsf/Content/Medicare-Benefits-Schedule-MBS-1>

The most common methods of billing in general practice are:

- private bill all patients
- bulk-bill all patients
- combination of both.

The process

- Regardless of which method your practice uses, each patient is billed with item numbers so the patient or the practice can claim from Medicare.
- The Medicare Benefits Schedule book lists information on all item numbers and is updated on 1 November each year. Each GP will receive a copy. Copies can also be obtained from **<http://www.health.gov.au/internet/mbsonline/publishing.nsf/Content/Medicare-Benefits-Schedule-MBS-1>** or by phoning **1800 020 103**
- Each consultation has an item number which is charged and most procedures also have an item number attached to them.

Common item numbers for consultations are:

- Level A Consultation: item number 3
- Level B Consultation: item number 23
- Level C Consultation: item number 36
- Level D Consultation: item number 44.

Examples of item numbers for common procedures are:

- ECG (12 lead): item number 11700
- pregnancy test: item number 73806
- wound care: item number 10996
- immunisation: item number 10993.

Medicare Benefits Schedule attendance items

The MBS contains a unique item number for each professional medical service or 'attendance'.

Visit <http://www.health.gov.au/internet/mbsonline/publishing.nsf/Content/Medicare-Benefits-Schedule-MBS-1>

The needs of patients vary widely and practices need to have flexible appointment systems that can accommodate patients with urgent, non-urgent, complex, planned chronic care and preventive health needs during normal opening hours.

Appointment systems vary widely from practice to practice and have evolved to meet community and practice needs. The majority of practices, but not all, make appointments within 10 to 15 minute time frames for the majority of patients. Patients are billed according to the consultation scale below. The GP determines the level of consultation according to the needs of the patient. Patients can be encouraged to book consultations of appropriate length particularly if they know they will need a long consultation for a complex issue or a procedure such as a Pap smear.

GP standard patient attendances — classifications

The attendances are divided into four categories relating to the level of complexity. To assist medical practitioners in selecting the appropriate item number for Medicare benefit purposes the following notes and examples in respect of the various levels are given. The fact that a particular case is used as an example does not mean that such cases would always be claimed at the level used in the example. Other modifying circumstances might prevail and each case must be treated on its merits.

LEVEL A

This will be used for obvious and straightforward cases and this should be reflected in the practitioner's records. In this context, the practitioner should undertake the necessary examination of the affected part if required, and note the action taken.

Example: Triple Antigen or Tetanus Immunisation

LEVEL B

Professional attendance by a general practitioner lasting less than 20 minutes involving, where clinically relevant:

- taking a history
- undertaking clinical examination
- arranging any necessary investigation

- implementing a management plan
- providing appropriate preventive health care
- in relation to one or more health related issues, with appropriate documentation.

The essential difference between Levels A and B relate not to time but to complexity.

Example: Otitis media presenting as earache

LEVEL C

Professional attendance by a general practitioner lasting at least 20 minutes involving, where clinically relevant:

- taking a detailed history
- undertaking clinical examination
- arranging any necessary investigation
- implementing a management plan
- providing appropriate preventive health care
- in relation to one or more health related issues, with appropriate documentation.

Example: Essential hypertension presenting as headache

LEVEL D

Professional attendance by a general practitioner lasting at least 40 minutes involving, where clinically relevant:

- taking an extensive history
- undertaking clinical examination
- arranging any necessary investigation
- implementing a management plan
- providing appropriate preventive health care

in relation to one or more health related issues, with appropriate documentation.

This item number covers the difficult problems where the diagnosis is elusive and highly complex, requiring consideration of several possible differential diagnoses, and the making of decisions about the most appropriate investigations and the order in which they should be performed. These items also cover cases which need prolonged discussion.

Examples: Migraine with peripheral neurological signs
 Depression presenting as insomnia or headaches
 Complex psychological or family relationship problems

For more information, visit MBS online: www9.health.gov.au/mbs

Desktop Guide to MBS Item Numbers

Commonly used item numbers

Item	Name	Description	Frequency
3	Level A	Short consultation	No restriction
23	Level B	<20 min	No restriction
36	Level C	>20 min	No restriction
44	Level D	>40 min	No restriction
10990	Bulk Billing	DVA, under 16's and Commonwealth concession card holders	No restriction

Health Assessment (H/A)

701 <30mins	Healthy Kids Check	Children aged at least 3yrs old and less than 5yrs, who have received or who are receiving their 4yr old immunisations	Once only
or			
703 30-45mins	40-49 diabetes risk check	Aged between 40-49yrs old (inclusive) with a high risk of developing type 2 diabetes determined by the AUSDRISK tool	Once every 3 years
or	45-49 yr H/A	Aged 45-49 yrs (inclusive) who are at risk of developing a chronic disease	Once only
705 45-60mins	75+ H/A	Health Assessment in home or at surgery for patients at least 75yrs old	Annual
or	Comprehensive Medical Assessment	Permanent resident of aged care facility	Annual
707 >60mins	Intellectual Disability H/A	Person with intellectual disability; no age restriction	Annual
	Refugee H/A	Pt granted residency under humanitarian program within first 12months	Once only
10986	Healthy Kids Check	As above (Performed by Practice Nurse or Aboriginal Health Worker only)	Once only
715	H/A for Aboriginal or Torres Strait Islander patients	Health assessment for patient of Aboriginal or Torres Strait Islander descent; from age 4mths	Recommended annually (not less than 9 months)
10987	H/A follow up for Aboriginal or Torres Strait Islander patients	Monitoring and support by Practice Nurse or Aboriginal Health Worker for Aboriginal or Torres Strait Islander patients who have had a Health Assessment	10 visits per calendar year

Desktop Guide to MBS Item Numbers

Chronic Disease Management

Item	Name	Description/Eligibility	Frequency
721	GP Management Plan (GPMP)	Chronic or terminal condition lasting more than 6 months	Recommended 2 yearly (not less than 12 months)
723	Team Care Arrangement (TCA)	Pt with complex care requiring ongoing care from multi-disciplinary team. Need contribution from two other providers, pt entitled to 5 rebated allied health services per calendar year	Recommended 2 yearly (not less than 12 months)
732	Review (r/v) of GPMP or TCA	Claimable twice on same day for review of GPMP and TCA	Recommended 6 monthly (not less than 3 months)
731	GP contribution to Care Plan by RACF	Contribution to, or review of a care plan prepared by a Residential Aged Care Facility, at the request of the facility	Not less than 3 months
2517(B) 2521(C) 2525(D)	Diabetes Annual Cycle of Care	For accredited practices. Claimed once all components of cycle of care are met over previous 11-13 months. Replaces usual attendance item	Between 11-13 months
2546(B) 2552(C) 2558(D)	Asthma Cycle of Care	For accredited practices. For patients with moderate to severe asthma	Not less than 12 monthly
10997	Chronic Disease Management	Monitoring and support by Practice Nurse for patients with GPMP in place.	5 visits per calendar year
10987	ATSI Health Assessment follow up	Monitoring and support by Practice Nurse or Aboriginal Health Worker for Aboriginal or Torres Strait Islander patients who have had a H/A	10 visits per calendar year

Desktop Guide to MBS Item Numbers

Practice Nurse/Clinical

Item	Name	Description/Eligibility	Frequency
11506	Spirometry	Measurement of respiratory function before and after inhalation of bronchodilator	
11700	ECG	12 lead ECG	
10993	Immunisation	Immunisation provided by a practice nurse	
10996	Wound care	Wound care provided by a practice nurse (other than normal after care)	
10994	Pap smear and preventative check	Patient between the ages of 20-69. Nurse must be appropriately qualified	
10986	Healthy Kids Check	Children aged at least 3yrs old and less than 5yrs, who have received or who are receiving their 4yr old immunisations. (Performed by Practice Nurse or Aboriginal Health Worker)	Once only
10997	Chronic disease Management	Monitoring and support by Practice Nurse or Aboriginal health Worker for patients with GPMP in place.	5 visits per calendar year

Mental Health

2710 (GP undertaken M/H training) 2702 (GP no M/H training)	GP Mental Health Treatment Plan	Preparation of GP Mental Health Treatment Plan for patient with mental disorders. Option to refer for up to 6 rebated psychological services	Annually
2712	Review of GP Mental Health treatment Plan	Review of progress, can refer for further 6 services for psychological services. In exceptional circumstances can refer for further 6 services after 2 nd review (18 in total)	Initial review 1-6 months. 2 nd review 3 months later. (Max of 2 r/ vs in 12 months)
2713	Mental health consultation	Consultation lasting >20mins, where the primary treating problem is related to a mental disorder	Unlimited (Not on same day as 2710/2702/2712)

