

EPC Chronic Disease Management MBS items explanatory notes

MBS Explanatory Notes

A.22 Enhanced Primary Care – Chronic Disease Management Items (Items 721, 723, 725, 727, 729 and 731)

A.22.1 This note is in addition to the note on the existing EPC multidisciplinary care planning items at A.21 in the 1 November 2004 Medicare Benefits Schedule Book, and refers to new EPC Chronic Disease Management (CDM) items. These new items replace the existing EPC items for multidisciplinary care planning services – items 720, 722, 724, 726, 728 and 730.

A.22.2 The existing EPC multidisciplinary care planning items are retained until 1 November 2005 so that services commenced but not completed by 1 July 2005 can be completed.

A.22.3 New EPC Medicare items 721, 723, 725, 727, 729 and 731 provide rebates for GPs to manage chronic disease by preparing, coordinating, reviewing or contributing to CDM plans. These new items have been developed in consultation with GP groups to improve the operation of the EPC items and reduce red tape.

A.22.4 Medical practitioners should use the new items when preparing, reviewing or contributing to CDM plans from 1 July 2005. Where patients have existing multidisciplinary care plans, it is not necessary to prepare a new plan using the new items until required by the patient's circumstances. Existing EPC multidisciplinary care plans can be reviewed from 1 July using the new CDM review items. (See A.22.52 for more information on transitional arrangements).

A.22.5 The new CDM items are able to be claimed by a medical practitioner, including a general practitioner but not including a specialist or consultant physician. The term 'GP' is used in these notes as a generic reference to medical practitioners able to claim these items.

Overview

A.22.6 The new EPC chronic disease management items are for:

- preparation by a GP of a GP Management Plan (GPMP);
- coordination by a GP of Team Care Arrangements (TCA);
- review by a GP of a GP Management Plan;
- coordination by a GP of a review of Team Care Arrangements; and
- contribution to a multidisciplinary care plan or contribution to a review of a multidisciplinary care plan (for patients who are not residents of aged care facilities).
- contribution to a multidisciplinary care plan or contribution to a review of a multidisciplinary care plan (for residents of aged care facilities).

GPMPs and TCAs should be comprehensive documents that set out and enable evidence-based management of the patient's health and care needs.

A.22.7 Patients with a chronic or terminal medical condition are eligible for a GP Management Plan item. Patients who also have complex needs requiring care from a multidisciplinary team are eligible for a Team Care Arrangements item.

A.22.8 A GP Management Plan and Team Care Arrangements, together, broadly equate to an EPC multidisciplinary plan.

EPC Chronic Disease Management MBS items explanatory notes

A.22.9 While a GP Management Plan and a Team Care Arrangements are able to be provided independently, it is expected that in most cases a patient with complex needs would have both services. It is not mandatory, however, to follow the preparation of a GP Management Plan with the coordination of Team Care Arrangements or to prepare a GP Management Plan before coordinating Team Care Arrangements.

A.22.10 For patients to be eligible to access rebates under the allied health and dental care items (item numbers 10950 to 10977 inclusive) they must have both a GP Management Plan and a Team Care Arrangements in place and claimed on Medicare. However, residents of aged care facilities are eligible to access rebates under the allied health and dental care items where their GP has contributed to a care plan prepared for them (Item 731) and the contribution item has been claimed on Medicare (see A.22.38 and A.22.39).

Preparing a GP Management Plan (GPMP) - Item 721

A.22.11 This item is for patients with a chronic or terminal medical condition who will benefit from a structured approach to management of their care needs. A rebate can be claimed once the patient's usual GP (or another GP in the same practice) has prepared a GPMP by completing the steps at A.22.12 and meeting the relevant requirements listed under A.22.40 and A.22.41. 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 (see A.22.43). The service must include a personal attendance by the GP with the patient, as part of Item 721.

A.22.12 The steps in preparing a GPMP must include:

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

The GP may, with the permission of the patient, provide a copy of the GPMP or of relevant parts of the GPMP, to other providers involved in the patient's care.

A.22.13 This GP service is available to patients in the community. It is also available to private in-patients (including private in-patients who are residents of aged care facilities) being discharged from hospital, where their usual GP (or a GP from the same practice) who prepares the GPMP is providing in-patient care; in this case the GPMP is claimed as an in-hospital service. A GPMP is not available to public in-patients being discharged from hospital. It is not available to residents of aged care facilities, except where they are private-in patients being discharged from hospital.

A.22.14. The recommended frequency of this service is once every two years, with regular reviews of the patient's progress against the plan, except in the discharge setting, where a new GPMP may be required following separate hospital admissions. The review item is the key component for assessing and managing the patient's progress once a GPMP has been prepared.

EPC Chronic Disease Management MBS items explanatory notes

A rebate will not be paid within twelve months of a previous claim for a GPMP, within twelve months of a claim for item 720 (preparation of a community care plan) or within three months of any other EPC chronic disease management item, other than in exceptional circumstances eg repeated discharge from hospital (see A.22.50 and A.22.51).

Coordinating the development of Team Care Arrangements (TCA) - Item 723

A22.15 This item is for patients with a chronic or terminal medical condition and who require ongoing care from a multidisciplinary team of at least three health or care providers (including their GP). A rebate can be claimed once the patient's usual GP (or a GP in the same practice) has coordinated the development of TCA by completing the steps at A.22.17 and meeting the relevant requirements listed under A.22.40 and A.22.41. 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 (see A.22.43). The service must include a personal attendance by the GP with the patient as part of item 723.

A.22.16 This service 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.

A.22.17 The steps in coordinating TCA must include:

- a) discussing with the patient which treatment/service providers should be asked to collaborate with the GP in completing TCA;
- b) gaining the patient's agreement to share relevant information about their medical history, diagnoses, GPMP etc (with or without restrictions) with the proposed providers;
- c) contacting the proposed providers and obtaining their agreement to participate, realising that they may wish to see the patient before they provide input but that they may decide to proceed after considering relevant documentation, including any current GPMP;
- d) collaborating with the participating providers to discuss potential treatment/services they will provide to achieve management goals for the patient;
- e) 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; and
- f) providing the relevant parts of the TCA to the collaborating providers and to any other persons who, under the TCA, will give the patient the treatment/services mentioned in the TCA.

The GP may, with the permission of the patient, provide a copy of the TCA or of relevant parts of the TCA, to other providers involved in the patient's care.

A.22.18 The collaboration between the coordinating GP and participating providers at A.22.17 (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). 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.

A.22.19 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. This includes people who will be organising or

EPC Chronic Disease Management MBS items explanatory notes

coordinating care services for the patient that will be provided by their organisation. Each of the health or care providers must provide a different kind of ongoing care to the patient. One of the service providers collaborating with the GP may be another medical practitioner (normally a specialist or consultant physician but not usually another GP). The patient's informal or family carer may be included in the collaborative process but does not count towards the minimum of three collaborating providers (see A.22.48).

A.22.20 Once a GPMP (item 721) and TCA (item 723) have been prepared for a patient and claimed on Medicare (or item 731 for aged care residents), the patient is eligible for access to certain allied health and dental services (items 10950 to 10977 inclusive). The patient can be referred by their GP for services identified in their TCA after the TCA has been completed and claimed. Medicare rebates are not payable for allied health providers' involvement in contributing to the development of the TCA or the review of the TCA.

A.22.21 A TCA should document all the health or care services required to address the patient's needs – this should include services to be provided by people or organisations that are not members of the TCA team.

A.22.22 This GP service is available to patients in the community. It is also available to private in-patients (including private in-patients who are residents of aged care facilities) being discharged from hospital, where their usual GP (or a GP from the same practice) is coordinating the development of the TCA and is providing in-patient care; in this case the TCA is claimed as an in-hospital service. A TCA is not available to public in-patients being discharged from hospital. It is not available to residents of aged care facilities, except where they are private in-patients being discharged from hospital.

A.22.23 The recommended frequency of this service is once every two years with regular reviews of the patient's progress against the TCA. However, in the discharge setting a new TCA may be required following separate hospital admissions. The review item is the key component for assessing and managing the patient's progress once a TCA has been prepared. A rebate will not be paid within twelve months of a previous claim for the same item, within twelve months of a claim for item 720 (preparation of a community care plan) or within three months of a claim for a TCA review (item 727), other than in exceptional circumstances eg discharge (see A.22.50 and A.22.51).

Reviewing a GP Management Plan - Item 725

A.22.24 This item is for patients who have a current GPMP in place and who will benefit from a review of that GPMP. A review is the principal mechanism for ensuring the continued appropriateness of the GPMP and the management of the patient's chronic condition. A rebate can be claimed once the GP who prepared the patient's last GPMP (or another GP in the same practice or a new GP where the patient has changed practices) has undertaken a systematic review of the patient's progress against the GPMP goals by completing the steps at A.22.25 and meeting the relevant requirements listed under A.22.40 and A.22.41. 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 (see A.22.43). The service must include a personal attendance by the GP with the patient, as part of item 725.

A.22.25 The steps in reviewing a GPMP must include:

EPC Chronic Disease Management MBS items explanatory notes

- a) reviewing the patient's needs and goals, patient actions and treatment/services;
- b) making relevant changes to the documented GPMP; and
- c) adding a new review date;

The GP may, with the permission of the patient, provide a copy of the reviewed GPMP or of relevant parts of the reviewed GPMP, to other providers involved in the care of the patient.

A.22.26 This GP service is available to patients in the community. It can also be used to review GPMPs prepared for private in-patients (including private in-patients who are residents of aged care facilities) being discharged from hospital; in most cases such post-discharge reviews would be undertaken when the patient is living in the community setting.

A.22.27 The recommended frequency of this service is once every six months. 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 preparing a GPMP, other than in exceptional circumstances.

Coordinating a review of Team Care Arrangements - Item 727

A.22.28 This item is for patients who have a TCA in place and who will benefit from a 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 patient has changed practices) has coordinated a systematic review of the patient's progress against the TCA goals by completing the steps at A.22.29 and meeting the relevant requirements listed under A.22.40 and A.22.41. 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 (see A.22.43). The service must include a personal attendance by the GP with the patient as part of item 727.

A.22.29 The steps in coordinating a review of TCA must include:

- a) discussing or confirming with the patient which treatment/service providers should be asked to collaborate with the GP in the review and gaining agreement to share relevant information with them;
- b) collaborating with the participating providers to establish the patient's progress against the previously nominated treatment/service goals, and agreeing on any necessary changes and on the specific treatment/services to be provided by each member of the team;
- c) making necessary changes to the documented TCA; and
- d) providing the relevant parts of the revised TCA (if any) to the collaborating providers and to any other persons who, under the revised TCA, will give the patient treatment/services mentioned in the TCA.

A.22.30 See A.22.18 and A.22.19 for information on collaboration and on the required number and roles of collaborating providers.

A.22.31 This GP service is available to patients in the community. It can also be used to review TCAs prepared for private in-patients (including those private in-patients who are residents of aged care facilities) being discharged from hospital; in most cases such post-discharge reviews would be undertaken when the patient is living in the community setting.

EPC Chronic Disease Management MBS items explanatory notes

A.22.32 The recommended frequency of this service is once every six months. 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 coordinating the development of TCA, other than in exceptional circumstances such as hospital discharge (see A.22.50 and A.22.51).

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

A.22.33 This item 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 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. 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, by completing the steps at A.22.34.

A.22.34 The steps involved in contributing to a multidisciplinary care plan or to a review of the care plan must include:

- a) 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;
- b) collaborating with the person preparing the care plan to set goals and specify treatment/services to be provided by the GP;
- c) 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).

A.22.35 See A.22.18 and A.22.19 on collaboration and communication.

A.22.36 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 (see item 731 below).

A.22.37 The recommended frequency of this service is once every six months. Other than in exceptional circumstances, a rebate will not be paid within twelve months of a GPMP or TCA claimed by the same practitioner for that patient, within three months of a previous claim for the same item or within three months of a claim for other EPC review or contribution items.

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 - Item 731.

A.22.38 This item, including the components of the service, is similar to Item 729 (see A.22.33 to A.22.37 inclusive) except that:

- (a) this service is only available to residents of aged care facilities;
- (b) 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;

EPC Chronic Disease Management MBS items explanatory notes

- (c) 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;
- (d) 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
- (e) 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 EPC CDM items.

A.22.39 Where a resident's GP has contributed to a care plan prepared by the aged care facility or discharging hospital for the resident, the resident is eligible to access rebates under the allied health and dental care items (item numbers 10950 to 10977 inclusive).

Additional Information

A.22.40 Before proceeding with any EPC CDM service (other than a care plan contribution under items 729 and 731) the GP must ensure that:

- (a) 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;
- (b) 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
- (c) the patient's agreement to proceed is recorded.

Note that Medicare rebates are only payable for certain allied health and dental services, provided to the patient on referral from the patient's GP, after both a GPMP and TCA are in place and claimed on Medicare or after item 731 (for aged care residents) is in place and claimed on Medicare. Medicare rebates are not payable for allied health providers' involvement in contributing to the development of TCAs, multidisciplinary care plans, TCA reviews or multidisciplinary care plan reviews.

A.22.41 Before completing any EPC 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.

A.22.42 For the purpose of paragraphs A.22.1 to A.22.52:

- (a) "a chronic medical condition" is one that has been or is likely to be present for at least six months, including but not limited to asthma, cancer, cardiovascular illness, diabetes mellitus, mental health conditions (including dementia), musculoskeletal conditions and stroke;
- (b) "the patient's usual GP" 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; and
- (c) offering a copy of a documented GPMP, documented TCA or a reviewed or amended version of either of them to a patient should include, if the patient permits, offering a copy to their carer, where appropriate.

EPC Chronic Disease Management MBS items explanatory notes

A.22.43 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.

A.22.44 The GP Management Plan and Team Care Arrangements CDM items cover the consultations at which the relevant items are undertaken:

- (a) 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;
- (b) 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;
- (c) 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.

A.22.45 A benefit is not claimable and an account should not be rendered until all components of the relevant item have been provided.

A.22.46 Whenever an EPC chronic disease management service is available to a hospital private in-patient and is provided to that patient in a hospital, the Medicare voucher (assignment of benefit) or patient invoice must be marked accordingly. In-hospital services attract a Medicare rebate at 75% of the schedule fee. See 7.1.2(vi) of the General Explanatory Notes.

A.22.47 The care and treatment provided to the patient when implementing a GPMP or TCA (including when reviewed) should be provided through normal consultation items. The EPC chronic disease management items are not substitutes for normal medical care and treatment.

A.22.48 If a patient agrees, their informal or family carer may be involved in the preparation/review of the GPMP and/or the development/review of TCA, having regard to the patient's circumstances, the degree of support provided by the carer for the patient and the capacity of the carer to provide ongoing support to the patient and to participate in the relevant processes. The patient and their informal or family carer do not count as one of the minimum three members of the multidisciplinary team.

A.22.49 Where a patient changes practices, so that a GP in the new practice becomes the patient's usual GP, the new GP may use item 725 or item 727 to review the patient's existing GPMP or TCA, in accordance with the requirements of those items, at the request of the patient or their carer.

Exceptional circumstances

A.22.50 There are minimum time intervals for payment of rebates for EPC chronic disease management items (as detailed above), with provision for claims to be made earlier than these minimum intervals in exceptional circumstances. 'Exceptional circumstances' apply where there has been a significant change in the patient's clinical condition or care circumstances that require a new GPMP or TCA or a new review, rather than, for example, amending the existing GPMP or TCA.

EPC Chronic Disease Management MBS items explanatory notes

A.22.51 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.

Transitional Arrangements and Reviewing EPC Multidisciplinary Care Plans from 1 July 2005

A.22.52 Where a patient was being managed under an active EPC multidisciplinary care plan (Item 720 or 722) before 1 July 2005, that patient will be regarded as having both a GP Management Plan and Team Care Arrangements in place from the date on which the active multidisciplinary care plan was completed and claimed. In order to review an existing EPC multidisciplinary care plan from 1 July 2005, a GP can use the relevant CDM review items (a GPMP Review item, for review by a GP alone, or a TCA Review item, for review with input from a multidisciplinary team).