

Utilising Nurse visits under Medicare to ease pressure on GP shortages and improve patient outcomes

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Learning Objectives

- Identify eligibility and MBS requirements
- Understand how Nurse visits under Medicare can benefit patients, GPs and the practice
- Explore practical ideas for utilising Nurse visits
- Tools to assist with planning Nurse visits



MBS requirements



- Nurse services are provided for and on behalf of a GP
- Nurses should be adequately trained and maintain up to date CPD in chronic disease management and culturally safe care to ensure care provided is evidence based best practice
- The GP under whose supervision the service is being provided retains responsibility for the health, safety and clinical outcomes of the patient
- The GP is not required to see the patient when claiming Nurse item numbers unless clinically required
- If the patient also consults with a GP on the same day, the GP attendance item doesn't include the time a patient spends with the Nurse

Patient and Practitioner eligibility



Service	Calendar year	F2F	Video	Phone	Who
Monitoring & support for Chronic Disease Management	5	10997	93201	93203	RN, EN, AHP
Follow Up of patients with a 715 Health Assessment	10	10987	93200	93202	RN, EN, AHP
Patient end support for telehealth with specialist	N/A	10983			RN, EN, AHP, AHW
Antenatal: RRMA 3-7	10	16400			MW, RN, EN, AHP

The Nurse providing the service for and on behalf of the supervising Doctor must document the care they provided and how it relates to the patient’s goals of care in order for the Doctor to substantiate billing the item number to Medicare.

Nurse visits benefit everyone



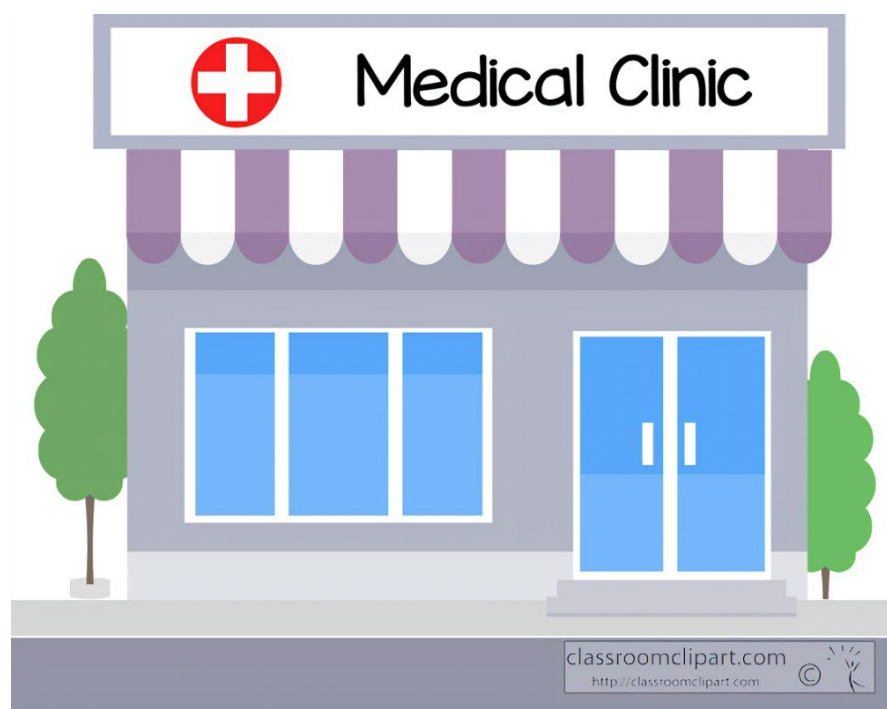
Patients:

- Timely access
- Trusted practice
- Reduced costs



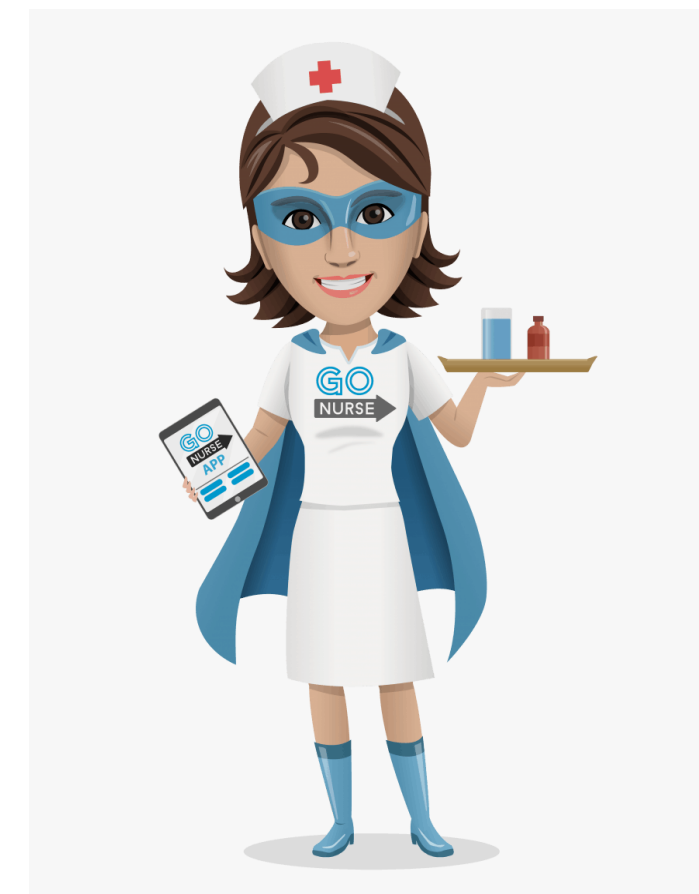
Doctors:

- Team approach
- Reduce fragmented care
- Increase GP availability



Practices:

- Reduces ad-hoc visits
- Options when GPs are fully booked
- Generates income



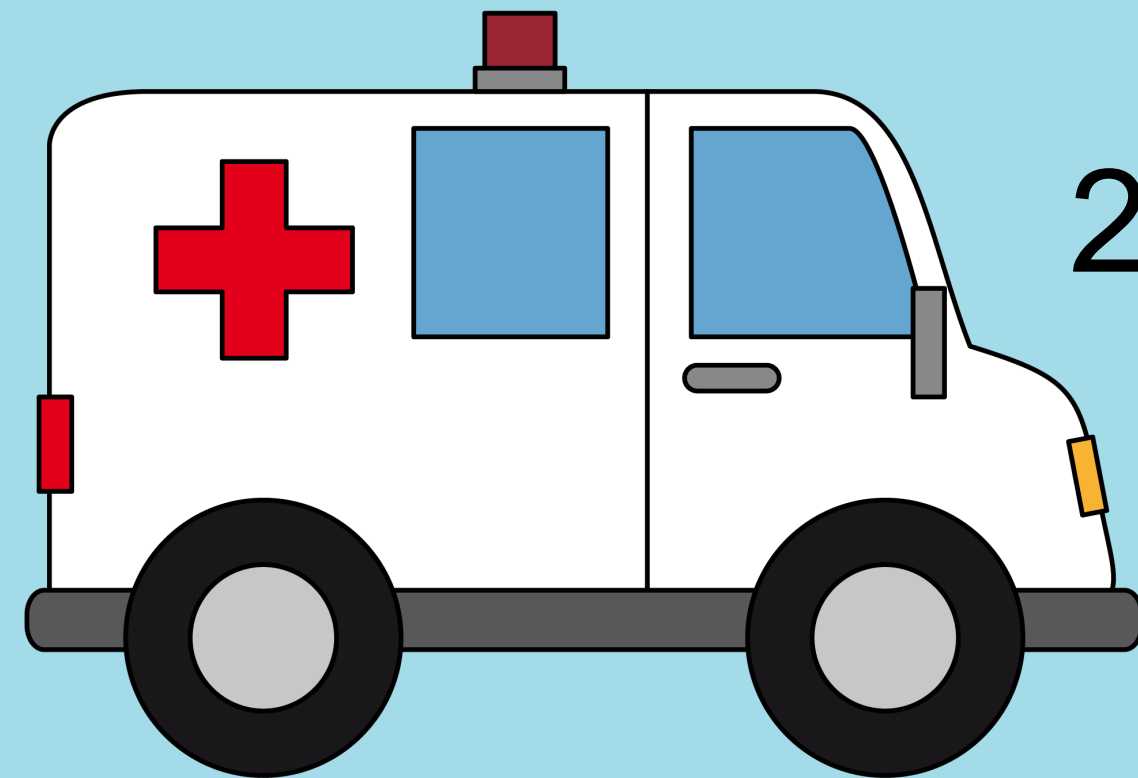
Nurses:

- Utilise scope and skills
- Continuity of care
- Cost effective

10997 and 10987 Nurse services may be:



1. Planned in advance

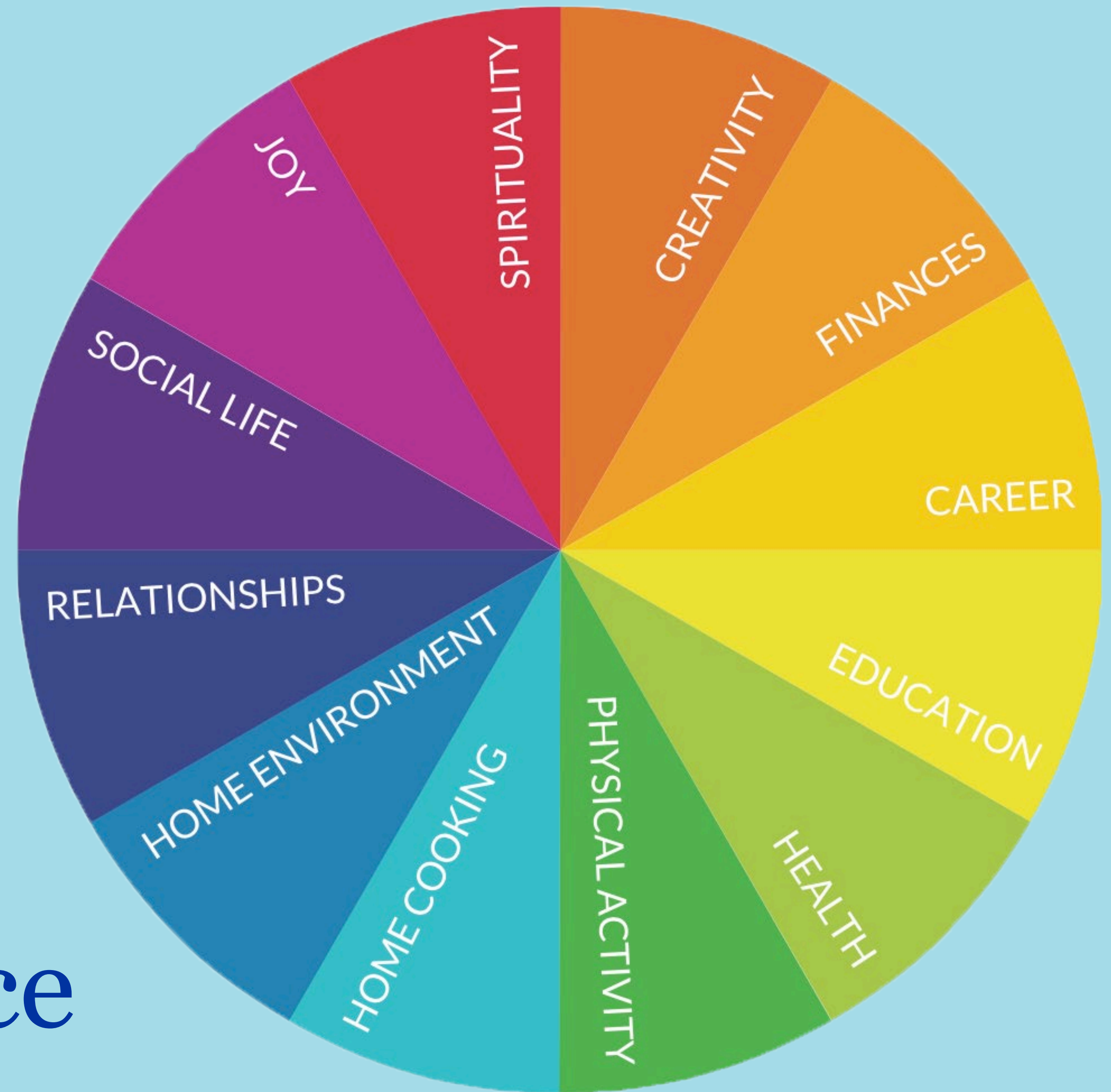


2. Responsive to patient need



3. Opportunistic when the patient is in your practice

Provide self
management advice



Monitor
medication
compliance



Collect
information to
support the review
of a care plan



Education regarding medication compliance and associated monitoring

Prevention advice for health conditions and associated follow up

Education, monitoring and counselling activities and lifestyle advice

Checks on clinical progress and service access

Examinations/ interventions as indicated by the health assessment

Taking a medical history

10987
Nurse follow-up services may be used to provide

Examples of documenting Nurse visits

10997 – *“Phoned patient following notification of recent hospital discharge in line with goal to reduce hospital admission/readmission related to chronic disease management. New medication noted. Patient reports they have accessed the new medication and are confident self administering same. Reports nil unexpected side effects and continuing with all other medications as prescribed by GP. Has booked appointment with GP next week for follow up pathology tests related to new medication”.*

10987 – *“Immunisations administered as per NIP schedule and Dr’s order. Per goals of 715, completed PLUM tool with Mum to assess hearing which identified audiology referral indicated. Discussed same with GP who physically examined ears and agreed early referral is a good plan. Provided Mum with number for Hearing Australia (declined assistance to make appointment). Mum has agreed to Nurse phone consult in 5 days to see if any assistance required with booking or accessing audiology appointment”.*

Services to support First Nations people:



Ethnicity: Aboriginal but not Torres Strait Islander
Address Line 1: 12 John St

SMS: Enabled
Best Health App: Not Enrolled

Registered for CTG PBS Co-payment relief



Integrated Team Care providers can also be included in the care team for First Nations people with specific chronic conditions requiring support with:

- Coordinating services
- Facilitating gap payments
- Consultations
- Transportation
- Assists in providing medical aids
- Health literacy
- Supporting clients to achieve self-management

New England: Healthwise

Hunter: Hunter primary care

Taree: Biripi AMS

Central Coast: Yerin AMS

Forster: Tobwabba

Singleton: Ungooroo

Services to help you with support, monitoring and follow up:

Allied Health with 715HA

Asthma cycle of care

Diabetes Cycle of care

Diabetes group services

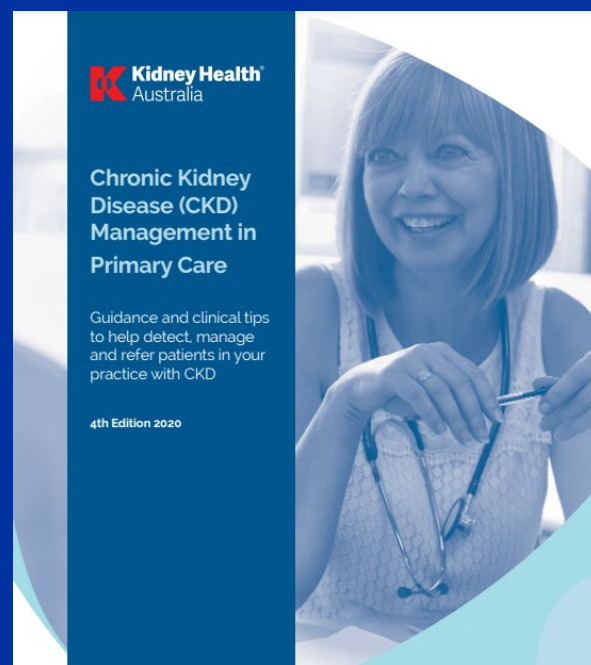
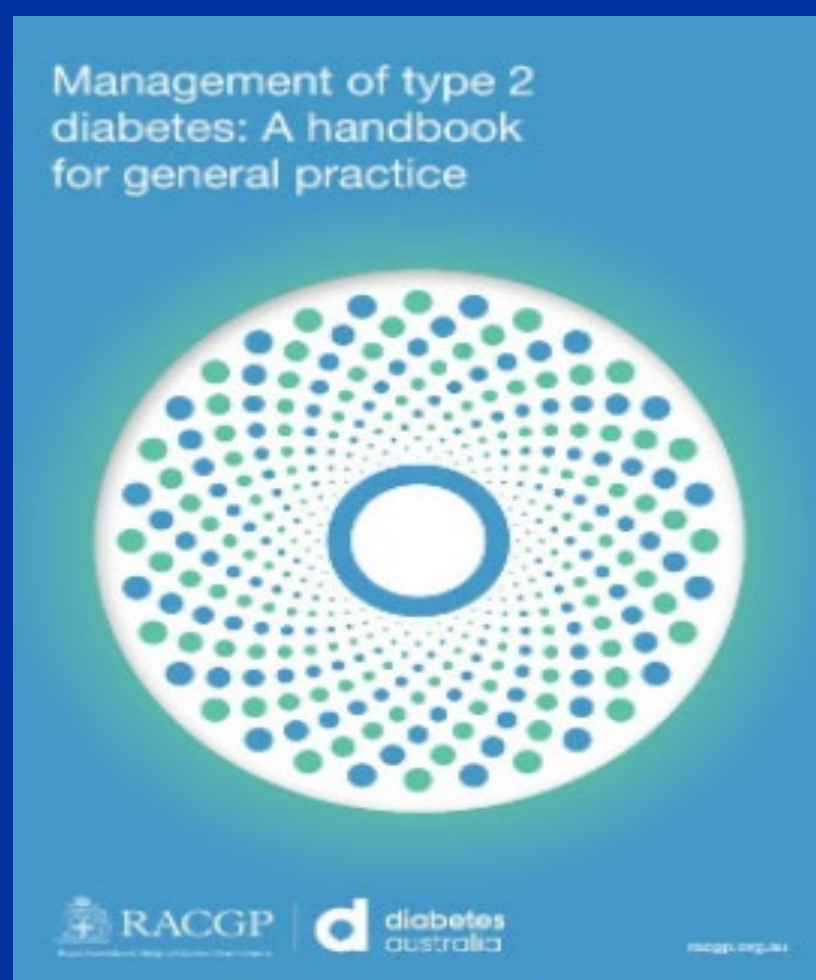
Ambulance Care plans

Home medicine review

Kidney Health Checks

Heart health checks

Case conferencing



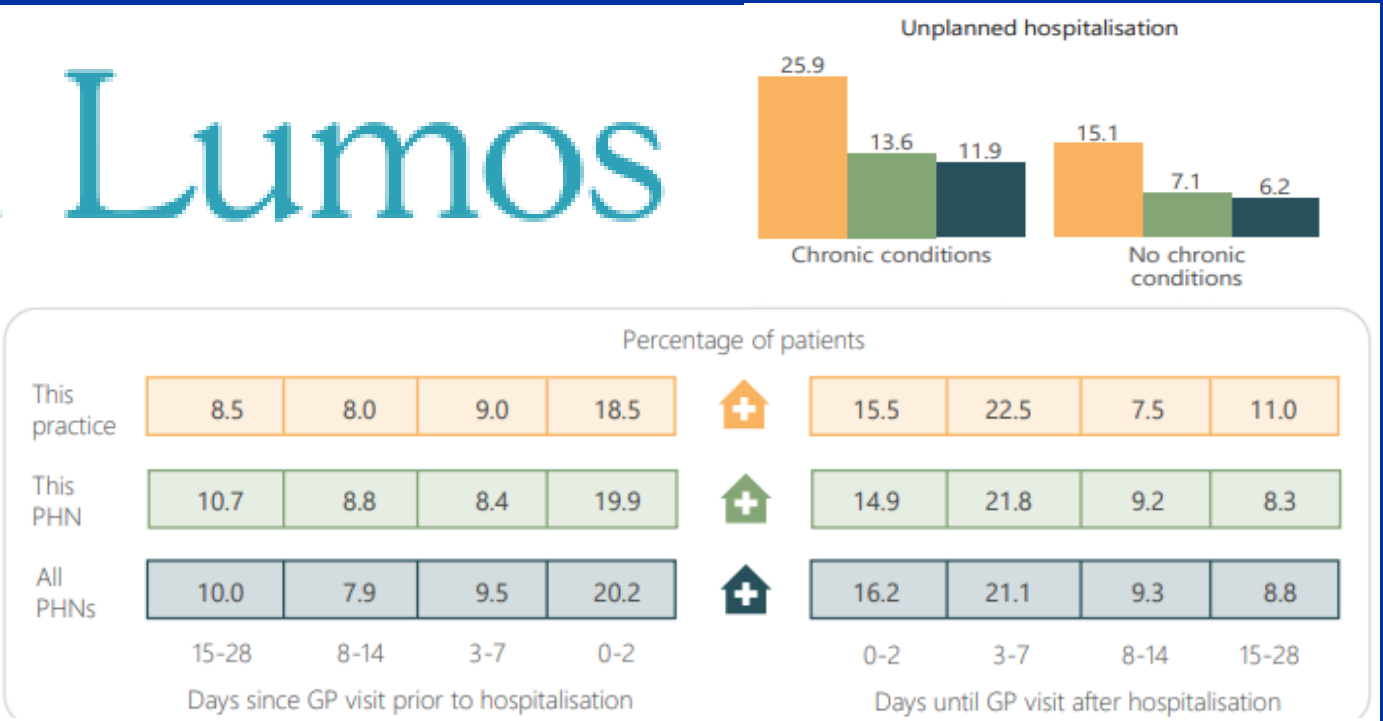
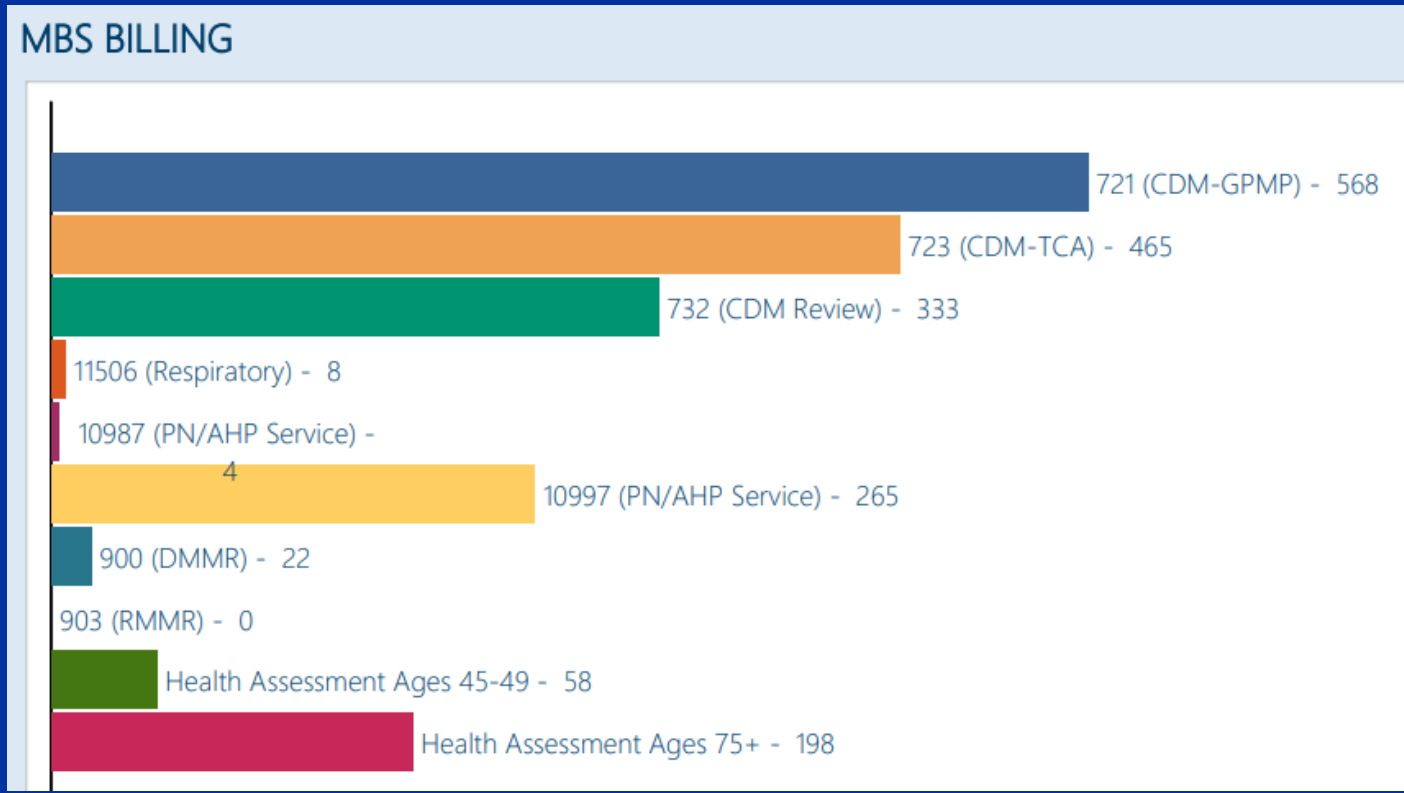
Tools to assist with support, monitoring and follow up:

MBS ELIGIBILITY SETTINGS **topbar**

Relevant hide

The following recommendations have been identified as relevant for this patient

TITLE	UP TO DATE
TCA	2/2
721 GPMP	1/1
900 DMMR	1/1
2517, 2521, 2525 Diabetes CoC	4/15
2546, 2552, 2558 Asthma Cycle Of Care	3/5
10997 10997 (PN/AHP Service)	0/1



Pen CS CAT4 - CAT4

File Edit View Tools Data Submission Prompts Help

Support

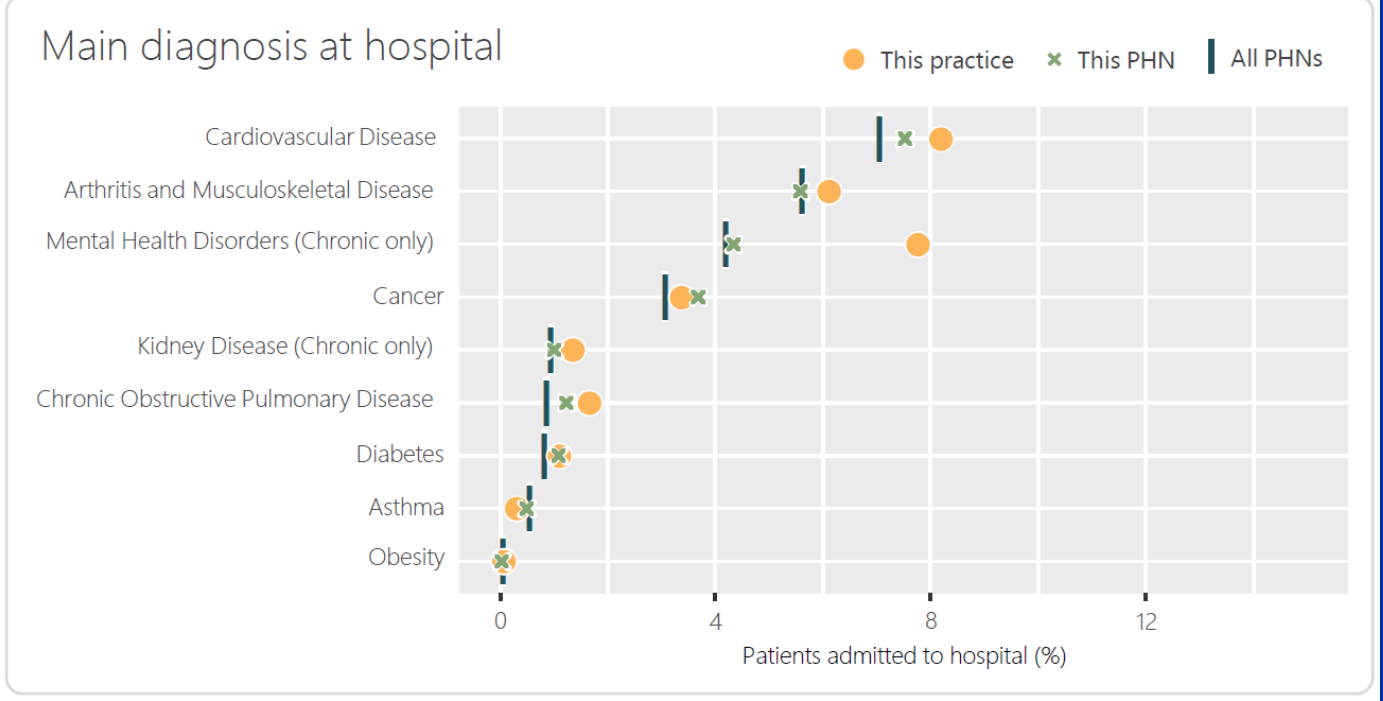
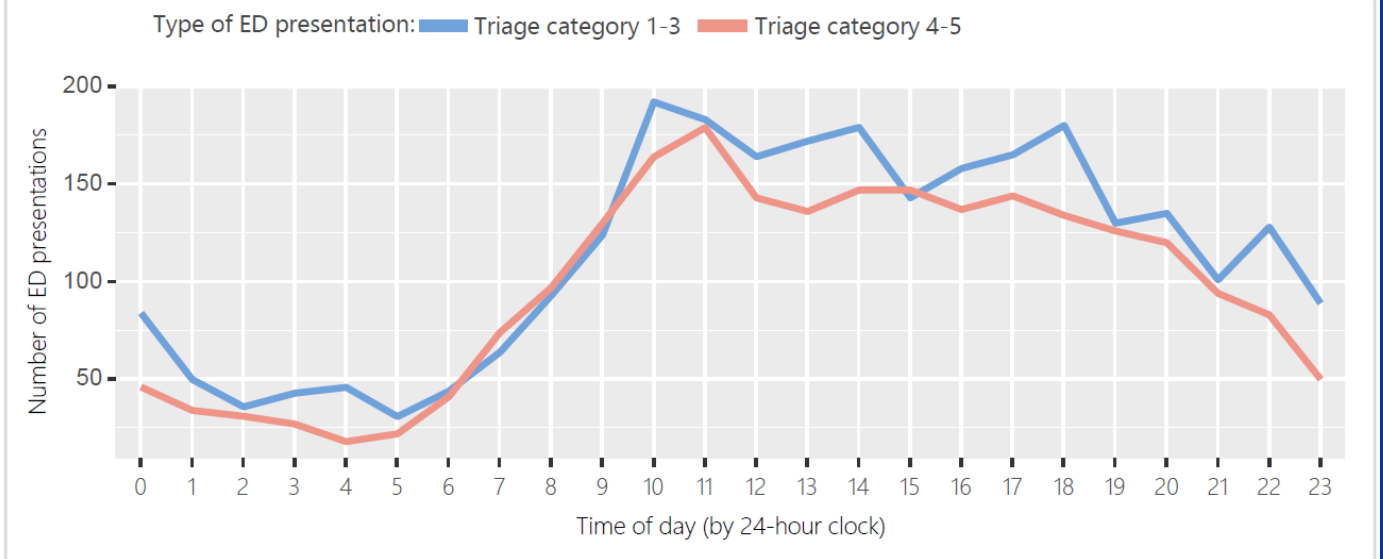
Collect Report View Population **CAT 4** Cleansing CAT Registrar CAT Daily CAT Programs Clear Filters Recalculate

Filter

General Ethnicity **Conditions** Medications Date Range (Results) Date Range (Visits) Patient Name Patient Status Providers Risk Factors Health Care Homes MBS Attendance

Chronic Mental Health Cancer Other

Diabetes	Respiratory	Cardiovascular	Musculoskeletal	Renal Impairment
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Type II <input type="checkbox"/> No	<input type="checkbox"/> Asthma <input type="checkbox"/> No	<input type="checkbox"/> Hypertension <input type="checkbox"/> No	<input type="checkbox"/> Inflammatory <input type="checkbox"/> No	<input type="checkbox"/> Chronic Renal <input type="checkbox"/> No
<input type="checkbox"/> Type I <input type="checkbox"/> No	<input type="checkbox"/> COPD <input type="checkbox"/> No	<input type="checkbox"/> Cardiovascular Disease (CVD):	<input type="checkbox"/> Musculoskele <input type="checkbox"/> No	<input type="checkbox"/> Acute Renal <input type="checkbox"/> No
<input type="checkbox"/> Undefined <input type="checkbox"/> No		<input type="checkbox"/> Heart Failure <input type="checkbox"/> No	<input type="checkbox"/> Bone Disease <input type="checkbox"/> No	<input type="checkbox"/> Dialysis <input type="checkbox"/> No
<input type="checkbox"/> Type I or II		<input type="checkbox"/> CHD <input type="checkbox"/> No <input type="checkbox"/> PAD <input type="checkbox"/> No	<input type="checkbox"/> Osteoporosis <input type="checkbox"/> No	
<input type="checkbox"/> Gestational <input type="checkbox"/> No		<input type="checkbox"/> Stroke <input type="checkbox"/> No <input type="checkbox"/> Carotid <input type="checkbox"/> No	<input type="checkbox"/> Osteoarthritis <input type="checkbox"/> No	<input type="checkbox"/> Kidney <input type="checkbox"/> No
		<input type="checkbox"/> MI <input type="checkbox"/> No <input type="checkbox"/> Renal Artery <input type="checkbox"/> No		<input type="checkbox"/> Clear Conditions





For further training on chronic disease management and health assessments:

