

**Australian Government
Department of Health & Ageing**

**GP MENTAL HEALTH CARE
MEDICARE ITEMS**

Questions & Answers

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1. GENERAL

1.1 What information is available about the GP Mental Health Care Medicare items?

Information on the GP Mental Health Care items is available:

- on the Department's web site at www.health.gov.au (and use the 'A-Z Index' link to go to 'Mental Health Care – GP Medicare Items');
- under paragraph A.43 of the Explanatory Notes of the Medicare Benefits Schedule book, 1 November 2008; and
- by calling Medicare Australia on 132 150 (for GPs) or 132 011 (for patients).

1.2 What are the GP Mental Health Care Medicare items?

On 1 November 2006, three GP Mental Health Care Medicare items were introduced on to the Medicare Benefits Schedule. They are:

- Item 2710 Preparation of a GP Mental Health Care Plan
- Item 2712 Review of a GP Mental Health Care Plan
- Item 2713 GP Mental Health Care Consultation

The items provide a structured framework for GPs to undertake early intervention, assessment and management of patients with mental disorders, as well as providing referral pathways to clinical psychologist and allied mental health service providers.

From 1 November 2006, where a patient has a mental disorder only, it is anticipated that they will be managed using the GP Mental Health Care items.

Although it is not mandatory, it is strongly recommended that GPs providing mental health care using these items have appropriate mental health training, such as training recognised through the General Practice Mental Health Standards Collaboration. GP organisations support the value of appropriate mental health training for GPs using these items.

GPs can contact the General Practice Mental Health Standards Collaboration (GPMHSC) to discuss education and training options available to support them as part of the *Better Access* initiative, including the use of Outcome Measurement Tools.

The contact details for the GPMHSC are: Tel 03 8699 0554, Fax 03 8699 0570 or email gpmhsc@racgp.org.au

GPs can also consider contacting either the Australian General Practice Network (AGPN) or the Mental Health Professionals' Association (MHPA) for details of current and future information/training sessions being conducted by these organisations.

These Medicare items have been developed in consultation with the GP profession.

1.3 What are the fees and minimum claiming periods?

Item	Description	Time	Nov 08 Fee	Nov 08 Rebate	Claiming Restrictions
2710	Preparation of a GP Mental Health Care Plan	Not timed	\$156.85	\$156.85*	Once in a twelve month period, with provision for exceptional circumstances.
2712	Review of a GP Mental Health Care Plan	Not timed	\$104.55	\$104.55*	Twice in a twelve month period, with provision for exceptional circumstances.
2713	GP Mental Health Care Consultation	At least 20 minutes	\$69.00	\$69.00	No restrictions

** Items 2710 and 2712 attract a 100% rebate of the MBS scheduled fee (except where the patient has been admitted to a hospital and the service is provided as an in-hospital service).*

1.4 Are the items eligible for 100% Medicare and bulk billing incentives?

The items attract a 100% rebate of the MBS scheduled fee (except where the patient has been admitted to a hospital and the service is provided as an in-hospital service).

Where the GP Mental Health Care Medicare items are bulk-billed for eligible patients (i.e. Commonwealth concession card holders or children under 16), the service attracts the relevant bulk-billing incentive payment.

1.5 Should these services be provided by the patient's 'usual doctor'?

It is the profession's expectation, consistent with the EPC and CDM items, that GP Mental Health Care items would generally be provided by the patient's usual doctor.

This is not a mandatory or regulatory provision for the EPC or CDM items but is set out as guidance in the relevant MBS explanatory notes.

The MBS explanatory notes for the EPC items define 'usual doctor' as the doctor (or practice) that has provided the majority of services to the patient over the previous 12 months, and/or that will provide the majority of services over the coming 12 months. This is not designed to be an enforceable provision and takes account of the patient's right to choose their own doctor.

1.6 Can a GP be assisted in using the GP Mental Health Care items?

All consultations conducted as part of the GP Mental Health Care items must be rendered by the GP. A specialist mental health nurse, other allied health practitioner or Aboriginal Health Worker with appropriate mental health qualifications and training may provide general assistance to GPs in provision of mental health care where the GP considers that they have skills appropriate to the assistance required.

While this indicates that there is some scope for a GP to be assisted by an appropriately qualified health professional it is not intended that this assistance replace the requirement for the service to be rendered by the GP.

It would not be expected that a health professional, such as a practice nurse, would undertake the more involved activities associated with the GP Mental Health Care items such as administering an outcome measurement tool, conducting a mental state examination, making a diagnosis/formulation or discussing these details with the patient to form the patient's GP Mental Health Care Plan.

1.7 Will the GP Mental Health Care items be reviewed?

Yes. It is anticipated that there will be a post-implementation review of the items after an initial period of operation (around 2 years after introduction), and a full evaluation after around 4 years.

1.8 What is considered a mental disorder for the purposes of these items?

The GP Mental Health Care items are for patients with a mental disorder who would benefit from a structured approach to the management of their care needs. Mental disorder is a term used to describe a range of clinically diagnosable disorders that significantly interfere with an individual's cognitive, emotional or social abilities.

This includes patients with the following mental disorders:

- Chronic psychotic disorders
- Acute psychotic disorders
- Schizophrenia
- Bipolar disorder
- Phobic disorders
- Generalised anxiety disorder
- Adjustment disorder
- Unexplained somatic complaints
- Depression
- Sexual disorders
- Conduct disorder
- Bereavement disorders
- Post Traumatic Stress Disorder
- Eating disorders
- Panic disorder
- Alcohol use disorders
- Drug use disorders
- Mixed anxiety and depression
- Dissociative (conversion) disorder
- Neurasthenia
- Sleep problems
- Hyperkinetic (attention deficit) disorder
- Enuresis (non-organic)
- Obsessive Compulsive Disorder
- Mental disorder, not otherwise specified

This list of mental disorders is informed by the World Health Organisation, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care: ICD-10 Chapter V Primary Care Version.

Dementia, delirium, tobacco use disorder and mental retardation are not regarded as mental disorders for the purposes of the GP Mental Health Care items.

2. PATIENT ELIGIBILITY

2.1 What patients are eligible for these items?

The GP Mental Health Care items are available to eligible patients in the community. GP Mental Health Care Plan and Review services can also be provided to private in-patients (including private in-patients who are residents of aged care facilities) being discharged from hospital, where the GP who provides the GP Mental Health Care item is providing in-patient care: in this case the item is claimed as an in-hospital service (at 75% MBS rebate).

GPs are able to contribute to care plans for patients (including public patients being discharged from hospital) using item 729, Contribution to a Multidisciplinary Care Plan, and to care plans for residents of aged care facilities using item 731.

2.2 How do I find out if a patient already has a GP Mental Health Care Plan?

Where it is unclear whether a patient has had a GP Mental Health Care Plan or a 3 Step Mental Health Process completed within the previous 12 months, Medicare Australia should be contacted (on ph.132 152 for GPs) to confirm whether an item 2710, 2574 to 2578, or 2704 to 2708 has previously been paid and if so, when.

2.3 What if a patient has already had a GP Mental Health Care Plan provided?

Where a patient has had either a GP Mental Health Care Plan or 3 Step Mental Health Process completed within the previous 12 months, a common sense approach, consistent with normal professional practice, should be taken in relation to the mental health Medicare services to be provided to the patient.

The GP can:

- firstly ask the patient if they are able to provide a copy of the GP Mental Health Care Plan previously prepared;
- if not, then, with the patient's permission, attempt to obtain a copy of the GP Mental Health Care Plan from the previous GP;
- if this is not possible, again with the patient's permission, consider contacting the allied mental health professional who has been providing referred services to the patient.

Where a GP is able to obtain a copy of the patient's previous GP Mental Health Care Plan, the GP should consider whether the existing plan is still appropriate for the patient. If necessary, the GP Mental Health Care Plan may be reviewed using MBS item 2712 (Review of a GP Mental Health Care Plan). Note: Item 2712 cannot be used within 4 weeks of the GP Mental Health Care Plan or 3 months of a previous item 2712, unless exceptional circumstances apply.

Where a GP is unable to obtain a copy of the patient's existing GP Mental Health Care Plan it would generally not be practical for the GP to use MBS item 2712 as this item is to be used to review the existing GP Mental Health Care Plan.

Within their clinical judgement, GPs have the ability to determine whether a new GP Mental Health Care Plan is needed earlier than the minimum 12 month interval, if it is considered that exceptional circumstances apply. These apply where there has been a significant change in the patient's clinical condition or care circumstances that requires a new GP Mental Health Care Plan. Factors that a GP might take into account in assessing whether the patient requires a new plan may include whether the patient has a clinical need for services which might otherwise not be able to be met.

Note that where a new GP Mental Health Care Plan is provided due to exceptional circumstances, any allied mental health services provided earlier in the calendar year under a previous GP Mental Health Care Plan will still be counted towards the patient's calendar year limit of 12 (18 in exceptional circumstances).

In keeping with the 'usual doctor' guidance, a GP should generally only provide GP Mental Health Care items where they reasonably expect that they will be the patient's 'usual GP' and have an ongoing role in the management of the patient and their mental disorder.

2.4 Are Commonwealth funded residents of an aged care facility eligible for a GP Mental Health Care Plan?

No. The GP Mental Health Care items are available for eligible patients living in the community. However, GPs are able to contribute to care plans for residents of aged care facilities using the EPC Chronic Disease Management Medicare item 731.

In this case the resident's GP can contribute to the care plan prepared by the facility and the resident is eligible for referral to allied health and dental care services, including for services by psychologists, mental health workers and occupational therapists.

If a resident of an aged care facility is a private in-patient being discharged from hospital the resident may be eligible for a 'discharge' GP Mental Health Care Plan, if clinically appropriate.

2.5 Are privately funded residents of aged care facilities eligible for a GP Mental Health Care Plan?

Yes. A privately funded resident means a person who is living independently in an aged care facility where the facility is not receiving a subsidy for their care from the Australian Government under the Aged Care Act.

However, the GP should not provide a GP Mental Health Care Plan or Review service to a resident where they have already contributed to a care plan prepared by the facility (item 731) for treatment of the same condition, i.e. where they have already provided a service to the resident as a resident of the aged care facility for treatment of the resident's mental disorder.

2.6 How does a GP establish if someone is a Commonwealth funded resident of an aged care facility?

The GP or practice staff should ask the patient and, if unsure, ask the aged care facility whether the patient is a privately funded resident. The advice of the patient and/or aged care facility should be accepted and a note made in the patient record indicating by whom and when the advice was provided.

2.7 Can a home visit item number and a GP Mental Health Care plan be billed by a GP at the same time?

This would not be expected to be a common or routine occurrence, as in general a separate consultation should not be undertaken in conjunction with a GP Mental Health Care Plan or Review item unless it is clinically indicated that a problem must be treated immediately. If both services must be provided at the same time, the MBS requirements for both services must be met.

3. PREPARATION OF GP MENTAL HEALTH CARE PLAN

3.1 What are the steps involved in preparing a GP Mental Health Care Plan?

Preparation of a GP Mental Health Care Plan involves both assessing the patient and preparing the GP Mental Health Care Plan document.

Assessment

An assessment of a patient must include:

- recording the patient's agreement for the GP Mental Health Care Plan service;
- taking relevant history (biological, psychological, social) including the presenting complaint;
- conducting a mental state examination;
- assessing associated risk and any co-morbidity;
- making a diagnosis and/or formulation; and
- administering an outcome measurement tool, except where it is considered clinically inappropriate.

Plan

Preparation of a GP Mental Health Care Plan must include:

- discussing the assessment with the patient, including the mental health formulation and/or diagnosis;
- identifying and discussing referral and treatment options with the patient, including appropriate support services;
- agreeing goals with the patient – what should be achieved by the treatment - and any actions the patient will take;
- provision of psycho-education;
- a plan for crisis intervention and/or for relapse prevention, if appropriate at this stage;
- making arrangements for required referrals, treatment, appropriate support services, review and follow-up; and

- documenting this (results of assessment, patient needs, goals and actions, referrals and required treatment/services, and review date) in the patient's GP Mental Health Care Plan.

The assessment can be part of the same consultation in which the GP Mental Health Care Plan is developed, or they can be undertaken in different visits. Where separate visits are undertaken for the purpose of assessing the patient and developing the GP Mental Health Care Plan, they are part of the GP Mental Health Care Plan service and are included in item 2710. That is, for separate visits that are undertaken to assess the patient and develop the plan, no MBS item would be claimed for the first visit and item 2710 would be claimed for the second visit (see Explanatory Notes A.43 of the MBS Book, 1 November 2008 edition).

Where the patient has a carer, the practitioner may find it useful to consider having the carer present for the assessment and preparation of the GP Mental Health Care Plan or components thereof (subject to patient agreement).

GPs should ensure that:

- the steps involved have been explained to the patient (and their carer, if appropriate and the patient agrees);
- a copy of the Plan is offered to the patient (or carer, if appropriate); and
- a copy of the Plan is added to the patient's records.

3.2 Is there a template I can follow for the GP Mental Health Care Plan?

It is not mandatory to use any particular form when preparing and claiming for a GP Mental Health Care Plan, but it is mandatory to document the GP Mental Health Care Plan in a way which addresses the Medicare requirements (see Explanatory Note A.43 of the MBS Book, 1 November 2008 edition).

A sample form is available on the Department's website at www.health.gov.au (and use the 'A-Z Index' link to go to 'Mental Health Care – GP Medicare Items') as an optional tool to assist GPs in the patient assessment and preparation of the GP Mental Health Care Plan.

3.3 Which Outcome Measurement Tool should I use?

The choice of outcome measurement tool to be used is at the clinical discretion of the practitioner. GPs using such tools should be familiar with their appropriate clinical use, and if not, should seek appropriate education and training.

Some examples of Outcome Measurement Tools include:

- Kessler Psychological Distress Scale (K10)
- Short Form Health Survey (SF12)
- Health of the Nation Outcome Scales (HoNOS)

3.4 Where can I find information on Outcome Measurement Tools?

GPs who are familiar with outcome measurement tools for mental health can visit www.gpcare.org to access information and links to 3 recommended tools - the Kessler Psychological Distress Scale (K10), Short Form Health Survey (SF12) and the Health of the Nation Outcome Scales (HoNOS).

GPs who are not familiar with outcome measurement tools for mental health are encouraged to consider participating in mental health education and training activities. GPs can contact the General Practice Mental Health Standards Collaboration (GPMHSC) to discuss education and training options available, including the use of Outcome Measurement Tools.

The contact details for the GPMHSC are: Tel 03 8699 0554, Fax 03 8699 0570 or email gpmhsc@racgp.org.au.

3.5 How often should I prepare a GP Mental Health Care Plan for a patient?

Many patients will not require a new GP Mental Health Care Plan after their initial plan has been prepared. A new plan should not be prepared unless clinically required, and generally not within 12 months of a previous plan.

A rebate for preparation of a GP Mental Health Care Plan will not be paid within 12 months of a previous claim for the patient for the same item or within 12 months of a claim for a 3 Step Mental Health Process (items 2574, 2575, 2577, 2578 and 2704, 2705, 2707, 2708) or within three months following a claim for a review (item 2712), other than in exceptional circumstances.

3.6 Must the patient be given a copy of the GP Mental Health Care Plan document?

Before completing any GP Mental Health Care Plan (item 2710) or Review (item 2712) service and claiming a benefit for that service, the GP must offer the patient a copy of the care plan or reviewed care plan and add the document to the patient's records. This should include, subject to the patient's agreement, offering a copy to their carer, where appropriate. The GP may, with the permission of the patient, provide a copy of the GP Mental Health Care Plan, or relevant parts of the plan, to other providers involved in the patient's care.

It can also be useful to have the patient sign the GP Mental Health Care Plan - this can help ensure that the patient understands and agrees with the plan, with benefits for patient compliance. It is not mandatory, however, for the patient to sign the GP Mental Health Care Plan.

4. GP MENTAL HEALTH CARE REVIEW

4.1 When should a Review of a GP Mental Health Care be done?

Patients with a GP Mental Health Care Plan should have at least one formal review (item 2712). As a general rule, a formal review should occur four weeks to six months after the completion of a GP Mental Health Care Plan. If a further review is required, this can occur three months after the first review. Most patients should not need more than two formal reviews in a 12 month period.

GPs are able to provide ongoing management through either the GP Mental Health Care Consultation item or standard consultation items as required.

The Review of a GP Mental Health Care Plan item can also be used for a patient where a psychiatrist has prepared a referred assessment and management plan (item 291), as if that patient had a GP Mental Health Care Plan.

A Review of a GP Mental Health Care Plan should not be done within three months of a previous claim for the same item (item 2712) or within four weeks following a claim for a GP Mental Health Care Plan item (item 2710) other than in exceptional circumstances.

It is also expected that item 2712 would generally not be claimed within four weeks of a claim for a referred psychiatrist assessment and management plan (item 291).

It is not necessary to complete a review using MBS item 2712 in order to refer a patient for further allied mental health services. However, a patient's need for further referred allied mental health services should be considered in the context of their GP Mental Health Care Plan and feedback from the allied mental health professional providing the referred services.

4.2 What are the steps involved in a Review of a GP Mental Health Care Plan?

A Review of a GP Mental Health Care Plan should be a systematic review of the patient's progress against their GP Mental Health Care Plan and must include:

- recording the patient's agreement for the service;
- reviewing the patient's progress against the goals outlined in the GP Mental Health Care Plan;
- modifying the Plan, if required;
- checking, reinforcing and expanding education;
- a plan for crisis intervention and/or for relapse prevention, if appropriate and if not previously provided;
- re-administration of the outcome measurement tool used in the assessment stage, except where considered clinically inappropriate; and
- a personal attendance by the GP with the patient.

GPs should ensure that:

- the steps involved have been explained to the patient (and their carer, if appropriate and the patient agrees);

- a copy of the reviewed Plan is offered to the patient (or carer, if appropriate); and
- a copy of the reviewed Plan is added to the patient's records.

See Explanatory Note A.43 of the MBS Book, 1 November 2008 edition.

4.3 Can I use item 2712 to review a GP Management Plan or Team Care Arrangements for a patient with a mental disorder?

Review of a GP Mental Health Care Plan (item 2712) is only available where a patient is being managed under either a GP Mental Health Care Plan (item 2710) or a referred psychiatrist assessment and management plan (item 291).

Patient's with a mental disorder who are being managed under either a GP Management Plan or Team Care Arrangements should have their care plan reviewed using the relevant CDM item, either item 725 (Review of a GP Management Plan) or item 727 (Coordination of Review of Team Care Arrangements).

4.4 Can I use item 2712 for a patient who has a referred psychiatrist assessment and management plan (item 291)?

Review of a GP Mental Health Care Plan (item 2712) can also be used where a GP is managing a patient under a referred psychiatrist assessment and management plan (item 291), as if that patient had a GP Mental Health Care Plan.

It is also expected that item 2712 would generally not be claimed within four weeks of a claim for a referred psychiatrist assessment and management plan (item 291).

4.5 For a patient with a referred psychiatrist assessment and management (item 291), should the GP re-administer the outcome measurement tool during the review?

Yes, if clinically appropriate in the circumstances.

Where a GP is using item 2712 to review a patient's referred psychiatrist assessment and management plan (item 291), the GP must ensure they meet the MBS requirements for this item. **If a GP is unable to meet these requirements they should consider using another MBS item to review the patient's referred psychiatrist assessment and management plan.**

The Explanatory Notes for the Review of a GP Mental Health Care Plan item provide that the outcome measurement tool used in the assessment stage should be re-administered during the review, except where considered clinically inappropriate.

For patients with a referred psychiatrist assessment and management plan (item 291) the same outcome measurement tool that was used during the assessment should be re-administered during the review if this is clinically appropriate in the circumstances.

Where a GP is unsure what outcome measurement tool was used during a patient's initial assessment under item 291, or is unsure whether it would be appropriate to re-administer the outcome measurement tool, it is recommended that the patient's GP contact the referring psychiatrist to discuss the matter.

GPs using outcome measurement tools should be familiar with their appropriate clinical use, and if not, should seek appropriate education and training.

5. GP MENTAL HEALTH CARE CONSULTATION

5.1 When can I use the GP Mental Health Care Consultation item (item 2713)?

The GP Mental Health Care Consultation item applies to surgery consultations which are of at least 20 minutes duration and where the primary treating problem is related to a mental disorder.

This item is for the ongoing management of patients with a mental disorder, including patients being managed under a GP Mental Health Care Plan. However, it can be used whether or not a patient has a mental health care plan.

This item should not be used for the patient assessment or preparation of a GP Mental Health Care Plan.

There are no restrictions on how often this item can be used.

5.2 What are the steps involved in a GP Mental Health Care Consultation?

A GP Mental Health Care Consultation must include:

- taking relevant history and identifying the patient's presenting problem(s) (if not previously documented);
- providing treatment, advice and/or referral for other services or treatment; and
- documenting the outcomes of the consultation in the patient's medical records and other relevant mental health plan (where applicable).

See Book Explanatory Note A.43 of the MBS Book, 1 November 2008 edition.

6. REFERRING PATIENTS

6.1 When can I refer a patient?

Once a GP Mental Health Care Plan (item 2710) or a referred psychiatrist assessment and management plan (item 291) has been completed and claimed on Medicare, patients are eligible to be referred by their GP for services by:

- clinical psychologists providing psychological therapies; or
- appropriately trained GPs or allied mental health professionals providing focussed psychological strategy (FPS) services.

While patients are eligible for referral for up to 12 individual and 12 group sessions per calendar year, it is expected that they will only be referred for services on an as required basis.

After the initial course of treatment (a maximum of six services but may be less depending on the referral) the GP should consider the patient's need for further treatment. This decision will be assisted by the report which an allied mental health professional is required to provide after each course of treatment. Once a GP Mental Health Care Plan is in place for a patient, the patient's GP can make referrals for allied mental health sessions. Referrals can be made using a GP Mental Health Care Plan Review item, a GP Mental Health Care Consultation item or a standard consultation item but it is not mandatory for the GP to see the patient specifically to make such referrals.

6.2 What items count towards a patient's calendar year entitlement for allied mental health services?

Eligible patients may be referred for up to 12 individual services (18 in exceptional circumstances) and 12 group services per calendar year.

The following services count towards a patient's calendar year entitlement:

For individual services:

- Psychological Therapy Services items (MBS items 80000, 80005, 80010 and 80015)
- Allied Focussed Psychological Strategies items (MBS items 80100, 80105, 80110, 80110, 80125, 80130, 80135, 80140, 80150, 80155, 80160 and 80165)
- GP Focussed Psychological Strategies items (MBS items 2721, 2723, 2725, and 2727); and
- Access to Allied Psychological Services (ATAPS) Focussed Psychological Strategies services available through Divisions of General Practice (GPs should check availability with their local Division of General Practice).

In addition, a GP may provide a new referral to enable a patient to access a further six individual sessions in the calendar year in exceptional circumstances. Exceptional circumstances apply where there has been a significant change in the patient's clinical condition or care circumstances that requires further therapy.

In these cases, both the patient's GP Mental Health Care Plan and referral should be annotated to briefly indicate the reason why the service involved was required (also see Explanatory Note A.43 of the MBS Book Explanatory Notes, 1 November 2008 edition).

For group services:

- Psychological Therapy Services item 80020; and
- Allied Focussed Psychological Strategies items 80120, 80145 and 80170.

Exceptional circumstances do not apply to group services.

In addition to the above services, patients may be referred for other medical treatment and services under normal GP referral arrangements at any time.

6.3 What information should be included in the referral?

When referring patients GPs should provide similar information as per normal GP referral arrangements, and specifically consider including both a statement identifying that a GP Mental Health Care Plan has been completed for the patient (including, where appropriate and with the patient's agreement, attaching a copy of the GP Mental Health Care Plan) and clearly identifying the specific number of sessions the patient is being referred for.

Where a referral is provided due to exceptional circumstances, the referral should be annotated to briefly indicate the reason why the referral is required.

6.4 Does the patient's GP Mental Health Care Plan (item 2710) need to be processed by Medicare before they can claim their allied health visit?

It is important to note that the claim for a patient's GP Mental Health Care Plan needs to have been processed by Medicare Australia before the Medicare system recognises that the patient is eligible to access rebates for clinical psychology or focussed psychological strategy services. Ideally this would mean that a claim for a GP Mental Health Care Plan has been processed prior to the patient attempting to claim a rebate for a referred clinical psychology or focussed psychological strategy service.

If a claim for a GP Mental Health Care Plan has not been processed by Medicare Australia first then the Medicare system will not recognise the patient as being eligible for a rebate in relation to the referred services. In this case, the patient (or patient's GP, if the item is being direct billed to Medicare Australia) should take steps to have the GP Mental Health Care Plan item claimed prior to submitting (or resubmitting) the claim for the referred service/s. Note that the date of the referred service/s must be on or after the date the GP Mental Health Care Plan was provided.

6.5 Does a patient need a GP Mental Health Care Plan or item 291 to be referred to ATAPS under the Better Access initiative?

GPs must be managing a patient under a GP Mental Health Care Plan or a referred psychiatrist assessment and management plan (item 291) to refer patients for services through ATAPS under the Better Access initiative.

Where a 3 Step Mental Health Process Plan was completed for a patient prior to 1 May 2007, GPs can continue to manage the patient under that 3 Step Mental Health Process Plan while it is still appropriate to the patient's needs. Patients with a 3 Step Mental Health Process Plan can still access ATAPS, where available, through their local Division of General Practice and GP FPS services from appropriately trained GPs. GPs should check with their local Division of General Practice to clarify the requirements for accessing ATAPS in their area.

A new mental health care plan should not be prepared until clinically required.

6.6 What happens if a patient is referred for allied mental health services by a psychiatrist or paediatrician and the GP is unaware and prepares a GP Mental Health Care Plan and also refers the patient for allied mental health services?

A patient is eligible to access Medicare rebates for up to 12 individual and/or 12 group services from a clinical psychologist or other allied mental health professional in a calendar year, regardless of whether they have been referred from one provider or many (i.e. a psychiatrist, paediatrician or another GP). Referral from another provider (eg psychiatrist, paediatrician or another GP) does not generate a new entitlement for additional clinical psychology or other allied mental health services.

7. 3 STEP MENTAL HEALTH PROCESS

7.1 What happened to the 3 Step Mental Health Process items?

The 3 Step Mental Health Process items ran in parallel with the GP Mental Health Care items from 1 November 2006 to 30 April 2007. The 3 Step Mental Health Process incentive payment and associated MBS trigger items were withdrawn from 30 April 2007.

From 1 November 2006, it is anticipated that patients with a mental disorder will be managed under the new GP Mental Health Care items (items 2710, 2712 and 2713). However, it is not necessary to prepare a GP Mental Health Care Plan until required by the patient's circumstances. The GP Mental Health Care Plan and Review items cannot be used in addition to the 3 Step Mental Health Process items for treatment of the same patient.

7.2 What about patients already managed under a 3 Step Mental Health Process?

Where a GP has completed a 3 Step Mental Health Process for a patient prior to 1 May 2007, they may continue to provide ongoing management for that patient using the existing 3 Step Mental Health Process Plan while it is still appropriate to the patient's needs. GPs can continue to refer these patients, as required, for Focused Psychological Strategy services under Access to Allied Psychological Services (ATAPS), available through Divisions of General Practice (up to 12 per calendar year).

A new mental health care plan should not be prepared for a patient unless clinically indicated.

Patients being managed under a 3 Step Mental Health Process are also able to be referred to appropriately trained (Level 2 trained) GPs for GP Focused Psychological Strategy services.

Patients with mental health plans completed and reviewed prior to 1 May 2007 using the 3 Step Mental Health Process can receive ongoing management, as required, from their GP through the new GP Mental Health Care Consultation item or standard consultation items.

7.3 What should I do if I've started (but not completed) a 3 Step Mental Health Process for a patient?

The 3 Step Mental Health Process trigger items ran in parallel with the GP Mental Health Care items from 1 November 2006 to 30 April 2007 to allow GPs to complete and claim for work started but not finalised by 1 November 2006.

The 3 Step Mental Health Process incentive payment and associated MBS trigger items were withdrawn on 30 April 2007.

From 1 May 2007, claims for completion of a 3 Step Mental Health Process can only be processed where the 3 Step Mental Health Process was completed by 30 April 2007.

7.4 If I'm managing a patient using a 3 Step Mental Health Process can I refer them to the same services available for GP Mental Health Care Plan patients?

No. To be eligible for referral to the Medicare rebateable services associated with the GP Mental Health Care Plan, a patient must be managed under either a GP Mental Health Care Plan (item 2710) or a referred psychiatrist assessment and management plan (item 291).

Patients being managed under a 3 Step Mental Health Process are also able to be referred to appropriately trained (Level 2 trained) GPs for GP Focussed Psychological Strategy services.

Patients may be referred for other medical treatment and services under normal GP referral arrangements at any time.

8. CHRONIC DISEASE MANAGEMENT (CDM) ITEMS

8.1 The CDM items are still available. Should I still use them?

The Chronic Disease Management (CDM) Medicare items continue to be available for patients with chronic medical conditions, including patients needing multidisciplinary care. The CDM items have not changed.

From 1 November 2006, patients with a mental disorder only, who require a care plan to be prepared, should be managed under the new GP Mental Health Care items (items 2710, 2712 and 2713). It would not be appropriate for a patient with only a mental health disorder to have both a GP Mental Health Care Plan and a GP Management Plan.

Where a patient has a mental disorder as well as significant co-morbidities and complex needs requiring team-based care, the GP is able to use both the CDM items (for team-based care) and the GP Mental Health Care items.

The GP should consider whether it is necessary to develop two separate care plans. As a general principle the creation of multiple plans should be avoided, unless the

patient clearly requires an additional plan for the management of a separate medical condition.

8.2 What if I've prepared a GP Management Plan (item 721) for a patient with a mental disorder?

For patients with a mental disorder who have a GP Management Plan (item 721), GPs can continue to manage the patient using the CDM items and standard consultation items.

GPs will now also have the option of using the GP Mental Health Care Consultation item (item 2713) for the ongoing management of the patient.

8.3 What if I've prepared a GP Management Plan (item 721) for a patient with a separate chronic medical condition?

Where a patient has a separate chronic medical condition, it may be appropriate to manage the patient's medical condition through a GP Management Plan, and to manage the patient's mental disorder through a GP Mental Health Care Plan (item 2710). In this case, both items can be used.

The GP should consider whether it is necessary to develop two separate care plans. As a general principle the creation of multiple plans should be avoided, unless the patient clearly requires an additional plan for the management of a separate medical condition.

8.4 If I have a patient with a GP Mental Health Care Plan, and they have complex needs, can I access item 723 (Team Care Arrangements)?

Where a patient has a mental disorder as well as significant co-morbidities and complex needs requiring team-based care, the GP is able to use both the CDM items (for team-based care) and the GP Mental Health Care items.

The GP should consider whether it is necessary to develop two separate care plans. As a general principle the creation of multiple plans should be avoided, unless the patient clearly requires an additional plan for the management of a separate medical condition.

9. TRAINING

9.1 Do I need to have completed training to access the GP Mental Health Care items?

All GPs are able to use the GP Mental Health Care items. Although it is not mandatory, it is strongly recommended that GPs providing mental health care using the GP Mental Health Care items have completed appropriate mental health training (in addition to normal medical training), such as training recognised through the General Practice Mental Health Standards Collaboration.

GP organisations support the value of appropriate training for GPs using these items.

Level 2 training is still required for GPs to use the GP Focussed Psychological Strategy items.

GPs can contact the General Practice Mental Health Standards Collaboration (GPMHSC) to discuss education and training options available to support them as part of the *Better Access* initiative, including the use of Outcome Measurement Tools. The contact details for the GPMHSC are: Tel 03 8699 0554, Fax 03 8699 0570 or email gpmhsc@racgp.org.au.

GPs can also consider contacting either the Australian General Practice Network (AGPN) or the Mental Health Professionals' Association (MHPA) for details of current and future information/training sessions being conducted by these organisations.

10. PSYCHIATRIC ASSESSMENT AND MANAGEMENT PLAN (ITEM 291)

10.1 What if I'm managing a patient under a psychiatric assessment and management plan (item 291)?

Where a GP is managing a patient with a mental disorder under a referred psychiatric assessment and management plan, the GP can continue to manage the patient using either the GP Mental Health Care Consultation item or standard consultation items.

For patients with a referred psychiatric assessment and management plan, GPs are also able to use, as necessary, the GP Mental Health Care Review item (item 2712) as if the patient had a GP Mental Health Care Plan.

If a GP determines that the patient requires a GP Mental Health Care Plan in addition to the management plan prepared by the referring psychiatrist, the GP is able to prepare a GP Mental Health Care Plan using item 2710. Note that this is expected to be an infrequent occurrence and that in this case the GP is still required to undertake an assessment of the patient as well as preparing the plan.

As a general principle the creation of multiple plans should be avoided, unless the patient clearly requires an additional plan. In these cases, the GP should be satisfied that the GP's peers would regard the provision of an additional plan as appropriate for that patient, given the patient's needs and circumstances.

11. CLAIMING RESTRICTIONS

11.1 What are the fees and minimum claiming periods?

Item	Description	Time	Fee	Rebate	Claiming Restrictions
2710	Preparation of a GP Mental Health Care Plan	Not timed	\$156.85	\$156.85*	Once in a twelve month period, with provision for exceptional circumstances.
2712	Review of a GP Mental Health Care Plan	Not timed	\$104.55	\$104.55*	Twice in a twelve month period, with provision for exceptional circumstances.
2713	GP Mental Health Care Consultation	At least 20 minutes	\$69.00	\$69.00	No restrictions

** Items 2710 and 2712 attract a 100% rebate of the MBS scheduled fee (except where the patient has been admitted to a hospital and the service is provided as an in-hospital service).*

11.2 What are exceptional circumstances?

There are minimum time intervals for payment of rebates for the GP Mental Health Care Plan and Review items, with provision for claims to be made earlier than these minimum intervals in exceptional circumstances. 'Exceptional circumstances' apply where there has been a significant change in the patient's clinical condition or care circumstances that requires a new GP Mental Health Care Plan or a new Review, rather than, for example, amending the existing GP Mental Health Care Plan.

Where a service is provided in exceptional circumstances, the patient's invoice or Medicare voucher (assignment of benefit form) should be annotated to briefly indicate the reason why the service involved was required earlier than the minimum time interval for the relevant item (eg annotated as clinically indicated, discharge, exceptional circumstances, significant change etc). (also see paragraph A.43 of the MBS Book Explanatory Notes, 1 November 2008 edition).

In addition, a GP may provide a new referral to enable a patient to access a further six individual sessions in the calendar year in exceptional circumstances. Exceptional circumstances apply where there has been a significant change in the patient's clinical condition or care circumstances that requires further therapy. A referral provided in these circumstances should be annotated to briefly indicate the reason why the referral is required.

11.3 Can a separate consultation be done in conjunction with a GP Mental Health Care service?

The GP Mental Health Care Plan, Review and Consultation items cover the consultations at which the relevant items are undertaken, noting that:

- if a GP Mental Health Care item is undertaken or initiated during the course of a consultation for another purpose, the GP Mental Health Care Plan, Review or Consultation item and the relevant item for the other consultation may both be claimed;

- if a GP Mental Health Care Plan is developed over more than one consultation, and those consultations are solely for the purposes of developing the plan, only the GP Mental Health Care Plan item should be claimed at the completion of the service; and
- if a consultation is for the purpose of a GP Mental Health Care Plan, Review or Consultation item, a separate and additional consultation should not be undertaken in conjunction with the mental health consultation, unless it is clinically indicated that a separate problem must be treated immediately.

Where separate consultations are undertaken in conjunction with mental health consultations, the patient's invoice or Medicare voucher (assignment of benefit form) for the separate consultation should be annotated (eg separate consultation clinically required/indicated).