Home Medicines Review (HMR)

*HMR is also known as Domiciliary Medication Management Review (DMMR) and is covered by Medicare Benefit Schedule Item Number 900.*

An HMR is a consumer-focused, structured and collaborative health care service provided in the community setting, to optimise quality use of medicines and consumer understanding. It involves the consumer, their general practitioner (GP), an accredited pharmacist, and the consumer’s regular pharmacy, along with any other relevant members of the health care team. Full details of MBS Item Number 900 are shown in Appendix 1.

Changes to the rules for HMRs will come into place on the 1st October 2011 that will allow GPs to directly refer patients to an accredited pharmacist (see Appendix 2).

1. **What are the benefits of an HMR?**

Following referral, an interview is conducted with the consumer and an accredited pharmacist prepares a report for the GP. This review has a number of major benefits.

- Provides the GP and patient with a comprehensive, up-to-date summary of all the medicines, complementary products, devices and other prescriptions being used by the patient.
- Reinforces the medication related advice given by the GP to the patient.
- Provides recommendations for the GP on any potential or actual drug related problems that may be an issue for the patient.
- Assists the patient with medications/aids/devices to improve compliance and early detection and management of medicine-related problems.
- Provides patients with an understanding of their medicines and enhances their ability to manage their medicines appropriately.

A bibliography of the key articles outlining the clinical benefits of medication reviews can be found in Appendix 3.

2. **Who can have an HMR?**

Fundamentally, any patient with a chronic disease taking medication is likely to obtain some benefit from an HMR. Particular patient groups have, however, been identified as having improved clinical outcomes following HMRs. These include patients taking anticoagulants, and patients with heart failure, hypertension, diabetes or asthma (see references at end of document). In addition patients in the post-discharge period often benefit from a review to clarify and implement medication changes made in the tertiary care setting.

Examples of known risk factors that may lead to medication misadventure in patients are shown below. The issues listed are only some of the risk factors for medication misadventure and are NOT eligibility criteria.
Currently taking 5 or more regular medications;
Taking more than 12 doses of medication/day;
Significant changes made to the medication regimen in the last 3 months;
Medication with a narrow therapeutic index or medications requiring therapeutic monitoring;
Symptoms suggestive of an adverse drug reaction;
Sub-therapeutic response to treatment with medicines;
Suspected non-compliance or inability to manage medication related therapeutic devices;
Patients having difficulty managing their own medicines because of literacy or language difficulties, dexterity problems or impaired sight, confusion/dementia or other cognitive difficulties;
Patients attending a number of different doctors, both general practitioners and specialists;
Recent discharge from a facility/hospital (in the last 4 weeks) and/or
OTHERS (e.g. loss of spouse, different health care professional involved in treatment)

A consumer flyer that can be personalized is attached at Appendix 4.

3. What is the HMR Process?

Once consent is gained from the patient, the referral can be sent to the patient’s routine pharmacy, or from the 1st October 2011, directly to an accredited pharmacist of the patient’s choice. An interview is then conducted with the patient and their medications are checked. Ideally this would take place in the patient’s home, but if they do not wish to have the pharmacist visit, it could be arranged in the pharmacy or the medical clinic. A report is provided to the GP and a medication management plan is developed using the recommendations from the accredited pharmacist.

The recommendations from the accredited pharmacist can be used to assist in the completion of a number of other team care and management plan items (see example below). Further details in Appendix 5.
### Suggested Annual Care Cycle for Chronic Disease Patients (using GP Management Plans)

<table>
<thead>
<tr>
<th>Month</th>
<th>Visit 1: Standard health assessment- 703 (referral for HMR as part of this and recommendation that a GP Management Plan be set up for patients with chronic diseases) <strong>Fee:</strong> $132.70 <strong>Benefit:</strong> 100% = $132.70</th>
<th>703: $132.70</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month 3</td>
<td>Visit 2: Preparation of a GP Management Plan- (MBS Item 721 <strong>Fee:</strong> $138.75 <strong>Benefit:</strong> 75% = $104.10 100% = $138.75), review and claim HMR (Item 900- <strong>Fee:</strong> $148.90 <strong>Benefit:</strong> 100% = $148.90)</td>
<td>721: $138.75</td>
</tr>
<tr>
<td></td>
<td>900: $148.90</td>
<td></td>
</tr>
<tr>
<td>Month 6</td>
<td>Visit 3: 3 months after visit 2, review GPMP (MBS Item 732 <strong>Fee:</strong> $69.35 <strong>Benefit:</strong> 75% = $52.05 100% = $69.35 )</td>
<td>732: $69.35</td>
</tr>
<tr>
<td>Month 9</td>
<td>Visit 4, 3 months after visit 3, review GP Management Plan (MBS Item 732 <strong>Fee:</strong> $69.35 <strong>Benefit:</strong> 75% = $52.05 100% = $69.35)</td>
<td>732: $69.35</td>
</tr>
<tr>
<td>Month 12</td>
<td>Visit 5: 3 months after visit 4, review GPMP (MBS Item 732 <strong>Fee:</strong> $69.35 <strong>Benefit:</strong> 75% = $52.05 100% = $69.35).</td>
<td>732: $69.35</td>
</tr>
<tr>
<td></td>
<td>Conduct a new Health assessment (annual MBS item 703) and refer for an annual HMR (MBS Item 900) and continue cycle as above</td>
<td></td>
</tr>
</tbody>
</table>

### Suggested Annual Care Cycle for Chronic Disease Patients (Using Team Care Arrangements)

<table>
<thead>
<tr>
<th>Month</th>
<th>Visit 1: Standard health assessment- 703 (referral for HMR as part of this and recommendation that a Team Care Arrangement be set up for patients with chronic diseases) <strong>Fee:</strong> $132.70 <strong>Benefit:</strong> 100% = $132.70</th>
<th>703: $132.70</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month 3</td>
<td>Visit 2: Coordination of Team Care Arrangements (MBS Item 723 <strong>Fee:</strong> $109.95 <strong>Benefit:</strong> 75% = $82.50 100% = $109.95) and claim HMR (Item 900- <strong>Fee:</strong> $148.90 <strong>Benefit:</strong> 100% = $148.90)</td>
<td>723: $109.95</td>
</tr>
<tr>
<td></td>
<td>900: $148.90</td>
<td></td>
</tr>
<tr>
<td>Month 6</td>
<td>Visit 3: 3 months after visit 2, review Team Care Arrangement (MBS Item 732 <strong>Fee:</strong> $69.35 <strong>Benefit:</strong> 75% = $52.05 100% = $69.35)</td>
<td>732: $69.35</td>
</tr>
<tr>
<td>Month 9</td>
<td>Visit 4, 3 months after visit 3, review Team Care Arrangement (MBS Item 732 <strong>Fee:</strong> $69.35 <strong>Benefit:</strong> 75% = $52.05 100% = $69.35)</td>
<td>732: $69.35</td>
</tr>
<tr>
<td>Month 12</td>
<td>Visit 5: 3 months after visit 4, review Team Care Arrangement (MBS Item 732 <strong>Fee:</strong> $69.35 <strong>Benefit:</strong> 75% = $52.05 100% = $69.35).</td>
<td>732: $69.35</td>
</tr>
<tr>
<td></td>
<td>Conduct a new Health assessment (annual MBS item 703) and refer for an annual HMR (MBS Item 900) and continue cycle as above</td>
<td></td>
</tr>
</tbody>
</table>
How can I incorporate HMRs into my Practice?

Once the decision to incorporate HMRs into the care of patients with chronic disease is made, there are a number of models for implementation that can be considered. One of the key aspects of all of these models is the identification of appropriate patients.

**Patient Identification**

There are multiple mechanisms for determining patients who may benefit from an HMR (see above) in a systematic way. Incorporating an HMR into the care cycle for patients with chronic diseases who are having either a GP management plan or a team care arrangement is one mechanism.

**HMRAlert Software**

The efficiency of the identification of patients can be optimised by HMR-Alert a purpose designed software that integrates with Medical Director and Best Practice. This software allows each GP to set their own parameters for patients and generates an alert when the patient’s file is opened. Once consent is obtained the referral is sent electronically to the pharmacist or pharmacy of the patient’s choice. More details about HMR Alert can be found in Appendix 6.

**Dispensing History**

Pharmacies can be involved in identifying patients, and this can be done on a day-to-day or campaign basis. On a day-to-day basis, pharmacists dispensing prescriptions can inform patients of the benefits of HMRs and obtain approval to notify the medical clinic of the patient’s interest. On a campaign basis, the pharmacy can send information to its high volume prescription customers regarding HMRs, and they can then come in to the clinic or pharmacy to arrange an HMR.

**Accredited Pharmacist Interview**

The interview with the patient can take place in the patients home, however, if the patient prefers the discussion can take place in another location. Many pharmacies have a consulting room that can accommodate this process and some medical clinics may have a spare consulting room on some days. This model of having the accredited pharmacist consulting on a monthly or fortnightly basis in the medical clinic has a number of benefits that make the HMRs more effective. Pharmacists have access to the medical records of the patients being interviewed and are often in the position to discuss some of the issues with the GP prior to preparing a medication review report.

**Medication Management Plan**

The end point of the MBS Item 900 is a medication management plan endorsed by the GP and a discussion with the patient to implement the plan. A consistently effective approach has been for the accredited pharmacist to prepare their HMR report in the format of a draft medication management plan. A suggested format for a HMR report and medication Management plan is attached in Appendix 7.
Appendix 1: Full details of Medicare Benefits Schedule - Item 900

A42 Medication Management Reviews - (Items 900 and 903)

Item 900 - Domiciliary Medication Management Review

A Domiciliary Medication Management Review (DMMR) (Item 900), also known as Home Medicines Review,

is intended to maximise an individual patient's benefit from their medication regimen, and prevent medication-related problems through a team approach, involving the patient's GP and preferred community pharmacy or accredited pharmacist.

Patient eligibility

The item is available to people living in the community who meet the criteria for a DMMR.

The item is not available for in-patients of a hospital, or care recipients in residential aged care facilities.

DMMRs are targeted at patients who are likely to benefit from such a review: patients for whom quality use of medicines may be an issue or; patients who are at risk of medication misadventure because of factors such as their co-morbidities, age or social circumstances, the characteristics of their medicines, the complexity of their medication treatment regimen, or a lack of knowledge and skills to use medicines to their best effect.

Examples of risk factors known to predispose people to medication related adverse events are:

- currently taking five or more regular medications;
- taking more than 12 doses of medication per day;
- significant changes made to medication treatment regimen in the last three months;
- medication with a narrow therapeutic index or medications requiring therapeutic monitoring;
- symptoms suggestive of an adverse drug reaction;
- sub-optimal response to treatment with medicines;
- suspected non-compliance or inability to manage medication related therapeutic devices;
- patients having difficulty managing their own medicines because of literacy or language difficulties, dexterity problems or impaired sight, confusion/dementia or other cognitive difficulties;
- patients attending a number of different doctors, both general practitioners and specialists; and
- recent discharge from a facility / hospital (in the last four weeks).
REGULATORY REQUIREMENTS

In conducting a DMMR, a medical practitioner must:

(a) assess a patient's medication management needs; and

(b) following that assessment, refer the patient to a community pharmacy or an accredited pharmacist for a DMMR; and

(c) with the patient's consent, provide relevant clinical information required for the review; and

(d) discuss with the reviewing pharmacist the results of that review, including suggested medication management strategies; and

(e) develop a written medication management plan following discussion with the patient.

Claiming

A DMMR includes all DMMR-related services provided by the medical practitioner from the time the patient is identified as potentially needing a medication management review to the preparation of a draft medication management plan, and discussion and agreement with the patient.

The benefit is not claimable until all the components of the item have been rendered.

Benefits for a DMMR service under item 900 are payable only once in each 12 month period, except where there has been a significant change in the patient's condition or medication regimen requiring a new DMMR (e.g. diagnosis of a new condition or recent discharge from hospital involving significant changes in medication). In such cases the patient's invoice or Medicare voucher should be annotated to indicate that the DMMR service was required to be provided within 12 months of another DMMR service.

If the DMMR is initiated during the course of a consultation undertaken for another purpose, this consultation may also be claimed separately.

If the consultation at which the medication management review is initiated is only for the purposes of initiating the review only item 900 may be claimed.

If the medical practitioner determines that a DMMR is not necessary, item 900 does not apply. In this case, normal consultation items should be used.

Where a DMMR cannot be completed due to circumstances beyond the control of the medical practitioner (e.g. because the patient decides to not proceed further with the DMMR, or because of a change in the circumstances of the patient), the relevant MBS attendance items should be used.
FURTHER GUIDANCE

A DMMR should generally be undertaken by the patient’s usual medical practitioner. This is the medical practitioner, or a medical practitioner working in the medical practice, that has provided the majority of services to the patient over the previous 12 months and/or will be providing the majority of services to the patient over the coming 12 months.

The potential need for a DMMR may be identified either by the medical practitioner in the process of a consultation or by receipt of advice from the patient, a carer or another health professional including a pharmacist.

The process of referral to a community pharmacy or an accredited pharmacist includes:

· Obtaining consent from the patient, consistent with normal clinical practice, for a pharmacist to undertake the medication management review and for a charge to be incurred for the service for which a Medicare rebate is payable. The patient must be clearly informed of the purpose and possible outcomes of the DMMR, the process involved (including that the pharmacist will visit the patient at home, unless the patient prefers another location or other exceptional circumstances apply), what information will be provided to the pharmacist as part of the DMMR, and any additional costs that may be incurred; and

· Provision to the patient’s preferred community pharmacy or accredited pharmacist, of relevant clinical information, by the medical practitioner for each individual patient, covering the patient’s diagnosis, relevant test results and medication history, and current prescribed medications.

· A DMMR referral form is available for this purpose. If this form is not used, the medical practitioner must provide patient details and relevant clinical information to the patient’s preferred community pharmacy or accredited pharmacist.

The discussion of the review findings and report including suggested medication management strategies with the reviewing pharmacist includes:

· Receiving a written report from the reviewing pharmacist; and

· Discussing the relevant findings and suggested management strategies with the pharmacist (either by phone or face to face); and

· Developing a summary of the relevant review findings as part of the draft medication management plan.

Development of a written medication management plan following discussion with the patient includes:

· Developing a draft medication management plan and discussing this with the patient; and

· Once agreed, offering a copy of the written medication management plan to the patient and providing a copy to the community pharmacy or accredited pharmacist.

The agreed plan should identify the medication management goals and the proposed medication regimen for the patient.
Participation by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) in a **Domiciliary Medication Management Review (DMMR)** for patients living in the community setting, where the medical practitioner:

- assesses a patient's medication management needs, and following that assessment, refers the patient to a community pharmacy or an accredited pharmacist for a DMMR, and provides relevant clinical information required for the review, with the patient's consent; and

- discusses with the reviewing pharmacist the results of that review including suggested medication management strategies; and

- develops a written medication management plan following discussion with the patient.

Benefits under this item are payable not more than once in each 12 month period, except where there has been a significant change in the patient's condition or medication regimen requiring a new DMMR.

**Fee:** $148.90 **Benefit:** 100% = $148.90
Appendix 2: DOHA Factsheet on HMR Changes on 1st October 2011

Home Medicines Review (HMR)

The Home Medicines Review (HMR) service is available to people living in the community setting where their medical practitioner determines that an HMR is clinically necessary to ensure quality use of medicines or to address the consumer’s needs. The HMR service is not available for in-patients of a hospital, day hospital facility or care recipients in Commonwealth funded residential aged care facilities.

Between July 2010 and June 2015, the Fifth Community Pharmacy Agreement (SCPA) includes funding of up to $62.11 million for the provision of HMR services.

Under the SCPA, a number of changes will be implemented to the HMR Program.

From June 2011:
Medicare Australia will write to all HMR Service Provider community pharmacies, requesting information about the accredited pharmacists that conduct their HMRs. Pharmacies will be provided with a Section 90 Pharmacy Notification of Accredited Pharmacists Form by Medicare Australia.

From 1 October 2011:
General practitioners can continue to provide an HMR referral to a patient’s usual community pharmacy, as well as directly to an accredited pharmacist who has been approved as a HMR Service Provider.

Medicare Australia will cease making payments for the HMR Rural Loading on 30 September 2011. This incentive will be replaced by the HMR Rural Allowance, administered by The Pharmacy Guild of Australia (the Guild) from 1 October 2011. From that date, all claims for HMR Rural Loading should be sent to the Guild, regardless of whether the service was provided before or after 1 October. Further details on how to claim for the HMR Rural Allowance will be provided closer to 1 October and will be available at www.5cpa.com.au

Home Medicine Review Services

What do I need to do to provide a HMR from 1 October 2011?
If your Section 90 community pharmacy is currently a HMR Service Provider, you must complete a Section 90 Pharmacy Notification of Accredited Pharmacists Form and return it with copies of each pharmacist’s accreditation certificates to Medicare Australia by 31 August 2011. This form will be sent to you by Medicare Australia in June 2011.

If you have not received this form by 31 July 2011, please contact Medicare Australia HMR Program staff on 08 8274 9641 or sa.guild.govt.prg@medicareaustralia.gov.au

If your Section 90 community pharmacy is not a HMR Service Provider and would like to provide the HMR service, you must:

1. apply to be a HMR Service Provider by completing a Medication Management Review Programs Service Provider Application Form
2. submit the form to Medicare Australia
3. if your application is approved, you will be notified by Medicare Australia in writing.

If you are an accredited pharmacist who would like to receive HMR referrals directly from general practitioners from 1 October 2011, you must:

1. apply to be a HMR Service Provider by completing a Medication Management Review Programs Service Provider Application form
2. submit the application form to Medicare Australia
3. if your application is approved, you will be notified by Medicare Australia in writing.

The Home Medicines Review Program is funded by the Australian Government of Health and Ageing as part of the Fifth Community Pharmacy Agreement between the Commonwealth and The Pharmacy Guild of Australia.
Who can provide a HMR between now and 30 September 2011?

If your Section 90 community pharmacy is currently a HMR Service Provider, you can continue to provide HMR services.

If your Section 90 community pharmacy is not a HMR Service Provider, you can apply to become an HMR Service Provider by completing the current HMR Application Form. Medicare Australia will send you a letter confirming your approval to provide the HMR service. Medicare Australia will also advise you of any further requirements to ensure your approval status remains current from 1 October. The HMR Service Provider Application Form is available from the Medicare Australia website: www.medicareaustralia.gov.au

Will there be any change to claiming arrangements?

Medicare Australia will be changing the HMR Claim Form for HMR services to capture extra information associated with these changes. For a limited time, HMR Service Providers will be able to use the new HMR Claim Form to submit claims for services that were provided prior to 1 October. From 16 January 2012, claims for services conducted prior to 1 October 2011 will not be processed.

The Section 90 Pharmacy Notification of Accredited Pharmacists Form will be posted to all HMR Service Provider community pharmacies by Medicare Australia in June 2011. If you do not receive this form by 31 July 2011, please contact Medicare HMR Program staff on 08 8274 9641 or sa.guild.govt.prog@medicareaustralia.gov.au

The HMR Service Provider Application Form and the Medication Management Review Programs Service Provider Application Form can be located at the Medicare Australia website: www.medicareaustralia.gov.au

Appendix 3: Bibliography of Articles showing Clinical Benefits of HMRs


Appendix 4: HMR Consumer Flyer

HMR Consumer Flyer

Get the best out of your medicines.
Ask your doctor or pharmacist about a Home Medicines Review.

For further information visit: www.guild.org.au

Home Medicines Review

Do your medicines need a check up?
Get the best out of your medicines.

Would you or someone you care for benefit from a Home Medicines Review? ... Take the test √

Tick the boxes that apply:

☐ Have you recently been discharged from hospital?
☐ Are you taking several medicines? (including supermarket or herbal medicines)
☐ Have you had recent changes to your medicines?
☐ Do your medicines need monitoring? (e.g. blood thinning medicines)
☐ Do any of your medicines make you feel unwell?
☐ Do you use devices to assist with medication management such as monitoring blood glucose or a nebuliser?
☐ Do you attend more than one doctor including general practitioners and specialists?
☐ Are you sometimes unsure about which medicines you should be taking?
☐ Would you like to be more confident about understanding your medicines?

Many different people are helped by a Home Medicines Review.

☐ Are you a child or adolescent with an ongoing health condition? (e.g. asthma)
☐ Are you from a non-English speaking background?
☐ Are you receiving palliative care?
☐ Do you have a heart condition?
☐ Do you have asthma or emphysema?
☐ Do you have a mental health condition?
☐ Do you have diabetes?

If you have ticked one or more of the above boxes, you may benefit from a Home Medicines Review.

Home Medicines Review

Are your medicines right for you?
Every year, up to 210,000 Australians are admitted to hospital due to medication problems. At least 50% of these admissions could be avoided by better medicine management.

A Home Medicines Review (HMR) helps you understand your medicines and stay out of hospital.

What is a Home Medicines Review?
A Home Medicines Review is a free health service funded by the Commonwealth Government.

A Home Medicines Review involves a pharmacist visiting you at home and reviewing all your medicines. The pharmacist then works together with your doctor to develop a plan to manage and record the medicines you take.

By working together with you, your doctor and pharmacist can identify any medication problems and make sure your medicines are:

☐ The best treatment option for you;
☐ Suitable and safe to take together; and
☐ Taken correctly.

Why have a Home Medicines Review?
A Home Medicines Review will help you better manage your medicines. It will help

☐ Increase your knowledge about your medicines;
☐ Increase your confidence in using your medicines; and
☐ Reduce your risk of an avoidable trip to hospital.

Ask your doctor or pharmacist about a Home Medicines Review.
TEAM CARE ARRANGEMENTS AND OTHER ENHANCED PRIMARY CARE

Enhanced Primary Care (EPC) is a term used to describe certain GP activities that attract an individual MBS item number allowing the GP to claim payment for specific services. EPC Item numbers require the input of other health care professionals as a part of the patients overall management. Pharmacists are often invited to participate in a patient’s care as a part of these EPC activities but sometimes unsure of how they can best participate.

A HMR is the best way for a pharmacist to participate in CDM as it gives them a better insight into the patient’s medication management and at the same time allowing the pharmacist to be paid for their time.

Examples of EPC Items include:

1. GP Management Plan
   - Item is for patients with chronic health conditions or a terminal illness and requires care from at least three other health care providers. Sometimes the GP may identify that an HMR may be useful and start it at the same time and the GP Management Plan.

2. Team Care Arrangement (TCAs)
   - Aim is to minimise potential health risk and have more appropriate use of medication, home care and other services.
   - Includes at least three other health care professionals who are willing to participate and are available to provide care or monitoring.
   - If pharmacies receive a Team Care Arrangement (TCA) the only response is to conduct an HMR.
   - The pharmacy will need to contact the GP to gain the correct information for an HMR as there is not enough information on the TCA to conduct an HMR.

3. Case Conference
   - Aim is to minimise potential health risk and have more appropriate use of medication, home care and other services.
   - GP is required to meet with at least three other health care providers involved in the care of the patient. It can be face to face, video-conference or in a telephone link.
   - If pharmacist asked to participate, it would be useful for HMR to be conducted before the case conference.

4. Health Assessment
   - Aim to minimize potential health risks.
   - Conducted annually for patients > 75 years and Aboriginal or TSI >55.
   - Contains ‘medication review’ component for GP to conduct but this is much briefer and different to HMR. A HMR would be useful before GP conducts HA.

HMR Fact Sheet #6 HMR & Other Medicare Items
The Pharmacy Guild of Australia NSW Branch 02 9467 7124
carlene.smith@nsw.guild.org.au
There are four time-based health assessment items, consisting of brief, standard, long and prolonged consultations.

**Brief Health Assessment (MBS 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 (MBS 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 (MBS 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 (MBS 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.

Medical practitioners may select one of the MBS health assessment items to provide a health assessment service to a member of any of the target groups listed in the table below. The health assessment item that is selected will depend on the time taken to complete the health assessment 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.

MBS Items 701, 703, 705 and 707 may be used to undertake a health assessment for the following target groups:

<table>
<thead>
<tr>
<th>Target Group</th>
<th>Frequency of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Healthy Kids Check for children aged at least 3 years and less than 5 years of age, who have received or who are receiving their 4 year old immunisation</td>
<td>Once only to an eligible patient</td>
</tr>
<tr>
<td>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</td>
<td>Once every three years to an eligible patient</td>
</tr>
</tbody>
</table>
## Risk Assessment Tool

<table>
<thead>
<tr>
<th>Description</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>A health assessment for people aged 45-49 years (inclusive) who are at risk of developing chronic disease</td>
<td>Once only to an eligible patient</td>
</tr>
<tr>
<td>A health assessment for people aged 75 years and older</td>
<td>Provided annually to an eligible patient</td>
</tr>
<tr>
<td>A comprehensive medical assessment for permanent residents of residential aged care facilities</td>
<td>Provided annually to an eligible patient</td>
</tr>
<tr>
<td>A health assessment for people with an intellectual disability</td>
<td>Provided annually to an eligible patient</td>
</tr>
<tr>
<td>A health assessment for refugees and other humanitarian entrants</td>
<td>Once only to an eligible patient</td>
</tr>
</tbody>
</table>

A health assessment means the assessment of a patient’s health and physical, psychological and social function and consideration of whether preventive health care and education should be offered to the patient, to improve that patient's health and physical, psychological and social function.

Health assessments are not available to people who are in-patients of a hospital or care recipients in a residential aged care facility (with the exception of a comprehensive medical assessment provided to a permanent resident of a residential aged care facility).

Before a health assessment is commenced, the patient (and/or his or her parent(s), carer or representative, as appropriate) must be given an explanation of the health assessment process and its likely benefits. The patient must be asked whether he or she consents to the health assessment being performed. In cases where the patient is not capable of giving consent, consent must be given by his or her parent(s), carer or representative. Consent to the health assessment must be noted in the patient’s records.

A health assessment must include the following elements:

1. **Information collection**, including taking a patient history and undertaking or arranging examinations and investigations as required;
2. **Making an overall assessment** of the patient;
3. **Recommending appropriate interventions**;
4. **Providing advice** and information to the patient;
5. **Keeping a record of the health assessment**, and offering the patient a written report about the health assessment, with recommendations about matters covered by the health assessment; and
6. Offering the patient's carer (if any, and if the medical practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report relevant to the carer.
A health assessment may only be claimed by a medical practitioner (including a general practitioner but not including a specialist or consultant physician).

A health assessment should generally be undertaken by the patient's 'usual doctor'. For the purpose of the health assessment items, 'usual doctor' means the medical practitioner, or a medical practitioner 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.

A health assessment should not take the form of a health screening service

MBS health assessment items 701, 703, 705, 707 must be provided by a medical practitioner personally attending upon a patient. Suitably qualified health professionals, such as practice nurses or Aboriginal health workers, employed and/or otherwise engaged by a general practice or health service, may assist medical practitioners in performing health assessments. Such assistance must be provided 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.

The medical practitioner should be satisfied that the assisting health professional has the necessary skills, expertise and training to collect the information required for the health assessment.

Medical practitioners should not conduct a separate consultation for another health-related issue in conjunction with a health assessment unless it is clinically necessary (ie. the patient has an acute problem that needs to be managed separately from the assessment). The only exceptions are:

(a) a health assessment provided as a Healthy Kids Check, where a consultation associated with the four year old immunisation can be conducted on the same occasion; and

(b) the comprehensive medical assessment, where, if this health assessment is undertaken during the course of a consultation for another purpose, the health assessment item and the relevant item for the other consultation may both be claimed.

Items 701, 703, 705 and 707 do not apply for services that are provided by any other Commonwealth or State funded services. However, where an exemption under subsection 19(2) of the Health Insurance Act 1973 has been granted to an Aboriginal Community Controlled Health Service or State/Territory Government health clinic, items 701, 703, 705 and 707 can be claimed for services provided by medical practitioners salaried by or contracted to, the Service or health clinic. All other requirements of the items must be met.
Item 10990 or 10991 (bulk billing incentives) can be claimed in conjunction with any health assessment, provided the conditions of item 10990 and 10991 are satisfied.

Related Items: 701, 703, 705, 707

HEALTH ASSESSMENTS

HEALTH ASSESSMENT - BRIEF

Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) to perform a brief health assessment, lasting not more than 30 minutes and, including:

a) Collection of relevant information, including taking a patient history;

b) A basic physical examination;

c) Initiating interventions and referrals as indicated; and

d) Providing the patient with preventive health care advice and information.

Fee: $57.10 Benefit: 100% = $57.10

(See para A25, A26, A27, A28, A29, A30, A31, A32 of explanatory notes to this Category)

Category 1 - PROFESSIONAL ATTENDANCES

HEALTH ASSESSMENT - STANDARD  ITEM 701

Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) to perform a standard health assessment, lasting more than 30 minutes but less than 45 minutes, including:

a) Detailed information collection, including taking a patient history;

b) An extensive physical examination;

c) Initiating interventions and referrals as indicated; and

d) Providing a preventive health care strategy for the patient.

Fee: $132.70 Benefit: 100% = $132.70

(See para A25, A26, A27, A28, A29, A30, A31, A32 of explanatory notes to this Category)
HEALTH ASSESSMENT - LONG

Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) to perform a long health assessment, lasting at least 45 minutes but less than 60 minutes, including:

a) Comprehensive information collection, including taking a patient history;

b) An extensive examination of the patient's medical condition and physical function;

c) Initiating interventions and referrals as indicated; and

d) Providing a basic preventive health care management plan for the patient.

Fee: $183.05 Benefit: 100% = $183.05

(See para A25, A26, A27, A28, A29, A30, A31, A32 of explanatory notes to this Category)

HEALTH ASSESSMENT - PROLONGED

Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) to perform a prolonged health assessment, lasting at least 60 minutes, including:

a) Comprehensive information collection, including taking a patient history;

b) An extensive examination of the patient's medical condition, and physical, psychological and social function.

c) Initiating interventions and referrals as indicated; and

d) Providing a comprehensive preventive health care management plan for the patient.

Fee: $258.65 Benefit: 100% = $258.65

(See para A25, A26, A27, A28, A29, A30, A31, A32 of explanatory notes to this Category)

<table>
<thead>
<tr>
<th>Description</th>
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<td>Preparation of a GP Management Plan (GPMP)</td>
<td>721</td>
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<td>Coordination of Team Care Arrangements (TCAs)</td>
<td>723</td>
<td>12 months</td>
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Contribution to a Multidisciplinary Care Plan, or to a Review of a Multidisciplinary Care Plan, for a patient who is not a care recipient in a residential aged care facility | 729 | 3 months

Contribution to a Multidisciplinary Care Plan, or to a review of a multidisciplinary care plan, for a resident in an aged care facility | 731 | 3 months

Review of a GP Management Plan or Coordination of a Review of Team Care Arrangements | 732 | 3 months

- CDM services may be provided more frequently in the exceptional circumstances defined below.

Exceptional circumstances exist for a patient if there has been a significant change in the patient's clinical condition or care requirements that necessitates the performance of the service for the patient.

**Regulatory requirements**

Items 721, 723, 729, 731 and 732 provide rebates for GPs to manage chronic or terminal medical conditions by preparing, coordinating, reviewing or contributing to chronic disease management (CDM) plans. They apply for a patient who suffers from at least one medical condition that has been present (or is likely to be present) for at least six months or is terminal.

**Patient eligibility**

In addition to the eligibility requirements listed in the individual CDM item descriptors, the General Medical Services Table (GMST) mandates the following eligibility criteria:

**CDM items 721, 723 and 732**

These are:

- available to:
  - i. patients in the community; and
  - ii. private in-patients of a hospital (including private in-patients who are residents of aged care facilities) being discharged from hospital.

- not available to:
  - i. public in-patients of a hospital; or
  - ii. care recipients in a residential aged care facility.

**CDM item 729**

This is:

- available to:
i. patients in the community;

ii. both private and public in-patients being discharged from hospital.

not available to care recipients in a residential aged care facility.

**CDM item 731**

This item is available to care recipients in a residential aged care facility only.

**Item 721**

A comprehensive written plan must be prepared describing:

(a) the patient's health care needs, health problems and relevant conditions;

(b) management goals with which the patient agrees;

(c) actions to be taken by the patient;

(d) treatment and services the patient is likely to need;

(e) arrangements for providing this treatment and these services; and

(f) arrangements to review the plan by a date specified in the plan.

In preparing the plan, the provider must:

(a) explain to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) the steps involved in preparing the plan; and

(b) record the plan; and

(c) record the patient's agreement to the preparation of the plan; and

(d) offer a copy of the plan to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees); and

(e) add a copy of the plan to the patient's medical records.

**Item 723**

When coordinating the development of Team Care Arrangements (TCAs), the medical practitioner must:

(a) consult with at least two collaborating providers, each of whom will provide a different kind of treatment or service to the patient, and one of whom may be another medical practitioner, when
making arrangements for the multidisciplinary care of the patient; and

(b) prepare a document that describes:

i. treatment and service goals for the patient;

ii. treatment and services that collaborating providers will provide to the patient; and

iii. actions to be taken by the patient;

iv. arrangements to review (i), (ii) and (iii) by a date specified in the document; and

(c) explain the steps involved in the development of the arrangements to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees);

(d) discuss 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; and

(e) record the patient's agreement to the development of TCAs;

(f) give copies of the relevant parts of the document to the collaborating providers;

(g) offer a copy of the document to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees); and

(h) add a copy of the document to the patient's medical records.

One of the minimum two service providers collaborating with the GP can be another medical practitioner. The patient's informal or family carer can be included in the collaborative process but does not count towards the minimum of three collaborating providers.

Item 729

A multidisciplinary care plan means a written plan that:

(a) is prepared for a patient by:

   i. a medical practitioner in consultation with two other collaborating providers, each of whom provides a different kind of treatment or service to the patient, and one of whom may be another medical practitioner; or

   ii. a collaborating provider (other than a medical practitioner) in consultation with at least two other collaborating providers, each of whom provides a different kind of treatment or services to the patient; and

(b) describes, at least, treatment and services to be provided to the patient by the collaborating
When contributing to a multidisciplinary care plan or to a review of the care plan, the medical practitioner must:

(a) prepare part of the plan or amendments to the plan and add a copy to the patient's medical records; or

(b) give advice to a person who prepares or reviews the plan and record in writing, on the patient's medical records, any advice provided to such a person.

**Item 731**

A multidisciplinary care plan in a Residential Aged Care Facility (RACF) means a written plan that:

(a) is prepared for a patient by a collaborating provider (other than a medical practitioner, e.g. a RACF), in consultation with at least two other collaborating providers, each of whom provides a different kind of treatment or services to the patient; and

(b) describes, at least, treatment and services to be provided to the patient by the collaborating providers.

When contributing to a multidisciplinary care plan or to a review of the care plan, the medical practitioner must:

(a) prepare part of the plan or amendments to the plan and add a copy to the patient's medical records; or

(b) give advice to a person who prepares or reviews the plan and record in writing, on the patient's medical records, any advice provided to such a person.

Item 731 can also be used for contribution to a multidisciplinary care plan prepared for a resident by another provider before the resident is discharged from a hospital or an approved day-hospital facility, or to a review of such a plan prepared by another provider (not being a service associated with a service to which items 735 to 758 apply).

**Item 732**

An "associated medical practitioner" is a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) who, if not engaged in the same general practice as the
medical practitioner mentioned in that item, performs the service mentioned in the item at the request of the patient (or the patient’s guardian).

When reviewing a GP Management Plan, the medical practitioner must:

(a) explain to the patient and the patient’s carer (if any, and if the practitioner considers it appropriate and the patient agrees) the steps involved in the review;

(b) record the patient’s agreement to the review of the plan;

(c) review all the matters set out in the relevant plan;

(d) make any required amendments to the patient's plan;

(e) offer a copy of the amended document to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees);

(f) add a copy of the amended document to the patient's records; and

(g) provide for further review of the amended plan by a date specified in the plan.

When coordinating a review of Team Care Arrangements, a multidisciplinary community care plan or a multidisciplinary discharge care plan, the practitioner must:

(a) explain the steps involved in the review to the patient and the patient’s carer (if any, and if the practitioner considers it appropriate and the patient agrees);

(b) record the patient’s agreement to the review of the TCAs or plan;

(c) consult with at least two health or care providers (each of whom provides a service or treatment to the patient that is different from each other and different from the service or treatment provided by the medical practitioner who is coordinating the TCAs or plan) to review all the matters set out in the relevant plan;

(d) make any required amendments to the patient's plan;

(e) offer a copy of the amended document to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees);

(f) provide for further review of the amended plan by a date specified in the plan;

(g) give copies of the relevant parts of the amended plan to the collaborating providers; and

(h) add a copy of the amended document to the patient's records.

Item 732 can also be used to COORDINATE A REVIEW OF a Multidisciplinary Community Care Plan
(former item 720) or to COORDINATE REVIEW OF A Discharge Care Plan (former item 722), where these services were coordinated or prepared by that medical practitioner (or an associated medical practitioner), and not being a service associated with a service to which items 735-758 apply.

Claiming of benefits

Each service to which item 732 applies (i.e. Review of a GP Management Plan and Review of Team Care Arrangements) may be claimed once in a three-month period, except where there are exceptional circumstances arising from a significant change in the patient's clinical condition or care circumstances that necessitates earlier performance of the service for the patient.

Where a service is provided in exceptional circumstances, the patient's invoice or Medicare voucher should be annotated to indicate the reason why the service was required earlier than the minimum time interval for the relevant item. Payment can then be made.

Item 732 can be claimed twice on the same day providing an item 732 for reviewing a GP Management Plan and another 732 for reviewing Team Care Arrangements (TCAs) are both delivered on the same day as per the MBS item descriptors and explanatory notes.

Medicare requirements when item 732 is claimed twice on the same day

If a GPMP and TCAs are both reviewed on the same date and item 732 is to be claimed twice on the same day, both electronic claims and manual claims need to indicate they were rendered at different times:

· Non electronic Medicare claiming of items 732 on the same date
  The time that each item 732 commenced should be indicated next to each item

· Electronic Medicare claiming of item 732 on the same date
  Medicare EasyClaim: use the 'ItemOverrideCde" set to 'AP', which flags the item as not duplicate services
  Medicare Online/ECLIPSE: set the 'DuplicateServiceOverrideIND' to 'Y', which flags the item as not duplicate

Items 721, 723 and 732

The GP Management Plan items (721 and 732) and the Team Care Arrangement items (723 and 732) can not be claimed by general practitioners when they are a recognised specialist in the specialty of palliative medicine and treating a referred palliative care patient under items 3005-3093. The referring practitioner is able to provide the CDM services.

Additional information

Advice on the items and further guidance are available at: www.health.gov.au/mbsprimarycareitems
Items 721-732 should generally be undertaken by the patient's **usual medical practitioner**. The patient's "usual GP" means the GP, or a GP working in the medical practice, who has provided the majority of care to the patient over the previous twelve months and/or will be providing the majority of GP services to the patient over the next twelve months. The term "usual GP" would not generally apply to a practice that provides only one specific CDM service.

A **practice nurse, Aboriginal health worker or other health professional** may assist a GP with items 721, 723, and 732 (e.g. in patient assessment, identification of patient needs and making arrangements for services). However, the GP must meet all regulatory requirements, review and confirm all assessments and see the patient.

Patients being managed under the chronic disease management items may be eligible for:

- individual allied health services (items 10950 to 10970); and/or
- group allied health services (items 81100 to 81125); and/or
- dental services (items 85011-87777).

More information on eligibility requirements can be found in the explanatory note for dental services, individual allied health services and group allied health services.

Further information is also available for providers from the Medicare Australia provider inquiry line on 132 150.

Related Items: [721, 723, 729, 731, 732]

Related Items

**Category 1 - PROFESSIONAL ATTENDANCES**

**721**

Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) for the PREPARATION of a **GP MANAGEMENT PLAN** (GPMP) for a patient (not being a service associated with a service to which items 735 to 758 apply).

This CDM service is for a patient who has at least one medical condition that:
(a) has been (or is likely to be) present for at least six months; or

(b) is terminal.

A rebate will not be paid within twelve months of a previous claim for item 721, or within three months of a claim for items 729, 731 or 732 (for a review of a GPMP), except where there are exceptional circumstances that require the preparation of a new GPMP.

**Fee:** $138.75  **Benefit:** 75% = $104.10  100% = $138.75

(See para A37 of explanatory notes to this Category)

**Category 1 - PROFESSIONAL ATTENDANCES**

**723**

Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) to COORDINATE the development of TEAM CARE ARRANGEMENTS (TCAs) for a patient (not being a service associated with a service to which items 735 to 758 apply).

This CDM service is for a patient who:

(a) has at least one medical condition that:

i. has been (or is likely to be) present for at least six months; or

ii. is terminal; and

(b) requires ongoing care from at least three collaborating health or care providers, each of whom provides a different kind of treatment or service to the patient, and at least one of whom is a medical practitioner.

A rebate will not be paid within twelve months of a previous claim for item 723, or within three months of a claim for item 732 (for a review of TCAs), except where there are exceptional circumstances that require the coordination of new TCAs.

**Fee:** $109.95  **Benefit:** 75% = $82.50  100% = $109.95

(See para A37 of explanatory notes to this Category)

**Category 1 - PROFESSIONAL ATTENDANCES**

**729**

**CONTRIBUTION** by a medical practitioner (including a general practitioner, but not including
a specialist or consultant physician) TO A MULTIDISCIPLINARY CARE PLAN prepared by another provider OR TO A REVIEW OF A MULTIDISCIPLINARY CARE PLAN prepared by another provider (not being a service associated with a service to which items 735 to 758 apply).

This CDM service is for a patient who:

(a) has at least one medical condition that:

i. has been (or is likely to be) present for at least six months; or

ii. is terminal; and

(b) requires ongoing care from at least three collaborating health or care providers, each of whom provides a different kind of treatment or service to the patient, and at least one of whom is a medical practitioner; and

(c) is not a care recipient in a residential aged care facility.

A rebate will not be paid within twelve months of a claim by the same practitioner for item 721 or 723, within three months of a claim for item 729 or within three months of a claim for item 731 or 732, except where there are exceptional circumstances that require a new contribution to the multidisciplinary care plan.

Fee: $67.70 Benefit: 100% = $67.70

(See para A37 of explanatory notes to this Category)

Category 1 - PROFESSIONAL ATTENDANCES

CONTRIBUTION by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) to:

(a) a multidisciplinary care plan for a patient in A RESIDENTIAL AGED CARE FACILITY (RACF), prepared by that facility, or to a REVIEW of such a plan prepared by a RACF; or

(b) a multidisciplinary care plan prepared for a resident by another provider before the resident is discharged from a hospital or an approved day-hospital facility, or to a review of such a plan prepared by another provider; (not being a service associated with a service to which items 735 to 758 apply).
This CDM service is for a patient who:

(a) has at least one medical condition that:

   i. has been (or is likely to be) present for at least six months; or
   
   ii. is terminal; and

(b) requires ongoing care from at least three collaborating health or care providers, each of whom provides a different kind of treatment or service to the patient, and at least one of whom is a medical practitioner; and

(c) is a care recipient in a residential aged care facility.

A rebate will not be paid within three months of a previous claim for item 731 or within three months of a claim for item 721, 723, 729 or 732 except where there are exceptional circumstances that require a new contribution to the multidisciplinary care plan.

Fee: $67.70 Benefit: 100% = $67.70

(See para A37 of explanatory notes to this Category)

Category 1 - PROFESSIONAL ATTENDANCES

732

Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) to:

(a) REVIEW A GP MANAGEMENT PLAN to which item 721 applies.

Where these services were provided by that medical practitioner (or an associated medical practitioner), and not being a service associated with a service to which items 735-758 apply.

This CDM service is for a patient who has at least one medical condition that:

i. has been (or is likely to be) present for at least six months; or

ii. is terminal.

or

(b) COORDINATE A REVIEW OF TEAM CARE ARRANGEMENTS to which item 723 applies.
This CDM service is for a patient who:

i. has at least one medical condition that has been (or is likely to be) present for at least six months; or is terminal, and

ii. also requires ongoing care from at least three collaborating health or care providers, each of whom provides a different kind of treatment or service to the patient, and at least one of whom is a medical practitioner.

Each service to which item 732 applies may only be claimed once in a three-month period, except where there are exceptional circumstances that necessitate earlier performance of the service to the patient.

Fee: $69.35  Benefit: 75% = $52.05  100% = $69.35

(See para A37 of explanatory notes to this Category)

A42  Medication Management Reviews - (Items 900 and 903)

Item 900 - Domiciliary Medication Management Review

A Domiciliary Medication Management Review (DMMR) (Item 900), also known as Home Medicines Review,

is intended to maximise an individual patient's benefit from their medication regimen, and prevent medication-related problems through a team approach, involving the patient's GP and preferred community pharmacy or accredited pharmacist.

Patient eligibility

The item is available to people living in the community who meet the criteria for a DMMR.

The item is not available for in-patients of a hospital, or care recipients in residential aged care facilities.

DMMRs are targeted at patients who are likely to benefit from such a review: patients for whom quality use of medicines may be an issue or; patients who are at risk of medication misadventure because of factors such as their co-morbidities, age or social circumstances, the characteristics of their medicines, the complexity of their medication treatment regimen, or a
lack of knowledge and skills to use medicines to their best effect.

Examples of risk factors known to predispose people to medication related adverse events are:

- currently taking five or more regular medications;
- taking more than 12 doses of medication per day;
- significant changes made to medication treatment regimen in the last three months;
- medication with a narrow therapeutic index or medications requiring therapeutic monitoring;
- symptoms suggestive of an adverse drug reaction;
- sub-optimal response to treatment with medicines;
- suspected non-compliance or inability to manage medication related therapeutic devices;
- patients having difficulty managing their own medicines because of literacy or language difficulties, dexterity problems or impaired sight, confusion/dementia or other cognitive difficulties;
- patients attending a number of different doctors, both general practitioners and specialists; and
- recent discharge from a facility / hospital (in the last four weeks).

REGULATORY REQUIREMENTS

In conducting a DMMR, a medical practitioner must:

(a) assess a patient's medication management needs; and

(b) following that assessment, refer the patient to a community pharmacy or an accredited pharmacist for a DMMR; and

(c) with the patient's consent, provide relevant clinical information required for the review; and

(d) discuss with the reviewing pharmacist the results of that review, including suggested medication management strategies; and

(e) develop a written medication management plan following discussion with the patient.
Claiming

A DMMR includes all DMMR-related services provided by the medical practitioner from the time the patient is identified as potentially needing a medication management review to the preparation of a draft medication management plan, and discussion and agreement with the patient.

The benefit is not claimable until all the components of the item have been rendered.

Benefits for a DMMR service under item 900 are payable only once in each 12 month period, except where there has been a significant change in the patient's condition or medication regimen requiring a new DMMR (e.g. diagnosis of a new condition or recent discharge from hospital involving significant changes in medication). In such cases the patient's invoice or Medicare voucher should be annotated to indicate that the DMMR service was required to be provided within 12 months of another DMMR service.

If the DMMR is initiated during the course of a consultation undertaken for another purpose, this consultation may also be claimed separately.

If the consultation at which the medication management review is initiated is only for the purposes of initiating the review only item 900 may be claimed.

If the medical practitioner determines that a DMMR is not necessary, item 900 does not apply. In this case, normal consultation items should be used.

Where a DMMR cannot be completed due to circumstances beyond the control of the medical practitioner (e.g. because the patient decides to not proceed further with the DMMR, or because of a change in the circumstances of the patient), the relevant MBS attendance items should be used.

FURTHER GUIDANCE
A DMMR should generally be undertaken by the patient's usual medical practitioner. This is the medical practitioner, or a medical practitioner working in the medical practice, that has provided the majority of services to the patient over the previous 12 months and/or will be providing the majority of services to the patient over the coming 12 months.

The potential need for a DMMR may be identified either by the medical practitioner in the process of a consultation or by receipt of advice from the patient, a carer or another health professional including a pharmacist.

The process of referral to a community pharmacy or an accredited pharmacist includes:

· Obtaining consent from the patient, consistent with normal clinical practice, for a pharmacist to undertake the medication management review and for a charge to be incurred for the service for which a Medicare rebate is payable. The patient must be clearly informed of the purpose and possible outcomes of the DMMR, the process involved (including that the pharmacist will visit the patient at home, unless the patient prefers another location or other exceptional circumstances apply), what information will be provided to the pharmacist as part of the DMMR, and any additional costs that may be incurred; and

· Provision to the patient's preferred community pharmacy or accredited pharmacist, of relevant clinical information, by the medical practitioner for each individual patient, covering the patient's diagnosis, relevant test results and medication history, and current prescribed medications.

· A DMMR referral form is available for this purpose. If this form is not used, the medical practitioner must provide patient details and relevant clinical information to the patient's preferred community pharmacy or accredited pharmacist.

The discussion of the review findings and report including suggested medication management strategies with the reviewing pharmacist includes:

· Receiving a written report from the reviewing pharmacist; and

· Discussing the relevant findings and suggested management strategies with the pharmacist (either by phone or face to face); and

· Developing a summary of the relevant review findings as part of the draft medication management plan.

Development of a written medication management plan following discussion with the patient includes:

· Developing a draft medication management plan and discussing this with the patient; and

· Once agreed, offering a copy of the written medication management plan to the patient and providing
a copy to the community pharmacy or accredited pharmacist.

The agreed plan should identify the medication management goals and the proposed medication regimen for the patient.

**Item 903 - Residential Medication Management Review**

A Residential Medication Management Review (RMMR) is a collaborative service available to permanent residents of a Residential Aged Care facility (RACF) who are likely to benefit from such a review. This includes residents for whom quality use of medicines may be an issue or residents who are at risk of medication misadventure because of a significant change in their condition or medication regimen.

**Patient eligibility**

RMMRs are available to:

- new residents on admission into a RACF; and

- existing residents on an 'as required' basis, where in the opinion of the resident's medical practitioner, it is required because of a significant change in medical condition or medication regimen.

RMMRs are not available to people receiving respite care in a RACF. Domiciliary Medicines Reviews are available to these people when they are living in the community setting.

**REGULATORY REQUIREMENTS**

When conducting a RMMR, a GP must:

(a) discuss the proposed review with the resident and seek the resident's consent to the review; and

(b) collaborate with the reviewing pharmacist about the pharmacist's involvement in the review; and
(c) provide input from the resident's most recent comprehensive medical assessment or, if such an assessment has not been undertaken, provide relevant clinical information for the review and for the resident's records; and

(d) If recommended changes to the resident's medication management arise out of the review, participate in a post-review discussion (either face-to-face or by telephone) with the pharmacist to discuss the outcomes of the review including:

(i) the findings; and

(ii) medication management strategies; and

(iii) means to ensure that the strategies are implemented and reviewed, including any issues for implementation and follow-up; and

(iv) develop or revise the resident's medication management plan after discussion with the reviewing pharmacist; and

(v) finalise the plan after discussion with the resident.

A medical practitioner's involvement in a residential medication management review also includes:

(a) offering a copy of the medication management plan to the resident (or the resident's carer or representative if appropriate); and

(b) providing copies of the plan for the resident's records and for the nursing staff of the residential aged care facility; and

(c) discussing the plan with nursing staff if necessary.

A post-review discussion is not required if:

(a) there are no recommended changes to the resident's medication management arising out of the review; or

(b) any changes are minor in nature and do not require immediate discussion; or

(c) the pharmacist and medical practitioner agree that issues arising out of the review should be considered in a case conference.
A RMMR comprises all activities to be undertaken by the medical practitioner from the time the resident is identified as potentially needing a medication management review up to the development of a written medication management plan for the resident.

Claiming

A maximum of one RMMR rebate is payable for each resident in any 12 month period, except where there has been a significant change in the resident's medical condition or medication regimen requiring a new RMMR.

Benefits are payable when all the activities of a RMMR have been completed. A RMMR service covers the consultation at which the results of the medication management review are discussed and the medication management plan agreed with the resident:

- any immediate action required to be done at the time of completing the RMMR, based on and as a direct result of information gathered in the RMMR, should be treated as part of the RMMR item;
- any subsequent follow up should be treated as a separate consultation item;
- an additional consultation in conjunction with completing the RMMR should not be undertaken unless it is clinically indicated that a problem must be treated immediately.

In some cases a RMMR may not be able to be completed due to circumstances beyond the control of the medical practitioner (e.g. because the resident decides not to proceed with the RMMR or because of a change in the circumstances of the resident). In these cases the relevant MBS attendance item should be used in relation to any consultation undertaken with the resident.

If the consultation at which the RMMR is initiated, including discussion with resident and obtaining consent for the RMMR, is only for the purposes of initiating the review, only the RMMR item should be claimed.

If the RMMR is initiated during the course of a consultation undertaken for another purpose, the
other consultation may be claimed as a separate service and the RMMR service would also apply.

If the medical practitioner determines that an RMMR is not necessary, the RMMR item does not apply. In this case, relevant consultation items should be used.

FURTHER GUIDANCE

A RMMR should generally be undertaken by the resident's 'usual GP'. This is the medical practitioner, or a medical practitioner working in the medical practice, that has provided the majority of care to the resident over the previous 12 months and/or will be providing the majority of care to the resident over the next 12 months.

GPs who provide services on a facility-wide contract basis, and/or who are registered to provide services to RACFs as part of aged care panel arrangements, may also undertake RMMRs for residents as part of their services.

Generally, new residents should receive an RMMR as soon as possible after admission. Where a resident has a Comprehensive Medical Assessment (CMA), the RMMR should be undertaken preferably after the results of the CMA are available to inform the RMMR.

A RMMR service should be completed within a reasonable timeframe. As a general guide, it is expected that most RMMR services would be completed within four weeks of being initiated.

The resident's medical practitioner may identify the potential need for an 'as required' RMMR for existing residents, including in the course of a consultation for another purpose. The potential need for an RMMR may also be identified by the reviewing pharmacist, supply pharmacist, Residential Aged Care Facility staff, the resident, the resident's carer or other members of the resident's health care team.
The medical practitioner should assess the clinical need for an RMMR from a quality use of medicines perspective with the resident as the focus, and initiate an RMMR if appropriate, in collaboration with the reviewing pharmacist.

The medical practitioner and reviewing pharmacist should agree on a preferred means for communicating issues and information relating to the provision of an RMMR service. This should include the method(s) of initiating the RMMR, exceptions to the post review discussion, and the preferred method of communication. This can be done on a facility basis rather than on a case-by-case basis.

Where the provision of RMMR services involves consultation with a resident it should be read as including consultation with the resident and/or their carer or representative where appropriate.

RMMRs do not count for the purposes of derived fee arrangements that apply to other consultations in a Residential Aged Care Facility.

Related Items: 900, 903

Related Items

Category 1 - PROFESSIONAL ATTENDANCES

900

Participation by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) in a Domiciliary Medication Management Review (DMMR) for patients living in the community setting, where the medical practitioner:

- assesses a patient's medication management needs, and following that assessment, refers the
patient to a community pharmacy or an accredited pharmacist for a DMMR, and provides relevant clinical information required for the review, with the patient's consent; and

- discusses with the reviewing pharmacist the results of that review including suggested medication management strategies; and

- develops a written medication management plan following discussion with the patient.

Benefits under this item are payable not more than once in each 12 month period, except where there has been a significant change in the patient's condition or medication regimen requiring a new DMMR.

Fee: $148.90 Benefit: 100% = $148.90

(See para A42 of explanatory notes to this Category)

Category 1 - PROFESSIONAL ATTENDANCES

Participation by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) in a collaborative Residential Medication Management Review (RMMR) for a permanent resident of a residential aged care facility, where the medical practitioner:

- discusses and seeks consent for an RMMR from the new or existing resident;

- collaborates with the reviewing pharmacist regarding the pharmacy component of the review;

- provides input from the resident's Comprehensive Medical Assessment (CMA), or if a CMA has not been undertaken, provides relevant clinical information for the resident's RMMR;

- discusses findings of the pharmacist review and proposed medication management strategies with the reviewing pharmacist (unless exceptions apply);

- develops and/or revises a written medication plan for the resident; and

- consults with the resident to discuss the medication management plan and its implementation.

Benefits under this item are payable for one RMMR service for new residents on admission to a Residential Aged Care Facility and for continuing residents on an as required basis, with a maximum of one RMMR for a resident in any 12 month period, except where there has been a significant change in medical condition or medication regimen requiring a new RMMR.
Fee: $101.95  Benefit: 100% = $101.95

(See para A42 of explanatory notes to this Category)
Appendix 6: HMR Alert- Medscope’s HMR patient Identification Solution

**HMRAlert project.**

HMRAlert is a practice based system designed to facilitate, standardise and manage home medication review (HMR) referrals.

**Components:**

a) HMRAlert database manager. A software application installed onto the GP clinic file server that:
   a. Registers the GP clinic as an HMRAlert site.
   b. Installs the HMRAlert database.
   c. Automatically updates the HMRAlert database as new database versions are released.
   d. Automatically notifies the Medscope support server that the HMRAlert database is operational.

b) HMRAlert Network printer driver. A software application that allows:
   a. GP to send the HMR referral to a pharmacy electronically using PKI encryption.

c) HMRAlert GP client. A software application installed on the GP desktop (or terminal server) that:
   a. Registers GPs as HMRAlert users.
   b. Allows the GP to configure the HMRAlert alarm settings.
   c. Scans the GP clinical system for patients that meet the HMRAlert alarm settings.
   d. Automatically notifies the Medscope support server that the HMRAlert GP client is operational.

**Key functions**

a) Facilitation

A desktop software application installed on the GP computer that enables individual GPs to define the type of patient that would benefit from a home medication review (based on demographics, diagnosis and treatment). HMRAlert notifies the GP when a patient meeting the criteria is being consulted.

A specialised printer driver installed on the GP desktop that allows the GP to print the HMR referral and send it electronically to the nominated pharmacy (via their existing clinical software application) in a secure manner using the PKI encryption.

The referral sent to the pharmacy consist of an electronic copy of the printed form generated by the GP’s clinical software and an electronic xml representation of the referral that can be imported into third-party software.

On receiving the completed referral from the pharmacist, HMRAlert will (if supported by the clinical application) attach the pharmacist’s report to the patient’s clinical record.
b) Standardisation
   A standardised HMR report format.

c) Management
   HMRAlert provides a mechanism by which every referral initiated by IPN using the system can be tracked and audited. At any point in time IPN staff can determine if a referral has been delivered to the pharmacy, received by the pharmacy and/or returned by the pharmacy. Automatically generated email alerts will notify IPN staff if a referral has failed to progress to the next tracking stage within pre-defined time frames.

   HMRAlert provides a reporting mechanism that allows the practice manager to determine the number of patients eligible for HMRs versus the number of referrals initiated for each GP.

Demonstration

See the on-line video demonstration of how to configure and use HMRAlert. The video illustrates HMRAlert working with Best Practice. Integration with Medical Director 3.0 is similar.


Data extracted from Clinic

The following data is extracted from the clinical system during normal operation of HMRAlert.

Data: HMR Alert site installation ID and authentication code
When: During installation/registration process and for every version update check ping
Purpose: Authentication and software support.

Data: Copy of HMR referral form
When: When a HMR referral is generated by GP.
Purpose: To enable the pharmacist to print a hard copy of the referral.

Data: eReferral. An atomized XML representation of the referral including:
   - Patient name, gender, date of birth, medicare number, address
   - Referring Doctor name, practice details, prescriber number
   - Pharmacy details
   - Patient medical history
   - Patient observations (height / weight, Blood pressure etc)
   - Pathology
   - Medications
   - Allergies
When: When an HMR referral is sent to the pharmacist using the HMRAlert network printer.
Purpose: To enable the pharmacist to load the HMR referral electronically into the Medication Review Management system.

Data: Alert ping
When: When an HMR Alert is activated.
Purpose: Reporting and invoicing

**Installing HMRAAlert**

HMRAAlert is installed by Medscope support staff with the cooperation of the GP’s IT support personnel. Before HMRAAlert can be installed both GP and pharmacist must:


- To assist Medscope in preparing for the installation process, we ask both pharmacist and GP to provide us with information about their respective IT infrastructure. These forms can be downloaded from [http://www.medscope.com.au/index.php?lMenuId=172](http://www.medscope.com.au/index.php?lMenuId=172) and returned to support@medscope.com.au when completed.


  Medscope Support
  Level 2, 149A Hobart
  Tasmania, 7000


**Enquiries can be directed to:**

Chief Executive Officer: George Giannakopoulos
Ph: +61 3 6223 8822
Mob: 0411 206690

Medscope Pty Ltd
www.medscope.com.au
149A Macquarie street
Hobart, 7000
HMRAAlert Cheat-sheet

Running HMRAAlert

HMRAAlert will automatically start every time your computer is turned on. The application sits in the system tray and is not visible.

Setting Alert Parameters

Double click on the HMRAAlert icon in the system tray to display the settings screen.

Sending a HMR Referral Electronically – printing the referral

Create a DMMR referral in Best Practice as normal.

When printing the referral ALWAYS select the print option from the file menu so that the system print dialog box is displayed.
Print referral

Print to the HMRAalert Network Printer

Click the OK button. This will start the HMRAalert electronic (PKI encrypted) messaging system

Referral recipient preset. No need to specify

HMRAalert messaging system

Click Send to send.
HMRAalert will electronically atomise referral data, encrypt data and email to pharmacist

Type instructions to pharmacists here

Further Assistance


Medscope support
Medscope support (George Giannakopoulos)
Ph: 03 6223 8822
support@medscope.com.au
www.medscope.com.au
Appendix 7: Draft HMR Report and Management Plan

Dr Heath Ledger 29 February
Medscope Clinical Practice
Shop 4 The Plaza
Hobart, 7000

Dear Dr Ledger,

Re: Home Medicines Review for
Stella Johns, DOB: 03 Apr 1935

Thank you for referring Stella Johns for a Home Medicines Review (HMR), I conducted an interview with her on 03/Jun/2011. All medications were reviewed in light of the information you provided in the referral and that obtained during the interview. Please find attached a draft Medication Management Plan for your consideration. Her current medications and any relevant comments are as follows:

Additional notes or medication identified from interview

<table>
<thead>
<tr>
<th>Signs and Symptoms</th>
<th>Patient concern</th>
<th>Says it is keeping her awake at night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headache</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Medications not on GP list
Blackmores St John's Wort Tab
Celebrex 200mg Cap

Medications on GP list but not being taken
Paracetamol (APO-Paracetamol 500mg Tab) 1-2prn Finds these are 'useless' and takes celebrex instead

Medication (Note: medications in bold are not being taken in accordance with prescribed instructions)

<table>
<thead>
<tr>
<th>Prescribed Drug</th>
<th>Admin</th>
<th>Comment/Compliance</th>
<th>Purpose (according to patient)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Celecoxib (Celebrex 200mg Cap)</strong></td>
<td>1 d</td>
<td>neighbour's supply</td>
<td>for pain</td>
</tr>
<tr>
<td><strong>St John's Wort (Blackmores St John's Wort Tab)</strong></td>
<td>1 m</td>
<td>is her sister’s supply</td>
<td>Taking because she is 'feeling down'</td>
</tr>
<tr>
<td>Digoxin (Lanoxin 250mcg Tab)</td>
<td>1 m</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Frusemide (Chem mart Frusemide 40mg Tab)</strong></td>
<td>1m 1midi</td>
<td>Misses the occasional lunchtime dose</td>
<td></td>
</tr>
<tr>
<td>Paracetamol (APO-Paracetamol 500mg Tab)</td>
<td>1-2prn</td>
<td>Finds these are 'useless' and takes celebrex instead</td>
<td>Pain- but they don't work</td>
</tr>
<tr>
<td>Simvastatin (@Simvastatin 20mg AD Tab)</td>
<td>1n</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please complete the attached Medication Management Plan and forward a copy to Your Company Name (Fax: 12345678) and to Medscope Community Pharmacy: 12345678). MBS item number 900 can then be claimed.

I can be contacted via phone (1234567891) or email (zz.zzzzz@bigpond.com) to discuss the report.

Yours Sincerely,
# Home Medication Review
## Report and Management Plan

<table>
<thead>
<tr>
<th>Patient:</th>
<th>Stella Johns</th>
<th>DOB</th>
<th>03 Apr 1935</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor:</td>
<td>Dr. Heath Ledger</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact Pharmacist</td>
<td>Pharmacist’s Details</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of Review:</td>
<td>03/Jun/2011</td>
<td>Suggested Next Review:</td>
<td>12 months</td>
</tr>
<tr>
<td>Community Pharmacy</td>
<td>Medscope Community Pharmacy (Ph: 03 62238822  Fax:12345678)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Issues and Recommendations

#### Renal function
Mrs. Johns is receiving the "triple whammy" combination of a diuretic, agent affecting angiotensin and a non steroidal antiinflammatory. This combination may predispose to sudden deterioration of renal function. Close clinical and laboratory monitoring should take place if any changes are made to any of the elements of the combination. This may be particularly relevant in this case as a degree of renal dysfunction is evident.

#### Digoxin Dose for Heart Failure
Ms. Johns (before Interview) is taking digoxin, presumably for heart failure alone, and the most recent level is 0.9ng/mL or greater. Digoxin levels of 0.5 to 0.8ng/mL are more appropriate for heart failure. The digoxin dose should be adjusted to ensure levels are in this range in order to optimise benefit and reduce risk.

#### Cough
Mrs. Johns complains of a cough. Although a number of causes of this are possible (Mrs. Johns has heart failure), the potential role of the ACE inhibitor they are taking should be considered. A change to an angiotensin II antagonist may be a suitable strategy.

### Management Plan (to be completed by GP)

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**Doctor’s Signature:**

Dr H Ledger  Prov No: 12345678

**Date:**

This Medication Management Plan is formalised when recommendations are considered and the plan is signed and dated by the General Practitioner.

Please fax completed plan to xxxxxxx. Medicare Benefits Schedule Item 900 can then be claimed.