

Medicare services for residents of aged care facilities

Standard Residential Aged Care Facility Item Numbers

Items 20 35 43 51

Refer to the usual (VR) GP attendance to a resident of a Residential Aged Care Facility and are used in place of standard consultation items (level A, B, C, D).

Items 92 93 95 96

Refer to the usual (non-VR) GP attendance to a resident of a Residential Aged Care Facility.

NB: An attendance to a patient at which it is determined that life is extinct can be claimed under the appropriate attendance item but cannot be claimed for writing a death certificate alone.

These items do not apply to patients living in self contained units within a Residential Aged Care Facility. Normal attendance items for surgery attendance or home visit apply. Usual bulk billing incentives apply.

Comprehensive Medical Assessment

Item 712

Available for permanent residents of Residential Aged Care Facilities including both high and low care.

100% rebate & MBS fee = \$191.80
115% DVA = \$220.55

Residential Medication Management Review

Item 903

Available for permanent residents of Residential Aged Care Facilities including both high and low care.

100% rebate & MBS fee = \$93.85
115% DVA = \$107.95

After Hours Attendances

Items 5010, 5028, 5049, 5067, 5260, 5263, 5265, 5267

Routine visits after hours

Items 5010, 5028, 5049, 5067, 5260, 5263, 5265, 5267

Emergency visit initiated during business hours but conducted after hours

Items 1, 97, 601, 697

Emergency visit initiated and conducted after hours

Enhanced Primary Care Multidisciplinary Care Items

- Patients with one or more chronic medical conditions (present or likely to be present for 6 months) or a terminal condition;
- and, complex care needs requiring multidisciplinary care from a team of (at least 2) health 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

Item 731

100% rebate & MBS fee = \$62.30
115% DVA = \$71.65

Allied health and dental care item eligibility

If the resident's GP has contributed to a care plan, the resident may be eligible to access up to 5 allied health and 3 dental care services per year.

Organise & Coordinate a Case Conference in RACF

Item 734

100% rebate & MBS fee = 85.00
115% DVA = \$98.45 (15-30 min)

Item 736

100% rebate & MBS fee = 128.40
115% DVA = \$147.65 (30-45 min)

Item 738

100% rebate & MBS fee = \$171.15
115% DVA = \$196.80 (>45 min)

Participate in a Case Conference in RACF

Item 775

100% rebate & MBS fee = \$61.10
115% DVA = \$70.25 (15-30 min)

Item 778

100% rebate & MBS fee = \$97.80
115% DVA = \$112.45 (30-45 min)

Item 779

100% rebate & MBS fee = \$134.45
115% DVA = \$154.60 (>45 min)

Comprehensive Medical Assessments

A Comprehensive Medical Assessment (CMA) is available to all permanent residents of Residential Aged Care Facilities (RACF).

A GP can provide a CMA to new residents on admission to an aged care facility (recommended within first six weeks) and to existing residents on an as required basis.

A CMA is a voluntary service for residents and must include:

- a detailed medical history
- a comprehensive medical examination
- developing a list of diagnoses and/or problems
- a written summary.

The CMA (MBS Item 712) can be claimed once in a 12-month period.

A practice nurse can assist the GP to obtain information relevant to the CMA for the GPs consideration, e.g. liaising with the RACF to collect information the facility has. However, the nurse cannot replace the GPs involvement in these components of the CMA.

The CMA must include a personal attendance by the GP to the resident, usually in the aged care facility.

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.

GPs may wish to review and incorporate into a CMA any relevant assessment or information about the resident that is available from the facility.

A CMA can provide the GP with useful information to contribute to an eligible resident's care plan and Residential Medication Management Review.

Residential Medication Management Review (RMMR)

MBS Item 903 enables participation by a GP in a collaborative review of medication management. This item is available for permanent residents of RACFs for whom quality use of medicines may be an issue.

Designed to complement the other MBS items listed, benefits are payable for one RMMR service for residents on admission and for continuing residents on an as required basis, with a maximum of one per year, except where there has been a significant change in their condition or medication regimen.

It is currently recommended that GPs discuss their plans for RMMR's for existing residents with the reviewing Pharmacist prior to referral.

Care Plans

The resident's 'usual' GP can contribute to a care plan upon the request of the RACF as a member of a multi-disciplinary care plan team (Item 731).

The patient's informal or family carer may also be included as an additional formal member of the team.

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 a RACF.

Residents with a care plan may be eligible for up to five allied health services and three dental services (where the dental condition is significantly impacting on their chronic medical condition) per year on referral from their GP.

Allied health services already funded by the Department of Veterans' Affairs or other sources are not eligible for these rebates.

The services to be referred to must be listed on the care plan. If not, a review may be necessary to incorporate the required service.

Case Conferences

In addition to multidisciplinary care planning, the resident's GP can be involved in case conferencing activities with the multidisciplinary team (although both items cannot be claimed on the same day).

Eligibility for accessing these items is 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.

A GP can organise or participate in a case conference in a RACF. It is expected that a patient would not require more than five case conferences in a 12-month period.

After Hours and Emergency Items

An after hours consultation or visit is a reference to an attendance on public holidays; on Saturdays before 8 am or after 1 pm; on Sundays; or, at any time other than between 8 am and 8 pm on a weekday not being a public holiday.

MBS Items 5010, 5028, 5049 or 5067 and 5260, 5263, 5265, 5267 apply to a professional attendance which begins in an after hours period regardless of when the appointment or request was made.

MBS Items 1, 601, 97, 697 apply to an attendance to a patient at a RACF where the visit is initiated by or on behalf of the patient in the same unbroken after hours period and, where the patient's medical condition requires immediate treatment. These items can only be used in respect to the first patient.