

Australian Government
Department of Health and Ageing

Chronic Disease Management (CDM) Medicare Items

Questions & Answers

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1. GENERAL

1.1 *What are the GP Chronic Disease Management (CDM) items?*

The CDM Medicare items are for GPs to manage the health care of patients who have chronic or terminal medical conditions. These Qs and As provide guidance on the requirements relating to Medicare eligibility for the items and the rules that apply if Medicare benefits are to be paid for them.

GPs are able to choose Medicare rebatable items for GP-managed care planning and/or team-assisted care planning, depending on the health needs of their patients.

Patients who have a chronic or terminal medical condition, with or without complex care needs, and who would benefit from a structured care approach, are eligible for a GP Management Plan (GPMP) (MBS item 721) providing they are not public in-patients of a hospital or Australian Government funded residents of an aged care facility. The item enables GPs to provide GP-only care planning services for eligible patients.

Patients who have a chronic or terminal condition **and** complex care needs requiring ongoing care from a multidisciplinary team comprising their GP and at least two other health or care providers are eligible for a Team Care Arrangements (TCAs) service (MBS item 723), providing they are not public in-patients of a hospital or Australian Government funded residents of an aged care facility.

While many patients will be eligible for both a GPMP and TCAs, the services can be provided independently. It is not mandatory to follow the preparation of a GPMP with the coordination of TCAs or to prepare a GPMP before coordinating TCAs.

There is a review item for patients who have a CDM plan or plans in place. MBS item 732 provides a rebate for a GP to review a GPMP and/or TCAs. The recommended frequency for review is every six months.

Using the CDM items, GPs can also contribute to other provider's care plans or to a review of these plans. MBS item 729 allows the GP to contribute to a multidisciplinary care plan or to a review of a multidisciplinary care plan prepared by another health or care provider for a patient who is not a resident of an aged care facility.

MBS item 731 allows for GPs to contribute to a multidisciplinary care plan for a resident of an aged care facility, or to a review of such a plan, where the care plan was developed by that facility. The GP's contribution to the resident's care plan should be through direct collaboration with the aged care facility, at the request of the facility.

1.2 *How can patients have access to allied health services through the Chronic Disease Management (CDM) items?*

Once a GP Management Plan (GPMP) and Team Care Arrangements (TCAs) have been prepared, the patient may be eligible for access to certain individual allied health services (MBS items 10950 to 10970 inclusive) on referral from their GP. Residents of aged care homes whose GP has contributed to a care plan prepared by the residential aged care facility (item 731) may also have access to the allied health items.

The allied health services provided through these referrals must be directly related to the management of the patient's chronic condition/s. Only the GP can determine whether the patient's chronic condition would benefit from allied health services and the need for allied health services must be identified in the patient's care plan. Patients with a GPMP and type 2 diabetes can access Medicare rebates for allied health group services (MBS items 81100 to 81125) in addition to the individual allied health services.

The chronic disease care planning process is not simply a mechanism to provide Medicare rebates for allied health services. Care planning helps the GP to coordinate the services and treatment that a patient requires. It can be used as a tool for organising the care a patient needs and help reduce the need for ad hoc, episodic consultations. A care plan is a useful mechanism for recording comprehensive, accurate and up-to-date information about the patient's condition and all of the treatment they are receiving. Development of a care plan can also help encourage the patient to take some responsibility for their care, including the identification of any actions the patient might take to help achieve the goals of the treatment.

1.3 What conditions must a patient have to be eligible for a Chronic Disease Management (CDM) service?

To be eligible for any of the CDM items, a patient must have a chronic or terminal medical condition. This is one that has been or is likely to be present for six months or longer and includes but is not limited to asthma, cancer, cardiovascular illness, diabetes mellitus, musculoskeletal conditions and stroke.

The Medicare Benefits Schedule (MBS) does not comprehensively list all possible medical 'conditions' that either are/are not regarded as chronic medical conditions for the purposes of the CDM items.

Whether a patient is eligible for a CDM service or services is essentially a matter for the GP to determine, using their clinical judgement and taking into account both the eligibility criterion and the general guidance. Where a patient's 'condition' would not obviously come within the MBS definition, a GP may still consider that the patient's condition and circumstances are such that they require the preparation of a care plan because of such factors as non-compliance, inability to self-manage or functional disability.

The Department has received queries about whether the following are chronic medical conditions for the purposes of the items: alcohol or other substance abuse; smoking; obesity; unspecified chronic pain; hypertension, hypercholesterolemia, or syndrome X; impaired fasting glucose tolerance or impaired glucose tolerance; pregnancy. In some cases these would not be commonly regarded as chronic medical conditions in themselves: some may more accurately be regarded as risk factors for development of chronic conditions; some possibly relate more to personal choice/behavioral issues; and some (pregnancy without complications) could be regarded as a normal part of life.

The Department recognises, however, that conditions such as these can occur across a wide spectrum of severity and in a broad range of circumstances, with, for example, some patients with one (or more) of the above conditions being unable to self-manage or comply with care and treatment, being functionally disabled by their condition etc. In many cases a patient may have complications or comorbidities that may be a result of or exacerbated by such conditions or risk factors and would make them eligible for CDM services.

In these cases, the GP should satisfy themselves that their peers would regard the provision of a CDM service as appropriate for that patient, given the patient's needs and circumstances.

1.4 Is there an age restriction on Chronic Disease Management (CDM) services?

No. Patients need to have a chronic or terminal condition and their GP has to determine that the patient's condition would benefit from a CDM service or services, regardless of age.

1.5 Do 'chronic conditions and complex care needs' include people with severe disabilities for the purpose of the Chronic Disease Management (CDM) items?

If patients with severe disabilities have a chronic medical condition, they could be eligible for a GP Management Plan (GPMP). If they have a chronic condition *and* complex care needs, they could also be eligible for Team Care Arrangements (TCAs).

1.6 Who determines whether a patient is eligible for a Chronic Disease Management (CDM) service?

Whether a patient is eligible for a CDM service or services is essentially a matter for the GP to determine, using their clinical judgement and taking into account both the eligibility criterion and the general guidance.

This is also the case for CDM allied health services. Only the GP can determine whether a patient's chronic condition would benefit from Medicare rebateable allied health services, and the need for these services must be identified in the patient's care plan.

1.7 Who can provide Chronic Disease Management (CDM) services?

The GP items are intended to be provided by the patient's usual GP (see section 1.8).

GPs are required to collaborate with two or more other health or care providers in the development of Team Care Arrangements (TCAs). To be one of the minimum three members of a TCAs team, a provider should have an ongoing role and involvement with the patient. In addition to the patient's usual GP, the team can be comprised of health or care providers such as allied health providers, home or community service providers and medical specialists.

Other GPs would not usually be a team member.

Only one specialist or consultant physician can be counted towards the minimum of two contributing team members who, with the coordinating GP, make up the core TCAs team.

Persons who may be included in a team are discussed more fully in section 3.

1.8 What is meant by the term 'usual GP'?

The patient's 'usual GP' means:

- a GP who has provided the majority of care to the patient over the previous twelve months; or
- a GP who will be providing the majority of care to the patient over the next twelve months; or
- a GP who is located at a medical practice that provided the majority of services to the patient in the past twelve months or is likely to provide the majority of services in the next twelve months.

1.9 Who can assist a GP with services covered by the Chronic Disease Management (CDM) items?

General assistance

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

A GP's receptionist could assist with the logistics but it would not be appropriate for a receptionist to assess the patient or identify their health and care needs.

Medicare rebateable assistance

Item 10997 may be claimed under Medicare for monitoring or support services provided to a person with a chronic disease by a practice nurse or registered Aboriginal health worker if:

- the patient has a GPMP, TCAs or multidisciplinary care plan in place; and
- the service is provided on behalf of and under the supervision of the GP; and
- the service is consistent with the patient's care plan/s.

to a maximum of five services per patient in a calendar year.

As the service is being provided on behalf of, and under the supervision of the GP, the GP retains responsibility for the health, safety and clinical outcomes of the patient. This does not mean that the GP is required to see the patient or be present with the practice nurse or registered Aboriginal health worker when the chronic disease monitoring and support is undertaken. It is up to the GP to decide whether they need to see the patient and, where a consultation with the patient occurs, the GP is entitled to claim a Medicare item for the time and complexity of their personal attendance on the patient. The time the patient spends receiving a service from the practice nurse or Aboriginal health worker is itemised separately under item 10997 and should not be counted as part of the Medicare item claimed for time spent with the GP.

1.10 Must the patient be offered a signed copy of the GP Management Plan (GPMP) or Team Care Arrangements (TCAs) document?

Yes. The patient must be offered a copy of the GPMP and the TCAs and a copy must be added to the patient's medical records.

1.11 What is the recommended frequency and the claiming rules for the Chronic Disease Management (CDM) items?

The recommended frequency and minimum claiming periods for the CDM items are set out in the following table.

Name	Item no.	Recommended frequency	Minimum claiming period*
Preparation of a GP Management Plan	721	2 yearly	12 months
Coordinate the development of Team Care Arrangements	723	2 yearly	12 months
Review of a GP Management Plan and/or review of Team Care Arrangements	732	6 monthly	3 months
Contribution to a multidisciplinary care plan prepared by another provider	729	6 monthly	3 months
Contribution to a multidisciplinary care plan prepared by a residential aged care facility	731	6 monthly	3 months

* CDM services can be provided more frequently in 'exceptional circumstances', i.e., where there has been a significant change in the patient's clinical condition or care circumstances (such as development of co-morbidities or complications, deteriorating condition, illness/death of carer etc), that require a new GPMP, TCAs or review service.

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.

1.12 What information is available to help GPs with the Chronic Disease Management (CDM) items?

Information about the CDM items is available on the Department's web site at www.health.gov.au/mbsprimarycareitems, or use the A-Z Index tool to go to Chronic Disease Management (CDM) Medicare Items.

Questions about the items can be sent to mbsonline@health.gov.au.

The CDM items and explanatory notes are included in the Medicare Benefits Schedule (MBS) that is available online at: www.health.gov.au/mbsonline.

2. ITEM 721: GENERAL PRACTICE MANAGEMENT PLAN (GPMP)

2.1 When are patients eligible for a GP Management Plan (GPMP)?

To be eligible for a Medicare funded GP Management Plan, a patient must have a chronic (or terminal) medical condition (see section 1.2) with or without complex care needs. The item is for GPs to provide GP-only care planning services for eligible patients.

2.2 What are the steps in the GP Management Plan (GPMP) service?

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;
- (b) record the plan;
- (c) record the patient's agreement to the preparation of the plan;
- (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.

The patient's progress against the plan should be periodically reviewed using the GPMP review item (MBS item 732), and ongoing management and care provided through normal consultation items.

2.3 Should a patient with multiple chronic conditions have a GP Management Plan (GPMP) for each condition?

No. A GP Management Plan (GPMP) should address all of the patient's health care needs and a rebate will not be paid within twelve months of a previous claim for the same item other than in exceptional circumstances.

Patients with multiple chronic conditions are eligible for a single GPMP and, if those multiple conditions result in complex needs requiring care from a multidisciplinary team (team care), the patient will also be eligible for the Team Care Arrangements (TCAs) service.

3. ITEM 723: TEAM CARE ARRANGEMENTS (TCAs)

3.1 *When is it appropriate to coordinate Team Care Arrangements (TCAs) for a patient?*

TCAs are for patients who have a chronic or terminal medical condition **and** complex needs requiring ongoing care from a multidisciplinary team. Medicare funding for the service is not aimed at patients with straightforward needs requiring 'standard treatment' from one consultation only. It is designed for patients who require care from at least three collaborating health or care providers, each of whom provides a different kind of treatment or service and at least one of whom is a medical practitioner.

TCAs are likely to be indicated where a patient has complex health care needs and one or more of the following:

- little or no capacity to access or receive needed services by the usual referral process;
- an unstable or deteriorating condition and/or co-morbidities;
- increasing frailty and/or dependence;
- increasing incidence and/or complexity of health problems;
- complications, including falls or incontinence;
- significant change in social circumstances (e.g. death, illness or 'burnout' of carer);
- two or more hospital admissions for their chronic condition in the past six months;
- inability to comply with required treatment without ongoing management and coordination; and/or
- a need to see other providers on a regular, frequent and ongoing basis to manage the chronic condition (as distinct from one or two visits for one specific treatment).

However, whether or not a patient is eligible for TCAs is essentially a matter for the GP to decide.

3.2 *What are the steps in the Team Care Arrangements (TCAs) service?*

When coordinating the development of Medicare-funded TCAs, the medical practitioner must:

- (a) consult with at least two other health or care providers to make arrangements for the multidisciplinary care of the patient; and
- (b) prepare a document that describes:
 - treatment and service goals for the patient; and
 - treatment and services that collaborating providers will provide to the patient; and
 - actions to be taken by the patient; and
 - arrangements to review by a specified date; 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); and
- (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; and
- (f) give copies of the relevant parts of the document to the collaborating providers; and

- (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.

The patient's progress against the TCAs should be periodically reviewed using the TCAs review item (MBS item 732), and ongoing management and care should be provided through normal consultation items.

3.3 What does collaboration with the other health and care providers mean when developing Team Care Arrangements (TCAs)?

Collaboration means communicating with the other providers to discuss potential treatment or services they will provide. The requirements for collaboration are set out in the MBS Explanatory Notes for coordinating TCAs.

Communication must be two-way, preferably oral or, if not practicable, in writing (including by exchange of faxes or email). It should relate to the specific needs and circumstances of the patient. The communication from the collaborating providers must include advice on treatment and management of the patient.

While it is not mandatory that an allied health provider must see the patient before contributing to the plan (unless they wish to), they do need to provide input to the TCAs on the treatment or services they will provide, based on their understanding of the patient's needs. Note that, in many cases, it is expected that the allied health professional can provide advice about the treatment/services they will provide based on the information provided by the GP, including the patient's current GP Management Plan (GPMP).

On the other hand, it would not be sufficient for a provider to simply say 'I will assess the patient and then I will advise you what treatment I will provide', as this would not constitute discussing or providing advice on potential treatment or services and would leave nothing to be documented in the TCAs.

It is not necessary to 'case conference' with the collaborating providers (i.e. talk with all of the providers at the same time).

3.4 Can a 'blanket' agreement form be sent by a GP if the patient is in need of straightforward treatment or monitoring?

While it makes sense for practices to establish which allied health professionals are prepared to participate in Team Care Arrangements (TCAs) teams, a contribution to a care plan needs to be specific to each patient. The MBS Explanatory Notes for coordinating TCAs refer to 'collaborating with the participating providers to discuss potential treatment/services they will provide to achieve management goals for the patient'. Collaboration 'should relate to the specific needs and circumstances of the patient' and a 'blanket agreement' to participate in TCAs would not be sufficient itself to meet this requirement.

3.5 Is a fax form an acceptable form of communication for collaboration between GPs and providers on a Team Care Arrangements (TCAs) service?

The preferred means of communication is oral communication.

Where oral communication is not practicable, collaboration could be covered by a fax form that enables the provider to advise the treatment or services they will provide to meet the specific needs and circumstances of the patient, based on their assessment of the patient's needs from information provided by the GP. A form by itself would not meet the requirement for collaboration if it does not include the treatment or services to be provided by the provider, matched to the specific needs of the patient.

Note that in communicating patient information, the GP must ensure that the privacy of patient's information is safeguarded.

3.6 How does a provider have 'ongoing involvement' with a patient?

To develop Team Care Arrangements (TCAs) for a patient, at least two health or care providers who will be providing ongoing treatment or services to the patient must collaborate with the GP in the development of TCAs.

The term 'ongoing' has its normal common meaning. This allows appropriate scope for the GP's judgment of the nature and extent of the contact expected between the other providers and the patient when the GP is assessing whether they should be members of the team.

The contact between the other providers and the patient must be based on more than a one-off and/or routine consultation(s) with the patient. For example, seeing a specialist for a check-up or assessment on a referral basis, with the likelihood of a once-only visit and no ongoing involvement or treatment, would not constitute ongoing treatment or services and qualify that specialist as one of the three minimum members of the team. Conversely, a pharmacist providing a Home Medicines Review (HMR) service would be able to comprise one of the minimum two other members of the team, as HMRs are expected to include some element of post-HMR monitoring and follow up.

It is good practice for care plans to identify all of the health and care services the patient requires. Accordingly, health or care professionals who may not meet the criterion of providing ongoing treatment and services can still be included in a TCAs team, although they would not count as one of the minimum two other members of the team (in addition to the GP). Once-only or non-ongoing treatment providers could be either an additional member of the team (i.e. additional to the three minimum) or identified in the patient's GP Management Plan (GPMP) or TCAs as providing specified services to the patient.

3.7 Can a GP claim item 723 more than once for consulting separately with other health or care providers about a patient's chronic condition?

No. Item 723 can only be claimed once. GPs cannot claim multiple Team Care Arrangements (TCAs) for communicating with different providers.

3.8 If a patient's medical condition has changed, how can these changes be incorporated into Team Care Arrangements (TCAs)?

Once TCAs are in place, they should be regularly reviewed by the GP using item 732. The recommended review frequency is every six months. In general, new Medicare funded TCAs should not be prepared unless required by the patient's conditions, needs and circumstances. However, the minimum claiming interval for this item is twelve months to allow for the completion of new TCAs where required. The intention is for the initial plan to be reviewed using the TCAs review item. Changes to TCAs can be made as part of the review process.

3.9 Who can be a member of a Team Care Arrangements (TCAs) team?

The TCAs team must include the patient's GP and at least two persons who are providing different kinds of ongoing care to the patient and who have contributed to the plan. The TCAs can (and should) also refer to treatment and care to be provided by care and service providers who are not contributing to the plan.

TCAs are intended for patients with complex needs requiring ongoing multidisciplinary care. They are not aimed at patients with straightforward needs requiring 'standard treatment' from one consultation only. For example, an optometrist would not count as one of the two minimum members of a TCAs team (in addition to the GP) unless they are providing ongoing treatment or services to the patient, i.e. more than a one-off visit for standard treatment.

Team members could include:

- the allied health professionals to whom a GP can refer patients for Medicare-rebateable CDM allied health services (i.e. Aboriginal health workers; audiologists; chiropractors; diabetes educators; dietitians; exercise physiologists; mental health workers; occupational therapists; osteopaths; physiotherapists; podiatrists; psychologists; and speech pathologists; and/or
- other allied health professionals such as asthma educators, orthoptists, orthotists or prosthetists; and/or
- other health or care providers such as registered nurses, social workers, optometrists and pharmacists.

A GP could include a public sector allied health professional as part of TCAs. The services provided for the patient by the public sector allied health professional will be provided as part of the public sector allied health professional's responsibilities.

A team might also include home and community service providers, or care organisers such as: education providers; 'meals on wheels' providers; personal care workers (workers who are paid to provide care services); and probation officers where they are contributing to the plan and not simply providing a service identified in the plan.

Similarly, persons such as a Workcover Rehabilitation Case Manager fitness instructor and personal trainer could be members of a TCAs team if they are contributing to the plan.

Another GP can count as one of the minimum two members collaborating with the GP to develop the TCAs only where they are providing ongoing treatment or services to the patient that are clearly distinct and different to normal general practice services. Services such as acupuncture that require special expertise and qualifications could be regarded as distinct and different to normal general practice services. Therefore if a GP is a qualified medical acupuncturist and provides medical acupuncture services as ongoing care to the patient to meet their health care needs, they could qualify as one of the minimum three members of the TCAs team, whether they are from the same practice or not.

There is not a prescriptive list but the following is mandatory:

- the team members must collaborate with the coordinating GP; they must discuss potential treatment/services they will provide to achieve management goals for the patient;
- the collaboration must relate to the specific needs and circumstances of the patient;
- the treatment or services must be ongoing; and
- the collaborating team members must be providing different kinds of ongoing care to the patient.

Note also that the development of the TCAs involves discussing with the patient which treatment/service providers should be asked to collaborate with the GP in completing the TCAs.

3.10 Can a specialist or consultant physician be a member of a Team Care Arrangements (TCAs) team?

Yes. It is not intended that this collaboration replace a referral to a consultant (or other health or care professional) for advice and treatment, or that a consultant is expected to 'approve' a care plan for a patient they have not seen. If the collaborating providers have not already assessed the patient, they can only contribute in broad terms about the potential treatment or services they would provide. There is no obligation for a health care provider to contribute to a care plan if they do not believe they are able to meaningfully do so.

Only one specialist or consultant physician can be counted towards the minimum of two contributing team members who, with the coordinating GP, make up the core TCAs team.

This does not prevent coordinating GPs from including the care/treatment to be provided by two or more specialists in the actual TCAs document, but it does mean that the minimum number of three providers cannot be constituted by a GP and two specialists.

3.11 Do allied health providers need to be a member of a Team Care Arrangements (TCAs) team for the GP to be able to refer patients to them for Medicare eligible services?

No. A GP can refer patients to allied health providers who are not members of the TCAs team as long as TCAs are in place for the patient and the referral is for services that are recommended in the patient's TCAs.

3.12 Under what circumstances can a nurse/practice nurse or Aboriginal health worker be one of the three minimum members of a multidisciplinary Team Care Arrangements (TCAs) team?

If a nurse/practice nurse or Aboriginal health worker is independently providing ongoing treatment or services to the patient, that is:

- not as part of the general practice medical services provided by the GP;
- not under the supervision of the GP; and
- different to the ongoing care provided by the other members of the team;

they **could** constitute one of the minimum three members of the team.

Where the nurse/practice nurse is:

- providing general practice services *on behalf* of the patient's GP (including Medicare items for immunisation, wound management and Pap smears, which must be provided on behalf of and under the supervision of a GP); and/or
- otherwise providing services under supervision, not in their own independent professional capacity;

they **could not** qualify as one of the three independent members of the team.

Within the general guidance above, it is up to the GP to determine in the specific circumstances whether the practice nurse is skilled or qualified to independently provide ongoing treatment or services to the patient that is different to the care provided by the other members of the team.

If a GP believes that there is a clear case for the practice nurse to qualify as one of the minimum three members of a TCAs team, given the particular needs and circumstances of the patient and the treatment to be provided by the practice nurse, the GP should be clearly satisfied that their peers would regard the involvement of the practice nurse as a member of the TCAs team to be appropriate in the circumstances.

4. ITEM 732: REVIEW OF A GP MANAGEMENT PLAN (GPMP) AND/OR REVIEW OF TEAM CARE ARRANGEMENTS (TCAS)

Note: From 1 May 2010, item 732 replaces items 725 (for a review of a GPMP) and 727 (for a review of TCAs). Item 732 retains ALL of the requirements of the former items and has the same Medicare benefit. Items 721 and 723 were combined into one new item to streamline and simplify the Medicare Benefits Schedule (MBS) and remove red tape.

4.1 When are patients eligible for item 732?

Item 732 is for patients who have a current GP Management Plan (GPMP) and Team Care Arrangements (TCAs) and require a review of one or both of these care plans. The item can also be used to review a community or discharge care plan that was put in place under the previous Enhanced Primary Care (EPC) items (former items 720 or 722).

4.2 How often should care plans be reviewed?

It is expected and strongly encouraged that once a GP Management Plan (GPMP) and Team Care Arrangements (TCAs) are in place, they will be regularly reviewed. The recommended frequency is every six months.

In general, a new GPMP or TCAs should not be prepared unless required by the patient's conditions, needs and circumstances. However, the minimum claiming interval for these items is twelve months (unless there are exceptional circumstances) to allow for the completion of new plans where required. Changes to the plans can be made as part of the review process.

4.3 Can a GP claim item 732 twice on the same day?

Yes. Providing an item 732 for reviewing a GP Management Plan (GPMP) and another for reviewing Team Care Arrangements (TCAs) are both delivered on the same day as per the MBS item descriptors and explanatory notes, they can be claimed 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 item 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 service*.

Medicare Online/ECLIPSE: set the 'DuplicateServiceOverrideIND' to 'Y', which flags the item as *not duplicate*.

4.4 Can a patient have more than two review items in a three-month period.

Yes, when exceptional circumstances apply, i.e. when there has been a significant change in the patient's clinical condition or care circumstances that necessitates the performance of the service for the patient.

When this is the case, both electronic and manual claims need to indicate that exceptional circumstances apply. As there is no override indicator for Medicare electronic claiming, the free text field should be endorsed "exceptional circumstances" to identify which item they apply to. Claims under exceptional circumstances will not be able to be transmitted via Medicare Easyclaim.

4.5 Can any GP do a review of a GP Management Plan (GPMP) or Team Care Arrangements (TCAs) and how do they check whether one has already been done?

The Chronic Disease Management (CDM) items are intended to be provided by the patient's usual GP. This means the GP, or a GP working in the same medical practice, that has provided the majority of 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.

The reviewing GP, if not the original GP or one from the same practice, should be the patient's new GP; a review cannot be done by 'any GP'. Where it is unclear whether the patient has a current GP Management Plan (GPMP) and Team Care Arrangements (TCAs) or both, a GP can call the Medicare Australia Provider Enquiry line on 132 150.

In addition, the patient (or their representative) can ring the Medicare Patient Enquiry Line on 132 011 to verify the date of the previous CDM item (if any). The patient (or their representative) will need to quote their Medicare Number and ask whether an item in the range 721 to 731 has previously been paid and if so, when. It should be noted that the patient's representative must have Power of Attorney and must have previously lodged this with Medicare Australia.

4.6 Are templates available for the Chronic Disease Management (CDM) review services?

No, the Department does not produce a template for the review items. GPs can use a template of their own choosing, provided the service is delivered as per the Medicare requirements outlined in the item descriptor and explanatory notes.

5. ITEM 729: GP CONTRIBUTION TO, OR CONTRIBUTION TO A REVIEW OF, A MULTIDISCIPLINARY CARE PLAN FOR A PATIENT WHO IS NOT A RESIDENT OF AN AGED CARE FACILITY.

5.1 What is the purpose of item 729?

MBS item 729 is for patients with a chronic or terminal medical condition and complex care needs who are having a multidisciplinary care plan prepared or reviewed for them by a health or care provider other than their usual GP. It is not available to residents of aged care facilities. Other health or care providers include (but are not limited to) allied health providers, home or community service providers and medical specialists, but not usually other GPs.

5.2 What are the steps involved in item 729?

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.

A rebate can be claimed once the patient's usual GP (or another GP in the same practice) has contributed to the care plan, or to the review of the care plan being prepared by the other provider.

5.3 Is it possible for a GP to claim Medicare items 721 and 723 after they have recently contributed and claimed item 729?

If a GP contributes to a multidisciplinary care plan prepared for a patient by another provider, they will not be able to prepare and claim a new GP Management Plan (GPMP) and Team Care Arrangements (TCAs) for that patient for three months, other than in exceptional circumstances. This is because it is expected that the GP's contribution will enable the care plan to be suitable for the patient's needs and circumstances.

In exceptional circumstances, where there has been significant change in a patient's clinical condition or care circumstances, the GP may determine a new GPMP (item 721) and TCAs (item 723) are required.

Where a service is provided in exceptional circumstances, the patient's invoice or Medicare voucher (assignment of benefit form) should be annotated to briefly indicate the reason why the service involved was required earlier than the minimum claiming interval for that item.

6. ITEM 731: CONTRIBUTION TO, OR CONTRIBUTION TO A REVIEW OF, A MULTIDISCIPLINARY CARE PLAN FOR A PATIENT WHO IS A RESIDENT OF AN AGED CARE FACILITY.

6.1 What is the purpose of item 731?

Item 731 is for Australian Government funded residents of a residential aged care facility. It is available for a GP to contribute to a multidisciplinary care prepared for a resident by the facility.

The item was introduced because it was recognised that Australian Government funded aged care residents are already required to have a care plan prepared for them by the aged care facility (usually on admission or soon after arrival), and that it would be appropriate for GPs to have input to this care plan. The plan is intended to be a comprehensive document covering the resident's health and care needs, including any behavioural or lifestyle needs.

For the GP to be able to contribute to the resident's care plan and claim a Medicare rebate, the plan needs to be multidisciplinary. This means that the resident must have a chronic medical condition and complex needs requiring ongoing care from a multidisciplinary team comprising a GP and at least two other health or care providers. Note that not all care plans prepared for residents of aged care homes will necessarily be multidisciplinary; this will depend on the needs of the resident.

It is expected that the GP's contribution to the resident's multidisciplinary care plan will be through direct collaboration with the aged care facility, at the request of the facility. The contribution should be based on the GP's knowledge of the resident and their health and care needs, and may include a personal attendance by the GP with the patient.

6.2 What are the steps involved in item 731?

This item, including the components of the service, is similar to Item 729 (see section 5) except that:

- it is only available to residents of aged care facilities;
- the service can only be provided to a resident where the multidisciplinary plan is being prepared by the aged care facility or by a hospital from which the resident is being discharged;
- a contribution to a care plan for an aged care resident should be at the request of the aged care facility or the discharging hospital;
- the GP's contribution should be documented in the care plan maintained by the aged care facility or discharging hospital and a record included in the resident's medical record; and
- a rebate will not be paid within three months of a previous claim for the same item or within three months of a claim for other Chronic Disease Management (CDM) items, other than in exceptional circumstances.

6.3 Can a patient receive rebates for allied health services if item 731 has been provided?

In general, if a GP has contributed to a multidisciplinary care plan prepared by the aged care facility (MBS item 731), the resident with the care plan is eligible for Medicare rebates for up to five allied health (individual) visits per calendar year (the period of time between January 1 and December 31). The resident must have a chronic condition and complex care needs and be referred by the GP. The need for allied health services must also be identified in the resident's care plan.

Where a resident's GP determines that the resident has a clinical need to access allied health services which attract a rebate, it is up to the GP to determine the type and number of services required by the resident and to complete the appropriate referrals.

6.4 Are both high-care and low-care residents eligible for allied health services?

All Australian Government funded residents of aged care facilities, regardless of their classification as high or low care, are eligible for Medicare rebates for up to five allied health (individual) services each calendar year, where their GP has contributed to a multidisciplinary care plan prepared by the aged care facility and referred them for services.

However, Medicare allied health services should not replace services already expected to be provided to residents by the facility as a requirement under the *Aged Care Act (1997)*.

Under the *Aged Care Act (1997)*, approved providers of residential aged care have an obligation, where an assessed care need has been identified, to provide allied health services to high-care residents at no additional cost to the resident, except for intensive long term rehabilitation services following serious injury, surgery or trauma. Therefore high-care residents should not be routinely referred for allied health services under Medicare.

Aged care facilities are required to assist low-care residents to access health practitioner and therapy services, including arranging for the practitioner or therapist to visit the home if necessary. While this level of assistance must be provided at no cost to the resident, the resident may be asked to bear the actual cost of the service. Therefore, low-care residents are most suited for referral to chronic disease allied health services under Medicare, where their GP has contributed to a multidisciplinary care plan using MBS item 731 and identified the need for these services.

6.5 Can an allied health professional or family member request an item 731 for a resident?

It is not appropriate for a third party to either request the GP's contribution on behalf of the aged care facility or to direct the GP on what their contribution should be. It is also inappropriate to assume that all residents of a particular aged care home are automatically eligible for item 731. This is a matter for the GP to determine on an individual basis in consultation with the aged care home.

A GP would use their judgment to determine the services required by the resident, based on the resident's health and care needs identified in the plan. The GPs decision would be based on assessing the resident's clinical need for services. These services may include allied health services for which a rebate is available. Services provided to residents through these referrals should be services which are directly related to the treatment or management of the resident's chronic condition/s.

6.6 What is considered ‘consent’ under item 731?

MBS item 731, along with all other MBS services, are voluntary services and the resident’s consent must be obtained prior to initiating these services. The resident’s consent should be obtained as per normal practice when obtaining consent for medical services. The GP should make sure the resident has agreed to the service and aware of any charges above the Medicare rebate that may be involved, at the time of obtaining consent.

If the resident is incapable of making decisions about medical treatment, normal practice for the provision of medical care to the resident should be followed. It may be useful for the GP contributing to the care plan through MBS item 731 (or other MBS services) 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 known, it would be useful to document this in the patient’s records.

6.7 Are residents of Multi-Purpose Services (MPS) eligible for item 731?

Only residents of an MPS who are receiving residential care within the meaning of the *Aged Care Act 1997* are eligible for item 731.

6.8 How does a GP establish if someone is an Australian Government funded resident of an aged care facility?

The GP or practice staff should ask the patient and, if unsure, ask the aged care facility whether the patient is a privately funded resident. The advice of the patient and/or aged care facility should be accepted and a note made in the patient record indicating by whom and when the advice was provided.

6.9 Can item 731 be claimed on the same day as a normal consultation with the same resident?

In general, a separate consultation should not be undertaken with item 731 unless it is clinically indicated that a problem must be treated immediately. In this case, the patient’s invoice or Medicare voucher (assignment of benefit form) for the separate consultation should be annotated (e.g. ‘separate consultation clinically required/indicated’).

7. GPMP and TCAs INTERFACE

7.1 Do Team Care Arrangements (TCAs) need to be a separate document to the GP Management Plan (GPMP)?

TCAs must be documented but the relevant information can be included as an addition to the patient's GPMP e.g., as an extra page that includes the goals, the collaborating providers, the treatment/services they have agreed to provide, patient actions and a review date.

7.2 Can a GP Management Plan (GPMP) and Team Care Arrangements (TCAs) both be claimed on the same day?

Provided the two services are delivered as per the Medicare requirements outlined in the item descriptors and explanatory notes, they can be claimed on the same day. In many cases this would be unlikely, given that TCAs involve collaboration with the participating providers to discuss the following:

- potential treatment/services they agree to provide to achieve management goals;
- documentation of the goals;
- collaborating providers;
- patient actions and; a review date.

7.3 Does a GP Management Plan (GPMP) need to be claimed before Team Care Arrangements (TCAs)?

~~TCAs is a service that can be provided to patients who have a current GPMP or to those patients whose care is, in the opinion of the providing GP, appropriately managed at the GP level without a GPMP.~~

~~When both services are required, it is intended that a TCAs service be done after a GPMP. Where both items are claimed the TCAs should be claimed after the GPMP. If a patient is to receive Medicare rebates on certain allied health services as outlined in their TCAs, they must have both a GPMP and TCAs in place.~~

Need to change this because p.5 says:

“While many patients will be eligible for both a GPMP and TCAs, the services can be provided independently. It is not mandatory to follow the preparation of a GPMP with the coordination of TCAs or to prepare a GPMP before coordinating TCAs.”

8. CDM ALLIED HEALTH ITEMS

Note: Information on Medicare dental items is available separately on the Department of Health and Ageing website www.health.gov.au/dental.

8.1 When is a patient eligible for Medicare rebates for Chronic Disease Management (CDM) allied health (individual) services?

Patients may be eligible for CDM allied health (individual) services if:

- their GP has put in place a GP Management Plan (GPMP) and Team Care Arrangements (TCAs); or
- their GP has reviewed their existing care plan using item 732; or
- their GP has contributed to (or contributed to a review of) a multidisciplinary care plan prepared for them as a resident of an aged care facility and claimed item 731;

and

- their GP determines that the patient's chronic medical condition would benefit from CDM allied health services.

8.2 When is a patient eligible for Chronic Disease Management (CDM) allied health (group) services?

People with type 2 diabetes can receive Medicare rebates for group services provided by eligible diabetes educators, exercise physiologists and dietitians, on referral from a GP. A patient must have in place one of the following:

- a GP Management Plan (GPMP); or
- where a patient has an existing GPMP, the GP has reviewed that plan (item 732); or
- for a resident of a residential aged care facility, the GP must have contributed to, or reviewed, a care plan prepared for them by the facility (item 731).

Patients being referred for allied health group services under items 81100 to 81125 do not need to have a Team Care Arrangements (TCAs) service (item 723). However, if the GP also wants to refer the patient for individual allied health services under items 10950 to 10970, TCAs must be in place in order to meet the eligibility requirements of those items.

Patients who will most benefit from group services are likely to be those who demonstrate a readiness to change, are able to contribute to group processes effectively and have a potential for self management.

Group services are in addition to the five individual allied health services available to eligible patients.

8.3 Can an allied health professional request allied health services for a patient?

No. It is up to a GP to determine whether a patient's chronic or terminal medical condition would benefit from allied health services. It is not appropriate for allied health professionals (or other health or care providers) to pre-empt the GP's decision about the services required by the patient or to provide part-completed referral forms to GPs for signature.

Allied health services provided through these referrals must be directly related to the management of the patient's chronic medical condition/s, and the need for allied health services must be identified in the patient's care plan.

8.4 Does a GP have to use a referral form issued by the Department of Health and Ageing?

No. GPs can use either a referral form that has been issued by the Department or a referral form that contains all the components of the form issued by the Department. The form issued by the Department of Health and Ageing is available on the Department's website at <http://www.health.gov.au/mbsprimarycareitems>.

8.5 How many individual allied health services can a Chronic Disease Management (CDM) patient obtain under Medicare?

A Medicare rebate is available for a maximum of five individual services per patient each calendar year. More services in a calendar year are not available under any circumstances. A calendar year is defined as the period of time between January 1 and December 31.

8.6 Can a GP refer the patient for five allied health visits under an existing GP Management Plan (GPMP) and Team Care Arrangements (TCAs)?

Yes. It is not necessary to have a new GPMP or TCAs prepared each calendar year in order to access a new referral(s) for eligible allied health services. Patients continue to be eligible for rebates for allied health services while they are being managed under a GPMP and TCAs as long as the need for eligible services continues to be recommended in their plan.

The review item (732) can be used to assess and manage the patient's progress once a GPMP and TCAs have been prepared. Reviews of GPMPs and TCAs are recommended every six months. During a review of the GPMP and TCAs, or a review of TCAs alone, the GP may identify that the patient requires additional allied health services and complete new referral forms.

Instead of undertaking a review of the patient's GPMP and TCAs, GPs may manage the referral process using a GP consultation item where appropriate.

8.7 Can a patient get five allied health referrals each year without a review of their GP Management Plan (GPMP) or Team Care Arrangements (TCAs)?

Yes. However, it is expected and strongly encouraged that a GPMP and TCAs would be regularly reviewed using the relevant MBS item. This is an important part of the planning cycle, enabling the GP and patient to check that goals are being met and agree on any changes that might be needed.

8.8 Do patients being managed under a Chronic Disease Management (CDM) care plan need to obtain a new referral for eligible allied health services when they have used up their current referrals?

Yes, if they wish to continue to access rebates for these services.

Referrals for eligible allied health services remain valid for the stated number of services. If the services are not used during the calendar year in which the patient is referred, the unused services may be used in the next calendar year. However, they will be counted as part of the five allied health services available to the patient during that calendar year.

When patients have used all of their referred services, or require a referral for a different type of allied health service recommended in their care plan, they need to obtain a new referral form from their GP.

Depending on the patient's circumstances and needs, GPs may choose to use this visit to undertake a review of the patient's care plan or, where appropriate, to manage the process using a GP attendance item. It is not necessary to have a new care plan prepared every twelve months in order to access new referrals for eligible allied health services.

8.9 Can allied health providers use the relevant Medicare item to bill a patient for contributing to their Chronic Disease Management (CDM) care plan?

The allied health items provide Medicare rebates for services and treatments that are identified in the patient's *completed* plan. They do not provide rebates for *contributions* to a care plan. This distinction was made early in the development of the allied health items and was clearly understood by both GP and allied health groups involved in their development.

8.10 Do allied health providers need to see the patient before contributing to their Chronic Disease Management (CDM) plan?

The CDM items do not require that an allied health provider see a patient before contributing to a CDM care plan. The involvement of allied health providers as members of a multidisciplinary team (e.g., to prepare Team Care Arrangements, TCAs), may occur in a variety of circumstances. For example, some providers may be publicly employed, while others may already be treating the patient privately and be aware of their treatment needs. In other cases, the allied health provider is able to provide input to the care plan in terms of the treatment or services they will provide to the patient after seeing the patient's GP Management Plan (subject to the patient's agreement) and/or discussion with the GP.

Where an allied health member of a TCAs team sees the patient before providing input to the TCAs and bills them for that service, the patient is not eligible for a Medicare rebate for that service.

8.11 What are the requirements of Chronic Disease Management (CDM) allied health (individual) services?

Services must be of at least 20 minutes duration and provided to an individual patient. The allied health professional must personally attend the patient.

The allied health provider has to provide a written report to the referring GP after the first and last service, or more often if clinically necessary.

Written reports should include any investigations, tests, and/or assessments carried out on the patient, any treatment provided and future management of the patient's condition or problem.

8.12 Can a Medicare rebate be claimed for an allied health service when the service to the patient is funded through other State/Territory or Australian Government programs?

Generally no. One of the conditions for claiming the allied health items is that the service provided to the patient has not been funded through other state/territory or Australian Government programs. Examples of such programs include state/territory government hospital outpatient clinics, the More Allied Health Services (MAHS) program, the Australian Government Hearing Services Scheme, and DVA services to veterans. Employment of allied health providers by Divisions would also come within this category. In such cases, the allied health provider is not permitted to access Medicare rebates as well as being on a salary employed by the Division.

However, where an exemption under section 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or State/Territory

Government health clinic, the allied health items can be claimed for services provided by eligible allied health professionals salaried by, or contracted to, the Service or clinic. All requirements of the item must be met, including registration of the allied health professional with Medicare Australia.

8.13 Can a patient see a different allied health professional to the one listed on their referral form?

If the patient's referral form contains the name *and* practice location of an allied health professional they can see any allied health professional at that practice. However, if a patient's referral form contains the name of an allied health professional, but no practice location, they must see the allied health professional who is specified on the form or else obtain a new referral form from their GP. If the GP has only specified the type of allied health professional, the patient is free to see any allied health professional of their choosing as long as they are registered with Medicare Australia to provide services.