Chronic disease management by consultant physicians

Last Updated: 26 February 2025

- Effective since **1 November 2007**, there have been two MBS items to provide for the assessment and development of management plans by consultant physicians (MBS items 132 and 133).
- **There have been no changes to these items**, this factsheet has been created to outline the existing arrangements.

What are the changes?

Effective **1 November 2007** two MBS items (132 and 133) were introduced to provide for consultation by a consultant physician for the assessment and review of a patient with at least two morbidities.

The current MBS item descriptors for MBS items 132 and 133 are listed in a table at the end of this factsheet.

Why are the changes being made?

These MBS items were introduced to support (but not limited to) patients being managed by their general practitioner (GP) with a GP Management Plan (GPMP) or Team Care Arrangement (TCA).

The intent of MBS item 132 is to support the development of options for discussion with the patient, and family members, if present, including the exploration of treatment modalities and the development of a comprehensive consultant physician treatment and management plan, with discussion of recommendations for services by other health providers as appropriate.

Item 133 is available in instances where a review of the consultant physician treatment and management plan provided under item 132 is required, up to a maximum of two claims for this item in a 12-month period. Should further reviews of the consultant physician treatment and management plan be required, the appropriate face to face item for such service/s is 116.

What does this mean for providers?

MBS item 132 currently requires a referral and must be provided by a consultant physician (other than specialist psychiatrists).

A GP referral for this item should include:

- presenting symptoms and current difficulties
- patient's history
- relevant pathology results
- medications details (including interactions)
- relevant care plans
- assessments by other health professionals

What does this mean for patients?

Patients will continue to receive Medicare benefits for consultant physician services that are clinically appropriate and reflect modern clinical practice.

Following the assessment, a consultant physician may refer a patient to an allied health professional, but the allied health service will not be eligible for a Medicare benefit because of this referral. To be eligible for a Medicare benefit for allied health services, the patient must be:

- managed by their GP using a GPMP and TCA, or
- referred to eligible services by their GP.

This does not prevent a consultant physician from identifying the need for allied health services, but it does require the GP to review the TCAs to incorporate specialist recommendation/s and to make an allied health referral that meets Medicare requirements.
Who was consulted on the changes?

The items were introduced in 2007 following consultation with the Australian Medical Association and the Australian Association of Consultant Physicians.

How will the changes be monitored and reviewed?

- Providers must ensure that Medicare services requested or claimed using their provider number meet all legislative requirements. These services should also be considered acceptable by a general body of their profession. All Medicare claiming and requesting is subject to compliance checks. Providers or requesters may be required to submit evidence about the services they bill or request and should retain adequate and contemporaneous records. More information about the Department of Health and Aged Care's (the department) compliance program can be found on its website at Medicare compliance.

Where can I find more information?

The full item descriptor(s) and information on other changes to the MBS can be found on the MBS Online website. You can also subscribe to future MBS updates by visiting MBS Online and clicking 'Subscribe'.

The Department of Health and Aged Care (the Department) provides an email advice service for providers seeking advice on interpretation of the MBS items and rules and the *Health Insurance Act 1973* and associated regulations. If you have a query relating exclusively to interpretation of the Schedule, you should email askMBS@health.gov.au.

Private health insurance information on the product tier arrangements is available at www.privatehealth.gov.au. Detailed information on the MBS item listing within clinical categories is available on the Department's website. Private health insurance minimum accommodation benefits information, including MBS item accommodation classification, is available in the latest version of the *Private Health Insurance (Benefit Requirements) Rules 2011* found on the Federal Register of Legislation. If you have a query in relation to private health insurance, you should email PHI@health.gov.au.

Subscribe to 'News for Health Professionals' on the Services Australia website and you will receive regular news highlights.

If you are seeking advice in relation to Medicare billing, claiming, payments, or obtaining a provider number, please go to the Health Professionals page on the Services Australia website or contact the Services Australia on the Provider Enquiry Line – 13 21 50.

The data file for software vendors when available can be accessed via the Downloads page.

Current item descriptors

Category 1 Professional attendances
Group A4 – consultant physician (other than psychiatry) attendances to which no other item applies
Subgroup - nil
Item 132 Professional attendance by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) lasting at least 45 minutes for an initial assessment of a patient with at least 2 morbidities (which may include complex congenital, developmental and behavioural disorders) following referral of the patient to the consultant physician by a referring practitioner, if: (a) an assessment is undertaken that covers:

Category 1 Professional attendances

(i) a comprehensive history, including psychosocial history and medication review; and
(ii) comprehensive multi or detailed single organ system assessment; and
(iii) the formulation of differential diagnoses; and

(b) a consultant physician treatment and management plan of significant complexity is prepared and provided to the referring practitioner, which involves:
(i) an opinion on diagnosis and risk assessment; and
(ii) treatment options and decisions; and
(iii) medication recommendations; and

(c) an attendance on the patient to which item 110, 116 or 119 applies did not take place on the same day by the same consultant physician; and

(d) this item has not applied to an attendance on the patient in the preceding 12 months by the same consultant physician

Fee: $305.15 **Benefit:** 75% = $228.90 85% = $259.40

(See para **AN.0.7**, **AN.0.23**, **AN.40.1** of explanatory notes to this Category)

Extended Medicare Safety Net Cap: $500.00

Item 133

Professional attendance by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) lasting at least 20 minutes after the initial attendance in a single course of treatment for a review of a patient with at least 2 morbidities (which may include complex congenital, developmental and behavioural disorders) if:

(a) a review is undertaken that covers:
(i) review of initial presenting problems and results of diagnostic investigations; and
(ii) review of responses to treatment and medication plans initiated at time of initial consultation; and
(iii) comprehensive multi or detailed single organ system assessment; and
(iv) review of original and differential diagnoses; and

(b) the modified consultant physician treatment and management plan is provided to the referring practitioner, which involves, if appropriate:
(i) a revised opinion on the diagnosis and risk assessment; and
(ii) treatment options and decisions; and
(iii) revised medication recommendations; and

(c) an attendance on the patient to which item 110, 116 or 119 applies did not take place on the same day by the same consultant physician; and

(d) item 132 applied to an attendance claimed in the preceding 12 months; and

(e) the attendance under this item is claimed by the same consultant physician who claimed item 132 or a locum tenens; and

Category 1 Professional attendances
(f) this item has not applied more than twice in any 12 month period **Fee:** $152.80 **Benefit:** 75% = $114.60 85%=$129.90 (See para **AN.0.7**, **AN.0.23**, **AN.40.1** of explanatory notes to this category) **Extended Medicare Safety Net Cap:** $458.40

Please note that the information provided is a general guide only. It is ultimately the responsibility of treating practitioners to use their professional judgment to determine the most clinically appropriate services to provide, and then to ensure that any services billed to Medicare fully meet the eligibility requirements outlined in the legislation.

This factsheet is current as of the Last updated date shown above and does not account for MBS changes since that date.