



**COMPREHENSIVE MEDICAL ASSESSMENTS –  
EXTRACT FROM THE MEDICARE BENEFITS SCHEDULE**

**ITEM DESCRIPTOR**

ENHANCED PRIMARY CARE	ENHANCED PRIMARY CARE
<b>GROUP A14 - HEALTH ASSESSMENTS</b>	
H 712	<p>Attendance by a medical practitioner (including a general practitioner but not including a specialist or consultant physician) <b>AT A RESIDENTIAL AGED CARE FACILITY OR AT CONSULTING ROOMS</b> for a comprehensive medical assessment (CMA) of a permanent resident of a residential aged care facility - not being a CMA of a resident in respect of whom, in the preceding 12 months, a payment has been made under this item.</p> <p>Benefits under this item are payable in respect of one CMA 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 CMA for a resident in any twelve month period.</p> <p><i>(See para A.20 of explanatory notes to this Category)</i></p> <p><b>Fee:</b> \$176.50                      <b>Benefit:</b> 75% = N/A      85% = \$150.05</p>

**EXPLANATORY NOTES**

**A.20.31 Comprehensive Medical Assessments**

The Comprehensive Medical Assessment complements other Medicare Benefits Schedule (MBS) items for services that medical practitioners (including GPs but not including specialists or consultant physicians) can provide to residents, including:

- (a) normal consultations; and
- (b) EPC items for contribution to a care plan and for case conferencing.

**Patient Eligibility**

A.20.32 This item applies to residents of a Residential Aged Care Facility. A **Residential Aged Care Facility (RACF)** is a facility in which residential care services are provided, as defined in the Aged Care Act 1997. This includes facilities that were formerly known as nursing homes and hostels. A person is a resident of a RACF if the person has been admitted as a permanent resident of that facility.

A.20.33 A CMA is a voluntary service. The resident's consent to a CMA should be obtained as per normal practice for obtaining consent to medical services.

**Involving the resident's carer**

A.20.34 Where the resident has an informal or family carer (see note A.20.8 above), the medical practitioner may find it useful to consider having the carer present for the CMA or components of the CMA (subject to the resident's agreement). The resident's carer may be able to provide useful information on matters such as medication usage and compliance, continence and physical, psychological and social function.

Where the provision of a CMA service involves consultation with a resident it should be read as including consultation with the resident's carer and/or representative where this is appropriate.

### **Medical Powers of Attorney and Advance Care Directives/Plans**

A.20.35 It may be useful for a medical practitioner providing a CMA to know whether the resident has given anyone an enduring power of attorney (covering medical treatment) or equivalent, or whether a guardian with power to make decisions about the resident's medical treatment has been appointed. Where this is known it may be useful to document this in the patient's records.

It may also be useful to know whether an Advance Care Directive or Advance Care Plan (terms may differ by location) for care at end of life or other major life change has been prepared for the resident. Where such a document has been prepared it may be useful to consider what implications this may have for the provision of medical care for the resident. The resident's medical practitioner may also take the opportunity to discuss issues about the degree of medical intervention in the event of further deterioration in health status with the resident (if able) or guardian.

A.20.36 A CMA is available to **new residents** on admission into a RACF. Generally, it is recommended that new residents should receive a CMA as soon as possible after admission, preferably within six weeks following admission into a RACF.

A.20.37 A CMA is available for **existing residents** where it is required in the opinion of the resident's medical practitioner, for instance, because of a significant change in medical condition, physical and/or psychological function, associated with, for example (but not limited to):

- (a) discharge from an acute care facility in the previous 4 weeks;
- (b) significant changes to medication regimen in the last 3 months;
- (c) change in medical condition or abilities;
- (d) falls in the last three months;
- (e) change in cognitive abilities and function;
- (f) change in physical function including Activities of Daily Living.

A.20.38 The potential need for an "as required" CMA may be identified by the resident's medical practitioner, staff of the Residential Aged Care Facility, the resident and/or the resident's carer; or by any other member of the resident's health care team including a pharmacist providing medication management review services. The resident's medical practitioner must assess that the resident requires a CMA.

### **Usual GP**

A.20.39 A CMA should generally be undertaken by the resident's 'usual GP'. This is broadly defined as 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. Medical practitioners who provide services on a facility-wide contract basis, and/or who are registered to provide services to RACF's as part of aged care panel arrangements, may also undertake CMAs for residents as part of their services.

A.20.40 A maximum of one Medicare rebate is payable for a CMA for a resident in any twelve month period.

## CONTENT OF A COMPREHENSIVE MEDICAL ASSESSMENT

A.20.41 A comprehensive medical assessment means a full systems review of the resident, including assessment of the resident's health and physical and psychological function. In undertaking a CMA, the medical practitioner may wish to consult appropriate guidelines (for example, the current edition of the Royal Australian College of General Practitioners (RACGP) publication: *Medical Care of Older Persons in Residential Aged Care Facilities* – the 'Silver Book'). Where practical, the medical practitioner may also use available knowledge and information from the RACF as relevant to the CMA.

A.20.42 A CMA of an aged care resident must include:

- (a) taking a detailed relevant medical history;
- (b) conducting a comprehensive medical examination of the resident;
- (c) developing a list of diagnoses or problems based on the medical history and medical examination; and
- (d) providing a written summary of the outcomes of the CMA for the resident's records to inform the provision of care for the resident by the RACF and to assist the reviewing pharmacist in providing medication management review services for the resident.

Elements of these components that would normally be undertaken, subject to the specific needs and circumstances of the resident, are set out below.

A.20.43 **A detailed relevant medical history** is an assessment of the resident's previous medical history and may include a review of:

- results of relevant assessments by previous GPs and/or specialists, including any relevant previous community-based assessments (such as EPC health assessments);
- results of relevant previous investigations and allied health interventions;
- results of assessment and intervention by nursing staff of the RACF;
- details of allergies and any drug intolerance;
- the resident's medication (including prescription and non-prescription drugs), to inform medication management review services for the resident;
- acute and chronic pain;
- falls in the last three months;
- immunisation status for influenza, tetanus and pneumococcus;
- continence; and
- factors leading to the admission into the RACF, taking into account the results of the resident's ACAT assessment.

A.20.44 **A comprehensive medical examination** is a full systems review of the resident. In undertaking the comprehensive medical examination the medical practitioner may wish to consider the following as appropriate to the resident:

- (a) cardiovascular and respiratory systems, and other systems as indicated
- (b) physical causes of acute and chronic pain;
- (c) assessment of the resident's:
  - physical function, including activities of daily living;
  - psychological function, including cognition and mood;
  - oral health, nutrition status and dietary needs; and
  - skin integrity.

### **Developing a list of diagnoses and/problems**

A.20.45 This should be based on the information from the medical history and examination of the patient. The list of diagnoses and/or problems is a useful output of the CMA and should form the basis of any actions to be taken as a result of the CMA. The list should be included in the summary of the CMA to facilitate the integration of the resident's medical care, medication review, care planning and provision of care by the aged care home.

A.20.46 **A written summary of the outcomes of the CMA** should contain sufficient information to serve as a communication tool from the medical practitioner to other health and care providers involved in the care of the resident. The medical practitioner may wish to include a list of diagnoses and problems and recommendations concerning the care of the resident.

A copy of this summary should be provided to the RACF to inform the provision of care by the RACF for the resident and to assist the reviewing pharmacist in providing medication management review services for the resident. The medical practitioner may wish to offer the resident (and their carer where appropriate) a copy of the summary or relevant parts thereof.

Where a facility uses a care documentation system that the medical practitioner considers relevant to the CMA, the medical practitioner may consider documenting the CMA outcomes of the CMA in that system or in a way that can be integrated with the facility's system.

A.20.47 **Additional matters of particular relevance to the resident** - the CMA will usually cover additional matters of particular relevance to the resident. The following additional components may be undertaken where and as relevant to the resident: fitness to drive; hearing; vision; smoking; foot care; sleep; cardiovascular risk factors; and alcohol use.

A.20.48 On completion of the CMA, the medical practitioner may consider referral to appropriate allied health providers, noting that this may involve a cost to the resident. Any follow up work following completion of the CMA should be treated as a different service.

A.20.49 The CMA should not take the form of a health screening service, in particular the CMA should not include category 5 (diagnostic imaging) services or category 6 (pathology) services unless the CMA detects problems that require clinically relevant diagnostic imaging or pathology services.

### **Combining with other consultation items**

A.20.50 The CMA item covers the consultation at which the CMA service is undertaken:

- (a) if a consultation is for the purpose of undertaking a CMA only, only the CMA item can be claimed;
- (b) if a CMA is undertaken during the course of a consultation for another purpose, the CMA item and the relevant item for the other consultation may both be claimed;
- (c) any immediate action required to be done at the time of completing a CMA, based on and as a direct result of information gathered in the CMA, should be treated as part of the CMA;
- (d) any follow up after the completion of the CMA should be treated as a separate consultation item; and
- (e) CMAs do not count for the purposes of derived fee arrangements that apply to other consultations in a Residential Aged Care Facility.