

## **Mental Health Medicare Items – Questions and answers**

**Can an ATSI adult health check and a 2710 be completed and claimed on the same day? This question was particularly relevant for the NT divisions where outreach and RFDS clinics are provided often only for 1-2 days at a time. It means that often there is no provision for the patient to come back the next day or a few days later for a follow up appointment as usually the visiting service is provided on a fortnightly or monthly basis.**

The MBS Book outlines the conditions and restrictions for MBS items.

There are no restrictions in place which prevent both an Aboriginal and Torres Strait Islander Adult Health Check (MBS item 710) and a GP Mental Health Care Plan (MBS item 2710) being provided to a patient on the same day where clinically appropriate and where the patient meets the eligibility criteria for each item.

More specific guidance is provided in the Explanatory Notes for the GP Mental Health Care Items under the Additional Claiming Information section (see extract below from the 1 November 2007 MBS Book).

A.40.32 The GP Mental Health Care Plan, Review and Consultation items cover the consultations at which the relevant items are undertaken, noting that:

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

(b) if a GP Mental Health Care Plan is developed over more than one consultation, and those consultations are for the purposes of developing the plan, only the GP Mental Health Care Plan item should be claimed; and

(c) if a consultation is for the purpose of a GP Mental Health Care Plan, Review or Consultation item, a separate and additional consultation should not be undertaken in conjunction with the mental health consultation, unless it is clinically indicated that a separate problem must be treated immediately.

A.40.33 Where separate consultations are undertaken in conjunction with mental health consultations, the patient's invoice or Medicare voucher (assignment of benefit form) for the separate consultation should be annotated (eg separate consultation clinically required/indicated).

**A situation which seems to be coming more common is when a patient presents to one of the larger corporate practices and a mental health**

**care plan 2710 is conducted and referral made for focussed psychological services. The patient then returns a few months later to their 'usual GP' (not the corporate practice) or another GP altogether (not uncommon in people who 'doctor shop' and in populations such as itinerants, young people, and many suffering mental illness). What course of action should the second GP take? This situation may even increase when the CYs under headspace take a more active role in the provision of services for young people.**

**To date I have recommended that the second GP with patient permission first check with Medicare that a 2710 has been conducted. However is the second GP able to do a review (2712) in order to refer for 6 more sessions of FPS or does the GP have to insist that the patient return to the first GP? (in most cases the patient won't return to the first GP). Can a GP review a plan that was developed by another GP? In many of these cases the patient doesn't actually have a copy of the plan to actually be reviewed. The second GP is in a difficult situation, assessing that the patient requires further FPS but being unable to refer for such services. Or could the second GP argue that these were extenuating circumstances and actually conduct another 2710 within 12 months of the first 2710 being conducted?**

Where it is unclear whether a patient already has a GP Mental Health Care Plan developed within the previous 12 months, Medicare Australia should be contacted to confirm whether an item 2710 has previously been paid and if so, when.

Where a patient already has a GP Mental Health Care Plan developed within the previous 12 months, a common sense approach consistent with normal professional practice should be taken in relation to the mental health Medicare services to be provided to the patient.

It is recommended that the GP firstly ask the patient if they are able to provide them with a copy of the GP Mental Health Care Plan that was previously prepared. If the patient does not have a copy of their plan it is recommended that the GP, with the patient's permission, attempt to obtain a copy of the patient's GP Mental Health Care Plan from the GP who prepared the plan.

Where a GP is able to obtain a copy of the patient's previous GP Mental Health Care Plan, the GP should consider whether the existing plan is still appropriate for the patient. If the GP deems it appropriate, they may review the patient's GP Mental Health Care Plan using MBS item 2712. The MBS enables another GP to review a GP Mental Health Care Plan where the patient has changed practices. A review of a patient's GP Mental Health Care Plan cannot be done within 4 weeks of the date of the mental health care plan or within three months of a previous review of the plan using item 2712 unless exceptional circumstances apply.

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

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

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

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

Please refer to the GP Mental Health Care Question and Answer document on the Department's website at <http://health.gov.au/internet/wcms/publishing.nfs/Content/health-pcd-gp-mental-health-care-medicare> for additional information around 'usual doctor' expectations.

**As the education and training modules roll out the other question that is being asked more frequently is the role of the practice nurse and how much they can assist in the development of the care plan. The guidelines on the level of support that the practice nurse can provide are not very clear and the DLO network is fielding increased questioning around this issue. Could you please supply some wording around the appropriate level of involvement by the practice nurse?**

As you would be aware, the GP Mental Health Care items require a professional attendance by the GP. The explanatory notes for these items support this by stating that 'All consultations conducted as part of the GP Mental Health Care items must be rendered by the GP.'

The explanatory notes also provide guidance that general assistance may be provided to the GP in conducting these consultations. Specifically, 'A specialist mental health nurse, other allied health practitioner or Aboriginal Health Worker with appropriate mental health qualifications and training may provide general assistance to GPs in the provision of mental health care.'

This wording was included at the request of the relevant GP professional organisations during the development of these items. The intention of the wording is to indicate that there is some scope for a GP to be assisted by an appropriately qualified health professional but it is not intended that this assistance replace the requirement for the service to be rendered by the GP.

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

**My email and phone are also running hot on the issue of whether after 12 months and the delivery of 12 FPS for a patient whether a new 2710 is required to trigger the MBS items for an additional 6 + 6 sessions of FPS.**

**The wording from Medicare on this issue is confusing and often different divisions, GPs and allied health professionals are receiving conflicting advice from Medicare hotlines**

The information quoted from the MBS book and provided by Dr David Rankin of Medicare Australia is correct. Patients continue to be eligible for referred services while they continue to be managed by their GP under the relevant care plan, eg. by regular reviews of their care plan. Where the managing GP identifies that a patient will benefit from further allied mental health Medicare services in a new calendar year a new referral may be provided (within their calendar year entitlement). This referral may be done as part of a review of the care plan (or standard consultation item if a review of the care plan is not yet required).

The Department will be looking to provide advice on this issue through a range of avenues over the coming months. It would be appreciated if AGPN could consider including articles in any newsletter that will be sent to Division and/or GPs. We would be happy to provide specific wording for these articles in a format that suits the particular document.

**...at the meeting in Melbourne there was considerable confusion about the 're-ordering' of a second or even a third set of 6 FPS sessions. Karen indicated to the group that it was not necessary for the patient to visit the doctor for the second set to be approved, but this was not my understanding. I understood that the psychologist could recommend another 6 sessions but the GP had to make a clinical decision as to whether the second 6 were clinically warranted and this was to be done via a face to face consultation (either a normal consult, a 2713 or a 2712). The group was informed however that this decision could be done via a phone call between the psychologist and the GP and that the patient did not need to attend the GP.**

The Better Access Medicare items were developed in consultation with GP organisations, including AGPN, to be as flexible as possible while still ensuring appropriate service delivery and the integrity of the Medicare payment system. Consistent with this approach, there is maximum flexibility available to GPs around the means by which they might consider that a patient will benefit from further allied mental health services.

As you note, the referring practitioner must make a clinical decision that a patient will benefit from further allied mental health Medicare services before agreeing that further services should be provided. While it is generally expected that the referring practitioner will consider the need for further services in a face-to-face consultation with the patient, in some instances the referring practitioner may consider that an attendance is not necessary (for example, having recently seen the patient, including for another reason) and may agree to further allied mental health Medicare services based on a report from and/or discussions with the allied mental health provider, or other evidence. Any clinical decision made by the referring practitioner in relation to further services should be documented in the patient's record