



Frequently Asked Questions Revised edition January 2007

Better Access

Will better Access items be accessible by GPs in non accredited practices?

Yes

With the changes to the Better Outcomes in Mental Health Care Initiative and the introduction of Better Access in Mental Health Care Initiative as announced on 1 November 2006, can GPs working in a non – accredited practice refer patients to the Division’s ATAPS program?

Until April 30 2007, there are two referral pathways available to GPs who wish to access ATAPS.

GPs can refer to ATAPS using the new GP Mental Health Care items and do not need to be working from an accredited practice to do so. GPs who are using the 3 Step Mental Health Process SIP trigger items to complete and claim for work not finalised by 1 November 2006, will still be required to be working from an accredited practice and to have completed Level 1 training. After 30 April 2007 these items will no longer be available and all referrals to ATAPS will be through the GP Mental Health Care items.

Can salaried GPs who work in Aboriginal Community Controlled Health Services (ACCHS) and who access Medicare refer patients to the Division’s ATAPS program?

What about salaried GPs who do not access Medicare?

A salaried GP in an ACCHS who accesses Medicare (ie the ACCHS has a section 19 (2) exemption to access Medicare) can use the GP Better Access items and refer patients to psychologists and other allied mental health providers, including ATAPS.

A salaried GP who does not access Medicare cannot access the GP Mental Health Care items. These GPs cannot access ATAPS as without access to Medicare they do not have a referral pathway.



**Can salaried GPs who work in non-accredited youth health services and who access Medicare refer to the Division's ATAPS program?
What about salaried GPs who do not access Medicare?**

The answer is the same as the answer supplied for the previous question relating to GPs work in ACCHS.

**Do referrals to psychologist have to be made by the persons 'usual GP'?
If so ... what is the definition of the Usual GP by Medicare standards?
This is a specialist practice that treats women with multiple problems including mental health issues – therefore they want to be able to refer the patients to specialist mental health providers under Better Access**

Under the new items a patient should generally be referred for allied mental health services (eg. a psychologist or other appropriate mental health provider) by the GP who has completed the patient's GP Mental Health Care Plan. It is the profession's expectation, consistent with the EPC and CDM items, that this would generally be the patient's usual doctor.

This is not a mandatory or enforceable 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 new GP Mental Health Care items do not specify that a patient's GP Mental Health Care Plan must be completed by the patient's usual GP, however, it is anticipated that this would generally be the case.

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 twelve months. This is not designed to be an enforceable provision and takes account of the patient's right to choose their own doctor.

If a patient is referred for allied health services by a psychiatrist or paediatrician and the GP is unaware of this and then does a GP Mental Health Care Plan and refers the patient for allied health services, will the patient be able to access rebates for these additional allied 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 and a 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.

If a patient is referred for these new items by a psychiatrist or paediatrician and the GP is unaware of this and then does a GPMP&TAC, etc will that be rejected by Medicare and along with that any Medicare AH referrals?

It is preferable that wherever possible, patients have only one plan for primary care management of their mental disorder. 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.

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.

Similarly, where a patient has been referred for allied mental health services available under the new mental health items by another health professional (eg a psychiatrist or paediatrician), the GP is able to use the CDM items for team-based care where the patient meets the MBS requirements for these services, ie where the patient requires team-based care using the CDM items to manage their chronic medical condition and complex needs.

Does the GP need to get patient consent for the GP MH Consultation item? (This relates to all the issues around confidentiality and insurance, etc).

There is no separate and specific requirement around the issue of patient consent for the GP Mental Health Care Consultation, other than the requirements that apply to consent for normal medical care using standard consultation items. As a matter of good practice, the nature of the service being provided should be explained to the patient including that it is a mental health consultation and the patient should be fully informed of their treatment options.

Is the GP required to check whether the patient has had a referral to an AHP in the past calendar year for group and/or individual therapy under Better Access before they refer? If so, how would they check this?

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. A further 6 services can be accessed in exceptional circumstances, following a review by the referring practitioner. If the patient exceeds this limit they will not be eligible to claim the Medicare rebate.

A GP is not required to check a patient's eligibility, however, if a GP is concerned that a patient may have had a Mental Health Care plan from another GP, or have already accessed allied mental health services up to the yearly limit, they can ask the patient to check their eligibility for services with Medicare Australia, as is the case with the CDM items and referrals to allied health services.

Will GPs, particularly those who have not been involved with the BOIMHC Program, be provided with information and examples of templates of the GP Mental Health Care Plan similar to the Familiarisation Training manual? If yes, will the Division's be required to provide GPs this type of information? Will Division's be funded to do this?

Can GPs just use the BOiMHC Assessment/Plan/Review templates? Do you have a Care Plan template for GP's to use?

The better access program mirrors the better outcomes program, in many ways. There are no prescribed templates for GPs for either program, but Divisions may choose to support their GPs in understanding the best practice examples that have been developed with better outcomes. This also means that GPs could be encouraged to use the assessment care plan and review templates that are able to be uploaded into medical director.

GPs are members of the Divisions, and it is *core business* to support their members with accurate and user friendly information about changes and processes like Better Access in Mental Health care. ADGP is committed to supporting to Divisions in getting information out to GPs in a user friendly way. To date we have worked closely with DoHA to develop three key documents all available on the AGPN Website www.primarymentalhealth.com.au for Divisions use:

- A patient referral pathways document
- A GP and Patient rebates under Better access for GP Mental Health care plan and review and consultation
- A Flow chart explaining the Better Access pathways

In addition we are working closely with the Department to continue to develop tools and resources for Divisions supporting the uptake of the Better Access program. AGPN will launch this package of information at a workshop at the National Primary Mental Health Care Symposium on the 25th of November 2006. To register for this free event please visit the website www.adgp.com.au

If a patient is referred under the GPMH Plan to an allied health provider, and has two sessions, and does not want to continue with that provider, does the GP refer them to another psychologist a) under the same GP MH Plan and b) how many sessions is the patient then entitled to, another 10 sessions, or to start again with 12 sessions?



Can the GP use the GP Mental Health Consultation item without doing a GPMH Plan?

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Can the GP use the GPMH Plan to refer to group therapy AND to individual therapy?

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What is it exactly, that a mental health nurse, practice nurse, AHP collocated in the GP practice, can do with regard to the GP Mental Health Care Plan?

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Can a GP Mental Health Care Plan (item 2710) be used for a child with ADHD and developmental delays? Does ADHD fit into the criteria of ICD-10 diagnosis as a mental disorder.

Please find following a response to the question that you have asked regarding use of a GP Mental Health Care Plan for a child with attention deficit hyperactivity disorder and developmental delays:-

Under the Better Access initiative, patients with an assessed mental disorder can access Medicare rebates for Psychological Therapy services provided by eligible clinical psychologists, and Focussed Psychological Strategies services provided by eligible psychologists, occupational therapists and social workers, on referral by a GP who is managing the patient's condition under a GP Mental Health Care Plan; or on referral by a psychiatrist or paediatrician.

While attention deficit hyperactivity disorder (ADHD) can be regarded as falling within the definition of a mental disorder, the medical practitioner should consider the individual needs of their patient to determine whether they would benefit from a GP Mental Health Care Plan and whether a course of treatment from a psychologist or other eligible allied mental health professional would be of benefit to the patient.

If the Better Access initiative is deemed an appropriate treatment option by the medical practitioner, patients are able to receive up to 12 individual and, where appropriate, 12 group therapy sessions with a psychologist or other eligible allied mental health professional per calendar year.



Education & Training

Will Divisions be funded to coordinate, organise and/or provided mental health education and training to GPs, psychiatrists and allied health professionals?

AGPN continues to advise DoHA of the capacity needs for Divisions to support the uptake of these measures under better access. Any developments will be conveyed through the National Primary Mental Health Care Network and the DLOs.

ATAPS / Better Outcomes

Given that GPs do not need to complete a specific form to refer patients on to eligible allied mental health professionals for treatment, GPs, are unlikely to complete the ATAPS referral forms which will impact on Division's ability to meet its data reporting obligations from the 1 November 2006. Given that it is a requirement of the Divisions ATAPS funding Agreement, how do you propose the Division's meet its reporting obligations?

Better Outcomes and the ATAPs component has funding until 2009. The new pathways under Better Access will open up opportunities for all GPs to undertake mental health work and make it easier for all patients to be referred to appropriate providers under a structured mental health care process. Local providers will require some form of referral process – but this will be locally determined, and Divisions have the opportunity to try to streamline this for their GPs. It does not need to be more complex than the ATAPs referral process. There is also the chance for Divisions to streamline the referral paperwork for their ATAPs programs as well.

It is likely that the new measures will serve to *improve* the current demand pressures on the ATAPs programs – where community need outweighs demand. There will be lots of reasons for GPs to choose the appropriate patient pathway for referral. ATAPs has provided low cost or no cost treatment options for patients, and this will remain unchanged. Divisions will have the opportunity to consider how their local models of ATAPs programs work to compliment the new measures, and align to the new measures. Divisions may consider revising their referral criteria to recognize at risk or target patient groups (eg youth mental health 12 – 25 Year olds) or to target those of lower socioeconomic groups. Divisions are required to complete the MDS for their ATAPs referrals only. If there is an increase or a decrease in the numbers of ATAPs referrals – this will be reflected in the MDS that is completed. It should not change the way the Divisions meet this reporting obligation.



Divisions will shortly be receiving a letter from the Department advising them that they should be thinking flexibly how the models of care for ATAPS will work with Better Outcomes.

What will be the incentive for BOIMHC GPs to continue referring to the ATAPS psychologists, when some private psychologists will accept the Medicare rebate as their full fee i.e. the service will not come at a cost to the patient.

Divisions will be asked to align their ATAPs models to complement the Better Access measures. This could mean that a Division in collaboration with its reference group chooses to change their referral criteria to be more specific – eg young people or ATSI or co-morbid populations or CALD. This could serve to encourage increased service levels from these groups. This approach might be useful where a Division is part of a CYS under headspace, as this could provide the service provision component of the CYS.

The underpinning message is *accessibility* of mental health care for all the patients and the carers. There will be enough need out there for all providers.

What will be the incentive for BOIMHC GPs to continue referring to the ATAPS psychologists, when the mental health conditions being treated under /Better Access /include all mental health conditions and many Division's ATAPS projects have been limited to specific mental health conditions?

Divisions need to consider how their local models will work with the new measures to provide better access to mental health care for all Australians. Where there is a locally defined client group for ATAPS Divisions should think about whether this is the right target group – or will there need to be a change in their model to best meet the needs of the community and complement the other mental health programs that they are undertaking (eg youth mental health under headspace)

What will be the incentive for BOIMHC GPs to maintain their registration?

Education is not mandatory – but will be encouraged. GPs already are required to complete ongoing education and training to maintain their practicing status. Mental health education and training that has been accredited will count as CPD for GPs and can be marketed in this way.

There has been a commitment from DoHA that they strongly encourage training and education for mental health skills. Divisions are in a good position to continue to provide education and training that involves the entire practice team (allied health professionals, practice nurses, mental health nurses, practice managers



and reception staff). There have been some excellent examples of this training like *teams of two* in NSW, and the Takeaway mental health package developed by QDGP as well as the national program *Managing the Mix: Your mental health and alcohol*.

GPs who choose to undertake mental health skills based training will have a better grasp of techniques and skills required to undertake a structured 3 step mental health process, and adhere to the necessary rules under Medicare. This is another motivating factor for GPs to undertake this kind of training.

Better Access Mental Health Care Medicare items – relationship with ATAPS and other Divisional arrangements for employment of allied health professionals

Some questions have been asked about employment arrangements between Divisions and ATAPS or other allied mental health professionals and the ability to claim for new Medicare items under the Better Access initiative.

There are two principles against which any such arrangements must be assessed:

- The new Medicare mental health care items are available for services provided by health professionals working in private practice
- Like other Medicare items, the new mental health care items are not claimable by health services or individual providers working under arrangements which are already funded by the Australian or State governments.

Is there anything in the Better Access Initiative that prevents Divisions from entering into private employment arrangements with eligible allied health providers, whereby Medicare rebates are claimed and directed to Divisions?

The arrangements many Divisions are currently using are totally acceptable. There is no problem with an employed psychologist (or OT, SW) providing ATAPS/MAHS services on behalf of the Division and also providing MBS funded services to *other* patients. MBS rebates are paid to the patient except where the patient is bulk billed and assigns the payment to the treating health professional. If the treating health professional has a business relationship with the Division with regards to the MBS payments, that is a private matter between the parties and is permissible. Double dipping is not acceptable.



For further explanation please see below for Department of Health & Ageing wording:

The only scenario under which Divisions could employ an allied health provider (AHP) to provide services for which Medicare rebates are in some way directed to Divisions is one where the employment arrangement is totally separate to any role or function of the Division for which the Division receives funding from the Australian or State/Territory governments.

A Medicare rebate itself can not be 'assigned' to a Division - a patient can assign the Medicare benefit to the doctor/health professional who provided the service (ie the service is bulk-billed). The doctor or health professional may then direct this payment to anyone s/he chooses. If an AHP has a business or employment relationship with the Division that is totally separate to the Division's Government-funded role or function, part or all of the income the AHP receives through Medicare could be forwarded to the Division as a condition of their employment.

If an individual AHP is receiving payment from the Division as part of the Division's Government-funded role or function, or providing services funded under an Australian Government program, such as MAHS or ATAPS, they would not be able to also provide and claim for Medicare items while working under the same arrangements. To claim for Medicare items an allied health provider would need to be working in private practice. If an AHP employed under a Government-funded program also accessed Government funding through Medicare as part of that employment they would clearly be double-dipping. Another related question is:

Many Divisions are private employers of psychologists. Provided funds from programs such as MAHS or ATAPS are not used to pay the provider for the same service for which they are claiming a Medicare rebate, can the Department confirm that Divisions are as eligible to do this as any other employer (such as a corporate practice) ie. provided there is a mutually agreed business arrangement between the Division and the psychologists, and there is no double dipping to pay for the service, the psychologist can 'assign' their rebate to the Division, and the Division pays the salary. This sort of scenario already exists for GPs who work in Division-managed general practices and youth services.

See above in relation to the circumstances in which an AHP could be employed by a Division and still claim Medicare items. If these



circumstances are met, the financial arrangements for such employment would be a matter for the AHP and the Division. Any such arrangements must clearly separate the AHP's private employment for the purposes of claiming Medicare items from their work under Australian or State Government funding arrangements.

Relationship between Better Access & EPC

If a GPMP&TAC is already in place for a patient with a mental health condition does that make them ineligible for the new item numbers?

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If a patient has a mental health condition as part of a list of other chronic conditions can the patient access mental health services through the new item numbers as well as the allied health services for the co-morbid condition via the GPMP&TCA & EPC Medicare Allied Health referral?

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How does item number 2713 relate to 729? If the GP uses 729 can they go on to use 2713 The GP Mental Health Consultation?

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If a patient has been referred under a GP care plan 2713 and referred under EPC for 5 sessions of counselling within the last 12 months - can the GP now provide a new MH care plan 2710 and refer the patient for a further 6 sessions for counselling, even though 12 months have not passed between the two different care plans?

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Medicare

Will a patient's claim be rejected if a GP has not claimed the MH Care Plan item number?

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Can a GP claim a GP MH Plan AND a Case Conference item on the same day?

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