Australian Government
Department of Health and Aged Care

ASKMBS ADVISORY

Updated October 2022

General practice services #1

WELCOME TO THE FIRST ASKMBS ADVISORY

The AskMBS advice service is located in the Australian Government Department of Health and Aged Care (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. This advisory covers the period from 1 March 2019 to December 31 2019. We will publish future advisories on a quarterly basis as well as ad hoc, should we identify a need.

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. Chronic disease management—GP Management Plans
3. GP Mental Health Treatment Plans
4. GP Health Assessments
5. Residential Aged Care Facility flag fall items

At the end of the advisory we also provide metrics on our performance against key performance indicators. The complete MBS and a range of related information resources are available at: MBS Online.

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 CHRONIC DISEASE MANAGEMENT—GP MANAGEMENT PLANS

RELEVANT ITEMS: 721, 723, 729, 731, 732, 10997

WHAT DO I NEED TO CONSIDER WHEN A PATIENT WITH A CHRONIC CONDITION/S TRANSFERS INTO MY CARE, AND SHOULD I PREPARE A NEW CARE PLAN OR REVIEW THE EXISTING PLAN PREPARED BY A PREVIOUS GP?

Where a new patient with complex chronic illness transfers to your care you may consider it clinically appropriate and necessary to put in place a GP Management Plan (GPMP) and potentially Team Care Arrangements (TCAs).

However the GPMP (item **721**) and the coordination of TCAs (item **723**) should only be claimed once by each patient regardless of the provider in any 12-month period.

Enquiring with the patient whether they have an existing GPMP or TCAs is necessary because, while provisions do exist in legislation for claiming these items more than once in the 12-month window, they are reserved for exceptional circumstances where a patient's clinical condition has changed

significantly. Furthermore, while a new plan may be claimed outside of that 12-month window it should only be done if it is clinically necessary and appropriate to do so.

Where a patient has an existing plan and chooses to attend a new practice the GP can review their existing GPMP or TCAs by claiming item **732** for each service if they consider it clinically necessary to do so.

Should the patient be unsure of whether they have a GPMP or TCA or when these services were claimed, the provider can find this out by contacting Services Australia's Medicare provider enquiries line on 132 150.

WHAT IF THE PREVIOUS/FORMER PRACTICE WON'T PROVIDE A COPY OF THE PLAN OR I THINK THE PLAN IS INADEQUATE?

It is a requirement of items **721** and **723** that the treating practitioner offers a copy of the GPMP and/or TCAs to the patient (and the patient's carer if applicable). A copy of the written plan must also be retained by the treating practitioner for a minimum of two years. Should a patient request this plan at a later date, it should be provided by the responsible practice.

In order for these items to be appropriately claimed, a plan needs to be created with the express intent that all information within it will be provided freely to the patient should they want a copy.

In addition, it is important to remember that the provision of the copy of this plan is included in the fee for the item. If a patient initially declines the offer for a copy, they still retain the right to one. An additional fee should not be charged for the provision of this plan at a later date.

Where a copy has been obtained and it is considered inadequate, the plan can still be reviewed using item **732** or the appropriate timed attendance item.

Patients having difficulties in accessing their medical records can make a formal complaint to the Office of the Australian Information Commission and/or the relevant state or territory Health Complaints Commissioner.

GPs who have concerns about the actions of another health provider in relation to the appropriate claiming of Medicare items can complete a tip-off form on the Department of Health website at the link below or call the Provider Benefits Integrity Hotline on 1800 314 808 between the hours of 9am to 5pm AEST. Please see: Health provider tip-offs page

THE EXPLANATORY NOTES FOR THE CHRONIC DISEASE MANAGEMENT AND HEALTH ASSESSMENT ITEMS REFER TO THE PATIENT'S 'USUAL GENERAL PRACTITIONER'. WHO CAN BE CAN BE CONSIDERED A PATIENT'S 'USUAL GP'?

For the purposes of Medicare claiming the patient's 'usual GP' means:

- a GP who has provided the majority of care to the patient over the previous 12 months; or
- a GP who will be providing the majority of care to the patient over the next 12 months; or
- a GP who is located at a medical practice that provided the majority of services to the patient in the past 12 months or is likely to provide the majority of services in the next 12 months.

The goal of the chronic disease management (CDM) items is to assist in the ongoing management of a patient's complex care needs. Where a GP, or the practice itself, does not have an existing relationship with a patient, or where they don't believe they will be seeing the patient regularly to provide ongoing care, they should not consider themselves the patient's 'usual GP' for the purposes of claiming these items.

Professional Services Review committees have found that a CDM item should not be billed at a first or second visit unless indicated. This is because peer expectation is that a practitioner might require a number of visits to familiarise themselves with a new patient's chronic disease/s to enable the generation of individualised goals for management and team care arrangements. This consideration has also been seen as a protection against practitioners billing this item when patients attend a practice in an acute situation, depriving the usual GP from billing the service.

WHAT ROLE DO PRACTICE NURSES AND ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PRACTITIONERS PLAY IN THE CARE OF PATIENTS WITH A CHRONIC CONDITION?

Practice nurses and Aboriginal and Torres Strait Islander health practitioners have a critical role across Australia in delivering effective health care that assists medical practitioners. It is important to note that GPs may only delegate activities to practice nurses and Aboriginal and Torres Strait Islander health practitioners which are consistent with accepted medical standards such as collecting information and providing patients with information about recommended interventions (at the direction of the medical practitioner).

WHEN IS IT APPROPRIATE TO USE ITEM 10997?

Item **10997** is for the provision of monitoring and support for a person with a chronic disease by a practice nurse or Aboriginal and Torres Strait Islander health practitioner on behalf of a medical practitioner. Item 10997 can only be claimed where a GP Management plan, Team Care Arrangements or Multidisciplinary Care Plan is in place and can be claimed for a maximum of 5 services per patient in a calendar year. It may be used to provide:

- checks on clinical progress;
- monitoring of medication compliance;
- self-management advice, and
- the collection of information to support GP/medical practitioner reviews of care plans.

The services provided by the practice nurse or Aboriginal and Torres Strait Islander health practitioner should be consistent with the scope of the patient's GP Management Plan, Team Care Arrangements, or Multidisciplinary Care Plan.

Item **10997** is intended to be used for monitoring or support services for a person with a chronic condition between the more structured reviews of the care plan by the patient's usual GP. This item should not be claimed in relation to assistance provided to the GP to prepare a GP Management Plan or Team Care Arrangements. It would not be expected that item **10997** would be routinely claimed on the same day as items **721** or **723**.

WHICH TASKS CAN BE DELEGATED TO PRACTICE NURSES, ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PRACTITIONERS OR ABORIGINAL HEALTH WORKERS WHEN DEVELOPING GPMPS AND TCAS?

A practice nurse, Aboriginal and Torres Strait Islander health practitioner, Aboriginal health worker or other health professional may assist a GP with the chronic disease management (CDM) items (for example in patient assessment, identification of patient needs and making arrangements for services). However, the GP must review and confirm all assessments and arrangements, and see the patient.

A GP's receptionist could assist with logistics but it would not be appropriate for a receptionist to assess the patient or identify their health and care needs.

Time spent by practice nurses or Aboriginal and Torres Strait Islander health practitioners in assisting medical practitioners with the CDM items applies only to the CDM item and may not be itemised additionally, such as to item **10997**. Item **10997** is for monitoring and support of patients with a chronic disease between normal GP visits and is not intended to be used for the creation of a care plan.

TEAM CARE ARRANGEMENTS—WHAT DO I NEED TO DO BEFORE CLAIMING ITEM 723?

A claim for item **723** requires a GP to consult with at least 2 collaborating providers for different treatments. This requires more than simply gaining the consent of the collaborating providers to participate in the team care arrangements. It is also a requirement of item **723** that the GP discusses with the patient the collaborating providers who will contribute to the development of the TCAs and provide treatment and services to the patient under those arrangements.

This requirement cannot be completed until after collaboration with the contributing providers has occurred. In some cases this will necessitate an additional attendance with the patient, after all of the collaboration requirements of item **723** have been completed.

It is at this point that item **723** can be claimed. It would not be expected that items **721** and **723** would be routinely co-claimed on the same day. As patient information is being shared with third parties who are part of the team, patient consent is required. Consent should outline the nature of the material to be provided to third parties, with only relevant material being shared.

Professional Services Review committees may review whether patient consent was secured before confidential information in the patient medical record was shared with third parties in a team care arrangement. The need for consent before sharing information in the medical record is a requirement of Australian privacy legislation.

3 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 a GP MHTP. 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 GP 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 – allied mental health provided by eligible psychologists, occupational therapists and social workers.

Patients with a GP 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.

New items have recently been introduced 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

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 symptoms
- the number of treatment services the patient needs to receive
- a statement about whether the patient has a GP MHTP, shared care plan or a psychiatrist assessment and management plan.

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 a GP 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 GP 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 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 a GP 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.

4 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

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 an acute 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.

5 RESIDENTIAL AGED CARE FACILITIES (RACF) FLAG ALL 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 **10990** or **10991** 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).

ASKMBS METRICS 1 MARCH 2019 – 31 DECEMBER 2019

AskMBS receives enquiries from medical practitioners providing MBS services as well as practice managers, billing agents, professional organisations, and a range of other stakeholders. The service averages around 120 enquiries per week. Between commencing in the Department and the end of December 2019, AskMBS received 5,751 enquiries and finalised responses to 5,605.

A key AskMBS metric is a response time of 15 working days. In some cases this is not achievable, such as when it is necessary for us to seek policy advice from the relevant area of the Department to inform our response. In the period from March to December 2019 AskMBS responded to 72.8% of enquiries within 10 working days, with an average response time across all enquiries of nine working days.

The chart below shows figures for monthly workflows from March to December 2019.