

Department of Health & Ageing

**Chronic Disease Management  
(CDM) Medicare Items**

**Qs & As**

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## Index

<b>1. General</b>	<b>8</b>
a) What are the Chronic Disease Management (CDM) items?	8
b) What are the fees for the CDM items?	9
c) Are the CDM items eligible for 100% Medicare and bulk billing incentives?	9
d) What information is available to help GPs with the CDM items?	9
e) What are the benefits of care planning?	9
f) Who can assist a GP with the CDM items?	10
g) Have the CDM items been reviewed?	10
h) How do CDM items increase care planning options for GPs?	10
i) Must the patient be given a signed copy of the GP Management Plan or Team Care Arrangements document?	11
j) What is meant by the term ‘usual GP’?	11
k) Why are GPs required to document care plans for the patient?	11
<b>2. General Practice Management Plan (GPMP)</b>	<b>13</b>
a) What are the steps in the GPMP Service (Item 721)?	13
b) What patients are eligible for a GP Management Plan?	13
c) Should a patient with multiple chronic conditions have a GPMP for each condition?	14
<b>3. Team Care Arrangements (TCA)</b>	<b>15</b>
<b>3.1 General</b>	<b>15</b>
a) What are the steps in the Team Care Arrangements Service?	15
b) When is it appropriate to coordinate Team Care Arrangements for a patient?	15
c) What does collaboration with the other health and care providers mean when developing Team Care Arrangements?	15
d) Can a ‘blanket’ agreement form be sent by a GP if the patient is in need of straightforward treatment or monitoring?	16
e) Is a fax form an acceptable form of communication for collaboration between GPs and service providers on a TCA?	17
f) How does a provider have ‘ongoing involvement’ with a patient?	17
g) Can a GP claim item 723 twice if they consult separately with each allied health provider in relation to a multiple chronic condition?	18
h) If a patient’s medical condition has changed, how can these changes be incorporated into Team Care Arrangements?	18
<b>3.2 Potential Members of a Team Care Arrangements</b>	<b>19</b>

a)	What health care providers can or cannot be used under item 723?	19
b)	Can a pharmacist qualify as part of the ‘team’ in Team Care Arrangements?	19
c)	Can a myofascial therapist, a massage therapist or a naturopath be one of the three core TCA team members?	20
d)	Can a GP include a public sector allied health professional as part of a management team when claiming a Medicare item?	20
e)	Can a Workcover Rehabilitation Case Manager be one of the three (core) members of the TCA team.	20
f)	In relation to Team Care Arrangements, what is the role of a registered nurse working as a service coordinator?	20
g)	Can people such as a fitness instructor, personal trainer, a Blue Care worker be a member of a TCA team?	21
h)	Can a GP who provides acupuncture services and is/is not from the same practice as the coordinating GP be one of the three core TCA team members?	21
i)	Can a consultant physician be a member of a TCA team?	21
j)	Can more than one specialist be a member of a TCA team?	22
<b>4.</b>	<b>GP Contribution to Other Provider’s Care Plans.</b>	<b>23</b>
<b>4.1</b>	<b>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 (MBS item 729)</b>	<b>23</b>
a)	What is the purpose of item 729?	23
b)	What are the steps involved with item 729?	23
c)	Can a GP contribute to hospital discharge plans using item 729?	23
<b>4.2</b>	<b>Contribution to, or contribution to a review of, a multidisciplinary care plan for a patient who is a resident of an Aged Care Facility.</b>	<b>24</b>
a)	What is the purpose of Item 731?	24
b)	What are the steps involved with item 731?	24
c)	Can a patient receive rebates for allied health services if item 731 has been claimed?	25
d)	Can an allied health professional or family member request an item 731 for a resident?	25
e)	Are high care residents eligible for Medicare allied health services?	25
f)	What is considered ‘consent’ under item 731?	26
g)	Are residents of Multi-Purpose Services (MPS) eligible for item 731?	26
<b>5.</b>	<b>Eligibility</b>	<b>27</b>
a)	What patients are eligible for a GP Management Plan?	27
b)	Who is eligible for item 729?	28

- c) Do ‘chronic conditions and complex care needs’ include people with severe disabilities for the purpose of the CDM items? 28
- d) Is there a list of chronic diseases which a patient must have to be eligible for a GPMP or TCA? 28
- e) Can any GP do a CDM review and how do they check whether one has already been completed? 29
- f) Are privately funded residents of aged care facilities eligible for a GPMP and TCA preparation and review? 29
- g) Are Commonwealth funded residents of an aged care facility eligible for a GPMP and TCA preparation and review? 29
- h) How does a GP establish if someone is a Commonwealth funded resident of an aged care facility? 29
- 6. Role of Practice Nurses/Aboriginal Health Workers 30**
- a) How can practice nurses, Aboriginal health workers and other health professionals assist with CDM items? 30
- b) What activities can a practice nurse or Aboriginal health worker undertake? 30
- c) Can the practice nurse or Aboriginal health worker, under instructions from the GP, collaborate with other providers as part of the TCA? 30
- d) Can practice nurses or Aboriginal health workers provide other Medicare funded services for patients with chronic diseases and a care plan? 31
- e) Can a nurse or Aboriginal health worker, employed outside the GP's practice, play a role in the development of GPMPs and TCA? 31
- f) Under what circumstances can a nurse or Aboriginal health worker be one of the three minimum members of a multidisciplinary TCA team? 32
- g) Can the practice nurse or Aboriginal health worker provide wound management services, complete blood tests, ECGs or Doppler studies on the same day that a GP Management Plan (item 721) is claimed? 32
- h) Can a nurse or Aboriginal health worker with wound management or diabetes education qualify as a member of the TCA? 33
- i) Can a nurse/Aboriginal health worker gather and document information for the GPMP or TCA and qualify as a member of the TCA? 33
- j) Can a nurse/Aboriginal health worker compile the information at a patient's home during a visit for a health assessment if the patient meets the criteria for a GPMP and TCA and, therefore, when reviewed by the GP, can items 721, 723, 702 all be billed on the same day in the GP clinic? 33
- 7. GPMP and TCA Interface 35**
- a) Does the TCA need to be a separate document to the GPMP? 35
- b) Can a GPMP and a TCA both be claimed on the same day? 35
- c) Once a TCA is set up, can the GP claim a TCA review (MBS 727) from the referral alone? 35

d)	Does a GPMP (item 721) need to be claimed before a TCA?	35
<b>8.</b>	<b>Relationship of CDM items to SIPs</b>	<b>36</b>
<b>8.1</b>	<b>General</b>	<b>36</b>
a)	Are the Service Incentive Payments (SIPs) under the Practice Incentives Program (PIP) still available?	36
b)	Can a GP provide GP-managed care (a GP Management Plan) and a SIP for the same patient at the same time?	36
c)	Can a GP undertake team-based care (a GPMP and Team Care Arrangements) and a SIP for the same patient at the same time?	36
d)	How can patients with asthma or diabetes benefit from the CDM items?	37
e)	Can a GP Management Plan and SIP (for diabetes) be claimed for the same patient in a 12 month period?	37
f)	Can a GP claim both a GPMP Review and a SIP if they are completed at different times (over the year)?	37
g)	Why is it inappropriate to claim a SIP and a review of a GPMP within 3 months of each other?	37
h)	Why is it acceptable for a GP to claim for diabetes GPMP and diabetes SIP on the same day but not acceptable to claim an asthma GPMP and an asthma SIP in this time frame?	38
<b>8.</b>	<b>Diabetes</b>	<b>38</b>
a)	Do CDM items trigger SIPs for diabetes?	38
b)	Can a GP conduct an annual cycle of care and complete diabetes SIP during the same period of time in which they have developed a GPMP?	39
c)	What other services are available for people with type 2 diabetes?	39
<b>8.3</b>	<b>Access to CDM items and SIPs for asthma and diabetes</b>	<b>40</b>
<b>9.</b>	<b>Relationship of CDM items to GP Mental Health Care Plan items</b>	<b>41</b>
a)	What are the GP Mental Health Care Medicare items?	41
b)	How do the GP Mental Health Care items relate to the CDM items?	41
<b>10.</b>	<b>Relationship with Allied Health Items</b>	<b>42</b>
a)	When is a patient considered to be managed under an EPC plan and eligible for Medicare rebates for allied health services?	42
b)	When is a patient eligible for group allied health services?	42
c)	Can allied health providers use the relevant Medicare item to bill a patient for contributing to their EPC plan? Do they need to see the patient before contributing?	42

- d) Can a GP refer the patient for a further five allied health visits under an EPC plan prepared in the previous 12 month period? 43
- e) Do patients being managed under an EPC plan need to obtain a new referral for eligible allied health services when they have used up their current referrals? 43
- f) Can a diabetes educator employed or hired by a Division and managing a patient under a Team Care Arrangement claim a Medicare rebate? 43
- g) Can a GP just do GPMP and TCA every 2 years with no reviews and the patient gets 5 allied health referrals each year? 44
- h) Once a TCA is set up, does the GP need to see a patient on the same day as the allied health professional? 44
- 11. Claiming Rules 45**
- a) What are the claiming periods for the CDM items? 45
- b) Can a GPMP and a TCA be claimed on the same day? 47
- c) Is there a set time period between the completion of a GPMP and the completion of the TCA that must be adhered to? 47
- d) Can an Item 725 and 727 be claimed on the same day? 47
- e) Does the bulk billing incentive apply to both items 721 and 723 if claimed at the same time? 47
- f) If you use items 721 to 731, are you able to claim an attendance item at the same time if you satisfy the descriptor in the MBS book? 48
- g) Can any GP do a CDM review and how do they check whether one has already been completed? 48
- h) Can a GP claim a Team Care Arrangement (item 723) based on a referral to an allied health professional alone? 48
- i) Should the GP claim a GPMP review item instead of a TCA review if there has been no response from the other team members? 49
- j) Can a GP claim item 721 or 723 if a claim for item 900 (Domiciliary Medication Management Review) is made on the same day? 49
- k) Is it possible for a GP to claim Medicare items 721 and 723 after they have recently contributed and claimed item 729? 49
- l) Can item 731 be claimed on the same day as a normal consultation with the same resident? 50
- m) If a GP contributes to a multidisciplinary care plan using Medicare item 729, is the patient eligible for Medicare rebates for allied health services identified in that care plan? 50
- n) Is it permissible, when doing an older age health assessment (MBS item 702), to also prepare a GPMP (MBS item 721), either at the same time or at a follow up visit for patients with multiple chronic problems? 50
- o) Can a practice claim a GPMP and/or TCA within three months of claiming a health assessment or a case conference item? 51

- p) Can a home visit item number and a GPMP be billed by a GP at the same time?  
51
- q) Can MBS item 10997 be claimed on the same day that the GP claims for the development or review of a CDM care plan (items 721, 723, 725, 727, 729, 731)?  
52
- r) Can item 727 (Coordinate a Review of Team Care Arrangements) be claimed within a week of item 740 (Organise and Coordinate a Community Case Conference)?  
52

## 1. General

### a) **What are the Chronic Disease Management (CDM) items?**

The CDM Medicare items replace the former Enhanced Primary Care (EPC) multidisciplinary care planning items. The CDM items apply to a wider range of patients and make it easier for GPs to manage the health care of patients with chronic medical conditions, including patients needing multidisciplinary, team-based care.

CDM items were developed in close consultation with representatives of GP organisations. They are a significant response to the findings of the Red Tape Taskforce review of the EPC items and have been welcomed by GPs.

As with other EPC items, the CDM items are intended to be provided by the patient's usual GP. This means the GP, or a GP working in the medical practice, that has provided the majority of care to the patient over the previous 12 months and/or will be providing the majority of care to the patient over the next 12 months.

CDM items offer care planning options for GPs, flexibility in who can provide CDM services and an increase in the assistance that practice nurses, Aboriginal health workers and other health professionals can provide. The care plans can be reviewed by a GP from the same practice or, if the patient has changed practices, their new GP.

Patients with a chronic or terminal medical condition are eligible for the GP Management Plan (**MBS item 721**). Patients who also have complex needs requiring care from a multidisciplinary team are eligible for a Team Care Arrangements (**MBS item 723**). Therefore, GPs are able to choose between items for GP care planning or team-assisted care planning, depending on the health needs of their patients.

Once a GPMP and TCA have been prepared for a patient and claimed on Medicare, the patient is eligible for access to certain allied health services.

Using the CDM items, GPs can also contribute to, or contribute to a review of, other provider's care plans. **MBS item 729** allows the GP to contribute to a multidisciplinary care plan or contribute to the 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 the contribution to, or review of, the care plan of a resident of an aged care facility, where the care plan was developed by that facility. These GP contributions should generally be at the request of care plan providers.

**b) What are the fees for the CDM items?**

The Medicare fees for the CDM items were agreed in consultation with GP organisations and can be seen in the following table.

Name	Item No	Medicare Fee (100%) Nov 2008	Recommended frequency	Minimum Claiming Period*
Preparation of a GP Management Plan	721	\$130.65	2 yearly	12 months*
Preparation of Team Care Arrangements	723	\$103.50	2 yearly	12 months*
Review of a GP Management Plan	725	\$65.30	6 monthly	3 months*
Coordination of Review of Team Care Arrangements	727	\$65.30	6 monthly	3 months*
Contribution to a multidisciplinary care plan	729	\$63.75	6 monthly	3 months*
Contribution to a multidisciplinary care plan by an Aged Care Facility	731	\$63.75	6 monthly	3 months*

\*CDM services can also be provided more frequently in 'exceptional circumstances' - 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 GP Management Plan, Team Care Arrangements or review service.

**c) Are the CDM items eligible for 100% Medicare and bulk billing incentives?**

Yes. The items attract a 100% rebate of the MBS scheduled fee (except where the patient has been admitted to a hospital and the service is provided in the hospital).

Where CDM items are bulk-billed for eligible patients (i.e. Commonwealth concession card holders or children under 16), the service attracts the relevant bulk-billing incentive payment.

**d) What information is available to help GPs with the CDM items?**

Copies of the Medicare item descriptors, explanatory notes and a fact sheet are available on the Department's web site at [www.health.gov.au](http://www.health.gov.au) (and use the A-Z Index tool to go to Chronic Disease Management Medicare Items). Questions about the items can be sent to [epc.items@health.gov.au](mailto:epc.items@health.gov.au). The CDM items and explanatory notes are included in the November 2008 MBS book, available online at: <http://www.health.gov.au/internet/mbsonline/publishing.nsf/Content/Medicare-Benefits-Schedule-MBS-1>.

**e) What are the benefits of care planning?**

Care planning helps to coordinate the services and treatment that a patient requires and can be used as a tool for organising the care a patient needs and help reduce the need for ad hoc, episodic consultations.

Care planning both enables and legitimises GPs in taking a proactive role managing the health care requirements of their patients. 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 treatment.

Effective care of chronic conditions such as diabetes requires an evolution from episodic, acute models towards a comprehensive system involving continuity of care across patient conditions, health care providers and settings over time. Key supports for this are structured information systems and multidisciplinary teamwork. Structured care planning is designed to support teamwork both within general practice and between it and other services and health professionals especially allied health professionals.

Positive research<sup>1</sup> is emerging that shows that multidisciplinary care plans improve the quality of care and clinical outcomes for people with chronic disease (such as improved total cholesterol and blood pressure outcome measures for people with diabetes).

**f) Who can assist a GP with the CDM items?**

A practice nurse, Aboriginal health worker or other health professional can assist a GP in preparing and reviewing a GPMP or TCA, for example, in assessing the patient, identifying the patient's needs and making arrangements for services.

While minimum qualifications are not specified, it is expected that persons providing such assistance are qualified to work as a practice nurse, Aboriginal health worker or other health professional.

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

**g) Have the CDM items been reviewed?**

Yes. A post-implementation review was undertaken in 2007 to assess the implementation, uptake and use of the items to determine whether any modifications to the items or other actions are required to encourage appropriate use of the items for effective chronic disease management.

**h) How do CDM items increase care planning options for GPs?**

GPs are able to choose between items for GP care planning or team-assisted care planning, depending on the needs of their patients.

A GP Management Plan (GPMP) item may be used by GPs for eligible patients with a chronic or terminal medical condition without multidisciplinary care needs.

Patients with a chronic or terminal medical condition and complex care needs are eligible for team-based care planning using both a GP Management Plan and Team Care Arrangements (provided by the GP in collaboration with at least two other providers). This maintains access to the allied health items. GPs are able to use their practice nurse, Aboriginal health worker or other health professional to assist them in chronic disease management using the CDM items.

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<sup>1</sup> Dr N A Zwar et al Australian Family Physician, Vol 36, No. 1/2, January/February 2007 *Do Multidisciplinary Care Plans result in better care for patients with type 2 diabetes?*

A GPMP can be reviewed by a GP from the same practice or, if the patient has changed practices, their new GP.

While time limits on services have been specified, GPs can provide care planning or care planning review services within these minimum time limits if there have been significant changes in the patient's condition or care circumstances.

***i) Must the patient be given a signed copy of the GP Management Plan or Team Care Arrangements document?***

Before proceeding with any CDM service (other than a care plan contribution under items 729 and 731) the GP must ensure that:

- the steps involved in providing the service are explained to the patient and (if appropriate and with the patient's permission) to the patient's carer;
- in the case of TCA and TCA review services, any likely out-of-pocket costs to the patient for the involvement of other providers are explained to the patient; and
- the patient's agreement to proceed is recorded.

Before completing any CDM service (other than a contribution item) and claiming a benefit for that service, the GP must offer the patient a copy of the relevant document and add the document to the patient's record.

The patient must agree to the CDM service being provided and this agreement must be recorded, for example, by noting this on the patient's record.

It can also be useful to have the patient sign the GPMP or TCA - this can help ensure that the patient understands and agrees with the plan, with benefits for patient compliance. It is not mandatory, however, for the patient to sign the GPMP or TCA.

The patient must be offered a copy of the GPMP or TCA. Where the patient has signed the GPMP or TCA, it is a matter for the GP and the patient as to whether the patient is offered a 'signed' copy of the plan or whether a printed (unsigned) copy of the GPMP and TCA off the system is sufficient.

***j) What is meant by the term 'usual GP'?***

The patient's 'usual GP' 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 12 months and/or will be providing the majority of care to the patient over the next 12 months. The usual GP should be of the opinion they will be responsible for the continuing primary care of the patient's condition that is being managed using the relevant EPC or related Medicare item. The GP should be satisfied that their peers would agree with this opinion, given the patient's needs and circumstances. The term 'usual GP' would not generally apply to a practice that provides only one specific EPC service.

***k) Why are GPs required to document care plans for the patient?***

A care plan is a useful mechanism for recording comprehensive, accurate and up-to-date information about the patient's condition. Care planning helps to coordinate the services and treatments that a patient requires. A written care plan can be used as a tool for organising the care a patient needs and can help reduce the need for ad hoc consultations. Appropriate documentation of relevant information is a key component of the care planning process.

As an ongoing process, the Department is continually looking at ways to minimise administrative requirements on GPs, particularly with the introduction of new services in response to community need, requests from the profession or Government policy. At the same time, it needs to be recognised that some requirements for the provision of information will continue to be a necessary part of providing Medicare services to meet the complex needs of patients with chronic medical conditions and of ensuring there is appropriate accountability for those items.

## 2. General Practice Management Plan (GPMP)

### a) *What are the steps in the GPMP Service (Item 721)?*

Preparing a GPMP includes:

- assessing the patient to identify and/or confirm all of their health care needs, problems and relevant conditions;
- agreeing management goals with the patient for the changes to be achieved by the treatment and services identified in the plan;
- identifying any actions to be taken by the patient;
- identifying treatment and services that the patient is likely to need, and making arrangements for provision of these services and ongoing management; and
- documenting the patient's needs, goals, patient actions, treatment/services and a review date i.e. completing the GPMP document.

The patient's progress against the plan should be periodically reviewed using the GP Management Plan Review items, and ongoing management and care provided through normal consultation items.

### b) *What patients are eligible for a GP Management Plan?*

To be eligible for a GP Management Plan a patient must have a chronic (or terminal) medical condition - one that has been or is likely to be present for 6 months or longer, including but not limited to asthma, cancer, cardiovascular illness, diabetes mellitus, musculoskeletal conditions and stroke. Patients who also have complex care needs are eligible for Team Care Arrangements. Patients with mental disorders are eligible for GP Mental Health Care items.

Whether a patient meets this criterion is essentially a matter for the GP and, other than the above reference, the MBS does not comprehensively list all possible medical 'conditions' that either are/are not regarded as chronic medical conditions for the purposes of the EPC or CDM items.

Questions have asked on 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.

The general position on these 'conditions' is that they have not been regarded as chronic medical conditions for the purpose of the EPC items to date and this remains the case with the CDM items. (Note that in many cases a patient may have complications or co-morbidities, that may be a result of or exacerbated by such conditions or risk factors, that would make them eligible for CDM services.)

In some cases these 'conditions' would not be commonly regarded as chronic medical conditions of themselves, others 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.

It is recognised, however, that conditions such as the above 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.

A GP must assess whether a patient is eligible for a CDM service, having reference firstly to the MBS eligibility criteria and the guidance above setting out the general position.

Where a patient's 'condition' would not obviously come within the MBS definition, a GP may still consider that, notwithstanding the above, the patient's condition and circumstances are such that they require the preparation of a GP Management Plan, for example, because of non-compliance, inability to self-manage, functional disability etc.

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

**c) *Should a patient with multiple chronic conditions have a GPMP for each condition?***

No. Concurrent GP Management Plans are not envisaged under these arrangements. A rebate will not be paid within twelve months of a previous claim for the same item other than in exceptional circumstances. A GP Management Plan should address all of the patient's health care needs.

Patients with multiple chronic conditions will be eligible for a single GP Management Plan and, if those multiple conditions result in complex needs requiring care from a multidisciplinary team (team care), will also be eligible for the Team Care Arrangements service. Where a variety of conditions are managed by the GP without the involvement of other providers, a single GP Management Plan is able to be used, with regular reviews as necessary.

### 3. Team Care Arrangements (TCA)

#### 3.1 General

##### **a) What are the steps in the Team Care Arrangements Service?**

Coordinating TCA for a patient includes:

- identifying and confirming with the patient which other treatment or service providers will be involved in completing the TCA and what information can be shared with them;
- collaborating with the participating providers to discuss potential treatment/services they will provide to achieve management goals for the patient; and
- documenting the goals, the collaborating providers, the treatment/services they have agreed to provide, patient actions and a review date i.e. completing the TCA document.

The patient's progress against the GPMP and TCA should be periodically reviewed using the GP Management Plan or TCA review items as appropriate, and ongoing management and care should be provided through normal consultation items.

##### **b) When is it appropriate to coordinate Team Care Arrangements for a patient?**

Team Care Arrangements are designed for patients with complex health and care needs, who are seeing or who need to see at least three health or care providers (including their GP) and who need team-based care.

Team Care Arrangements 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 regular, frequent and ongoing basis to manage the chronic condition (as distinct from one or two visits for one specific treatment).

##### **c) What does collaboration with the other health and care providers mean when developing Team Care Arrangements?**

Collaboration means communicating with the other providers to discuss potential treatment or services they will provide. Communication must be two-way - preferably oral communication, or, if not practicable, communication 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.

To provide input to the TCA that relates to the specific needs and circumstances of the patient, the participating providers may:

- refer to their existing knowledge of the patient, i.e. where they are an existing patient of that provider;
- provide input based on the information provided by the GP, including the patient's current GP Management Plan (GPMP); or
- on their own judgment, decide that they would prefer to see the patient before they provide input - but note that there is no MBS requirement for the allied health professional to undertake a consultation with the patient for the purposes of developing the TCA.

While it is not mandatory that the allied health provider must see the patient before contributing to the plan (unless they wish to), they do need to provide input to the TCA 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 TCA.

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

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

It makes sense for practices to establish which allied health professionals are, in a general sense, prepared to participate in TCA teams.

However, a contribution to a care plan needs to be specific to each patient. The MBS Explanatory Notes for coordinating TCA refers to 'collaborating with the participating providers to discuss potential treatment/services they will provide to achieve management goals for the patient' (under A.33. and on page 67 of the complete MBS publication). Collaboration 'should relate to the specific needs and circumstances of the patient'. A 'blanket agreement' to participate in TCA would not be sufficient itself to meet this requirement.

TCA 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 TCA 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.

**e) *Is a fax form an acceptable form of communication for collaboration between GPs and service providers on a TCA?***

The requirements for collaboration are set out in the MBS Explanatory Notes for coordinating TCA (page 67 of the complete MBS) including:

'The collaboration between the coordinating GP and participating providers at step (d) must be based on two-way communication between them, preferably oral, or, if this is not practicable, in writing (including by exchange of fax or email, but noting that the means of communication used must enable privacy to be safeguarded in relation to patient information). It should relate to the specific needs and circumstances of the patient. The communication from providers must include advice on treatment and management of the patient.'

The preferred means of communication is oral communication, not via fax form.

However, a fax can be used to set up arrangements for another health or care provider to participate in TCA, either on a general basis or in relation to a specific patient. It can also be used to facilitate the actual communication (e.g. by phone call) between the GP and the provider, where the communication (phone call) addresses the specific needs of the patient and the specific treatment or services to be provided by the AHP to meet those needs.

A form designed to facilitate the actual discussion by phone call would be acceptable. A form by itself would not meet the requirement for collaboration, however, as it does not include the treatment or services to be provided by the AHP, matched to the specific needs of the patient.

Where oral communication is not practicable, collaboration could be covered by a fax back form that enables the AHP 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.

Whilst oral communication is preferred, a fax back form can support general arrangements and provide the basis for oral communication about specific patients. Where oral communication is not possible, a fax back form as amended can support collaboration.

Please note also that in communicating patient information (e.g. GP Management Plan) the GP must ensure that the privacy of patient's information is safeguarded.

Please note also that an allied health provider does not necessarily need to be a member of the TCA team for the GP to be able to refer patients to them. A GP can refer patients to AHPs who are not members of the TCA team as long as the referral is for services that are recommended in the patient's TCA.

**f) *How does a provider have 'ongoing involvement' with a patient?***

To be one of the minimum 3 members of a TCA team, a provider should have an ongoing role and involvement with the patient that goes beyond standard treatment to meet straightforward needs. 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 3 minimum members of the team.

'Once only' or non-ongoing treatment providers could be either an additional member of the team (i.e. additional to the three minimum) or could be identified in the patient's GPMP or TCA as providing specified services to the patient. It is good practice for the GPMP or TCA to identify all of the health and care services the patient requires.

The MBS Explanatory Notes provide that 'To develop Team Care Arrangements 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 the TCA'.

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.

This requirement means that (at least two of) the other members of the TCA team must have an ongoing relationship with the patient, one that is expected to broadly continue over the period covered by the TCA (or at a minimum, for the initial review cycle - recommended as 6 months), even if they are not actively providing treatment to the patient over all of this period.

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, a pharmacist who is providing dispensing or dispensing-related services to the patient on a routine basis, consistent with normal services provided to patients generally, would not constitute one of the minimum two other members of the team.

A pharmacist providing a Home Medicines Review service would be able to comprise one of the minimum two other members of the team. (HMRs are expected to include some element of post-HMR monitoring and follow up).

Health or care professionals who may not meet the criterion of providing ongoing treatment and services can still be included in a TCA team, but would not count as one of the minimum two other members of the team (in addition to the GP).

**g) Can a GP claim item 723 twice if they consult separately with each allied health provider in relation to a multiple chronic condition?**

No. Item 723 can only be claimed once. GPs cannot claim multiple TCA items for communicating with different providers.

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

Once a TCA is in place, it should be regularly reviewed by the GP (approximately every 6 months). In general, a new TCA 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 a new TCA where required. The intention is for the initial plan to be reviewed using the review item 727. Changes to Team Care Arrangements can be made as part of the review process.

A rebate for item 727 will not be paid within 3 months of a previous claim for the same item or for a claim for item 723, other than in exceptional circumstances.

Exceptional circumstances apply where there has been a significant change in the patient's clinical condition or care circumstances. Where a service is provided in

exceptional circumstances, the patient's invoice or Medicare voucher should be annotated to indicate the reason by the service was required earlier than the minimum time interval for the relevant item.

If a review of the TCA is required, it is important to ensure that all requirements of item 727 are met in accordance with the MBS.

## 3.2 Potential Members of a Team Care Arrangements

### **a) What health care providers can or cannot be used under item 723?**

Below is a list of people who were designated as able to be involved in the multidisciplinary team under the previous arrangements. A list under the new (CDM) arrangements has not been reproduced however the capacity of these people to be team members has not changed.

For the purposes of care planning and case conferencing, persons who may be included in a team are allied health professionals such as, but not limited to: Aboriginal health workers; asthma educators; audiologists; dental therapists; dentists; diabetes educators; dietitians; mental health workers; occupational therapists; optometrists; orthoptists; orthotists or prosthetists; pharmacists; physiotherapists; podiatrists; psychologists; registered nurses; social workers; and speech pathologists.

A team may 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.

The above list of people is, of course, more extensive than the list of allied health professionals to whom a GP can refer patients for the purpose of the 5 annual allied health rebates under Medicare: Aboriginal health workers; audiologists, chiropractors; diabetes educators; dietitians; exercise physiologists; mental health workers; occupational therapists; osteopaths; physiotherapists; podiatrists, psychologists and speech pathologists.

The key points about involvement are that 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.

### **b) Can a pharmacist qualify as part of the 'team' in Team Care Arrangements?**

As with EPC multidisciplinary care planning teams, pharmacists are able to be part of a TCA team where they are providing ongoing treatment or services to the patient (other than just providing routine dispensing or dispensing-related services).

There is a range of scenarios in which there may be a need for collaboration between a GP when coordinating a TCA and a pharmacist, for example, in determining and monitoring medications and dosages for a patient who is recovering from surgery.

A GP might also identify a need for a Home Medicines Review (HMR) while coordinating Team Care Arrangements for a patient, with the pharmacist undertaking

the HMR as part of their contribution to the patient's TCA. A HMR might also identify that a patient would benefit from a GPMP or TCA. (Note that HMR and the CDM items are separate Medicare services and the requirements for both services need to be met before they can be claimed.)

In addition to the preparation of a medication management plan, a HMR is expected to include some element of post-HMR follow up and monitoring of implementation of the management plan. Where a community pharmacist and an accredited pharmacist are involved in the HMR, the pharmacist who is responsible for follow up and monitoring and who will have ongoing contact with the patient is the appropriate member of the TCA team. In most cases this is likely to be the community pharmacist.

If the pharmacist is not providing any ongoing treatment or services to the patient (e.g. other than routine dispensing or dispensing-related services), they would not comprise one of the minimum members of the team, but note that this would also not be consistent with expectations for the HMR service.

**c) *Can a myofascial therapist, a massage therapist or a naturopath be one of the three core TCA team members?***

No. Such providers were not regarded as health and care providers for the purposes of the EPC multidisciplinary care planning items and this remains the case with the CDM items. If a GP believes that there is a clear case for the inclusion of a particular type of provider as one of the minimum three members of a TCA team, given the particular needs and circumstances of the patient, they would need to be clearly satisfied that the GP's peers would regard the involvement of such a provider as appropriate.

**d) *Can a GP include a public sector allied health professional as part of a management team when claiming a Medicare item?***

Yes. The GP can include a public sector allied health professional as part of TCA. 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.

**e) *Can a Workcover Rehabilitation Case Manager be one of the three (core) members of the TCA team.***

If the case manager is contributing to the plan and providing ongoing treatment or services to the patient, they can be one of the minimum three team members.

Workcover rehabilitation case managers may have their own plan of care for the patient, for which they may seek the GP's input. If this plan is multidisciplinary (at least three team members) and is a bona fide plan of care (rather than a plan for some other purpose) then the GP could contribute and claim a rebate under item 729. This item cannot, however, be claimed within 12 months of a claim for preparing a GPMP or coordinating a TCA. (See explanatory notes for other claiming restrictions.)

**f) *In relation to Team Care Arrangements, what is the role of a registered nurse working as a service coordinator?***

The expectation is that in preparing a GPMP or TCA, the GP may be assisted by their practice nurse or other health professional already working in the GP's medical practice or health service.

It is not expected that a practice nurse working independently of the practice would assess patients and subsequently refer some on to their GP to review or confirm their plan, before the patient's GP had the opportunity to consider whether the patient is eligible for and would benefit from a CDM service (GPMP or TCA).

A registered nurse working as a service coordinator outside the practice might identify that a patient would benefit from a CDM service and suggest that the patient contact their GP to discuss whether such a service is appropriate (i.e. refer the patient for a possible CDM service). This is different from initiating a service and then asking the GP to confirm it at the next consultation. Preparation of a GPMP or a TCA must include a personal attendance by the GP with the patient, as part of the relevant item, not as part of the patient's 'next consultation'.

**g) Can people such as a fitness instructor, personal trainer, a Blue Care worker be a member of a TCA team?**

The TCA team needs to include the patient's GP and at least two persons providing different kinds of ongoing care to the patient who have also contributed to the plan. The TCA can also (and should) refer to treatment and care to be provided by care and service providers who are not contributing to the plan but at least two providers other than the GP must contribute to the plan (see page 67 of the complete MBS publication).

The Blue Care worker could be one of the TCA team members if they are contributing to the plan. Otherwise, they could be mentioned in the plan as one of the other care/service providers. Similarly, the fitness instructor and personal trainer could well be members of the team if they are contributing to the plan, but would not be appropriate members of the team if they are simply providing personal services to the patient which are unrelated to the patient's chronic condition or which e.g. relate to a minor injury that could not be classified as a chronic condition.

**h) Can a GP who provides acupuncture services and is/is not from the same practice as the coordinating GP be one of the three core TCA team members?**

Another GP can count as one of the minimum two members collaborating with the GP to develop the TCA only where they are providing ongoing treatment or services to the patient that are clearly distinct and different to normal general practice services. (A team comprising two GPs both providing general practice services and another health provider would not constitute multidisciplinary care.) Services such as acupuncture that require special expertise and qualifications could be regarded as distinct and different from normal general practice services.

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 TCA team, whether they are from the same practice or not.

**i) Can a consultant physician be a member of a TCA team?**

Yes. GPs are required to collaborate with two or more other health or care providers in the development of TCA. This can include a specialist such as a consultant physician. The providers must provide different kinds of ongoing care to the patient. The purpose

of the collaboration is to provide input to the TCA on the treatment or services they would provide (or already provide) based on their understanding of the patient's needs.

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.

***j) Can more than one specialist be a member of a TCA team?***

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 TCA team.

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

Advice on who can be a member of a multidisciplinary team for the purposes of care planning and case conferencing (including TCA) is also provided in the MBS explanatory notes for the multidisciplinary case conference items (A.35.) on page 73 of the complete MBS publication.

## **4. GP Contribution to Other Provider's Care Plans.**

### **4.1 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 (MBS item 729)**

#### **a) *What is the purpose of item 729?***

MBS item 729 is for patients who are having a multidisciplinary care plan (which may include Team Care Arrangements) prepared or reviewed for them by another health or care provider (i.e. other than the usual GP). 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.

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.

#### **b) *What are the steps involved with item 729?***

The steps involved in contributing to a multidisciplinary care plan or to a review of the care plan, using MBS item 729, must include:

- gaining or confirming the patient's agreement for the GP to contribute to the care plan or to the review of the care plan and to share relevant information with the other providers;
- collaborating with the person preparing the care plan to set goals and specify treatment/services to be provided by the GP; and
- adding to the patient's records a copy or notation of the GP's contribution to the plan (either the treatment/services to be provided by the GP or the GP's advice to the person preparing the plan).

#### **c) *Can a GP contribute to hospital discharge plans using item 729?***

Yes. Item 729 is an item for patients who are having a multidisciplinary care plan prepared or reviewed for them by another health or care provider (i.e. other than their usual GP). 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. This can include contribution to hospital discharge plans for both private and public inpatients being discharged from hospital. It is not available on discharge from hospital to patients who are residents of aged care facilities (see item 731).

A rebate can be claimed for item 729 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, by completing the steps itemised under A.33. on page 69 of the complete MBS document.

## **4.2 Contribution to, or contribution to a review of, a multidisciplinary care plan for a patient who is a resident of an Aged Care Facility.**

### **a) What is the purpose of Item 731?**

Item 731 is available for a GP to contribute to a multidisciplinary care plan for a resident of an aged care home that is prepared by the aged care home. This item was introduced because it was recognised that Commonwealth-funded aged care residents are already required to have a care plan prepared for them by the aged care home facility (usually on admission or soon after arriving at the facility), and that it would be appropriate for GP input to a resident's care to be made by way of contribution to the care plan required to be maintained by the aged care home. This 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, consistent with the other Chronic Disease Management Medicare items, the resident has a chronic medical condition and complex needs requiring care from a multidisciplinary team. Note that not all care plans prepared for residents of aged care homes will necessarily be multidisciplinary, depending on the needs of the resident.

It is expected that the GP's contribution to the resident's multidisciplinary care plan would be through direct collaboration with the aged care facility at the request of the facility. The contribution must 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.

### **b) What are the steps involved with item 731?**

This item, including the components of the service, is similar to Item 729 (see under A.33. on page 69 of the complete MBS publication) except that:

- this service is only available to residents of aged care facilities;
- this 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 must 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 CDM items, other than in exceptional circumstances.

**c) Can a patient receive rebates for allied health services if item 731 has been claimed?**

Once a GP has contributed to a resident's care plan, by completing the relevant steps and Medicare requirements for this item, (see under A.33. on page 69 of the complete MBS publication) and item 731 has been claimed on Medicare, the resident is eligible for Medicare rebates for access to up to 5 allied health visits per year. The need for allied health services must be identified in the resident's care plan.

Services provided to residents through these referrals should be services which are directly related to the treatment or management of the resident's chronic medical condition. It is not expected that routine services would be provided under these referrals. Also, it would not be appropriate to claim an allied health item where the service provided to the resident would normally be funded through other State or Commonwealth programs, e.g. if the aged care facility received funding to provide this service to the residents as a part of their normal care.

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.

**d) Can an allied health professional or family member request an item 731 for a resident?**

It would not be 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 would also not be appropriate 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.

In contributing to a resident's multidisciplinary care plan, 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 GP's 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.

Consequently, it is not appropriate for allied health providers to provide part-completed EPC referral forms to GPs for signature, particularly in a way that pre-empts the GP's decision about the services required by the patient.

**e) Are high care residents eligible for Medicare allied health services?**

In general, if a GP has contributed to a multidisciplinary care plan prepared by the aged care facility (MBS item 731), the resident is eligible for Medicare rebates for certain services provided by eligible allied health professionals. The resident must have a chronic condition and complex care needs and be referred by the GP.

However, these allied health Medicare services are not intended to replace any services already expected to be provided, at no additional cost, by an aged care home as a requirement of the *Aged Care Act (1997)*.

High care residents should be receiving allied health services, at no cost to them, if there is an assessed care need (except for intensive long term rehabilitation services following serious injury, surgery or trauma). Therefore, generally, high care residents should not be routinely referred for allied health services under Medicare. They are

intended to augment existing services and add to the health care referral options for high care residents with chronic conditions and complex care needs.

Under the *Aged Care Act (1997)* aged care facilities are required to assist low care residents to access allied health/therapy services. They are not, however, required to pay for allied health/therapy services provided to low care residents. Low care residents can therefore access the full range of allied health services under Medicare.

**f) 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 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 may be useful to document this in the patient's records.

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

If a resident of an MPS is receiving residential care within the meaning of Section 41-3 of the *Aged Care Act 1997*, they are eligible for item 731. There are MPS residents that meet these requirements. In these cases, the resident is eligible for item 731.

## 5. Eligibility

### **a) What patients are eligible for a GP Management Plan?**

To be eligible for a GP Management Plan a patient must have a chronic (or terminal) medical condition - one that has been or is likely to be present for 6 months or longer, including but not limited to asthma, cancer, cardiovascular illness, diabetes mellitus, musculoskeletal conditions and stroke. Patients who also have complex care needs are also eligible for Team Care Arrangements. Patients with mental disorders are eligible for GP Mental Health Care items.

Whether a patient meets this criterion is essentially a matter for the GP and, other than the above reference, the MBS does not comprehensively list all possible medical 'conditions' that either are/are not regarded as chronic medical conditions for the purposes of the EPC or CDM items.

Questions have asked 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.

The general position on these 'conditions' is that they have not been regarded as chronic medical conditions for the purpose of the EPC items to date and this remains the case with the CDM items. Note that in many cases a patient may have complications or co-morbidities, that may be a result of or exacerbated by such conditions or risk factors, that would make them eligible for CDM services.

In some cases these 'conditions' would not be commonly regarded as chronic medical conditions of themselves, others 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.

It is recognised, however, that conditions such as the above 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.

A GP must assess whether a patient is eligible for a CDM service, having reference firstly to the MBS eligibility criteria and the guidance above setting out the general position.

Where a patient's 'condition' would not obviously come within the MBS definition, a GP may still consider that, notwithstanding the above, the patient's condition and circumstances are such that they require the preparation of a GP Management Plan, for example, because of non-compliance, inability to self-manage, functional disability etc.

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

**b) Who is eligible for item 729?**

This GP service is available to patients in the community and to both private and public in-patients being discharged from hospital. It is not available to patients who are residents of aged care facilities. To be eligible for item 729, the patient must have a chronic medical condition (one that has been or is likely to be present for six months or longer) and complex care needs,

Item 729 is for patients who are having a multidisciplinary care plan (which may include Team Care Arrangements) prepared or reviewed for them by another health or care provider (i.e. other than the usual GP).

The 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.

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.

**c) Do 'chronic conditions and complex care needs' include people with severe disabilities for the purpose of the CDM items?**

If a person with severe disabilities also has a chronic medical condition, he/she could be eligible for a GP Management Plan. If the person has a chronic condition and complex care needs, that person could also be eligible for Team Care Arrangements.

Whether a patient meets the criteria for a GP Management Plan or Team Care Arrangements is essentially a matter for the GP to decide.

**d) Is there a list of chronic diseases which a patient must have to be eligible for a GPMP or TCA?**

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.

To be eligible for a GP Management Plan a patient must have a chronic (or terminal) medical condition - one that has been or is likely to be present for 6 months or longer, including but not limited to asthma, cancer, cardiovascular illness, diabetes mellitus, musculoskeletal conditions and stroke. Patients who also have complex care needs are also eligible for Team Care Arrangements. Patients with mental disorders are eligible for GP Mental Health Care items

A GP must assess whether a patient is eligible for a CDM service, having reference firstly to the MBS eligibility criteria and the guidance above setting out the general position. Where a patient's 'condition' would not obviously come within the MBS definition, a GP may still consider that, notwithstanding the above, the patient's condition and circumstances are such that they require the preparation of a GP Management Plan or Team Care Arrangements, for example, because of non-compliance, inability to self-manage, functional disability etc.

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

**e) Can any GP do a CDM review and how do they check whether one has already been completed?**

A review can not be done by 'any GP'. The reviewing GP, if not the original GP or one from the same practice, should be the patient's new GP. Where it is unclear whether the patient has a current GPMP, TCA 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.

**f) Are privately funded residents of aged care facilities eligible for a GPMP and TCA preparation and review?**

Yes. A privately funded resident means a person who is living independently in an aged care facility where the facility is not receiving a subsidy for their care from the Australian Government under the *Aged Care Act 1997*.

However, the GP should not provide a GPMP or TCA-related service to a resident where they have already contributed to a care plan prepared by the facility (item 731), i.e. where they have already provided a contribution to a care plan for the resident as a resident of the aged care facility.

**g) Are Commonwealth funded residents of an aged care facility eligible for a GPMP and TCA preparation and review?**

No. In this case the resident's GP can contribute to the care plan prepared by the facility using item 731 (other than where a resident is being discharged as a private patient from hospital and the GP prepares a 'discharge' GMP and/or TCA.)

**h) How does a GP establish if someone is a Commonwealth 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. Role of Practice Nurses/Aboriginal Health Workers

### **a) *How can practice nurses, Aboriginal health workers and other health professionals assist with CDM items?***

A practice nurse, Aboriginal health worker or other health professional can assist a GP in preparing or reviewing a GPMP or TCA, for example, in assessing the patient, identifying the patient's needs and making arrangements for services. This assistance is provided on behalf of the GP as part of the CDM service. It cannot constitute a separate Medicare service or contribute to a separate Medicare service. The GP must review and confirm all assessments and elements of the service and must see the patient as part of the service.

While it is not mandatory for a practice nurse or other health professional to assist a GP with these services, the CDM items should help free up GPs' time by encouraging an expanded role in care planning for practice nurses/other health professionals. The items give maximum flexibility to the GP in deciding how best to use their practice nurse/other health professional to assist in chronic disease management.

### **b) *What activities can a practice nurse or Aboriginal health worker undertake?***

Activities that a practice nurse or other health professional may undertake in assisting the GP are not prescribed but should be within their professional competencies. For example, they could assist in aspects of patient assessment, identification of patient needs and making arrangements for services. This could include gathering and documenting information for the GPMP or TCA. The GP must review and confirm all assessments and elements of the GPMP or TCA and must see the patient as part of the service.

### **c) *Can the practice nurse or Aboriginal health worker, under instructions from the GP, collaborate with other providers as part of the TCA?***

Generally, the GP is expected to collaborate with the other providers involved in the preparation of the patient's team care arrangements. This collaboration must be based on two-way communication between them, preferably oral, or, if this is not practicable, in writing (including by exchange of fax or email). The means of communication used must ensure the privacy of the patient's information is safeguarded. The practice nurse, Aboriginal health worker or other health professional can organise and facilitate this communication between the GP and the other health and care providers.

Where the patient's conditions and the knowledge and capacity of the practice nurse are, in the judgment of the GP, such that the practice nurse can confidently communicate about them on the GP's behalf with the other providers, then the practice nurse could undertake that communication on behalf of the GP. However, like all elements of CDM services that are completed by the practice nurse, the communication with the other providers should be subject to review and confirmation by the GP, i.e. the GP should see and confirm the information that is communicated, as contained in notes of discussions, copies of facsimiles etc.

The TCA service must also include a personal attendance by the GP with the patient as part of the service.

**d) Can practice nurses or Aboriginal health workers provide other Medicare funded services for patients with chronic diseases and a care plan?**

In addition to other practice nurse items provided on behalf of the GP, item 10997 may be claimed where a monitoring and support service for a person with a chronic disease care plan is provided by a practice nurse or registered Aboriginal health worker on behalf of that GP.

Item 10997 can only be accessed by a patient if items 721, 723, 725, 727, 729 or 731 have been claimed in respect of the patient in the last 12 months. Ongoing monitoring and support for a person with a chronic disease care plan can include:

- checks on clinical progress;
- monitoring medication compliance;
- self management advice; and
- collection of information to support GP reviews of care plans.

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. However, 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 during the service to claim item 10997.

**e) Can a nurse or Aboriginal health worker, employed outside the GP's practice, play a role in the development of GPMPs and TCA?**

The expectation is that in preparing a GPMP or TCA, the GP may be assisted by their practice nurse, Aboriginal health worker or other health professional in the GP's medical practice or health service. This refers to assistance with the GP's role in these services. This does not mean that the GP needs to employ such health professionals, but that they would be working in the medical practice or health service. The more likely role for a health professional employed outside the practice, such as a respiratory nurse in an area health service, would be to participate as one of the health or care providers that the GP would collaborate with in developing the TCA.

It is not expected that a practice nurse or Aboriginal health worker working independently of the practice would assess patients and subsequently refer some on to their GP to review or confirm their plan, before the patient's GP had the opportunity to consider whether the patient is eligible for, and would benefit from, a CDM service (GPMP or TCA). Preparation of a GPMP or a TCA must include a personal attendance by the GP with the patient, as part of the relevant item, not as part of the patient's 'next consultation'.

A practice nurse, Aboriginal health worker or other health professional might identify that a patient may benefit from a CDM service and suggest that the patient contact their GP to discuss whether such a service is appropriate (i.e. refer the patient for a possible CDM service). This is different from initiating a service and then asking the GP to confirm it at the next consultation.

**f) Under what circumstances can a nurse or Aboriginal health worker be one of the three minimum members of a multidisciplinary TCA team?**

If the nurse/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; and
- not under the supervision of the GP; and
- different to the ongoing care provided by the other members of the team;

they may constitute one of the minimum three members of the team.

Where the 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 would **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 TCA 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 the GP's peers would regard the involvement of the practice nurse as a member of the TCA team to be appropriate in the circumstances.

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

**g) Can the practice nurse or Aboriginal health worker provide wound management services; complete blood tests, ECGs or Doppler studies on the same day that a GP Management Plan (item 721) is claimed?**

The MBS explanatory notes for the CDM items set out the circumstances in which a medical practitioner may/may not claim another consultation in conjunction with a CDM item. They are provided on page 70 (under A.33. 'Additional information'):

The GP Management Plan and Team Care Arrangements CDM items cover the consultations at which the relevant items are undertaken, noting that:

- If a consultation is for the purpose of undertaking the GPMP or TCA item only, only the relevant GPMP or TCA item can be claimed.
- If a GPMP or TCA item is undertaken or initiated during the course of a consultation for another purpose, the GPMP or TCA item and the relevant item for the other consultation may both be claimed.

In general, a separate consultation should not be undertaken in conjunction with a GPMP or TCA item 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').

Practice nurse services for wound management, blood tests, ECGs or Doppler studies do not fall into this category - they are not normal GP consultations and/or do not involve a personal attendance by the GP.

While it is not expected that such services would routinely be provided in conjunction with or on the same day as CDM items, they can be claimed on the same day as a GP Management Plan or Team Care Arrangements. To avoid any possible claims processing problems, it would be prudent for the patient's invoice or Medicare voucher (assignment of benefit form) for the separate service (e.g. wound management) to be annotated (e.g. 'separate service/clinically required/indicated').

Needless to say, where multiple services are claimed for the same patient on the same day, the requirements of each service must be fully met.

***h) Can a nurse or Aboriginal health worker with wound management or diabetes education qualify as a member of the TCA?***

If the nurse or Aboriginal health worker has special expertise and is providing a different kind of ongoing care to the patient (i.e. different to normal general practice services), and is working independently as a member of the TCA team (i.e. not under the supervision of the GP), they could be one of the minimum two other members of the TCA team. A nurse or Aboriginal health worker with specific wound management or diabetes education skills and expertise could meet this requirement provided they were working as an independent member of the team.

However, if a nurse or Aboriginal health worker is providing wound management services that are being claimed under the practice nurse wound management item (10996), these services are by definition being provided on behalf of and under the supervision of the medical practitioner and the nurse or Aboriginal health worker in this case would not be regarded as independently providing different ongoing treatment or services to the patient in their own right.

***i) Can a nurse/Aboriginal health worker gather and document information for the GPMP or TCA and qualify as a member of the TCA?***

A nurse/Aboriginal health worker could assist a GP in this way where the GP is preparing a GPMP or TCA, but this activity would not qualify them to be an independent member of the TCA team.

***j) Can a nurse/Aboriginal health worker compile the information at a patient's home during a visit for a health assessment if the patient meets the criteria for a GPMP and TCA and, therefore, when reviewed by the GP, can items 721, 723, 702 all be billed on the same day in the GP clinic?***

While a nurse/Aboriginal health worker can assist with the information collection component of a health assessment, including at the patient's home, the use of a nurse must firstly be initiated by the patient's GP, after the patient has agreed to a health assessment and to the use of the nurse to collect information for the assessment. In relation to the CDM items, the GP must firstly identify whether a patient is eligible for

the CDM items. It would not be appropriate for a nurse to initiate these items, without the GP's prior involvement, during a home visit for another purpose.

Assuming the GP has identified that the patient is eligible for the respective services, that the relevant services have been explained to the patient (each of these services have specific requirements as to what information needs to be given to the patient - for a TCA this must include discussing with the patient who will be the other members of the team and what information the patient wants shared/withheld), and the patient has consented to the services and to the nurse's involvement, the nurse could assist with the collection of information for the health assessment and assist the GP with the preparation of a GPMP and coordination of a TCA.

The nurse/Aboriginal health worker does not 'carry out these services, complete the assessment and prepare forms for the GP to review', she/he assists the GP. In the case of GPMPs and TCA, a practice nurse, Aboriginal health worker or other health professional may assist a GP in preparing or reviewing a GPMP or TCA (for example in patient assessment, identification of patient needs and making arrangements for services). However, the GP must review and confirm all assessments and elements of the GPMP, TCA, reviewed GPMP or reviewed TCA and must see the patient as part of the service.

While, in theory, a nurse/Aboriginal health worker could undertake their role in relation to these services (i.e. collecting patient information in a home visit) in one visit to the patient, it is not expected that a GP would routinely be claiming for completion of a health assessment, preparation of a GPMP and coordination of team care arrangements for the same patient on the same day.

In general, it is not expected that separate medical services would be provided in conjunction with a health assessment, such as a GPMP or a TCA, or that all of these services would be claimed on the same day. For example, see MBS Explanatory Note under A.24. on page 43 of the complete MBS publication which states 'Practitioners should not conduct a separate consultation in conjunction with a health assessment unless it is clinically indicated that a problem must be treated immediately'.

Nonetheless, it is theoretically possible to provide a health assessment and CDM service on the same day. However, this would require that all of the Medicare requirements for the relevant services are fully met, including documentation of the services and collaboration with the other members of the team in the case of TCA. This collaboration includes discussion on potential treatment/services which are to be provided to achieve management goals for the patient and documentation of goals and agreed treatment/services.

## 7. GPMP and TCA Interface

**a) Does the TCA need to be a separate document to the GPMP?**

No. Provided the relevant information is documented, the TCA 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.

**b) Can a GPMP and a TCA both be claimed on the same day?**

Provided the two services are delivered as per the Medicare items and explanatory notes, they could be claimed on the same day. However, in many cases this would be unlikely, given that the TCA includes collaborating with the participating providers to discuss potential treatment/services they will provide to achieve management goals, documentation of the goals, the collaborating providers, the treatment/services they have agreed to provide, patient actions and a review date. Note that both items require that the GP see the patient as part of the service, and that a TCA is intended to be done after a GPMP. Where both items are claimed the TCA should be claimed after the GPMP.

**c) Once a TCA is set up, can the GP claim a TCA review (MBS 727) from the referral alone?**

No. Item 727 is for patients who have a TCA in place and who will benefit from a team based review of the TCA.

A rebate can be claimed once the GP who coordinated the development of the patient's TCA (or another GP in the same practice, or a new GP where the GP has changed practices) has coordinated a systemic team-based review of the patient's progress against the TCA goals by completing the steps on page 68 of the complete MBS publication and meeting the relevant requirements listed under 'Additional information'.

**d) Does a GPMP (item 721) need to be claimed before a TCA?**

TCA are 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.

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

## 8. Relationship of CDM items to SIPs

### 8.1 General

**a) *Are the Service Incentive Payments (SIPs) under the Practice Incentives Program (PIP) still available?***

Service Incentive Payments for best practice care of patients with asthma and diabetes continue to be available. The SIPs for mental health were superseded by the GP Mental Health Care items (items 2710, 2712 and 2713) introduced on 1 November 2006.

The CDM items offer an additional and alternative funding mechanism to the SIPs for providing best practice care of patients with chronic conditions, including patients with asthma and diabetes.

The impact of CDM items on the management of chronic disease will be continually assessed, including the need for separate disease specific items. Any change to the SIPs as a result would be considered in consultation with GPs and other key chronic disease stakeholders.

**b) *Can a GP provide GP-managed care (a GP Management Plan) and a SIP for the same patient at the same time?***

It is not appropriate to use both GPMP and the SIP for asthma for the same patient at the same time (unless the patient has a separate chronic condition), as the work involved in both services overlaps, such as the need to develop a plan of care. Sensible time limits between these services are suggested (i.e. not within the same 12 months).

A GP Management Plan and diabetes SIP can be claimed for the same patient, as one sets out the care to be provided over the period covered by the plan and the other rewards the provision of best practice care over the previous 12 months. A review of the GP Management Plan and the SIP (for asthma or diabetes) should not be claimed at the same time (i.e. within three months of each other) as the work involved in both services overlaps.

**c) *Can a GP undertake team-based care (a GPMP and Team Care Arrangements) and a SIP for the same patient at the same time?***

A GP can provide team-based care (a GP Management Plan and Team Care Arrangements) and the relevant SIP to eligible patients as these patients have complex needs that cannot be addressed by the SIP alone. This was also the case for EPC multidisciplinary care planning and SIPs. It is not appropriate, however, to both review the CDM items and claim the SIP at the same time as the review work involved in both services overlaps.

Interaction between the CDM items and the SIPs for asthma and diabetes is covered in the table at 8.3.

**d) How can patients with asthma or diabetes benefit from the CDM items?**

Patients with these or other chronic medical conditions are eligible for a GP Management Plan and review items. A GP Management Plan includes an assessment of the patient and the development of a written/printed plan and can be undertaken in one consultation. Progress against the GP Management Plan can be assessed through regular reviews.

This is a simple model of care that is easy to use for both GP and patient. The CDM items are available across all general practice, i.e. they are not restricted to practices participating in the Practice Incentives Program.

Patients who also have complex needs requiring team-based care are eligible for Team Care Arrangements, where the GP collaborates with the other providers to identify the treatment and services to be provided to the patient. Progress can be assessed through regular reviews using the CDM review items.

Note: GP Mental Health Care items became available on the MBS (items 2710, 2712 and 2713) on 1 November 2006. See note A.43. in the MBS Book.

**e) Can a GP Management Plan and SIP (for diabetes) be claimed for the same patient in a 12 month period?**

Yes. A GP Management Plan can be prepared for a patient with diabetes and a SIP can be claimed if the annual 'cycle of care' requirements are met. The GP Management Plan should set out the treatment and services to be provided to the patient over the period of the plan. For a patient with diabetes this should include the elements of best practice diabetes management (as set out in the guidelines distributed to GPs under the National Integrated Diabetes Program) that are relevant to the patient.

While it is possible to claim for both preparation of a GP Management Plan and a diabetes SIP for a patient with diabetes, it should be noted that there would be substantial overlap between reviewing the GP Management Plan after twelve months care and claiming the SIP for completion of a cycle of care (i.e. as set out in the plan) at twelve months. When completing a diabetes cycle of care, GPs should choose to use either the relevant diabetes SIP 'trigger' item, or the GP Management Plan review item, but not both. As a guide the SIP item and the GP Management Plan review item should not be claimed within three months of each other.

**f) Can a GP claim both a GPMP Review and a SIP if they are completed at different times (over the year)?**

Yes, provided the diabetes SIP item and the GP Management Plan review item are not claimed within 3 months of each other (i.e. the minimum period for claiming a GPMP review item).

**g) Why is it inappropriate to claim a SIP and a review of a GPMP within 3 months of each other?**

A review of the GP Management Plan and the SIP should not be claimed at the same time (i.e. within three months of each other) as the work involved in both services overlaps.

While it is possible to claim for both preparation of a GP Management Plan and a diabetes SIP for a patient with diabetes, there would be substantial overlap between reviewing the GP Management Plan after twelve months care and claiming the SIP for completion of a cycle of care (i.e. as set out in the plan) at twelve months (for both asthma and diabetes). When completing a diabetes or asthma cycle of care, GPs should choose to use either the relevant SIP ‘trigger’ item, or the GP Management Plan review item, but not both. As a guide the SIP item and the GP Management Plan review item should not be claimed within three months of each other.

***h) Why is it acceptable for a GP to claim for diabetes GPMP and diabetes SIP on the same day but not acceptable to claim an asthma GPMP and an asthma SIP in this time frame?***

A GP Management Plan (GPMP) and diabetes SIP can be claimed for the same patient, as one sets out the care to be provided over the period covered by the plan and the other rewards the provision of best practice care over the previous twelve months.

It is not appropriate to use both GPMP and the SIP for asthma for the same patient at the same time (unless the patient has a separate chronic condition), as the work involved in both services overlaps, such as the need to develop a plan of care. Sensible time limits between these services are suggested (i.e. not within the same twelve months).

For the treatment of a person with asthma alone, GPs should choose either to use the CDM items or the asthma SIP, but not both. The work of both of these services overlaps – the asthma SIP is based broadly on an assess/plan/review cycle similar to the process involved in the GPMP and review items (see Table 1). Therefore SIPs and GPMPs for the management of asthma conditions should not both be claimed for the same patient at the same time. The GPMP item should not be claimed within 12 months of asthma SIP, other than in exceptional circumstances (e.g. where the patient has/develops a separate chronic condition).

Patients with multidisciplinary care needs (i.e. needs that extend beyond the requirements for the asthma SIP alone) who require team-based care are eligible for the relevant CDM items for team care and the asthma SIP, both services can be claimed for these patients at the same time provided the relevant requirements are met. The CDM review items and the SIP should not be claimed at the same time (i.e. in the same three months), as both services involve reviewing the patients process.

## **8.2 Diabetes**

***a) Do CDM items trigger SIPs for diabetes?***

No. When completing a diabetes cycle of care, GPs should choose to use either the relevant diabetes SIP ‘trigger’ item, or the GP Management Plan review item, but not both. The GPMP review item does not trigger SIP or associated outcomes payments.

**b) Can a GP conduct an annual cycle of care and complete diabetes SIP during the same period of time in which they have developed a GPMP?**

Yes. A GP can prepare a GP Management Plan for a patient and then provide a diabetes cycle of care, consistent with the GP Management Plan and the diabetes SIP requirements. When the cycle of care is completed after twelve months, the GP can claim either the SIP item or the GP Management Plan review item, but not both as the two services would overlap substantially. The diabetes SIP item and the GP Management Plan review item should not be claimed within 3 months of each other.

**c) What other services are available for people with type 2 diabetes?**

Since May 2007, new allied health items (81100 to 81125) allow people with type 2 diabetes, who are being managed by their GP under a GPMP, to receive Medicare rebates for group services provided by eligible diabetes educators, exercise physiologists and dietitians, on referral from the GP.

People with diabetes and complex care needs, who are being managed by their GP using the CDM items, may also have access to Medicare rebates for a range of individual allied health services such as: dietitians, exercise physiologists and psychologists. These patients can be referred for up to five allied health services each calendar year.

In addition to the Medicare rebate for these allied health services, out-of-pocket expenses count towards the Extended Medicare Safety Net.

### 8.3 Access to CDM items and SIPs for asthma and diabetes

**KEY:**

**CDM** = Chronic Disease Management

**GPMP** = GP Management Plan (item 721)

**TCA** = Team Care Arrangements (item 723)

**SIP** = Service Incentive Payments

**MBS** = Medicare Benefits Schedule

Note: The asthma SIPs are based broadly on an assess/plan/review cycle which is similar to the process involved in GPMP and review items. SIPs and GPMPs for management of asthma conditions should not both be claimed for the same patient at the same time. The diabetes SIP pays an incentive for the provision of care over the previous annual cycle, and does not duplicate planning for the patient's care through a GPMP or TCA over the forward period.

Patient	CDM and SIP Items	Patients with Diabetes	Patients with Asthma
Patient with chronic condition (not requiring team-based care)	GPMP	✓	✓*
	GPMP Review	✓	✓
	SIP	✓	✓**
	SIP with GPMP	✓	x
	SIP with GPMP Review ***	Not both at same time	Not both at same time
Patient with chronic condition and complex needs (requiring team-based care)	GPMP with TCA	✓	✓
	GPMP or TCA Review	Either, as appropriate	Either, as appropriate
	GPMP and TCA plus SIP	✓	✓
	SIP plus GPMP or TCA Reviews ***	Not both at same time	Not both at same time

**NOTES:**

\* The GPMP item should not be claimed within 12 months of an asthma SIP, other than in exceptional circumstances (e.g. where the patient has/develops a separate chronic condition).

\*\* The asthma SIPs should not be claimed within 12 months of a GPMP, unless clinically indicated that a SIP is required, as opposed to ongoing management under the GP Management Plan and review items, and normal consultation items.

\*\*\* The SIP item and the CDM/TCA review items should not be claimed within three months of each other.

## 9. Relationship of CDM items to GP Mental Health Care Plan items

### a) *What are the GP Mental Health Care Medicare items?*

There are three GP Mental Health Care Plan items:

- Preparation of a GP Mental Health Care Plan (item 2710)
- Review of a GP Mental Health Care Plan (item 2712)
- GP Mental Health Care Consultation (item 2713)

The items provide a structured framework for GPs to undertake early intervention, assessment and management of patients with mental disorders, as well as providing new referral pathways to clinical psychologists and allied mental health service providers. These items are based on a similar model of care – assess, plan and review – as the Better Outcome in Mental Health Care 3 Step Mental Health Process.

GPs should use the GP Mental Health Care items, which became available on 1 November 2006, to prepare mental health care plans for patients (for further information see notes A.43. in the MBS Book).

### b) *How do the GP Mental Health Care items relate to the CDM items?*

The GP Mental Health Care items are based on a similar model of care – assess, plan and review – as the Better Outcomes in Mental Health Care 3 Step Mental Health Process. The GP items are also based on a similar structure to the Chronic Disease Management items, except that GP referral to clinical psychologists and allied mental health service does not require team care arrangements. These referral pathways reflect the different needs of patients with a mental disorder.

The Mental Health Care items and CDM items can be used in the following manner:

- Where a patient has a mental health condition only, it is anticipated that they will be managed under the new GP Mental Health Care items.
- Where a patient has a separate chronic medical condition, it may be appropriate to manage the patient's medical condition through a GP Management Plan and to manage their mental health condition through a GP Mental Health Care Plan. In this case, both items can be used.
- Where a patient has a mental health condition as well as significant co-morbidities and complex needs requiring team-based care, the GP is able to use both the CDM items (for team-based care) and the GP Mental Health Care items.

In considering the patient's needs the practitioner should determine whether it is necessary to develop separate care plans. As a general principle, the creation of multiple care plans should be avoided unless the patient clearly requires an additional plan for the management of a separate medical condition.

## 10. Relationship with Allied Health Items

Information on Medicare dental items is available separately on the Department of Health and Ageing website [www.health.gov.au](http://www.health.gov.au)

### a) **When is a patient considered to be managed under an EPC plan and eligible for Medicare rebates for allied health services?**

Care plans developed using the CDM items (both 721 and 723, together, or 731) are referred to in a generic way as 'EPC plans'.

Patients are considered to be managed under an EPC plan if, during the last two years:

- their GP has put in place a GPMP and TCA; or
- their GP has reviewed their existing EPC plan and claimed MBS items 725 and 727; 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.

Before a Medicare rebate can be paid for the allied health service, either the patient must have already claimed a rebate for the relevant Medicare item/s, or the GP must have lodged a direct bill (bulk billing) claim with Medicare Australia for the relevant Medicare item/s and that claim must have been processed. If there is any doubt about the patient's eligibility, Medicare Australia will be able to confirm whether there is an EPC plan in place. The allied health professional or the patient can call Medicare Australia on 132 011 to check this information.

### b) **When is a patient eligible for group allied health services?**

To be eligible for group services provided by diabetes educators, exercise physiologists and dietitians, a patient must have in place one of the following:

- a GPMP; or
- where a patient has an existing GPMP, the GP has reviewed that plan (item 725); 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).

The patient must also have type 2 diabetes and be referred by their GP.

### c) **Can allied health providers use the relevant Medicare item to bill a patient for contributing to their EPC plan? Do they need to see the patient before contributing?**

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.

The CDM items do not require that an allied health provider see a patient before contributing to an EPC plan. The involvement of allied health providers as members of a multidisciplinary team (for example, to prepare Team Care Arrangements), 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 a member of a TCA team sees the patient before providing input to the TCA and bills them for that service, the patient is not eligible for a Medicare rebate for that service.

Members of a TCA team are not expected to 'comment' on the patient's GPMP. Their primary role is to collaborate with the GP in terms of the potential treatment or services they will provide to help achieve the management goals for the patient.

It is not possible to complete and claim a TCA unless it includes the results of the collaboration with the participating providers on the potential treatment or services they will provide to help achieve the management goals for the patient, i.e. the TCA identifies the treatment and services they have agreed to provide.

It is of course possible (and desirable) to amend and update a patient's care plan following the relevant reviews. It is also recognised that in many cases the first 'treatment' consultation with an allied health provider under a TCA may include an element of assessment and refinement of treatment plans, which in turn can feed back to the GP through treatment reports from the allied health provider on services provided and as part of a TCA review.

**d) *Can a GP refer the patient for a further five allied health visits under an EPC plan prepared in the previous 12 month period?***

Yes. A GP does not need to prepare a new EPC plan (for example, a GPMP or TCA) in subsequent years in order for patients to continue to be eligible for Medicare rebates for allied health services in those subsequent years.

Once a patient has received an EPC plan, they may access the allied health items while they continue to be managed under the relevant plan and review services.

As a result of a review of the GPMP and TCA, or TCA review alone, the GP may identify that the patient requires additional allied health services and complete new referral forms.

**e) *Do patients being managed under an EPC 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 EPC 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 12 months in order to access new referrals for eligible allied health services.

**f) *Can a diabetes educator employed or hired by a Division and managing a patient under a Team Care Arrangement claim a Medicare rebate?***

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 or Commonwealth programs. Examples of such programs include State Government hospital outpatient clinics, the More Allied Health

Services (MAHS) program, the Commonwealth Hearing Services Scheme, and DVA services to veterans.

Employment of allied health providers by Divisions would also come within this category, i.e. a service funded through another Commonwealth or State program, in this case analogous to MAHS. 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.

**g) Can a GP just do GPMP and TCA every 2 years with no reviews and the patient gets 5 allied health referrals each year?**

It is expected and strongly encouraged that a GPMP and TCA would be regularly reviewed, given that the patient must have a chronic medical condition and complex needs. Certainly such plans would be expected to be reviewed at least once during a 2 year period, using the relevant CDM review item. In theory a GP could make a clinical decision to manage the patient using normal GP attendance items rather than CDM review items in the period between new plans and refer the patient for allied health services recommended in the plan. However, as noted above, the Medicare Australia system would look for a signal that the patient is continuing to be managed under an EPC plan, that is, one or more of the above items (see 10(a) above) being claimed in the previous two year period.

It is important to remember that 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 and 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.

**h) Once a TCA is set up, does the GP need to see a patient on the same day as the allied health professional?**

No. The GP does not need to see the patient on the same day as the allied health professional. The allied health professional is providing the service in their own right and should use their own Medicare provider number.

## 11. Claiming Rules

### a) What are the claiming periods for the CDM items?

Recommended frequency and minimum claiming periods for the CDM items are set out in the following table:

MBS Item	Item No	Medicare Fee (100%) Nov 2008	Recommended frequency	Minimum Claiming Period*
Preparation of a GP Management Plan	721	\$130.65	2 yearly	12 months*
Preparation of Team Care Arrangements	723	\$103.50	2 yearly	12 months*
Review of a GP Management Plan	725	\$65.30	6 monthly	3 months*
Coordination of Review of Team Care Arrangements	727	\$65.30	6 monthly	3 months*
Contribution to a multidisciplinary care plan	729	\$63.75	6 monthly	3 months*
Contribution to a multidisciplinary care plan by an Aged Care Facility	731	\$63.75	6 monthly	3 months*

\*CDM services can also be provided more frequently in 'exceptional circumstances' - 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 GP Management Plan, Team Care Arrangements or review service.

The **recommended frequency** for these services, allowing for variation in patients' needs, is once every two years, with regular reviews (recommended six monthly) of the patient's progress against the plan. This is recommended as an average frequency but should be applied with regard to the patient's requirements – in general, a new GPMP or TCA should not be prepared unless and until required by the patient's condition, needs and circumstances. The review items are the key components for assessing and managing the patient's progress once a GPMP or TCA have been prepared.

**Minimum claiming** intervals are specified to allow for earlier completion of a new GPMP, TCA or review where required. For example, in relation to a GPMP, a rebate will not be paid within twelve months of a previous claim for a GPMP, or within three months of items 725, 727, 729, 731, other than in exceptional circumstances, e.g. repeated discharge from hospital (see 'Exceptional circumstances' under A.33. on page 71 of the complete MBS publication).

**CLAIMING CHRONIC DISEASE MANAGEMENT ITEMS – LIMITATIONS**

For any particular patient, unless exceptional circumstances apply, a rebate will not be paid within:

**Item 721 - Develop GP Management Plan (GPMP)**

- 12 months of a previous claim for a GPMP; or
- 3 months of item 725, 727, 729 or 731.

**Item 723 - Coordinate Team Care Arrangements (TCA)**

For any particular patient, unless exceptional circumstances apply, a rebate will not be paid within:

- 12 months of a previous claim for the same item; or
- 3 months of a claim for a TCA review (item 727).

**Item 725 - Review a GP Management Plan**

For any particular patient, unless exceptional circumstances apply, a rebate will not be paid within:

- 3 months of a previous claim for the same item; or
- 3 months of a claim for item 721.

**Item 727 - Coordinate a review of Team Care Arrangements**

For any particular patient, unless exceptional circumstances apply, 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 item 723.

**Item 729 - Contribution to a multidisciplinary care plan or contribution to a review of a multidisciplinary care plan for a patient who is not a resident of an aged care facility**

For any particular patient, unless exceptional circumstances apply, a rebate will not be paid within:

- 12 months of item 721 or item 723 claimed by the same practitioner for that patient;
- 3 months of a previous claim for the same item; or
- within three months of a claim for item 725, 727 or 731.

**Item 731 - Contributing to another provider's multidisciplinary care plan or contributing to a review of a multidisciplinary care plan for a patient who is a resident of an aged care facility**

For any particular patient, unless exceptional circumstances apply, a rebate will not be paid within:

- 3 months of a previous claim for the same item;
- within three months of a claim for any other CDM item (i.e. 721, 723, 725, 727 or 729).

**Exceptional circumstances** apply 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 GP Management Plan, Team Care Arrangements or review service.

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 time interval for the relevant item (e.g. annotated as clinically indicated, discharge, exceptional circumstances, significant change etc).

If claims for payment in such circumstances are initially rejected they should be resubmitted for payment, ensuring that the reason is clearly identified.

**b) Can a GPMP and a TCA be claimed on the same day?**

Provided the two services are delivered as per the Medicare items and explanatory notes, they could be claimed on the same day. However, in many cases this would be unlikely, given that the TCA includes collaborating with the participating providers to discuss potential treatment/services they will provide to achieve management goals, documenting the goals, the collaborating providers, the treatment/services they have agreed to provide, patient actions and a review date.

Also, both items require that the GP see the patient as part of the service. It is also intended that a TCA is done after a GPMP; where both items are claimed the TCA should be claimed after the GPMP.

**c) Is there a set time period between the completion of a GPMP and the completion of the TCA that must be adhered to?**

No. There is no set time period.

The claiming restrictions for a GP Management Plan are that a rebate will not be paid (other than in exceptional circumstances) within:

- 12 months of a previous claim for a GPMP; or
- 3 months of item 725, 727, 729 or 731.

For Team Care Arrangements a rebate will not be paid (other than in exceptional circumstances) within:

- 12 months of a previous claim for the same item; or
- 3 months of a claim for a TCA review (item 727).

Although there is no set time period, in many cases it would be unlikely that a GPMP and a TCA would be completed on the same day, given the collaboration with other providers required as part of the TCA (see steps and collaboration requirements on page 67 of the complete MBS publication).

**d) Can an Item 725 and 727 be claimed on the same day?**

The claiming restrictions do not prohibit the two being claimed on the one day but it is unlikely that the collaboration which is required for the TCA review service would result in the services, if commenced on the same day, being completed on the same day.

In general, GPs should choose to use the review item which is appropriate to the type of review being undertaken, i.e. item 725 for a review by a GP alone or item 727 for a team-based review, but not both at the same time.

A GPMP review item (item 725) can be used to review a GPMP (item 721) or a former EPC community or discharge care plan (former items 720 or 722). A Team Care Arrangements review item (item 727) can be used to coordinate a review of Team Care Arrangements or of a former EPC community or discharge care plan (former items 720 or 722).

**e) Does the bulk billing incentive apply to both items 721 and 723 if claimed at the same time?**

Yes, if the services are provided to eligible patients.

**f) If you use items 721 to 731, are you able to claim an attendance item at the same time if you satisfy the descriptor in the MBS book?**

A standard consultation should not be routinely claimed with the CDM items.

The MBS notes specify that in general, a separate consultation should not be undertaken in conjunction with a GPMP or TCA item unless it is clinically indicated that a problem must be treated immediately or the CDM item was not the purpose of the consultation. 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, immediate treatment required/separate consultation' etc).

See Explanatory Notes under 'Additional information' on page 70 of the complete MBS publication:

*The GP Management Plan and Team Care Arrangements CDM items cover the consultations at which the relevant items are undertaken, noting that:*

- *If a consultation is for the purpose of undertaking the GPMP or TCA item only, only the relevant GPMP or TCA item can be claimed.*
- *If a GPMP or TCA item is undertaken or initiated during the course of a consultation for another purpose, the GPMP or TCA item and the relevant item for the other consultation may both be claimed.*

**g) Can any GP do a CDM review and how do they check whether one has already been completed?**

The CDM items are intended to be provided by the patient's usual GP. This means the GP, or a GP working in the medical practice, that has provided the majority of care to the patient over the previous 12 months and/or will be providing the majority of care to the patient over the next 12 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 GPMP, TCA 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.

**h) Can a GP claim a Team Care Arrangement (item 723) based on a referral to an allied health professional alone?**

No. Team Care Arrangements are designed for patients with a chronic or terminal medical condition who require ongoing care from at least three health or care providers, including their GP. The Medicare requirements for a TCA are explained in the Medicare Benefits Schedule A.33.

Once a GPMP and a TCA have been prepared for the patient and claimed on Medicare, (or item 731 for aged care residents), the patient is eligible for access to certain allied health services (items 10950 to 10970 inclusive) on referral from their GP.

**i) Should the GP claim a GPMP review item instead of a TCA review if there has been no response from the other team members?**

If a GP commences a TCA review but cannot collaborate with other members of the TCA team in order to complete the review, they cannot claim a TCA review as the requirements for this item have not been met.

If the patient has a GPMP, the GP can claim a GPMP review if they meet the requirements of a GPMP review by:

- reviewing the patient's needs and goals, patient actions and treatment/services;
- making relevant changes to the documented GPMP;
- adding a new review date;
- offering the patient a copy of the revised GPMP; and
- placing a copy of the revised GPMP in the patient record; and

the GPMP review claiming restrictions are not breached;

- a GPMP review has not been claimed within the previous three months; and
- a GPMP has not been claimed within the previous three months.

**j) Can a GP claim item 721 or 723 if a claim for item 900 (Domiciliary Medication Management Review) is made on the same day?**

Providing all of the requirements of the claimed items are met, including that the GP has seen the patient in respect of each service, a rebate could be claimed for a CDM item (GPMP or TCA) on the same day as a DMMR service, though given the work involved in each of these services it is unlikely that in practice they would actually be completed on the same day. It is also more likely that, in most cases, the need for a DMMR would be identified as part of doing a GPMP or TCA, rather than vice versa. It would not be expected that a GPMP, TCA and DMMR would be routinely claimed on the same day.

It should be noted that in the case of the CDM items, completion of the service includes offering a copy of the relevant plan to the patient and including a copy in the patient records. It is worth noting too in the case of the TCA service, that completing the service **also** includes incorporating the feedback from the other team members (on care and services to be provided) into the plan.

In the case of each service (DMMR, GPMP, TCA) there is a general expectation that another consultation would not be claimed in conjunction with the service. To avoid any possible claim processing difficulties, it would be prudent for the patient's invoice or Medicare voucher (assignment of benefit form) for the separate service (e.g. GPMP or TCA) to be annotated (e.g. separate service/clinically required/indicated).

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

MBS Item 729 is for the 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. It is a GP service available to patients in the community and to both private and public in-patients being discharged from hospital. If a GP contributes to a multidisciplinary care plan prepared by another provider, they will not be able to prepare and claim on a new GP Management Plan or Team Care Arrangement 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 GP Management Plan (721) and Team Care Arrangements (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.

***l) 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').

***m) If a GP contributes to a multidisciplinary care plan using Medicare item 729, is the patient eligible for Medicare rebates for allied health services identified in that care plan?***

No. Medicare item 729 is the 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. The GP must be the manager of the multidisciplinary care plan (e.g. items 721 and 723) to be able to refer the patient for allied health services.

***n) Is it permissible, when doing an older age health assessment (MBS item 702), to also prepare a GPMP (MBS item 721), either at the same time or at a follow up visit for patients with multiple chronic problems?***

It is not necessary for a patient to have multiple conditions to be eligible for a GPMP service. The patient needs only to be one with a chronic or terminal condition who will benefit from a structured approach to management of their care needs. (By contrast, for the TCA service the patient must have a chronic or terminal condition AND team care needs - which will often mean that they do have multiple chronic conditions.)

***Health Assessment and GPMP at the same time***

The health assessment items notes (A.24.) provide that a separate consultation should not be conducted in conjunction with a health assessment unless it is clinically indicated that a problem must be treated immediately. It is not expected that preparation of a GPMP would fall into this category as a general rule, and therefore it would generally not be appropriate to do a health assessment and prepare a GPMP at the same time.

In theory, the two items could be provided on the same day if they are provided as separate services and all of the requirements of both items are met, including documentation of the health assessment and the GP management plan, before the rebates are claimed. Note that each service has specific requirements as to the information that needs to be given to the patient in respect of the service, including the involvement of any other people assisting the GP with the service. The patient also needs to consent to each service.

Where services are provided on the same day, to avoid claiming problems, the Medicare voucher or patient invoice should be annotated as a separate service.

*GPMP as a follow up visit*

There are no claiming restrictions attached to the older age health assessment item that require any specific period of time to pass before a CDM service (GPMP and/or TCA related service) can be provided as a follow up visit.

***o) Can a practice claim a GPMP and/or TCA within three months of claiming a health assessment or a case conference item?***

There are no claiming restrictions that require a specified period of time to pass after the provision of an older age health assessment service before a GPMP or TCA service can be provided. A GPMP and/or TCA could be claimed within 3 months of a health assessment or a case conference provided the requirements of the relevant items are met.

It may be useful to also note that A.24. of the November 2008 MBS explanatory notes for the older age health assessment items states that: 'Practitioners should not conduct a separate consultation in conjunction with a health assessment unless it is clinically indicated that a problem must be treated immediately.' This means that it would generally not be appropriate to provide an older age health assessment and a CDM service (including GPMP) at the same time.

While it is theoretically possible to provide a health assessment and a CDM service (GPMP or TCA) on the same day, this would require that all of the requirements for the relevant services are fully met, including documentation of the relevant service and collaboration with the other members of the team in the case of TCA. In this case, to avoid any claiming difficulties, the patient's invoice or Medicare voucher should be annotated to indicate that the second service was provided as a separate service.

There are no time period/other service restrictions that require a specified period of time to pass after the provision of an Aboriginal and Torres Strait Islander Adult Health Check before a GPMP or TCA service can be provided. However, the requirements of both services must be met (including finalising input from other providers, in the case of the TCA, and offering the patient a copy of the finalised plan in all cases).

Similar time period/other service restrictions do not apply to Comprehensive Medical Assessments for residents of aged care facilities because residents are not eligible for a GPMP or TCA other than when they are being discharged from hospital as private patients, in which case they will not also be having a CMA at the same time/day.

As far as case conferences and CDM items are concerned, the CDM services cannot be claimed in respect of a service to which the case conferencing items apply i.e. the one service cannot be used to claim both a case conference item and a CDM item, and these services are restricted with each other from being claimed on the same day.

***p) Can a home visit item number and a GPMP be billed by a GP at the same time?***

This would not be expected to be a routine occurrence, as, in general, a separate consultation should not be undertaken in conjunction with a GPMP or TCA item unless it is clinically indicated that a problem must be treated immediately.

Nonetheless, it is theoretically possible to undertake a home visit and CDM service on the same day; however, this would require that all of the Medicare requirements for the relevant services are fully met.

**q) Can MBS item 10997 be claimed on the same day that the GP claims for the development or review of a CDM care plan (items 721, 723, 725, 727, 729, 731)?**

The intent of item 10997 is to assist patients who require access to frequent ongoing care for relatively routine treatment and ongoing monitoring and support between more structured reviews of a care plan by a patient's GP.

The services provided by the practice nurse/Aboriginal health worker should be consistent with the scope of the chronic disease care plan and it is anticipated that they would assist the patient to undertake the activities outlined in the chronic disease care plan and monitor their capacity to do this.

The item is a follow-up service and is not intended to be used to claim for any time spent by the practice nurse/Aboriginal health worker is assisting with the development of the chronic disease care plan. It would not therefore be claimed on the same day as items 721, 723, 725, 727, 729 or 731.

**r) Can item 727 (Coordinate a Review of Team Care Arrangements) be claimed within a week of item 740 (Organise and Coordinate a Community Case Conference)?**

A review of a TCA can be claimed within 3 months of a case conference provided the requirements of the relevant items are met. CDM services cannot be claimed in respect of a service to which the case conferencing items apply i.e. the one service cannot be used to claim both a case conference item and a CDM item, and these services are restricted with each other from being claimed on the same day.