Geriatrician or consultant physician assessment and management plans

Updated: 25 February 2025

- Effective since **1 November 2007**, there have been four MBS items to provide for the assessment and development of management plans by geriatricians or consultant physicians (MBS items 141, 143, 145 and 147) to support patients who are at least 65 years old.
- **There have been no changes to these items**, this factsheet has been created to transfer the existing arrangements on the new factsheet template.

What are the changes?

Effective **1 November 2007** four MBS items (141-147) were introduced for the comprehensive assessment and management of patients 65 years of age or more. The current MBS item descriptors 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).

What does this mean for providers?

MBS items 141, 143, 145 or 147 currently require a referral and must be provided by a consultant physician or a specialist in geriatric medicine as approved by the Royal Australasian College of Physicians.

A GP referral for these items should include:

- a patient history
- relevant pathology results
- medications and possible interactions (with a focus on presenting symptoms and current difficulties)
- other health professional documentation such as health assessments and care plans.

A written report of the assessment by the geriatrician or consultant physician, including the management plan, should be provided to the referring GP. This should occur within two weeks of the assessment; however earlier verbal communication may be appropriate.

What does this mean for patients?

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

Following the assessment, a geriatrician or 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 geriatrician 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 and New Zealand Society for Geriatric Medicine.

How will the changes be monitored and reviewed?

These geriatrician items will continue to be subject to routine MBS compliance processes and activities, including random and targeted audits which may require a provider to submit evidence about the services claimed.

Significant variation from forecasted expenditure may warrant review and amendment of fees, and incorrect use of MBS items can result in penalties including the health professional being asked to repay monies that have been incorrectly received.

Providers are responsible for ensuring services claimed from Medicare using their provider number meet all legislative requirements. These changes are subject to MBS compliance checks and providers may be required to submit evidence about the services claimed.

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 – current fees as at February 2025.

Category 1 Professional attendances
Group A28 Geriatric Medicine
Item 141 Professional attendance lasting more than 60 minutes at consulting rooms or hospital by a consultant physician or specialist in the practice of the consultant physician's or specialist's specialty of geriatric medicine, if: (a) the patient is at least 65 years old and referred by a medical practitioner practising in general practice (including a general practitioner, but not including a specialist or consultant physician) or a participating nurse practitioner; and (b) the attendance is initiated by the referring practitioner for the provision of a comprehensive assessment and management plan; and (c) during the attendance: (i) the medical, physical, psychological and social aspects of the patient's health are evaluated in detail using appropriately validated assessment tools if indicated (the assessment); and (ii) the patient's various health problems and care needs are identified and prioritised (the formulation); and (iii) a detailed management plan is prepared (the management plan) setting out: (A) the prioritised list of health problems and care needs; and (B) short and longer term management goals; and

Category 1 Professional attendances

(C) recommended actions or intervention strategies to be undertaken by the patient's general practitioner or another relevant health care provider that are likely to improve or maintain health status and are readily available and acceptable to the patient and the patient's family and carers; and

(iv) the management plan is explained and discussed with the patient and, if appropriate, the patient's family and any carers; and

(v) the management plan is communicated in writing to the referring practitioner; and

(d) an attendance to which item 104, 105, 107, 108, 110, 116 or 119 applies has not been provided to the patient on the same day by the same practitioner; and

(e) an attendance to which this item or item 145 applies has not been provided to the patient by the same practitioner in the preceding 12 months

Fee: $523.40 **Benefit:** 75% = $392.55 85% = $444.90

(See para **AN.0.26**, **AN.40.1** of explanatory notes to this Category)

Extended Medicare Safety Net Cap: $500.00

Item 143

Professional attendance lasting more than 30 minutes at consulting rooms or hospital by a consultant physician or specialist in the practice of the consultant physician's or specialist's specialty of geriatric medicine to review a management plan previously prepared by that consultant physician or specialist under item 141 or 145, if:

(a) the review is initiated by the referring medical practitioner practising in general practice or a participating nurse practitioner; and

(b) during the attendance:

(i) the patient's health status is reassessed; and

(ii) a management plan prepared under item 141 or 145 is reviewed and revised; and

(iii) the revised management plan is explained to the patient and (if appropriate) the patient's family and any carers and communicated in writing to the referring practitioner; and

(c) an attendance to which item 104, 105, 107, 108, 110, 116 or 119 applies was not provided to the patient on the same day by the same practitioner; and

(d) an attendance to which item 141 or 145 applies has been provided to the patient by the same practitioner in the preceding 12 months; and

Category 1 Professional attendances

(e) an attendance to which this item or item 147 applies has not been provided to the patient in the preceding 12 months, unless there has been a significant change in the patient's clinical condition or care circumstances that requires a further review.

Fee: $327.20 **Benefit:** 75% = $245.40 85% = $278.15

(See para **AN.0.26**, **AN.40.1** of explanatory notes to this Category)

Extended Medicare Safety Net Cap: $500.00

Item 145

Professional attendance lasting more than 60 minutes at a place other than consulting rooms or hospital by a consultant physician or specialist in the practice of the consultant physician's or specialist's specialty of geriatric medicine, if:

(a) the patient is at least 65 years old and referred by a medical practitioner practising in general practice (including a general practitioner, but not including a specialist or consultant physician) or a participating nurse practitioner; and

(b) the attendance is initiated by the referring practitioner for the provision of a comprehensive assessment and management plan; and

(c) during the attendance:

(i) the medical, physical, psychological and social aspects of the patient's health are evaluated in detail utilising appropriately validated assessment tools if indicated (the assessment); and

(ii) the patient's various health problems and care needs are identified and prioritised (the formulation); and

(iii) a detailed management plan is prepared (the management plan) setting out:

(A) the prioritised list of health problems and care needs; and

(B) short and longer term management goals; and

(C) recommended actions or intervention strategies, to be undertaken by the patient's general practitioner or another relevant health care provider that are likely to improve or maintain health status and are readily available and acceptable to the patient, the patient's family and any carers; and

(iv) the management plan is explained and discussed with the patient and, if appropriate, the patient's family and any carers; and

(v) the management plan is communicated in writing to the referring practitioner; and

(d) an attendance to which item 104, 105, 107, 108, 110, 116 or 119 applies has not been provided to the patient on the same day by the same practitioner; and

Category 1 Professional attendances

(e) an attendance to which this item or item 141 applies has not been provided to the patient by the same practitioner in the preceding 12 months.

Fee: $634.60 **Benefit:** 85% = $539.45

(See para **AN.0.26** of explanatory notes to this Category)

Extended Medicare Safety Net Cap: $500.00

Item 147

Professional attendance lasting more than 30 minutes at a place other than consulting rooms or hospital by a consultant physician or specialist in the practice of the consultant physician's or specialist's specialty of geriatric medicine to review a management plan previously prepared by that consultant physician or specialist under items 141 or 145, if:

(a) the review is initiated by the referring medical practitioner practising in general practice or a participating nurse practitioner; and

(b) during the attendance:

(i) the patient's health status is reassessed; and

(ii) a management plan that was prepared under item 141 or 145 is reviewed and revised; and

(iii) the revised management plan is explained to the patient and (if appropriate) the patient's family and any carers and communicated in writing to the referring practitioner; and

(c) an attendance to which item 104, 105, 107, 108, 110, 116 or 119 applies has not been provided to the patient on the same day by the same practitioner; and

(d) an attendance to which item 141 or 145 applies has been provided to the patient by the same practitioner in the preceding 12 months; and

(e) an attendance to which this item or 143 applies has not been provided by the same practitioner in the preceding 12 months, unless there has been a significant change in the patient's clinical condition or care circumstances that requires a further review.

Fee: $396.70 **Benefit:** 85% = $337.20

(See para **AN.0.26** of explanatory notes to this Category)

Extended Medicare Safety Net Cap: $500.00

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.