Wentworth Healthcare

Blue Mountains | Hawkesbury | Lithgow | Penrith

Desktop Guide:

Frequently used MBS Item Numbers

For General Practice Services

July 2019 - Revised Edition

phn NEPEAN BLUE MOUNTAINS

An Australian Government Initiative

Contents

Frequently used MBS Item Numbers

For a comprehensive explanation of each MBS Item Number, please refer to the Medicare Benefits Schedule online at www.mbsonline.gov.au

Commonly Used Item Numbers			
Item	**Name**	**$**	**Description / Recommended Frequency**
3	Level A	$17.45	Brief – see MBS for complexity of care requirements
23	Level B	$38.20	< 20 min – see MBS
36	Level C	$73.95	≥ 20 min - see MBS
44	Level D	$108.85	≥ 40 min - see MBS
10990	Bulk Billing item	$7.50	DVA, under 16's and Commonwealth Concession Card holders. Can be claimed concurrently for eligible patients.
10991	Bulk Billing item	$11.35	DVA, under 16's and Commonwealth Concession Card holders. Can be claimed concurrently for eligible patients.
11505	Spirometry	$41.75	Measurement of spirometry, that: (a) involves a permanently recorded tracing, performed before and after inhalation of a bronchodilator; and (b) is performed to confirm diagnosis of: (i) asthma; or (ii) chronic obstructive pulmonary disease (COPD); or (iii) another cause of airflow limitation; each occasion at which 3 or more recordings are made Applicable only once in any 12 month period
11506	Spirometry	$20.90	Measurement of spirometry, that: (a) involves a permanently recorded tracing, performed before and after inhalation of a bronchodilator; and (b) is performed to: (i) confirm diagnosis of chronic obstructive pulmonary disease (COPD); or (ii) assess acute exacerbations of asthma; or (iii) monitor asthma and COPD; or (iv) assess other causes of obstructive lung disease or the presence of restrictive lung disease; each occasion at which recordings are made.
11702	ECG Trace only	$15.80	Twelve-Lead Electrocardiography, tracing only

Residential Aged Care Facility – GP Call out Fee and consults			
Item	**Name**	**$**	**Description / Recommended Frequency**
90001	Single site call out fee	$55.90	A flag fall service to which item 90020, 90035, 90043 or 90051 applies. For the initial attendance at one residential aged care facility on one occasion, applicable to a maximum of one patient attended on. **Please refer to MBS Online for full description.**

90035	Standard	$38.20	< 20 min – see MBS for complexity of care requirements
90043	Long	$73.95	≥ 20 min - see MBS for complexity of care requirements
90051	Prolong	$108.85	≥ 40 min - see MBS for complexity of care requirements

Chronic Disease Management			
Item	**Name**	**$**	**Description / Recommended Frequency**
721	GP Management Plan (GPMP)	$146.55	Management plan for patients with chronic or terminal condition. Not more than once yearly.
723	Team Care Arrangement (TCA)	$116.15	Management plan for patients with chronic or terminal condition and complex needs requiring ongoing care from a team including the GP and at least 2 other health or care providers. Enables referral for 5 rebated allied health services. Not more than once yearly.
732	Review of GP Management Plan and/or Team Care Arrangement	$73.20	Recommended 6 monthly. Must be performed at least once over the life of the plan.
729	GP contribution to, or Review of, Multidisciplinary Care Plan	$71.55	Contribution to, or review of, a multidisciplinary care plan prepared by another provider (e.g. community, home, allied health providers, or specialists), for patients with a chronic or terminal condition and complex needs that requires ongoing care from a team including the GP and at least 2 other health or care providers. Not more than once every 3 months.
731	GP contribution to, or Review of, Multidisciplinary Care Plan prepared by RACF	$71.55	GP contribution to, or review of, a multidisciplinary care plan prepared by RACF, at the request of the facility, for patients with a chronic or terminal condition and complex needs requiring ongoing care from a team including the GP and at least 2 other health or care providers. Not more than once every 3 months.

Health Assessments			
Item	**Name**	**$**	**Description / Recommended Frequency**
699	Heart Health Assessment	$73.95	Lasting at least 20 minutes
701	Brief Health Assessment	$60.30	Lasting no more than 30 minutes
703	Standard Health Assessment	$140.10	> 30-44 minutes – see MBS for complexity of care requirements
705	Long Health Assessment	$193.35	> 45 - < 60 minutes – see MBS for complexity of care requirements

707	Prolonged Health Assessment	$273.10	> 60 minutes - see MBS for complexity of care requirements
715	Aboriginal and Torres Strait Islander Health Assessment	$215.65	See MBS for requirements

Practice Nurse Item (PNIP) Numbers			
Item	**Name**	**$**	**Description / Recommended Frequency**
10987	Follow Up Health Services for Indigenous people	$24.40	Follow up services for an Indigenous person who has received a Health Assessment. Not an admitted patient of a hospital. Maximum of 10 services per patient per calendar year.
10997	Chronic Disease Management	$12.20	Monitoring and support for patients being managed under a GPMP or TCA. Not more than 5 per patient per year.

Medication Management			
Item	**Name**	**$**	**Description / Recommended Frequency**
900	Home Medicines Review (HMR)	$157.30	Review of medications in collaboration with a pharmacist for patients at risk of medication related misadventure. Once every 12 months.
903	Residential Medication Management Review (RMMR)	$107.70	For permanent residents of Residential Aged Care Facilities who are at risk of medication related misadventure. Performed in collaboration with the resident's pharmacist. Once every 12 months.

Mental Health Item Numbers			
Item	**Name**	**$**	**Description / Recommended Frequency**
2700	GP Mental Health Treatment Plan	$72.85	Min 20 minutes. Prepared by GP who has **not** undertaken Mental Health Skills Training. Assessment of patient and preparation of a care plan with option to refer for rebated psychological services. Not more than once yearly.
2701	GP Mental Health Treatment Plan	$107.25	Min 40 minutes. Prepared by GP who has **not** undertaken Mental Health Skills Training. Assessment of patient and preparation of a care plan with option to refer for rebated psychological services. Not more than once yearly.
2712	Review of GP Mental Health Treatment Plan	$72.85	Plan should be reviewed between 1 – 6 months and no more than 2 per year.
2713	Mental Health Consultation	$72.85	Consult ≥ 20 minutes, for the ongoing management of a patient with mental disorder. No restriction on the number of these consultations per year.

2715	GP Mental Health Treatment Plan	$92.50	Min 20 minutes. Prepared by GP who **has** undertaken Mental Health Skills Training. Assessment of patient and preparation of a care plan with option to refer for rebated psychological services. Not more than once yearly.
2717	GP Mental Health Treatment Plan	$136.25	Min 40 minutes. Prepared by GP who **has** undertaken Mental Health Skills Training. Assessment of patient and preparation of a care plan with option to refer for rebated psychological services. Not more than once yearly.
2721	GP Focussed Psychological Strategies	$94.25	30 – 40 minutes. Provision of focussed psychological strategies by an appropriately trained and registered GP working in an accredited practice.
2723	GP Focussed Psychological Strategies	derived fee	Out of surgery consultation. 30 – 40 minutes. Provision of focussed psychological strategies by an appropriately trained and registered GP working in an accredited practice.
2725	GP Focussed Psychological Strategies	$134.85	> 40 minutes. Provision of focussed psychological strategies by an appropriately trained and registered GP working in an accredited practice.
2727	GP Focussed Psychological Strategies	derived fee	Out of surgery consultation. > 40 minutes. Provision of focussed psychological strategies by an appropriately trained and registered GP working in an accredited practice.

Allied Health Services

Allied Health Services for Chronic Conditions Requiring Team Care

GP must have completed a GP Management Plan (721) and Team Care Arrangement (723) or contributed to a Multidisciplinary Care Plan in a Residential Aged Care Facility (731).

Patient must have a chronic or terminal medical condition and complex care needs requiring care from a multidisciplinary team consisting of their GP and at least two other health or care providers.

Item	Name	Description / Recommended Frequency
10950	Aboriginal Health Worker Services	• Allied Health Provider must be Medicare registered • Maximum of 5 allied health services per patient per each calendar year • Can be 5 sessions with one provider or a combination e.g. 3 dietitian and 2 diabetes education sessions • GP refers to allied health professional using 'Referral Form for Chronic Disease Allied Health (Individual) Services under Medicare' or a referral form containing all components. One for each provider • Services must be at least 20 minutes duration and provided to an individual not a group • Allied health professionals must report back to the referring GP after first and last visit
10951	Diabetes Educator Services	
10952	Audiologist Services	
10953	Exercise Physiologist Services	
10954	Dietitian Services	
10958	Occupational Therapist Services	
10960	Physiotherapist Services	
10962	Podiatrist Services	
10964	Chiropractor Services	
10966	Osteopath Services	
10970	Speech Pathologist Services	
10956	Mental Health Worker Services	• For mental health conditions, use Better Access Mental Health Care items – 10 sessions • For chronic physical conditions, use GPMP and TCA – 5 sessions • Better access and GPMP can be used for the same patient where eligible
10968	Psychologist Services	

Allied Health Group Services for Patients with Type 2 Diabetes

For a comprehensive explanation of each MBS Item number, please refer to the Medicare Benefits Schedule online at **www.mbsonline.gov.au**.

Assessment and Provision of Group Services *GP must have completed a GP Management Plan (721), or reviewed an existing GPMP (732), or contributed to, or reviewed a Multidisciplinary Care Plan in a Residential Aged Care Facility (731).*		
Item	**Name**	**Description / Recommended Frequency**
81100	Assessment for Group Services by Diabetes Educator	• One assessment session only by either Diabetes Educator, Exercise Physiologist or Dietitian per calendar year • Medicare Allied Health Group Services for Type 2 Diabetes Referral Form
81110	Assessment for Group Services by Exercise Physiologist	
81120	Assessment for Group Services by Dietitian	
81105	Diabetes Education Group Services	• 8 group services per calendar year, can be 8 sessions with one provider or a combination e.g. 3 diabetes education, 3 dietitian and 2 exercise physiology sessions • Medicare Allied Health Group Services for Type 2 Diabetes Referral Form

After-Hours Services

<table>
<tr><th colspan="3">Attendance Period</th><th>Item No</th><th>MBS Payment</th><th>Brief Guide</th></tr>
<tr><td colspan="3">Urgent attendance – after hours</td><td rowspan="2">585 (GP)[1]

588 (Non-VR GP, rural area)[2]

591 (Non-VR GP, metropolitan area)

594 (additional patients at one location)[3]</td><td rowspan="2">$131.90

$131.90

$101.60

$42.60</td><td rowspan="8">• These items can only be used for the first patient, if more than one patient is seen on the one occasion, standard (non-urgent) after hours items apply

• The urgent after-hours items can only be used where the patient has a medical condition that requires urgent assessment which could not be delayed until the next in-hours period

• For consultations at the health centre it is necessary for the practitioner to return to, and specially open the consulting rooms for the attendance</td></tr>
<tr><td>Mon – Fri
7 – 8am or
6 – 11pm</td><td>Sat
7 – 8am or
12noon – 11pm</td><td>Sun & Pub Holidays
7am – 11pm</td></tr>
<tr><td colspan="3">Urgent attendance – unsociable hours</td><td rowspan="2">599 (GP)[1]
600 (Non-VR GP)</td><td rowspan="2">$155.45
$124.25</td></tr>
<tr><td>Mon – Fri
11pm –
7am</td><td>Sat
11 pm –
7am</td><td>Sun & Pub Holidays
11 pm – 7am</td></tr>
<tr><td colspan="3">Non-urgent after hours at a place other than consulting rooms</td><td colspan="2"><u>Home</u>

<u>GP:</u>
5003
5023
5043
5063

<u>Non-VR GP:</u>
5220
5223
5227
5228

<u>RACFS</u>

<u>GP:</u>
5010
5028
5049
5067

<u>Non-VR GP:</u>
5260
5263
5265
5267

*The above MBS Payments are for the 1st patient only. Please refer to MBS Online for multiple patient fee schedules.</td></tr>
<tr><td>Mon – Fri
Before 8am or after 6pm</td><td>Sat
Before 8am or after 12pm</td><td>Sun & Pub Holidays
All day</td></tr>
<tr><td colspan="3">Non-urgent after hours at consulting rooms</td><td rowspan="2"><u>GP</u>
5000 (Level A)
5020 (Level B < 20 min)
5040 (Level C > 20 min)
5060 (Level D > 40 min)

<u>Non-VR GP</u>
5200 (Level A)
5203 (Level B < 20 min)
5207 (Level C > 20 min)
5208 (Level D > 40 min)</td><td rowspan="2">Refer to MBS online for further information</td></tr>
<tr><td>Mon – Fri
Before 8am or after 8pm</td><td>Sat
Before 8am or after 1pm</td><td>Sun & Pub Holidays
All day</td></tr>
</table>

[1] 585 and 599 available to medical practitioners who are vocationally registered or vocationally recognised or practitioners who are AHOMPS program participants employed with full time general practice.

[2] 588 is available to non-vocationally recognised medical practitioners in areas MMM 3 to MMM 7. For our region this includes the following: **MMM Area 3:** Blackheath, Medlow Bath, Medlow Bath, Mt Victoria; **MMM Area 4:** Lithgow, Hartley, Bowenfels, Rydal, Marrangaroo; **MMM Area 5:** Portland, Wallerawang, Bilpin, Mt Irvin, Colo, Colo Heights.

[3] Professional attendance by a medical practitioner—each additional patient at an attendance that qualifies for item 585, 588 or 591 in relation to the first patient.

GP Multidisciplinary Case Conferences

Item	Name	Description / Recommended Frequency
735	Organise and coordinate a case conference	15 – 20 minutes. GP organises and coordinates case conference in RACF, community, or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs.
739	Organise and coordinate a case conference	20 – 40 minutes. GP organises and coordinates case conference in RACF, community, or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs.
743	Organise and coordinate a case conference	> 40 minutes. GP organises and coordinates case conference in RACF, community, or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs.
747	Participate in a case conference	15 – 20 minutes. GP participates in a case conference in RACF, community, or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs.
750	Participate in a case conference	30 – 40 minutes. GP participates in a case conference in RACF, community, or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs.
758	Participate in a case conference	> 40 minutes. GP participates in a case conference in RACF, community, or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs.

Health Assessments

For a comprehensive explanation of each MBS Item number, please refer to the Medicate Benefits Schedule online at **www.mbsonline.gov.au**.

Item	Name	Description / Recommended Frequency
699	Heart Health Assessment	>20 Minutes a) Collection of relevant information including taking a patient history that is aimed at identifying cardiovascular disease risk factors, including diabetes status, alcohol intake, smoking status, cholesterol status (if not performed within the last 12 months) and blood glucose b) A physical examination, which must include recording of blood pressure c) Initiating interventions and referrals to address the identified risk factors d) Implementing a management plan for appropriate treatment of identified risk factors e) Providing the patient with preventative health care advice and information, including modifiable lifestyle factors
701	Brief Health Assessment	< 30 Minutes a) Collection of relevant information, including taking a patient history b) A basic physical examination c) Initiating interventions and referrals as indicated d) Providing the patient with preventive health care advice and information Incorporating: • **Health Assessment – Type 2 Diabetes Risk Evaluation** Provision of lifestyle modification advice and interventions for patients aged 40-49 years who score ≥ 12 on AUSDRISK. Once every 3 years • **Health Assessment – 45 – 49 Year Old** Once only health assessment for patients 45 – 49 years who are at risk of developing a chronic disease • **Health Assessment – 75 Years and Older** Health assessment for patients aged 75 years and older. Once every 12 months • **Health Assessment – Comprehensive Medical Assessment**

		Comprehensive Medical Assessment for permanent residents of Residential Aged Care Facilities. Available for new and existing residents. Not more than once yearly • **Health Assessment for patient with an Intellectual Disability** Health assessment for patient with Intellectual Disability. Not more than once yearly • **Health Assessment for Refugees and other Humanitarian Entrants** Once only health assessment for new refugees and other humanitarian entrants, as soon as possible after their arrival (within 12 months of their arrival). A desktop guide – Caring for Refugee Patients in General Practice is available on the RACGP website www.racgp.org.au

Item	Name	Description / Recommended Frequency
703	Standard Health Assessment	30 – 44 minutes a) Detailed information collection, including taking patient history b) An extensive physical examination c) Initiating interventions and referrals as indicated d) Providing a preventative health care strategy for the patient
705	Long Health Assessment	45 – 59 Minutes a) Comprehensive information collection, including taking a patient history b) An extensive examination of the patient's medical condition and physical function c) Initiating interventions and referrals and indicated d) Providing a basic preventive health care management plan for the patient Incorporating the Health Assessment categories listed in 701.

707	Prolonged Health Assessment	> 60 minutes a) Comprehensive information collection, including taking a patient history b) An extensive examination of the patient's medical condition, and physical, psychological and social function c) Initiating interventions and referrals as indicated d) Providing a comprehensive preventive health care management plan for the patient Incorporating the Health Assessment categories listed in 701.
715	Aboriginal and Torres Strait Islander Health Assessment	No designated time or complexity requirements Incorporating: • **ATSI Child Health Assessment** Health Assessment for ATSI patients 0 – 14 years old. Not available to inpatients of hospitals or RACF. Not more than once every 9 months • **ATSI Adult Health Assessment** Health Assessment for ATSI patients 15 – 54 years old. Not available to inpatients of hospitals or RACF. Not more than once every 9 months • **ATSI Health Assessment for an Older Person** Health Assessment for ATSI patients 55 years and over. Not available to inpatients of hospitals or RACF. Not more than once every 9 months

Residential Aged Care Facility Item Numbers

For a comprehensive explanation of each MBS Item number, please refer to the Medicare Benefits Schedule online at **www.mbsonline.gov.au**.

Item	Name	Description / Recommended Frequency
701	Brief Health Assessment	< 30 minutes – see MBS for complexity of care requirements incorporating: **Health Assessment – Comprehensive Medical Assessment** Comprehensive Medical Assessment (CMA) for permanent residents of Residential Aged Care Facilities. Available for new and existing residents. Not more than once yearly.
703	Standard Health Assessment	30 – 44 minutes - see MBS for complexity of care requirements. Incorporating: **Health Assessment - CMA**
705	Long Health Assessment	45 – 60 minutes - see MBS for complexity of care requirements. Incorporating: **Health Assessment - CMA**
707	Prolonged Health Assessment	> 60 minutes - see MBS for complexity of care requirements. Incorporating: **Health Assessment - CMA**

CMA Activities:

- Time based, see MBS for complexity of care requirements for each item.
- CMA requires assessment of the resident's health and physical and psychological function, and must include:
  - Obtain and record resident's consent
  - Information collection, including taking patient history and undertaking or arranging examinations and investigations as required
  - Making an overall assessment of the patient
  - Recommending appropriate interventions
  - Providing advice and information to the patient
  - Keeping a record of the Health Assessment – CMA, and offering the patient a written report about the health assessment, with recommendations about matters covered by the Health Assessment – CMA
- Providing a written summary of the outcomes of the Health Assessment – CMA for the resident's records and to inform the provision of care for the resident by the RACF, and assist in the provision of Medication Management Review Services for the resident

731	GP Contribution to, or Review of, Multidisciplinary Care Plan prepared by RACF	GP contribution to, or review of, a multidisciplinary care plan prepared by RACF, at the request of the facility, for patients with chronic or terminal condition and complex needs requiring ongoing care from a team including the GP and at least 2 other health or care providers. Not more than once every 3 months.

Activities:

- Obtain and record resident's consent
- Prepare part of the plan or amendments to the plan and add a copy to the patient's medical records
- Give advice to a person (e.g. nursing staff in RACF) who prepares or reviews the plan and record in writing any advice provided on the patient's medical records

Item	Name	Description / Recommended Frequency

735	Organise and coordinate a case conference	15 – 19 minutes. GP organises and coordinates case conference in RACF, community, or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs.
739	Organise and coordinate a case conference	20 – 39 minutes. GP organises and coordinates case conference in RACF, community, or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs.
743	Organise and coordinate a case conference	> 40 minutes. GP organises and coordinates case conference in RACF, community, or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs.
747	Participate in a case conference	15 – 20 minutes. GP participates in a case conference in RACF, community, or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs.
750	Participate in a case conference	30 – 40 minutes. GP participates in a case conference in RACF, community, or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs.
758	Participate in a case conference	> 40 minutes. GP participates in a case conference in RACF, community, or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs.

Activities:

Time based items 735 – 743 Organise and Coordinate requires:

- Obtain and record resident's consent
- Record meeting details including date, start and end time, location, participant names, all matters discussed and identified;
- Discuss outcomes with patient and carer and offer a summary of the conference to them and team members
- Keep records in the patient's medical file

Telehealth – Residential MBS Items

Professional attendance by a general practitioner at a Residential Aged Care Facility that requires the provision of clinical support to a patient who is:

a) A care recipient receiving care in a residential aged care service (other than a professional attendance at a self-contained unit); or

b) At consulting rooms situated within such a complex where the patient is a resident of the aged care service (excluding accommodation in a self-contained unit)

Time based items 2125, 2138, 2179 and 2220.

Residential Medication Management Review (RMMR)

Item 903

For permanent residents (new or existing) of RACFs. A RMMR is a review of medications, in collaboration with a pharmacist, for patients at risk of medication related misadventure or for whom quality use of medicines may be an issue.

Activities:

- Obtain and record resident's consent
- Provide input from the resident's CMA or relevant clinical information for RMMR and resident's records
- Participate in post-review discussion with pharmacist (unless exemptions apply) regarding the findings, medication management strategies, issues, implementation, follow up and outcomes
- Develop and/or revise Medication Management Plan and finalise plan after discussion with resident

Systematic Care Claiming Rules

Legend MBS Item Numbers

	No claiming restrictions
721	GP Management Plan (GPMP)
723	Team Care Arrangement (TCA)
732	Review of GPMP and/or TCA
900	Home Medication Review
2700 / 2701	GP Mental Health Treatment Plan
2715 / 2717	GP Mental Health Treatment Plan
2712	Review of GP Mental Health Treatment Plan
2713	GP Mental Health Consultation

Recommended Months Until Next Claim for Service

***721**	24		6					
***723**		24	6					
****732**	6	6	6					
900				12				
2700 / 2701					12	3		
§2712					3	3	3	
2713								
2715 / 2717							12	
MBS Item Numbers	***721**	***723**	****732**	**900**	**2700 / 2701**	**§2712**	**2715 / 2717**	**2713**

Additional Claiming Rules

***721 & 733** Recommended claiming period 24 months, minimum claiming period 12 months

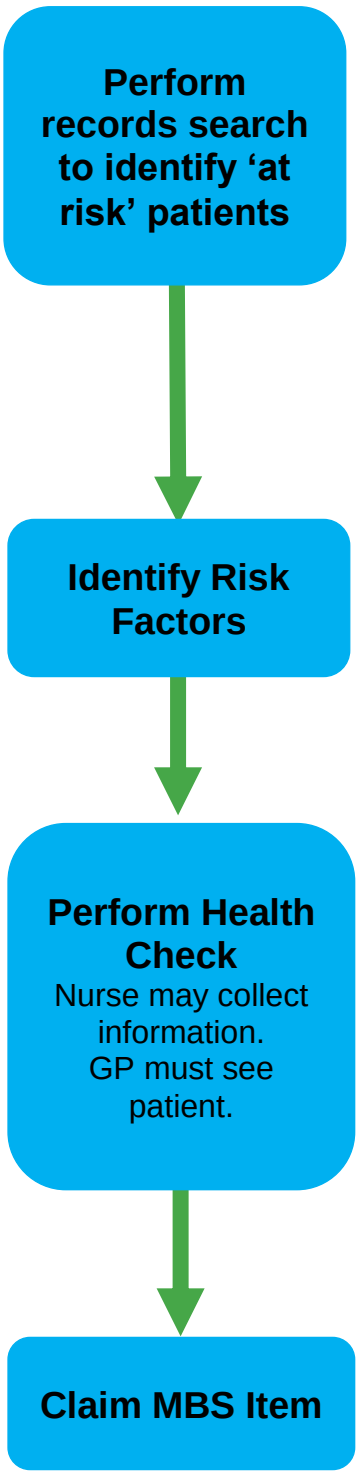
****732** Recommended claiming period 6 months, minimum claiming period 3 months. Can be claimed twice on the same day if review of both GPMP and TCA are completed, in this case the patient invoice and Medicare claim should be annotated.

§2712 Review recommended 1 month – 6 months after 2700, 2701, 2715, 2717 with not more than 2 reviews in a 12 month period.

Notes Where a service is provided earlier than minimum claiming periods the patient invoice and Medicare claim should be annotated. For example; clinically indicated/required, hospital discharge, exceptional circumstances significant change.

Standard consultations, health assessments, care plans and medication reviews should not be claimed on the same day. If provided on the same day the patient invoice and Medicare claim should be annotated, for example; clinically indicated/required, separate service.

Type 2 Diabetes Risk Evaluation – Health Assessment - Items 701, 703, 705 & 707



Eligibility Criteria

- Patients with newly diagnosed or existing diabetes are **not** eligible
- Patients aged 40 – 49 years inclusive
- Patients must score ≥ 12 points (high risk) on Australian Type 2 Diabetes Risk Assessment Tool (AUSDRISK)
- Not for patients in hospital

Clinical Content

- Explain Health Assessment process and gain consent
- Evaluate the patient's high risk score determined by AUSDRISK, which has been completed within a period of 3 months prior to undertaking Type 2 Diabetes Risk Evaluation
- Update patient history and undertake physical examinations and clinical investigations in accordance with relevant guidelines
- Make an overall assessment of the patient's risk factors, and results of relevant examinations and investigations
- Initiate interventions where appropriate, and follow-up relating to management of any risk factors identified
- Provide advice and information, such as Lifescripts resources, including strategies to achieve lifestyle and behaviour changes

Essential Documentation Requirements

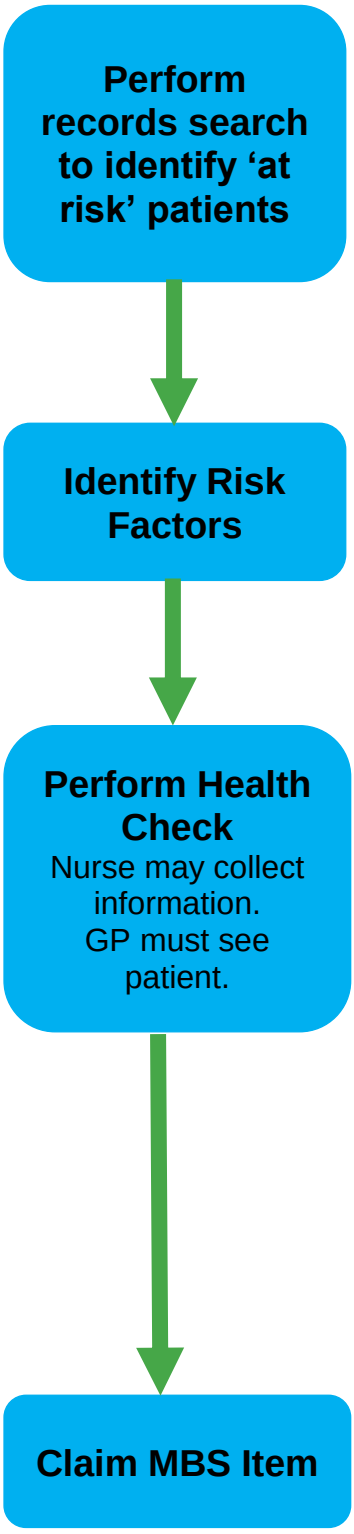
- Record patient's consent to Health Assessment
- Completion of AUSDRISK is mandatory, with score of ≥ 12 points required to claim; update patient history
- Record the Health Assessment and offer the patient a copy

Claiming

- All elements of the service must be completed to claim
- Requires personal attendance by GP with patient

MBS Item	*Name*	*Age Range*	*Recommended Frequency*
701 / 703 / 705 / 707	Health Assessment – Type 2 Diabetes Risk Evaluation	40 – 49 years	Once every 3 years

Heart Health Assessment – Item 699



Eligibility Criteria

- Aboriginal or Torres Strait Islander persons who are aged 30 years and above
- Adults aged 45 years and above
- The absolute cardiovascular disease risk must be calculated as per the Australian Absolute Cardiovascular Disease Risk Calculator which can viewed at http://www.cvdcheck.org.au/calculator/
- Not for patients in hospital

Risk Factors

Include, but are not limited to:

- Lifestyle: Smoking, physical inactivity, poor nutrition, alcohol use, biomedical, high cholesterol, high BP, impaired glucose metabolism, excessive weight
- Family history of chronic disease

Clinical Content

Mandatory

- Explain Health Assessment process and gain consent
- Collection of relevant information including taking a patient history that is aimed at identifying cardiovascular disease risk factors, including diabetes status, alcohol intake, smoking status, cholesterol status (if not performed within the last 12 months) and blood glucose
- A physical examination, which must include recording of blood pressure
- Initiating interventions and referrals to address the identified risk factors
- Implementing a management plan for appropriate treatment of identified risk factors
- Providing the patient with preventative health care advice and information, including modifiable lifestyle factors

Non- mandatory

- Written patient information is recommended

Essential Documentation Requirements

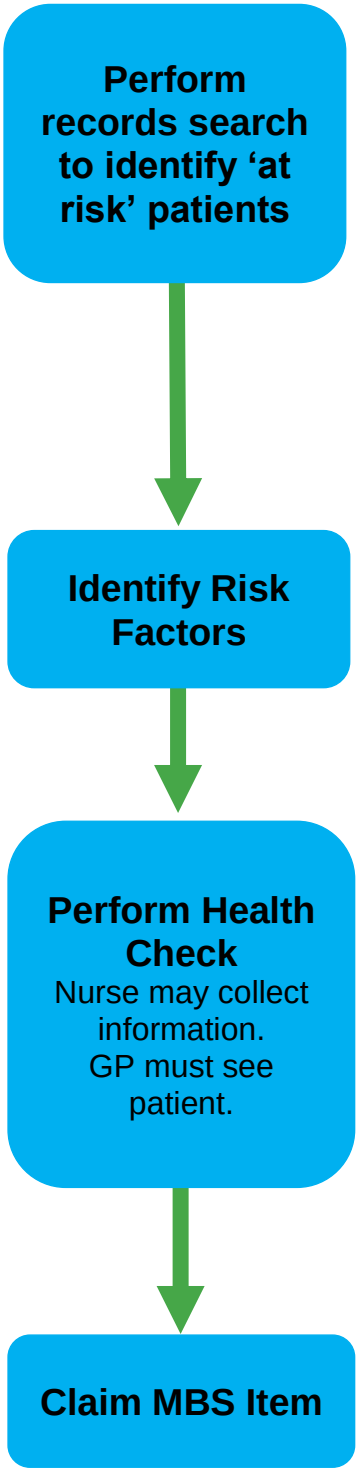
- Record patient's consent to Health Assessment
- Record the Health Assessment and offer the patient a copy

Claiming

- All elements of the service must be completed to claim

MBS Item	*Name*	*Age Range*	*Recommended Frequency*
699	Heart Health Assessment	• Aboriginal and Torres Strait Islander over 30 years • Adults over 45 years	Annually

45 – 49 Year Old – Health Assessment - Items 701, 703, 705 & 707



Eligibility Criteria

- Patients aged 45 – 49 years inclusive
- Must have an identified risk factor for chronic disease
- Not for patients in hospital

Risk Factors

Include, but are not limited to:

- Lifestyle: Smoking, physical inactivity, poor nutrition, alcohol use, biomedical, high cholesterol, high BP, impaired glucose metabolism, excessive weight
- Family history of chronic disease

Clinical Content

Mandatory

- Explain Health Assessment process and gain consent
- Information collection – takes patient history, undertake examinations and investigations as clinically required
- Overall assessment of the patient's health, including their readiness to make lifestyle changes
- Initiate interventions and referrals as clinically indicated. Advice and information about lifestyle modification programs and strategies to achieve lifestyle and behaviour changes

Non- mandatory

- Written patient information is recommended

Essential Documentation Requirements

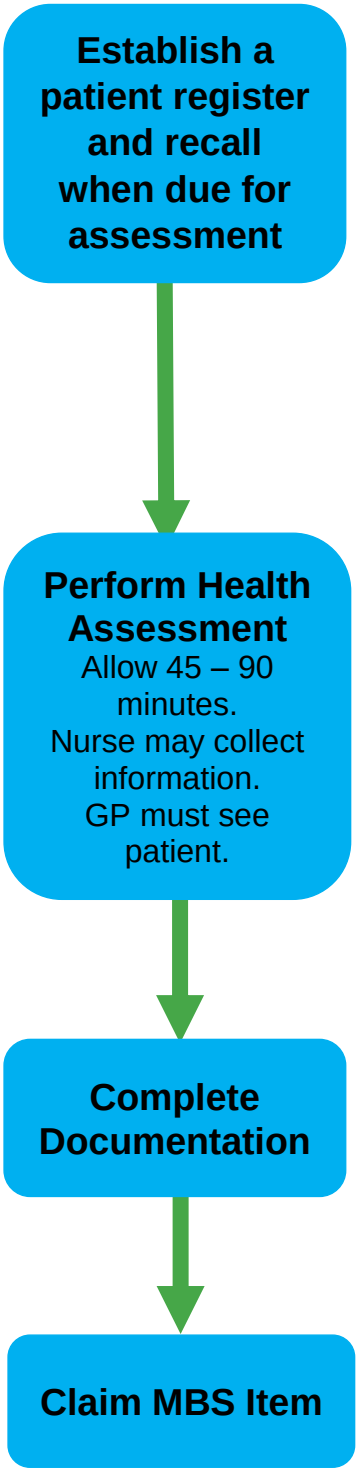
- Record patient's consent to Health Assessment
- Record the Health Assessment and offer the patient a copy

Claiming

- All elements of the service must be completed to claim

MBS Item	*Name*	*Age Range*	*Recommended Frequency*
701 / 703 / 705 / 707	Health Assessment – 45 – 49 Year Old	45 – 49 years	Once only

75 Years and Older – Health Assessment - Items 701, 703, 705 & 707



701 / 703 / 705 / 707 – Time based, see MBS for complexity of care requirements of each item

Eligibility Criteria

- Patients aged 75 years and older
- Patient seen in consulting rooms and/or at home
- Not for patients in hospital

Clinical Content

Mandatory

- Explain Health Assessment process and gain patient's/carer's consent
- Information collection – takes patient history, undertake examinations and investigations as clinically required
- Measurement of: BP, pulse rate and rhythm
- Assessment of: medication; continence; immunisation status for influenza, tetanus and pneumococcus; physical function including activities of daily living and falls in the last 3 months; psychological function including cognition and mood; and social function including availability and adequacy of paid and unpaid help and the patient's carer responsibilities
- Overall assessment of the patient
- Recommend appropriate interventions
- Provide advice and information
- Discuss outcomes of the assessment and any recommendations with patient

Non-mandatory

- Consider: need for community services; social isolation; oral health and dentition; nutritional status
- Additional matters as relevant to patient

Essential Documentation Requirements

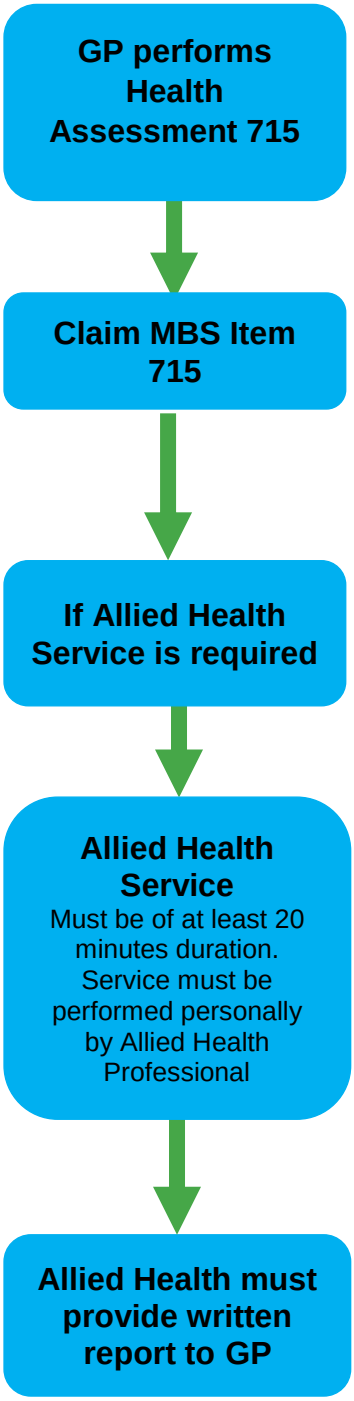
- Record patient's/carer's consent to Health Assessment
- Record the Health Assessment and offer the patient a copy (with consent, offer to carer)

Claiming

- All elements of the service must be completed to claim

MBS Item	*Name*	*Age Range*	*Recommended Frequency*
701 / 703 / 705 / 707	Health Assessment – 75 Years and Older	75 years and older	Once every 12 months

Aboriginal and Torres Strait Islander - Health Assessment - Item 715



Item 715 – Patients that have identified as Aboriginal and Torres Strait Islander and have undertaken the Item 715 Health Assessment can be referred for Allied Health follow-up if required (Referral to Care Coordination Team to assist with access to allied health). The Assessment covers all age groups; however, it may vary depending on the age of the person. Refer to MBS primary care items.

Items 81300 to 81360 – Allied Health Service

Eligibility Criteria

- Items 81300 to 81360 with the exception of 81305 (which does not require a health assessment) are in addition to items 10950 to 10970 and provide an alternative to the referral pathway to access Allied Health Services
- Items available to individual patients only, not a group service
- This patient is not an admitted patient of a hospital
- Eligible patients may access Medicare rebates for up to 5 allied health services in a calendar year. Allied Health Professionals may set their own fees. Charges in excess of the Medicare benefit for these items are the responsibility of the patient

Essential Documentation Requirements

Allied Health Professionals must provide a written report to the GP after the first and last service (more often if clinically required)

Mandatory

Health Assessment includes physical, psychological and social wellbeing. It also assesses what preventative health care, education and other assistance that should be offered to improve the patient's health and wellbeing. It must include:

- Information collection of patient history and undertaking examinations and investigations as required;
- Overall assessment of the patient;
- Recommending appropriate interventions;
- Providing advice and information to the patient;
- Recording the health assessment; and
- Offering the patient a written report with recommendations about matters covered by the health assessment

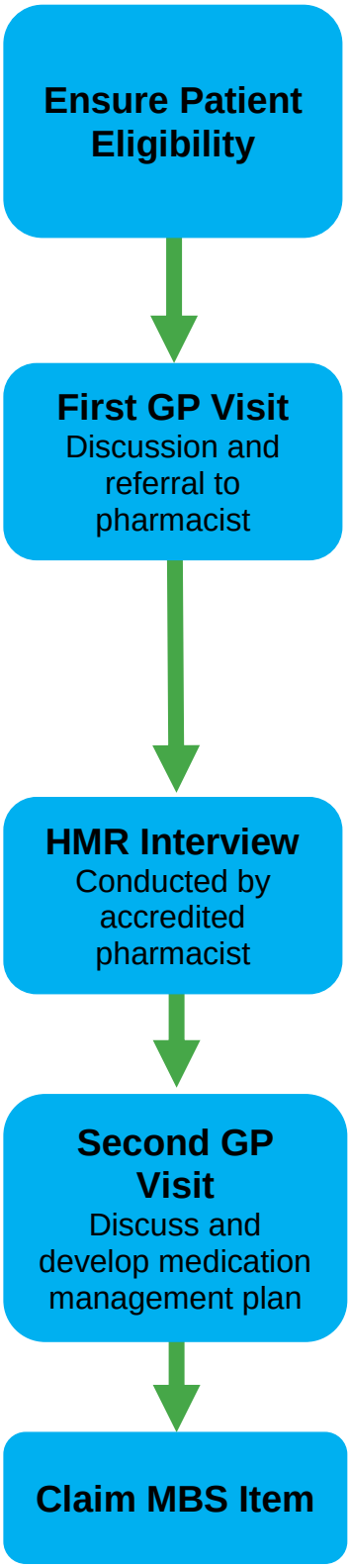
Optional

- Offering the patient's carer (if any, and the patient agrees) a copy of the report or extracts of the report relevant to the carer.

MBS Item	*Name*	*Age Range*	*Recommended Frequency*
715	Aboriginal and Torres Strait Islander Health Assessment	All Ages	Once in a 9 month period
81300 to 81360	Allied Health Services	All Ages	Max 5 services per year
10987	Services provided by practice nurse or registered Aboriginal Health Worker	All Ages	Max 10 services per year

Domiciliary Medication Management Review (DMMR) - Item 900

Also known as Home Medicines Review (HMR)



Eligibility Criteria

- Patients at risk of medication related problems or for whom quality use of medications may be an issue
- Not for patients in hospital or a Residential Aged Care Facility

Initial Visit with GP

- Explain purpose, possible outcomes, process, information sharing with pharmacist and possible out of pocket costs
- Gain and record patient's consent to HMR
- Inform patient of need to return for second visit
- Complete HMR referral and send to patient's preferred pharmacy or accredited pharmacist

HMR Interview

- Pharmacist holds review in patient's home unless patient prefers another location
- Pharmacist prepares a report and sends to the GP covering review findings and suggested medication management strategies
- Pharmacist and GP discuss findings and suggestions

Second GP Visit

- Develop summary of findings as part of draft medication management plan
- Discuss draft plan with patient and offer copy of completed plan
- Send a copy of plan to pharmacist

Claiming

- All elements of the service must be completed to claim
- Requires personal attendance by GP with patient

MBS Item	*Name*	*Recommended Frequency*
900	Domiciliary Medication Management Review	Once every 12 months

Residential Medication Management Review (RMMR) - Item 903

Eligibility Criteria

- For permanent residents (new or existing) of a Commonwealth funded Residential Aged Care Facility (includes veterans)
- Patients at risk of medication related misadventure because of significant change in their condition or medication regimen, or for whom quality use of medicines may be an issue
- Not for patients in hospital or respite patients in a RACF

GP Initiates Service

- Explain RMMR process and gain resident's consent
- Send referral to accredited pharmacist to request collaboration in medication review
- Provide input form Comprehensive Medical Assessment of relevant clinical information for RMMR and the resident's records

Accredited Pharmacist Component

- Review resident's clinical notes and interview resident
- Prepare Medication Review report and send to GP

GP and Pharmacist Post Review Discussion

- Discuss:
  - findings and recommendations of the Pharmacist;
  - Medication management strategies; issues; implementation; follow up and outcomes;
- If no (or only minor) changes recommended, a post review discussion is not mandatory

Essential Documentation Requirements

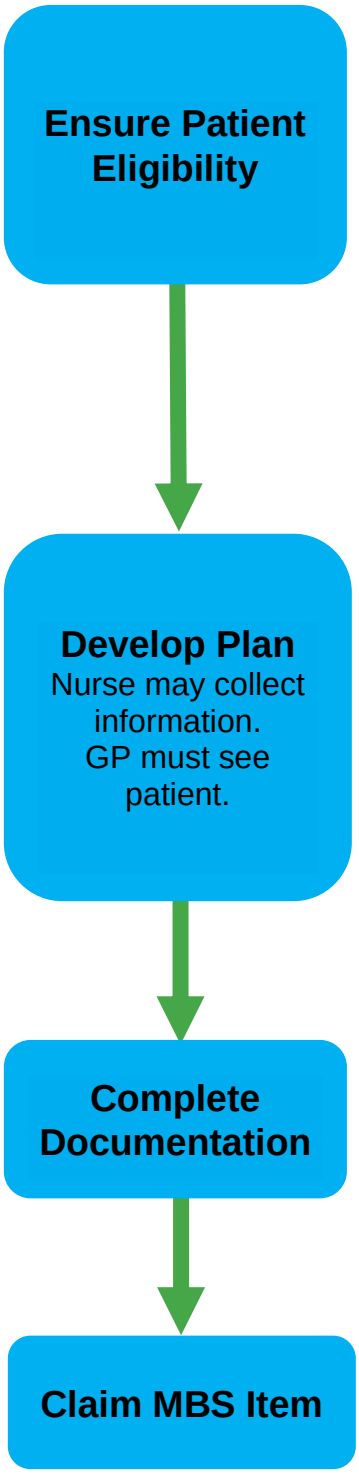
- Record resident's consent to RMMR
- Develop and/or revise Medication Management Plan which should identify medication management goals and medication regimen
- Finalise plan after discussion with resident
- Offer copy of plan to resident/carer, provide copy for resident's records and for nursing staff at RACF, discuss plan with nursing staff if necessary

Claiming

- All elements of the service must be completed to claim
- Derived fee arrangements do not apply to RMMR

MBS Item	*Name*	*Recommended Frequency*
903	Residential Medication Management Review	As required (minimum 12 monthly)

GP Management Plan (GPMP) – Item 721



Eligibility Criteria

- No age restrictions for patients
- Patients with a chronic or terminal condition
- Patients who will benefit from a structured approach to their care
- Not for public patients in a hospital or patients in a Residential Aged Care Facility

Clinical Content

- Explain steps involved in GPMP, possible out of pocket costs, gain consent
- Assess health care needs, health problems and relevant conditions
- Agree on management goals with the patient
- Confirm actions to be taken by the patient
- Identify treatments and services required
- Arrangements for providing the treatments and services
- Review using item 732 at least once over the life of the plan

Essential Documentation Requirements

- Record patient's consent to GPMP
- Patient needs and goals, patient actions, and treatment/services required
- Set review date
- Offer the patient a copy (with consent, offer to carer), keep copy in patient file

Claiming

- All elements of the service must be completed to claim
- Requires that there has been personal attendance by GP to assess and gain consent
- Review using item 732 at least once during life of the plan

MBS Item	*Name*	*Recommended Frequency*
721	GP Management Plan	2 Yearly (minimum 12 monthly)

Team Care Arrangement (TCA) – Item 723

Eligibility Criteria

- No age restrictions for patients
- Patients with a chronic or terminal condition and complex care needs
- Patients who need ongoing care from a team including the GP and at least 2 other health and care providers
- Not for public patients in a hospital or patients in a Residential Aged Care Facility

Clinical Content

- Explain steps involved in TCA, possible out of pocket costs, gain consent
- Treatment and service goals for the patient
- Discuss with patient which 2 providers the GP will collaborate with and the treatment and services the 2 providers will deliver
- Actions to be taken by the patient
- Gain patient's agreement on what information will be shared with other providers
- Ideally list all health and care services required by the patient
- Obtain potential collaborating providers' agreement to participate
- Consult with the 2 collaborating providers and obtain feedback on treatment/services they will provide to achieve patient goals

Essential Documentation Requirements

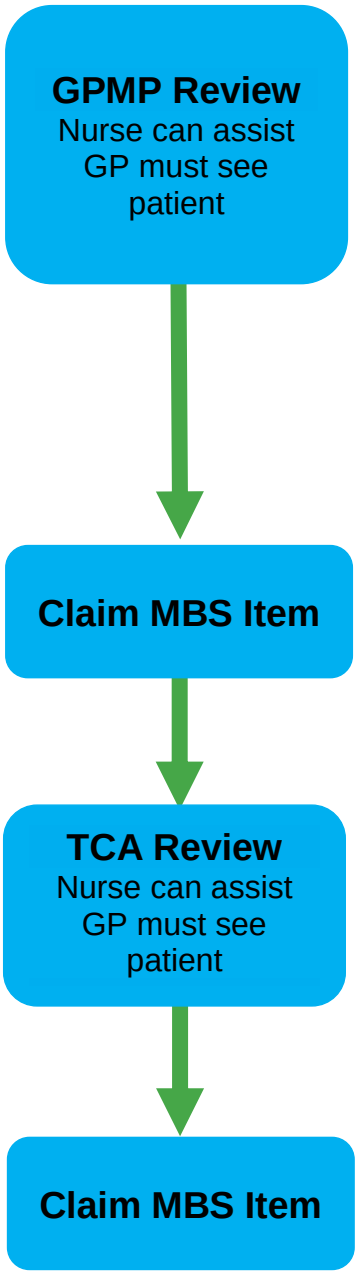
- Record patient's consent to TCA
- Goals, collaborating providers, treatment/services, actions to be taken by patient
- Set review date
- Send copy of relevant parts to collaborating providers
- Offer the patient a copy (with consent, offer to carer), keep copy in patient file

Claiming

- All elements of the service must be completed to claim.
- Requires that there has been personal attendance by GP to assess and gain consent
- Review using item 732 at least once during life of the plan
- Claiming a GPMP and TCA enables patients to receive 5 elaborated services from allied health

MBS Item	*Name*	*Recommended Frequency*
723	Team Care Arrangement	2 Yearly (minimum 12 monthly)

Reviewing a GP Management Plan (GPMP) and/or Team Care Arrangement (TCA) – Item 732



Reviewing a GP Management Plan

Clinical Content

- Explain steps involved in the review and gain consent
- Review all matters in relevant plan

Essential Documentation Requirements

- Record patient's agreement to review
- Make any required amendments to plan
- Set a new review date
- Offer copy to patient (with consent, offer to carer), keep copy in patient file

Claiming

- All elements of the service must be completed to claim
- Item 732 should be claimed at least once over the life of the plan
- Cannot be claimed within 3 months of a GPMP (item 721)
- Item 732 can be claimed twice on same day if review of both GPMP and TCA are completed, in this case, the Medicare claim should be annotated

Reviewing a Team Care Arrangement (TCA)

Clinical Content

- Explain steps involved in the review and gain consent
- Consult with 2 collaborating providers to review all matters in plan

Essential Documentation Requirements

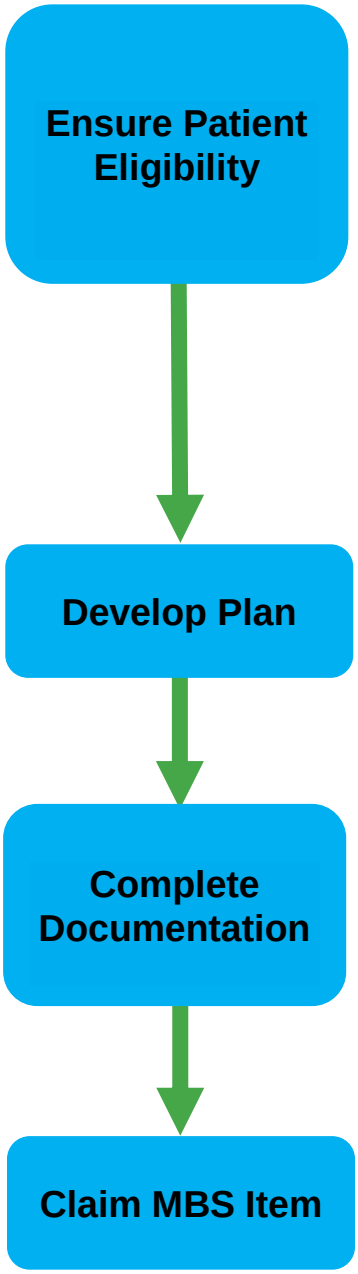
- Record patient's agreement to review
- Make any required amendments to plan
- Set a new review date
- Send copy of relevant parts of amended TCA to collaborating providers
- Offer copy to patient (with consent, offer to carer), keep copy in patient file

Claiming

- All elements of the service must be completed to claim
- Requires that there has been personal attendance by GP to assess and gain consent
- Item 732 should be claimed at least once over the life of the TCA
- Cannot be claimed within 3 months of a TCA (item 723)
- Item 732 can be claimed twice on same day if review of both GPMP and TCA are completed, in this case, the Medicare claim should be annotated

MBS Item	***Name***	***Recommended Frequency***
732	Review of GP Management Plan and/or Team Care Arrangement	6 monthly (minimum 3 monthly)

Mental Health Treatment Plan – Items 2700, 2701, 2715 and 2717



2700 / 2701 – prepared by a GP who **has not** undertaken mental health skills training
2715 / 2717 - prepared by a GP who **has** undertaken mental health skills training

Eligibility Criteria

- No age restrictions for patients
- Patients with a mental disorder, excluding dementia, delirium, tobacco use disorder and mental retardation (without mental health disorder)
- Patients who will benefit from structured approach to their treatment
- Not for patients in a hospital or patients in a Residential Aged Care Facility

Clinical Content

- Explain steps involved, possible out of pocket costs, gain patient's consent
- Relevant history – biological, psychological, social and presenting complaint
- Mental state examination, assessment of risk and co-morbidity, diagnosis of mental disorder and/or formulation
- Outcome measurement tool score (e.g. K10), unless clinically inappropriate
- Provide psycho-education
- Plan for crisis intervention/relapse prevention, if appropriate
- Discuss diagnosis/formulation, referral and treatment options with the patient
- Agree on management goals with the patient and confirm actions to be taken by the patient
- Identify treatments/services required and make arrangements for these

Essential Documentation Requirements

- Record patient's consent to GP Mental Health Treatment Plan
- Document diagnosis of mental disorder
- Results of outcome measurement tool
- Patient's needs and goals, patient actions and treatments/services required
- Set review date
- Offer the patient a copy (with consent, offer to carer), keep copy in patient file

Claiming

- All elements of the service must be completed to claim
- Requires personal attendance by GP with patient
- Review using item 2712 at least once during the life of the plan

MBS Item	*Name*	*Recommended Frequency*
2700, 2701, 2715, 2717	Mental Health Treatment Plan	No more than once yearly

Review of the Mental Health Treatment Plan – Item 2712

Clinical Content

- Explain steps involved, possible out of pocket costs, gain patient's consent
- Review patient's progress against goals outlined in the GP Mental Health Treatment Plan
- Check, reinforce and expand psycho-education
- Plan for crisis intervention and/or relapse prevention, if appropriate and if not-previously provided
- Re-administer the outcome measurement tool used when developing the GP Mental Health Treatment Plan (item 2700 / 2701 / 2715 / 2717), except where considered clinically inappropriate

Essential Documentation Requirements

- Record patient's consent to Review
- Results of re-administered outcome measurement tool
- Document relevant changes to GP Mental Health Treatment Plan
- Offer the patient a copy (with consent, offer to carer), keep copy in patient file

Claiming

- All elements of the service must be completed to claim.
- Requires personal attendance by GP with patient
- Item 2712 should be claimed at least once over the life of the GP Mental Health Treatment Plan
- Claiming 2712 enables patients to receive 4 further rebated individual and group psychology services
- A review can be claimed 1-6 months after completion of the GP Mental Health Treatment Plan
- If required, an additional review can be performed 3 months after the first Review

MBS Item	*Name*	*Recommended Frequency*
2712	Review of GP Mental Health Treatment Plan	1 – 6 months after GP Mental Health Treatment Plan

Practice Incentive Payment Summary

Item	Activity	Item Number & Type of Consultation	PIP ($ per SWPE)	Notes (PIP Enquiry Line 1800 222 032) http://www.humanservices.gov.au
My Health Record	**Requirement 1:** Integrating Healthcare Identifiers into Electronic Practice Records. **Requirement 2:** Secure messaging capability. **Requirement 3:** Data records and clinical coding. **Requirement 4:** Electronic transfer prescriptions. **Requirement 5:** My Health Record system.		$6.50 per SWPE, per annum Capped at $12,500 per quarter	To qualify, practices must meet each of the requirements: **Requirement 1:** • Apply for a Health Care Provider Identifier-Organisation (HPI-O) • Ensure each GP within the practice has a Healthcare Provider Identifier –Individual (HPI-I) • Use a compliant clinical software system to access, retrieve and store verified individual Healthcare Identifiers (IHI) for patients **Requirement 2:** • Apply for a NASH PKI Certificate • Have a standards-compliant secure messaging capability and use it where feasible • Work with your secure messaging vendor to ensure it is installed and configured correctly • Have a written policy to encourage its use **Requirement 3:** • Be working towards recording the majority of diagnoses electronically using a medical vocabulary that can be mapped against a nationally recognised disease classification or terminology system • Provide written policy to this effect to all GPs **Requirement 4:** • Use a software system that is able to send an electronic prescription to a Prescription Exchange Service (PES) • The majority of prescriptions are sent electronically to a (PES) **Requirement 5:** • Use compliant software to access the My Health Record system and create and post Shared Health Summaries (SHS) and Event Summaries • Apply to participate in the My Health Record system upon obtaining a HPI-O • Upload Shared Health Summaries for a minimum of 0.5 % of the practice's SWPE count of patients per PIP payment quarter

Item	Activity	Item Number & Type of Consultation	PIP ($ per SWPE)	Notes (PIP Enquiry Line 1800 222 032) http://www.humanservices.gov.au
My Health Record Continued				Please refer to the ePIP Incentive guidelines released by Medicare Australia https://www.humanservices.gov.au/health-professionals/services/medicare/practice-incentives-program
Quality Improvement	The PIP QI Incentive rewards practices for participating in continuous quality improvement activities in partnership with their local PHN		Maximum payment of $12,500 per quarter, based on $5.00 SWPE	To be eligible to receive PIP QI payment general practices must: • Be eligible for the PIP • **Register for the PIP QI Incentive (via PRODA) from 01/08/19** • Electronically submit the de-identified PIP Eligible Data Set to their local PHN quarterly via agreed Data Extraction Tool • Undertake continuous quality improvement activities in partnership with their local PHN. **Commences on 1 August 2019** For further information: https://www.health.gov.au/internet/main/publishing.nsf/Content/PIP-QI_Incentive_guidance
Teaching	Aims to encourage general practices to provide teaching sessions to undergraduate and graduate medical students preparing for entry into the Australian Medical profession.		$100.00 per session	Practices can access a maximum of $100.00 for each three hour teaching session provided to medical students. Each practice can claim a maximum of two sessions per GP, per day.

Item	Activity	Item Number & Type of Consultation	PIP ($ per SWPE)	Notes (PIP Enquiry Line 1800 222 032) http://www.humanservices.gov.au
Aged Care Access	**Tier 1:** GP completes the Qualifying Service Level (QSL) 1 – 60 MBS services in RACF claimed in a financial year.			MBS items that count towards QSLs include attendances in RACF, contributions to multidisciplinary care plans and Residential Medication Management Reviews. GPs need to provide the service using their PIP linked Medicare provider number. GPs do not need to apply to participate in the Incentive. Medicare will request bank details from GPs eligible to receive payments once they have reached the QSL.
	Tier 2: GP completes the Qualifying Service Level (QSL) 2 – 140 MBS services in RACF claimed in a financial year.			
Indigenous Health	Provision of better health care for Indigenous patients, including best practice management of chronic disease. Sign-on payment.		$1,000	One-off payment only. Practice must be registered for PIP – Practice: • Seeks consent to register their Aboriginal and/or Torres Strait Islander (ATSI) patients (regardless of age) who have, or are at risk of, chronic disease, with Medicare and the practice for chronic disease management in a calendar year • Establishes a mechanism to ensure their ATSI patients aged 15 years and over with chronic disease, are followed up e.g. recall/reminder system to ensure they return for ongoing care • Undertakes cultural awareness training within 12 months of joining incentive • Annotates PBS prescriptions for eligible ATSI patients for the PBS Co-payment

Item	Activity	Item Number & Type of Consultation	PIP ($ per SWPE)	Notes (PIP Enquiry Line 1800 222 032) http://www.humanservices.gov.au

Indigenous Health - continued	Annual patient registration payments.		$250.00 per registered ATSI patient, per calendar year	• Practice registers their eligible ATSI patients with Medicare for the PIP Indigenous Health Incentive or PBS Co-payment measure
				• Practice must actively plan and manage care of their ATSI patients with chronic disease for a calendar year
				• Payment made to practice for each ATSI patient who:
				  ○ Is aged 15 years or over & has chronic disease
				  ○ Has had (or has been offered) the 715 ATSI Health Assessment
				  ○ Has provided informed consent to be registered for the PIP Indigenous Health Incentive
				• The patient's registration period commences from the day they provide consent to participate in the incentive, and will end on 31 December that year
				• Practices are required to obtain consent to re-register patients each year

	Tier 1: Outcomes payment: Chronic Disease Management.		$100.00 per registered patient per calendar year	Payment made to practices that (in a calendar year): • Develop a 721 GP Management Plan or 723 Team Care Arrangement for the patient and undertake at least one 732 Review of the GPMP or TCA; or • Undertake two 732 Reviews of GPMP or TCA; or • Complete 731 contribute to, or review, a care plan for a patient in a RACF, on two occasions
	Tier 2: Outcomes payment: Total Patient Care.		$150.00 per registered patient per calendar year	• Payment made to practices that provide the majority (i.e. the highest number) of MBS services for the patient (with minimum of 5 MBS services) in a calendar year. This may include the MBS services provided for Tier 1.
Practice Nurse	Practice employs or retains the services of a Registered Nurse, Enrolled Nurse or Aboriginal Health Worker.		Capped at $125,000 per annum	• This incentive aims to broaden the range of services a nurse can provide. • Payments are based on practice SWPE and nurse hours. Refer to http://www.humanservices.gov.au/health-professionals/services/practice-nurse-incentive-programme/ for complete PNIP guidelines

Item	(PIP Enquiry Line 1800 222 032)
After Hours Incentive	The After Hours Incentive aims to support general practices to provide their patients with appropriate access to after hours care. **After hours periods:** For PIP the complete after hours period is: • Outside 8 am to 6 pm weekdays • Outside 8 am to 12 noon on Saturdays • All day on Sundays and public holidays The complete after hours period is broken into: • Sociable after hours period: 6 pm to 11 pm weeknights • Unsociable after hours period: 11 pm to 8 am weekdays, hours outside of 8 am and 12 noon Saturdays, and all day Sundays and public holidays **Core Eligibility Requirements** To be eligible for the PIP After Hours Incentive, practices must meet the following core eligibility requirements: 1 Be registered for the PIP and meet the requirements for the payment level claimed for the entire quarter before the payment month 2 Provide after hours care for patients in accordance with the RACGP Standards for general practices 3 Clearly communicate after hours arrangements to patients, including information available within the practice, on the practice website or through a telephone answering machine Guidelines and requirements for the new PIP After Hours Incentive are available at the Department of Human Services website. Please visit http://www.humanservices.gov.au/health-professionals/services/practice-incentives-programme/pip-after-hours-incentive or contact the PIP Enquiry Line on 1800 222 032.

Payment level and amount	Description
Level 1 Participation $1 per SWPE	Practices must have formal arrangements in place to ensure that practice patients have access to care in the complete after hours period (hours outside of 8 am to 6pm weeknights; hours outside of 8am to 12 pm Saturdays; and all day Sundays and public holidays).
Level 2 Sociable after hours cooperative coverage $4 per SWPE	Practices must participate in cooperative arrangement with other general practices that provide after hours care to practice patients in the sociable after hours period (6pm to 11 pm weeknights) and ensure formal arrangements are in place to cover the unsociable after hours period (11pm to 8am weekdays, hours outside of 8 am to 12 pm Saturdays and all day Sundays and public holidays).
Level 3 Sociable after hours practice coverage $5.50 per SWPE	Practices must provide after hours care to practice patients directly through the practice in the sociable after hours period (6pm to 11pm weeknights); and ensure formal arrangements are in place to cover the unsociable after hours period (11pm to 8am weekdays, hours outside of 8am and 12pm Saturdays and all day Sundays and public holidays).
Level 4 Complete after hours cooperative coverage $5.50 per SWPE	Practices must participate in a cooperative arrangement with other general practices that provides after hours care to practice patients for the complete after hours period (hours outside of 8 am to 6pm weeknights; hours outside of 8am to 12 pm Saturdays; and all day Sundays and public holidays).
Level 5 Complete after hours practice coverage $11 per SWPE	To be eligible for the Level 5 Complete After Hours Practice Coverage Payment, practices must provide after hours care to practice patients in the complete after hours period (hours outside of 8 am to 6 pm weeknights; hours outside of 8 am to 12 pm Saturdays; and all day Sundays and public holidays).

Acknowledgements

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