Australian Government
Department of Health, Disability and Ageing

ASKMBS ADVISORY

Updated July 2025

General practice services #1

WELCOME TO THE FIRST ASKMBS ADVISORY

The AskMBS advice service is located in the Australian Government Department of Health, Disability and Ageing (the department), following the transfer of the function from Services Australia, then known as the Department of Human Services, on 1 March 2019. AskMBS is an email service (askmbs@health.gov.au) providing advice to health providers and other users of the Medicare Benefits Schedule (MBS) on the interpretation and application of MBS items, explanatory notes and associated legislation, to assist them in billing Medicare correctly.

In this and future AskMBS advisories we will provide you with targeted advice on 'hot' topics, i.e. topics on which we get many enquiries. The information in this advisory is accurate as of 30 June 2025.

We expect that each advisory will focus on a particular provider group or area of practice and general practice has been selected as the focus for the first. The hot issues addressed in this advisory, in a question-and-answer format, are:

1. Bulk billing—Additional charges and split billing
2. GP mental health treatment plans
3. GP health assessments
4. Residential aged care facility flag-fall items

The complete MBS and a range of related information resources are available at: MBS Online. Item descriptors and explanatory notes can be viewed by searching MBS Online for the item or note number.

Note that some of the information in this advisory is necessarily broad in nature, reflecting AskMBS responses to a range of enquiries. Please contact AskMBS for clarification of any specific issues.

1 BULK BILLING—ADDITIONAL CHARGES WITH BULK-BILLED SERVICES

RELEVANT ITEMS: ALL ITEMS

CAN I RAISE ADDITIONAL CHARGES, FOR CONSUMABLES FOR EXAMPLE, WITH BULK-BILLED SERVICES?

With one exception, discussed below, no.

When a provider bulk bills an MBS item they are accepting the patient assignment of their Medicare benefit as full payment for the service. Additional charges cannot be raised in relation to a Medicare service being bulk billed, whether for consumables or some other reason.

The one exception to this rule is where the patient is provided with a vaccine or vaccines from the practitioner's own supply, held on the practitioner's premises. This exemption only applies to GPs and other non-specialist practitioners in association with a professional attendance and only relates to vaccines that are not available to the patient free of charge through government funding arrangements or through the Pharmaceutical Benefits Scheme. The additional charge must only be to cover the supply of the vaccine.

Where a practitioner chooses not to bulk bill a service, a fee may be privately charged for the service which is less than, equal to or greater than the Medicare benefit. Billing in this manner permits a provider to set a charge for the service which includes an amount to compensate for the use of consumables or to cover other costs, provided that this additional fee component is only in relation to the service being claimed.

AM I ABLE TO BULK BILL FOR SOME SERVICES AND PRIVATELY BILL FOR OTHERS?

This is permissible but carries a caveat.

Where a number of services are claimed under multiple MBS items on the one occasion (with the exception of diagnostic imaging and surgical operation items which will be discussed below), a GP can choose to bulk bill some services and privately bill others, charging an amount for the latter set at the provider's discretion. This amount may be higher than the MBS fee.

This is called split billing and is permissible unless the fee for one item being claimed would be reduced or amended as a result of it being claimed with another item, as happens with diagnostic imaging and procedural (operations) items. For example, where the Multiple Operation Rule or the Multiple Services Rule applies to two services, billing cannot be split to bulk bill one item and privately bill the other. Where the Multiple Operation Rule or the Multiple Services Rule applies, the patient receives the maximum benefit payable when the billing is not split.

Under this rule, and for the purposes of Medicare claiming, a provider can privately bill a patient for a biopsy on a suspicious skin lesion (item **30071**) inclusive of costs for consumables, as well as bulk billing a timed attendance item (such as **23**) for a second issue, as the Multiple Operation Rule is not impacted by the claiming of an attendance item with a single procedural item.

However, it would not be permissible to bulk bill a melanoma excision item (such as item **31375**) while privately billing a biopsy item (item **30071**). In this scenario, as both items are MBS Group T8 – Surgical Operations items to which the Multiple Operation Rule applies, both services must either be bulk billed or privately billed.

2 GP MENTAL HEALTH TREATMENT PLANS (GP MHTP)

RELEVANT ITEMS: 2700 TO 2717

WHAT STEPS ARE INVOLVED IN THE DEVELOPMENT OF A GP MENTAL HEALTH TREATMENT PLAN?

When claiming any of the GP mental health treatment items, it is important to note that compliance with the item requirements involves a number of mandatory steps which are detailed in MBS explanatory note **AN.0.56**. It is therefore vital that providers read this explanatory note in conjunction with the item descriptor.

A review of the GP mental health treatment plan (MHTP) is considered to be an essential part of the optimal management of the patient and should be done at some point in the treatment cycle. Reviews should consider feedback from the allied health provider and a reappraisal of the mental health status of the patient.

Professional Services Review committees have found that failure to perform a clinical review and consider feedback from allied health providers when reviewing an MHTP may constitute a clinical input concern.

All GPs are able to access the GP mental health treatment items. However, only GPs who have completed mental health skills training as accredited by the General Practice Mental Health Standards Collaboration can access higher schedule fee items **2715** or **2717** to develop anMHTP. Item **2715** provides for an MHTP lasting at least 20 minutes but less than 40 minutes and item **2717** provides for an MHTP lasting at least 40 minutes.

GPs who have not completed the training must develop MHTPs under MBS item **2700** or **2701**. Item **2700** provides for an MHTP lasting at least 20 minutes but less than 40 minutes and item **2701** provides for an MHTP lasting at least 40 minutes.

WHAT REFERRAL AND TREATMENT OPTIONS ARE AVAILABLE AFTER A PLAN HAS BEEN COMPLETED?

Under the Better Access initiative MBS items provide Medicare benefits for the following mental health services:

- GP/medical practitioner focussed psychological strategies services (GP items **2721** to **2727** or medical practitioner items **283** to **287**);
- psychological therapy provided by eligible clinical psychologists; and
- focussed psychological strategies services provided by registered psychologists, occupational therapists and social workers.

Patients with a mental health treatment plan in place are eligible to be referred for up to 10 Medicare-eligible allied mental health services per calendar year for psychological therapy or focussed psychological strategy services (up to a maximum of 6 services in any one referral). In addition, patients are also eligible to claim up to 10 separate services within a calendar year for group therapy services involving 6-10 patients provided by psychologists, social workers and occupational therapists. These group services are separate from the individual services and do not count towards the maximum 10 individual services per calendar year.

Items are also available to support a model of best practice evidence-based care for patients with anorexia nervosa and other eligible patients with eating disorders. Further information about these items can be found at MBS Online: Eating Disorders Factsheet and in explanatory notes **AN.36.1 – AN.36.5.**

WHAT INFORMATION SHOULD BE INCLUDED ON THE REFERRAL?

In preparing a GP mental health treatment plan (MHTP), the GP must specify the number of sessions required for the patient up to a maximum of 6 on any one referral. The corresponding allied health items require the allied mental health professionals to provide a written report to the referring medical practitioner.

There is no standard form for referrals. Eligible medical practitioners can refer patients for allied mental health services with a signed and dated referral letter. The referral should include:

- the patient's name, date of birth and address

- the patient's symptoms or diagnosis
- a list of any current medications
- the number of sessions the patient is being referred for (the 'course of treatment')
- a statement about whether the patient has an MHTP or a psychiatrist assessment and management plan
- a statement about whether the referral can be used for group therapy or individual therapy

Medical practitioners can refer up to 6 services for a course of treatment. The number of services stated in the patient's referral is a 'course of treatment'. A patient can have 2 or more courses of treatment within their calendar year limit of 10 services. Patients need a new referral for each course of treatment.

There is no requirement for the naming of an allied health professional in a referral, and where one is named, the patient has the choice to see a different provider. However, it is best clinical practice if a provider is named, and the patient receives treatment from that provider. It is expected that when preparing an MHTP that the management and referrals be discussed with the patient to develop the best plan. It is also understood that patients may not know at the time of developing a plan who they wish to see and thus the flexibility remains. It would be expected that this information be updated at the review of the MHTP.

HOW DO I ARRANGE FOR MENTAL HEALTH SERVICES FOR PATIENTS IN A RESIDENTIAL AGED CARE FACILITY (RACF)?

While Commonwealth-funded residents are not entitled to receive Medicare benefits for a GP mental health treatment plan (MHTP) unless they are a private in-patient being discharged from hospital, there are other pathways available for RACF residents to access referrals to psychologists and allied mental health providers.

Residents of RACFs are able access referrals to psychologists and allied mental health providers where a referral has been made by a psychiatrist from an eligible psychiatric service. GPs can therefore consider whether a referral to a psychiatrist is clinically appropriate for the needs of their patient.

In addition, GPs are able to contribute to care plans for residents of aged care facilities using the chronic disease management item **731**. In this case the resident's GP can contribute to the care plan prepared by the facility and the resident may then be eligible for referral to allied health services, including services by psychologists, mental health workers and occupational therapists.

Privately-funded RACF residents are entitled to receive Medicare benefits for an MHTP and the associated allied health services, as is clinically necessary and appropriate. A privately-funded resident means a person who is living independently in a RACF where the facility is not receiving a subsidy for their care from the Australian Government under the *Aged Care Act 1997*. RACFs will be able to confirm whether or not a resident is privately funded.

3 HEALTH ASSESSMENTS

RELEVANT ITEMS: 701, 703, 705, 707, 715, 699

HOW DO THE DIFFERENT HEALTH ASSESSMENT ITEMS WORK TOGETHER?

There are four different time-based items (**701**, **703**, **705** and **707**) able to be applied to seven different types of health assessments, each with their own eligibility and frequency restrictions. In addition, these items can interact with item **715**–Health assessment for Aboriginal and Torres Strait Islander People and the heart health assessment (item **699**).

A health assessment should be undertaken by the patient's 'usual doctor'. For the purpose of the health assessment, 'usual doctor' means the GP, or a GP working in the medical practice which has provided the majority of primary health care to the patient over the previous twelve months and/or will be providing the majority of care to the patient over the next twelve months (see explanations above). The four time-based health assessment items include brief, standard, long and prolonged attendances, defined as follows:

Brief health assessment (Item 701)

A brief health assessment is used to undertake simple health assessments. The health assessment should take no more than 30 minutes to complete.

Standard health assessment (Item 703)

A standard health assessment is used for straightforward assessments where the patient does not present with complex health issues but may require more attention than can be provided in a brief assessment. The assessment lasts more than 30 minutes but takes less than 45 minutes.

Long health assessment (Item 705)

A long health assessment is used for an extensive assessment, where the patient has a range of health issues that require more in-depth consideration, and longer-term strategies for managing the patient's health may be necessary. The assessment lasts at least 45 minutes but less than 60 minutes.

Prolonged health assessment (Item 707)

A prolonged health assessment is used for a complex assessment of a patient with significant, long-term health needs that need to be managed through a comprehensive preventive health care plan. The assessment takes 60 minutes or more to complete.

These items may be used to undertake a health assessment for the following target groups:

Target group	Frequency of service
A type 2 diabetes risk evaluation for people aged 40-49 years (inclusive) with a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool	Once every three years to an eligible patient
A health assessment for people aged 45-49 years (inclusive) who are at risk of developing chronic disease	Once only to an eligible patient

Target group	Frequency of service
A health assessment for people aged 75 years and older	Provided annually to an eligible patient
A comprehensive medical assessment for permanent residents of residential aged care facilities	Provided annually to an eligible patient
A health assessment for people with an intellectual disability	Provided annually to an eligible patient
A health assessment for refugees and other humanitarian entrants	Once only to an eligible patient
A health assessment for former serving members of the Australian Defence Force	Once only to an eligible patient

Detailed guidance on health assessments is available in explanatory notes **AN.0.36 – AN.0.46**.

CAN I INCLUDE NURSE TIME WHEN SELECTING THE APPROPRIATE TIME-BASED HEALTH ASSESSMENT ITEM?

GPs may select one of the MBS health assessment items to provide a health assessment service to a member of any of the target groups. The health assessment item selected will depend on the clinical requirements and the time taken to complete the service. This is determined by the complexity of the patient's presentation and the specific requirements that have been established for each target group eligible for health assessments.

Providers should not use the delegation of tasks to practice nurses to extend the time that could reasonably be claimed given the patient's presentation and the type of assessment undertaken.

Professional Services Review committees have found that health assessments that involve nursing staff collecting information, but do not include a practitioner performing an appropriate patient examination, generating required investigation and referrals for identified abnormalities, and a preventative health plan for potential health risks, may be a clinical input and item descriptor concern.

Practice nurses and Aboriginal and Torres Strait Islander health practitioners may assist medical practitioners in performing a health assessment, in accordance with accepted medical practice and under the supervision of the medical practitioner. This may include activities associated with information collection; and providing patients with information about recommended interventions at the direction of the medical practitioner. Time spent by practice nurses or Aboriginal and Torres Strait Islander health practitioners in assisting medical practitioners in performing a health assessment goes only to the health assessment item and cannot be itemised separately.

> All other components of the health assessment must include a personal attendance by a doctor. In addition, medical practitioners should be satisfied that the assisting health professional has the necessary skills, expertise and training to collect the information required for the health assessment.
>
> The medical practitioner is expected to take a primary role in the following activities when providing a health assessment:

- reviewing and analysing the information collected;
- making an overall assessment of the patient;

- undertaking and arranging investigations and referrals for identified abnormalities (dot point (c) in the item descriptor);
- generating a preventative health plan (dot point d in the item descriptor); and
- providing advice to the patient.

CAN A PATIENT HAVE MORE THAN ONE HEALTH ASSESSMENT IF THEY QUALIFY FOR MORE THAN ONE TYPE?

Where a patient qualifies for more than one type of health assessment, providers should note that such an assessment should only be performed if it is clinically relevant. In these cases, the GP should satisfy themselves that their peers would regard the provision of an additional health assessment service as clinically relevant and appropriate for that patient, given the patient's needs and circumstances. Similarly, the time-based item claimed by the provider should be appropriate for the service provided and the presentation of the patient.

Case study

A 46-year-old patient with a high risk of developing type 2 diabetes and at risk of developing cardiovascular disease attends your practice. They have not previously received a health assessment. Depending upon their clinical need, they could qualify for:

- A heart health assessment (item **699**) – not available if a patient has received a health assessment within the past 12 months
- A health assessment for people aged 45-49 years (inclusive) who are at risk of developing chronic disease – Once only to an eligible patient
- A type 2 diabetes risk evaluation for people aged 40-49 years (inclusive) with a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool – Once every three years to an eligible patient

If the GP determines that a heart health assessment is clinically necessary, this would need to be conducted before any other assessment as item **699** is unable to be claimed within 12 months of another health assessment. Additionally, if the GP decides that the type 2 diabetes risk evaluation is clinically necessary it may be appropriate to provide this assessment within a short time-frame.

As it will be three years until the patient will qualify for another diabetes health assessment, the GP may wish to consider scheduling the once-only health assessment for people aged 45-49 years in one of the years following, when the patient will not qualify for the type 2 diabetes risk assessment.

GPs should consider the content of each type of assessment and ensure that they are only providing services which are clinically relevant and which do not duplicate other services. In this example, where a heart health assessment has been recently undertaken, it would not be expected that non-mandatory elements of this assessment would be duplicated in the type 2 diabetes assessment if these were provided within a short timeframe. The GP should therefore ensure that they have selected the appropriate time-based item to provide the subsequent assessment, taking into account that the subsequent assessment will include fewer elements than would usually be the case.

CAN I CLAIM OTHER ITEMS WITH A HEALTH ASSESSMENT?

Doctors should not conduct a separate consultation for another health-related issue in conjunction with a health assessment unless it is clinically necessary (i.e. the patient has a problem that needs to be managed separately from the assessment).

In order to provide more than one service to a patient on the same day, the time requirements of each item must be separately met. That is, time spent with a patient cannot be counted more than once. Total time spent with a patient must at least equal the sum of each item's minimum time requirements.

Providers should not bill a health assessment item and additionally bill an individual service that is included as part of the assessment. For example, if the patient receives a health assessment where the descriptor references performing audiometry, a separate audiometry service cannot be claimed.

4 RESIDENTIAL AGED CARE FACILITY (RACF) FLAG-FALL ITEMS

RELEVANT ITEMS: 90001, 90002

WHAT ARE THE RACF FLAG FALL ITEMS FOR?

Flag fall items **90001** and **90002** provide a call-out fee for RACF visits by GPs and medical practitioners, intended as a one-off payment to help reimburse travel expenses. Only one call-out fee can be claimed when attending multiple patients in the same RACF on the same occasion. However, if a doctor has to return to a RACF on the same day and the attendance is not a continuation of an earlier episode of treatment, another call-out fee would apply. In such circumstances, doctors should retain evidence to support their claims, and should note that rest breaks would not warrant billing another call-out item. Similarly, where two or more RACFs are co-located or are adjacent to each other, a practitioner is not eligible for extra compensation for visiting the second facility.

The call-out fee is payable once per visit to any RACF regardless of whether the practitioner sees Department of Veterans' Affairs (DVA) or non-DVA patients or a combination of both.

HOW DO I BILL THE RACF FLAG-FALL ITEMS?

The flag-fall items cannot be billed with afterhours or telehealth services, nor can they be billed with urgent after-hours items. In addition, bulk billing incentive items and rural incentives apply only to attendance items, not to the flag fall items **90001** and **90002**, and may be claimed only once per patient.

The RACF items are only for Medicare-eligible GP and other medical practitioners providing primary care services in RACFs. Doctors employed by RACFs cannot claim the items, nor can specialists, consultant physicians, nurses and other allied health practitioners.

Items **90001** and **90002** provide a call-out fee for the initial attendance by a GP or other medical practitioner at one RACF, on one occasion, applicable only to the first patient seen on the RACF visit. The items must be billed in association with an attendance item and both services (call-out and attendance) must be billed in the same way (i.e. either both bulk billed or both patient billed).