

Enhanced Primary Care (EPC) Services

This section contains information on the health assessment, care planning and case conferencing services on the Medicare Benefits Schedule. It also contains information on the Allied Health and Dental Care rebates scheme (which is related to the EPC care planning services).

Overview of Enhanced Primary Care services

Enhanced Primary Care (EPC) services aim to improve the health and quality of life of older Australians, adult Aboriginal and Torres Strait Islander people and people of any age with a chronic or terminal condition.

EPC services cover five categories of General Practitioner (GP) activity:

1. annual older age health assessments for Aboriginal and Torres Strait Islander people aged 55 years and over, and other people aged 75 years and over;
2. two-yearly adult health checks for Aboriginal and Torres Strait Islander people aged 15 to 54 (inclusive);
3. comprehensive medical assessments for permanent residents of residential aged care facilities;
4. care planning for people with chronic conditions and for those who may also have complex (team) care needs; and
5. case conferencing for people with chronic conditions and complex care needs.

GPs should consult the relevant explanatory notes in the Medicare Benefits Schedule Book before providing any EPC service.

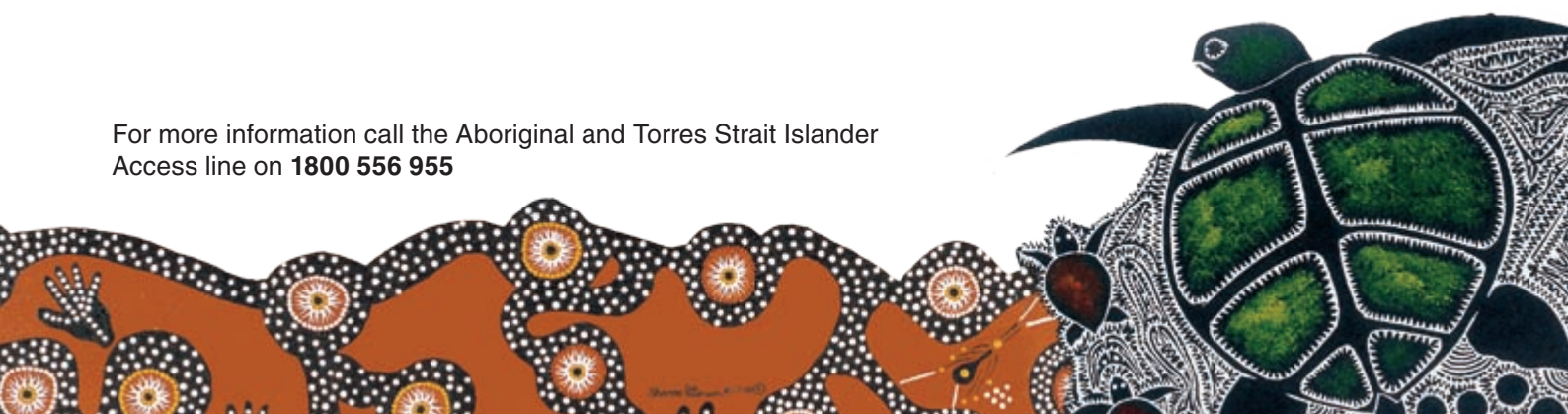
How your health service can benefit from EPC services

There are several ways your service may be able to benefit from EPC services:

- Your service employs a doctor who directly bills Medicare, the doctor will be able to bill Medicare directly for CDM services.
- If your clients go to other doctors or allied health professionals in your area, the CDM items provide the opportunity for your service to work together with these providers to give better care to your clients.

A Medicare benefit is only payable for a GP's involvement in EPC services, although doctors may be assisted by other health professionals, including Aboriginal Health Workers, in the provision of most EPC services.

For more information call the Aboriginal and Torres Strait Islander
Access line on **1800 556 955**



How you can build Enhanced Primary Care into your service

There are several steps you can take to incorporate EPC items into your service and ensure that the EPC services you provide meet Medicare requirements:

1. Make sure that staff are aware of the EPC services and how they operate by distributing this and other information about them;
2. Encourage staff to read distributed information and adapt it to your local needs and circumstances;
3. Talk to your client groups and patients about EPC services and how they can benefit from them;
4. Promote awareness of EPC services in the community by displaying available posters;
5. Make sure that doctors who work with your service are aware of EPC services, who can benefit from them, and what is involved in providing them;
6. If your service does not have a doctor, you may want to talk to doctors in the area about how you can work together to make sure patients get appropriate care. For example, Aboriginal health workers can be involved by contributing to care plans, taking part in case conferences or helping doctors get information for a health assessment.

Annual Older Age Health Assessments

There are four services on the Medicare Benefits Schedule for older age health assessments: two for Aboriginal and Torres Strait Islander people aged 55 years and over and two for other Australians aged 75 years and over.

Item number 704 is for an older age health assessment conducted for an Aboriginal and Torres Strait Islander person at a GP's consulting rooms. Item 706 is for the same service conducted at somewhere other than a GP's consulting rooms, a hospital or a residential aged care facility.

How are Indigenous status and age identified for an annual older age health assessment?

To be eligible for an older age Indigenous health assessment, a person must identify themselves as being of Aboriginal or Torres Strait Islander descent and state their age. Some patients may give this information without being asked. However, other patients will need to be asked. An appropriate way to ask this question is "Do you identify as an Aboriginal and/or Torres Strait Islander person?"

Information provided by the patient about their Indigenous status and age should be accepted, as stated by the patient, for the purposes of having a health assessment.

Who can do an annual older age health assessment?

An older age health assessment should be done by the patient's usual GP. Providing certain conditions are met, the GP can arrange for another person under his or her supervision to collect information needed for the health assessment, with the patient's agreement. The health assessment must include the GP seeing the patient.

What are the steps in an annual older age health assessment?

There are five main components:

1. seeking and gaining patient agreement to the service;
2. collecting specific information about the patient;
3. assessing the information to make recommendations for care/treatment;
4. talking to the patient about outcomes and recommendations; and
5. placing a copy of the assessment in the patient's record and offering a copy to the patient.

Note that the information collecting part of the check can be done by an Aboriginal Health Worker, nurse or other qualified health professional if certain conditions are met (see the relevant explanatory notes in the Medicare Benefits Schedule Book).

What are the benefits of annual older age health assessments?

Health assessments can help prevent sickness or help the patient and doctor manage a health problem better by finding health or other problems early.

Health assessments give the doctor and health workers up-to-date information about a patient's medical condition and health care needs. This can be very important in deciding how to care for a patient, and may mean better health outcomes.

Two-Yearly Aboriginal and Torres Strait Islander Adult Health Check

There is one service on the Medicare Benefits Schedule for a health check for Aboriginal and Torres Strait Islander people aged 15 to 54 (inclusive) who have not had the check in the previous 18 months. The relevant item number is 710.

How are indigenous status and age identified?

See the answer to this question for older age health assessments (above), noting that age range for the adult health check service is 15 to 54 (inclusive).

Who can do an adult health check?

The patient's usual GP should normally do the adult health check.

What are the steps in an adult health check?

1. deciding whether the patient should have an adult health check;
2. explaining the health check to the patient;
3. gaining and noting patient agreement to the service;
4. taking a patient history;
5. examining the patient (mandatory activities);
6. arranging or undertaking any investigations;
7. assessing the patient's health;
8. initiating interventions;
9. developing a strategy for the good health of the patient;
10. recording the health check;
11. offering the patient a written report (including the simple strategy); and
12. keeping a copy of the health check in the patient record.

Note that the information collecting part of the check can be done by an Aboriginal Health Worker, nurse or other qualified health professional if certain conditions are met (see the relevant explanatory notes in the Medicare Benefits Schedule Book).

What are the benefits of an adult health check?

The adult health check encourages early detection, diagnosis and intervention for common and treatable conditions.

Comprehensive Medical Assessments (CMAs)

There is one service on the MBS for a Comprehensive Medical Assessment (CMA) for permanent residents of residential aged care facilities who have not had a CMA in the previous twelve months. The relevant item number is 712. This service can be provided to a new resident on admission or to a continuing resident on an “as required” basis (with a maximum of one CMA Per resident in any twelve month period).

Who can do a Comprehensive Medical Assessment?

The patient’s usual GP should normally do the CMA. However, GPs who provide services on a facility-wide contract basis or who are registered to provide services to residential aged care facilities as a part of aged care panel arrangements may also provide CMAs as part of their services.

What are the steps in a Comprehensive Medical Assessment?

1. seeking and obtaining consent to the service;
2. taking a detailed medical history;
3. conducting a comprehensive medical examination;
4. developing a list of diagnoses or problems based on the medical history and medical examination; and
5. providing a written summary of the outcomes of the CMA.

What are the benefits of a Comprehensive Medical Assessment?

Listing diagnoses and problems helps provide better care for the resident. It also assists pharmacists who provide medication management review services for the resident.

Care Planning (Chronic Disease Management services)

There are six care planning or Chronic Disease Management (CDM) services on the MBS.

The two main services are:

- (a) **preparation by a GP of a GP Management Plan** (Item 721) for a patient with at least one chronic or terminal condition; and
- (b) **coordination by a GP of Team Care Arrangements** (Item 723), involving collaboration with at least two other service providers for a patient who has at least one chronic or terminal condition and complex (team) care needs.

A patient who has at least one chronic or terminal condition and complex (team) care needs will be eligible for both services.

There are two review services:

- (a) **review by a GP of a GP Management Plan** (Item 725); and
- (b) **coordination by a GP of a team review of Team Care Arrangements** (Item 727).

There is a service for a contribution by a GP to a **multidisciplinary care plan** (or to a review of a multidisciplinary care plan) **by another provider**, for example a hospital on discharge (Item 729).

There is also a service for a contribution by a GP to a **multidisciplinary care plan** (or to the review of a multidisciplinary care plan) **for a resident of an aged care facility** (Item 731).

There are restrictions on where the CDM services can be provided, who can provide them and on the frequency of provision. (See the relevant explanatory notes MBS Book.)

What are the steps in preparation of GP Management Plans (GPMPs)?

1. explaining the service to the patient and obtaining agreement to proceed;
2. assessing the patient to identify/confirm all of their health care needs, problems and relevant conditions;
3. agreeing management goals with the patient;
4. identifying actions to be taken by the patient;
5. identifying treatment and services that the patient is likely to need;
6. making arrangements for treatment/services and on-going management;
7. documenting the above (the plan) and offering it to the patient; and
8. including the plan in the patient's medical record.

What are the steps in coordinating Team Care Arrangements (TCAs)?

1. explaining the service to the patient and obtaining agreement to proceed;
2. explaining any likely out-of-pocket costs arising from the involvement of the other members of the TCA team;
3. discussing with the patient which treatment/service providers should be asked to collaborate with the GP in completing the plan;
4. gaining patient agreement to share their medical history, diagnoses and GPMP (with or without restrictions) with the proposed providers;
5. contacting the proposed providers and obtaining their agreement to participate;
6. collaborating (two-way communication) with the agreed providers to discuss the potential treatment/services they will provide to achieve the management goals for the patient;
7. documenting the goals, the collaborating providers, the treatment/services they have agreed to provide, patient actions and a review date.
8. providing relevant parts of the TCA to the collaborating providers and other service providers;
9. offering the plan to the patient; and
10. including the plan in the patient's medical record.

Note that for GPMPs and TCAs the GP may be assisted by a practice nurse, Aboriginal Health Worker or other health professional in the GP's medical practice or health service. However, the GP must see the patient and review and confirm all assessments and elements of the GPMP or TCA.

The TCA team **must** include the coordinating GP and at least two other health service providers, who must contribute to the plan, and who must be providing a different kind of service to the patient. These core members of the team may include a specialist medical practitioner but not two specialists. However, if the team consists of more than three members a second specialist could be included. The core members would not usually include a second GP or a practice nurse who is providing general practice services on behalf of the patient's GP.

Medicare provides a rebate for the GP's coordinating work or participation but does not provide a rebate for specialist medical practitioners or allied health professionals to contribute to a TCA. Examples of health or care providers, apart from specialist medical practitioners, who can work with the GP as part of the TCA team include (but are not restricted to):

Allied Health Professionals		Home and Community Service Providers
Asthma educators	Dieticians	Education Providers
Orthoptists	Exercise Physiologists	Meals on Wheels
Audiologists	Psychologists	Personal Care Workers
Orthotists or Prosthetists	Aboriginal Health Workers	Probation Officers
Dental therapists	Registered nurses	
Pharmacists	Mental health workers	
Dentists	Social workers	
Podiatrists	Occupational therapists	
Physiotherapists	Speech pathologists	
Diabetes educators	Optometrists	

Information on the circumstances in which a practice nurse and/or Aboriginal health worker can be included on the TCA team can be found on the chronic disease items web page.

What are the benefits of care planning (CDM) services?

These services make it easier for GPs to manage the care of patients with chronic or terminal conditions, including patients with complex (team) care needs.

Case Conferencing

There are eighteen GP case conferencing services on the Medicare Benefits Schedule for patients with at least one chronic or terminal condition and complex (team) care needs. The services are for GPs to organise/coordinate case conferences or to participate in case conferences organised by others.

The rebates for these services are based on the length of the conference: (a) at least 15 minutes but less than 30 minutes; (b) at least 30 minutes but less than 45 minutes and (c) at least 45 minutes. Item numbers for claiming purposes depend on the circumstances of the conference eg on discharge, in a residential aged care facility or in the community. See the MBS Book for individual item numbers.

A case conference must include a minimum of three participants (the GP plus two others) and the three participants must be present for all of the claimed conference period.

Who can participate in a case conference?

The GP case conferencing items on the Medicare Benefits Schedule provide rebates for GPs to organise/coordinate or participate in a case conference.

See material on TCA team members (earlier in this segment) for information on who, other than the patient's usual GP, can be a participant in a case conference, noting that Medicare does not provide a rebate for allied health professionals to participate.

What is the difference between an EPC case conference and a Team Care Arrangements care planning service?

A case conference is a meeting to look at the immediate needs of a patient. The meeting allows the GP and other care providers to discuss the immediate treatment and services needed by the patient.

A Team Care Arrangements service looks at the long term health and care needs of a patient. It allows the GP and other care and service providers to prepare a written plan on how the treatment and other services needed by the patient will be managed.

What are the steps in organising/coordinating a case conference?

1. explaining to the patient the nature of the conference;
2. recording the patient's agreement to the case conference;
3. conferring with the other conference participants and recording the relevant details (date, starting and finishing times, and names of participants);
4. recording identified multidisciplinary care needs, tasks to achieve specified outcomes and whether any previously specified outcomes have been achieved;
5. putting a copy of the record created in steps 3 and 4 on the patient's medical record;
6. offering the patients and participants a summary of the conference; and
7. discussing the results of the conference with the patient.

What are the steps in participating in a case conference?

Participation must be at the request of the person who is organising the case conference.

1. explaining to the patient the nature of the conference;
2. recording the patient's agreement to the GP's participation in the conference;
3. participating and recording the relevant details (date, starting and finishing times, and names of participants);
4. recording multidisciplinary care needs etc (see 4 above) as they relate to the GPs participation;
5. putting a copy of the record created in steps 3 and 4 in the patient's medical record; and
6. offering the patient and participants a summary of the conference.

Does the patient have to attend the case conference?

The patient may attend but is not required to.

What are the benefits of case conferencing?

CDM care planning and case conferencing allow the doctor, the patient and other people who care for the patient to discuss, plan and manage the treatment, health care and other services the patient needs.

Allied health and dental care services

Care plans developed using the new EPC chronic disease management (CDM) items or the former EPC multidisciplinary care planning items are referred to in a generic way as 'EPC plans'.

Patients who are being managed by their GP using EPC Plans are eligible for Medicare rebates for certain allied health and dental care services.

When is a patient considered to be managed under an EPC plan?

Patients are considered to be managed under an EPC plan if, during the last two years:

- their GP has prepared an EPC plan for them and claimed:
 - former MBS item 720—preparation of an EPC multidisciplinary care plan; or
 - former MBS item 722—preparation of an EPC multidisciplinary discharge care plan; or
 - new MBS items 721 and 723 together—CDM items for preparation of a GP Management Plan and coordination of Team Care Arrangements; or
- their GP has contributed to a plan prepared for them as a resident of an aged care facility and claimed former MBS item 730 or new MBS item 731; or
- their GP has reviewed their existing EPC plan and claimed former MBS item 724 or new MBE items 725 or 727.

How many rebates can eligible patients claim each year?

Eligible patients can claim rebates for a maximum of **5 allied health and 3 dental care services each calendar year (1 January–31 December)** on referral from their GP for services recommended in their EPC plan.

Are rebates payable for services provided in government funded Indigenous services?

Services funded by other Commonwealth or State programs are not usually eligible for Medicare rebates. However, where an exemption under subsection 19(2) of the HIA has been granted to an ACCHS or State/Territory clinic, the allied health and dental care items can be claimed for services provided by eligible providers salaried by, or contracted to, the service.

How do patients access rebates for allied health services?

Patients need to be referred by their GP for services recommended in their care plan on the EPC Program Referral form for Allied Health Services under Medicare. Where the GP is referring a patient to more than one allied health professional, s/he will need to use a **separate** form for each referral.

The form can be found on the DoHA website at:

www.health.gov.au/strengtheningmedicare or ordered by faxing **(02) 6289 7120**.

Who can provide allied health services?

Eligible services include those provided by Aboriginal health workers, audiologists, chiropractors, chiropodists, diabetes educators, exercise physiologists, dietitians, mental health workers, occupational therapists, osteopaths, physiotherapists, podiatrists, psychologists, and speech pathologists.

These services must be provided to individual patients, and last at least 20 minutes.

Eligible providers need to be registered with Medicare Australia. The list of eligibility criteria for allied health professionals is provided below.

How do patients access rebates for dental care services?

To be eligible for rebates for dental care services, patients must also have a dental condition that is making their chronic condition worse.

All patients must have a dental assessment (item 10975) prior to dental treatment (item 10976 or 10977).

A dentist, who provides a dental assessment under item 10975 and decides that the patient needs a further assessment or treatment from a dental specialist, needs to fill in the appropriate section of the EPC referral form to refer the patient. The item used by dental specialists is 10977.

Patients need to be referred to a dentist or dental specialist by their GP using the EPC Program Referral form for Dental Care under Medicare. Dentists and dental specialists must be registered with Medicare Australia.

The form can be found on the DoHA website at:

www.health.gov.au/strengtheningmedicare or ordered by faxing **02 6289 7120**.

If a dentist or dental specialist supplies and fits a dental prosthesis using dental care item 10976 or 10977, does the cost attract a Medicare rebate?

The cost of making or supplying prostheses such as, an inlay, crown, bridge, implant, denture, obturator, veneer or a combination of these, are NOT covered by Medicare. Dentists and dental specialists should separately itemise any costs associated with the making or supply of prostheses when billing patients for a dental treatment using item 10976 or 10977.

However, costs associated with fitting prostheses can be included under these items.

Must Medicare items for relevant GP services be claimed before a Medicare rebate can be paid for allied health or dental services?

Yes. Allied health and dental care services will not attract a Medicare rebate unless they are provided after the relevant GP service(s) are complete and the appropriate item(s) have been claimed.

Where GPs bulk-bill patients for care planning, it may sometimes happen that a patient will have their first referred allied health or dental care service before the GP has actually lodged a Medicare claim for direct payment. When this happens, Medicare will be unable to process the patient's claim (or allied health professional/dentist's claim for direct payment) until after the GP's claim is submitted.

Further information

Detailed information on the allied health and dental care items is available at:

- www.medicareaustralia.gov.au/providers/incentives_allowances/medicare_initiatives/allied_health.htm, and
- www.health.gov.au/strengtheningmedicare

Eligibility criteria for allied health professionals providing new Medicare services

Aboriginal Health Workers practising in the Northern Territory (NT) must be registered with the Aboriginal Health Workers Board of the NT. In other States and the Australian Capital Territory they must have been awarded a Certificate Level III (or higher) in Aboriginal and Torres Strait Islander Health from a Registered Training Organisation that meets training standards set by the Australian National Training Authority's Australian Quality Training Framework.

Audiologists must be either a 'Full Member' of the Audiological Society of Australia Inc (ASA), who holds a 'Certificate of Clinical Practice' issued by the ASA; or an 'Ordinary Member—Audiologist' or 'Fellow Audiologist' of the Australian College of Audiology (ACAud).

Chiropractors must be registered with the Chiropractors (or Chiropractors and Osteopaths) Registration Board in the State or Territory in which they are practising.

Diabetes Educators must be a Credentialed Diabetes Educator (CDE) as credentialed by the Australian Diabetes Educators Association (ADEA)

Dietitians must be an 'Accredited Practising Dietician' as recognised by the Dietitians Association of Australia (DAA).

Exercise Physiologists must be an 'Accredited Exercise Physiologist' as accredited by the Australian Association for Exercise and Sports Science (AAESS).

Mental Health Workers 'Mental health' can include services provided by members of five different allied health professional groups. 'Mental health workers' are drawn from the following:

- psychologists;
- mental health nurses;
- occupational therapists;
- social workers; and
- Aboriginal health workers.

Psychologists, occupational therapists and Aboriginal health workers are eligible in separate categories for these items.

A mental health nurse may qualify if they are—

- a registered mental health nurse in Tasmania or the Australian Capital Territory (ACT), if providing mental health services in Tasmania or the ACT; or
- a 'Credentialed Mental Health Nurse' as certified by the Australian and New Zealand College of Mental Health Nurses (ANZCMHN), if providing mental health services in other States or the Northern Territory.

To be eligible to provide mental health services for the purposes of this item, a **social worker** must be a 'Member' of the Australian Association of Social Workers (AASW); and be certified by AASW as meeting the standards for mental health set out in AASW's 'Standards for Mental Health Social Workers 1999'.

Occupational Therapists in Queensland, Western Australia, South Australia and the Northern Territory must be registered with the Occupational Therapists Board in the State or Territory in which they are practising; in other States and the Australian Capital Territory, they must be a 'Full-time Member' or 'Part-time Member' of OT AUSTRALIA, the national body of the Australian Association of Occupational Therapists.

Osteopaths must be registered with the Osteopaths (or Chiropractors and Osteopaths) Registration Board in the State or Territory in which they are practising.

Physiotherapists must be registered with the Physiotherapists Registration Board in the State or Territory in which they are practising.

Podiatrists/Chiropodists in all States and the Australian Capital Territory must be registered with the Podiatrists Registration Board in the State or Territory in which they are practising. If practising in the Northern Territory, Podiatrists/Chiropodists must be registered with the Podiatrists Registration Board in any other State or the Australian Capital Territory, or be a “Full Member” of the Australian Podiatry Association (APodA) in any other State or the Australian Capital Territory.

Psychologists must be registered with the Psychologists Registration Board in the State or Territory in which they are practising.

Speech Pathologists practising in Queensland must be registered with the Speech Pathologist Board of Queensland. In all other States, the Australian Capital Territory and the Northern Territory, they must be a ‘Practising Member’ of Speech Pathology Australia.

Allied Health professionals need to register with Medicare Australia to obtain a provider number.

Combining EPC and Other Services

In some cases patients with chronic conditions and complex care needs may require a combination of EPC and other services, in addition to ongoing medical care through normal consultation items. Some possible combinations of services that may be beneficial for some Aboriginal and Torres Strait Islander people are listed below.

Eligibility for individual services should be checked before proceeding with sequences of services, and the Medicare requirements of each of the services should be fully met.

- For an Aboriginal and Torres Strait Islander person aged 55 or over with a chronic condition and complex care needs: Older age health assessment + General Practice Management Plan + Team Care Arrangements + Allied Health Program.
- For an Aboriginal and Torres Strait Islander person aged 55 or over with a chronic condition and complex care needs, and who is at risk of medication problems: Older age health assessment + General Practice Management Plan + Team Care Arrangements + Allied Health Program + Home Medicines Review.
- For an Aboriginal and Torres Strait Islander person aged between 15 and 54 with a chronic condition and complex care needs: Adult Health Check + General Practice Management Plan + Team Care Arrangements + Allied Health Program.
- For an Aboriginal and Torres Strait Islander person aged between 15 and 54 with a chronic condition and complex care needs and who is at risk of medication misadventure: Adult Health Check + General Practice Management Plan + Team Care Arrangements + Allied Health Program + Home Medicines Review.

Patients with chronic conditions and complex needs may also benefit from EPC multidisciplinary case conferences.

Patients with a chronic medical condition but without complex care needs may benefit from the relevant health check/health assessment items and from a GP Management Plan.