






Medicare Items for managing chronic disease



Introduction

- These presentation slides are abbreviated - GPs and others should refer to the MBS explanatory notes for details.
 - The CDM items replace the former Enhanced Primary Care (EPC) multidisciplinary care planning items.
 - The CDM items were developed in consultation with GP organisations, and commenced in July 2005.
 - They are intended to be provided by the patient's usual GP.
 - The CDM items include a service for 'GP only' care planning (the GP Management Plan) in addition to services for multidisciplinary care planning (Team Care Arrangements).
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The item numbers and fees

Name	Item no	Medicare fee (100%) Nov 07	Recommended frequency	Minimum claiming period
Preparation of a GP Management Plan	721	\$127.70	2 yearly	12 months*
Preparation of Team Care Arrangements	723	\$101.15	2 yearly	12 months*
Review of a GP Management Plan	725	\$63.85	6 monthly	3 months*
Coordination of Review of Team Care Arrangements	727	\$63.85	6 monthly	3 months*
Contribution to a multidisciplinary care plan	729	\$62.30	6 monthly	3 months*
Contribution to a multidisciplinary care plan by an Aged Care Facility	731	\$62.30	6 monthly	3 months*

*CDM services can be provided more frequently in 'exceptional circumstances'.




MBS Item 721 - GP Management Plan (GPMP)

- To be eligible for a GPMP, a patient must have a chronic (or terminal) medical condition.
 - Recommended frequency for a GPMP is once every two years, with regular reviews every six months.
 - GPMPs involve the GP (who may be assisted by their practice nurse or others) assessing the patient, agreeing management goals, identifying patient actions, treatment and ongoing management and documenting this and a review date in the plan.
 - GPMPs allow GPs to prepare care plans for eligible patients where the involvement of other health or care providers is not required.
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MBS Item 723 - Team Care Arrangements (TCA)

- TCAs are for patients with chronic or terminal medical conditions who require ongoing care from a multidisciplinary team.
 - Whether or not a patient is eligible for TCA is essentially a matter for the GP to decide.
 - Recommended frequency for a TCA is once every two years, with regular reviews every six months.
 - TCAs involve a GP (who may be assisted by a practice nurse), discussing/agreeing with the patient which providers should be involved, what information can be shared, collaborating with the participating providers on required treatments/services and documenting this and a review date in the patient's plan.
 - A GP can provide TCA without a GPMP. However, to be eligible for Medicare rebates for the five individual allied health services, a patient must be managed by a GP under both a GPMP and TCA.
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MBS Items 725 and 727 - Reviews

- These items are for patients who have a current GPMP/TCA and require a review of their plan.
 - Recommended frequency is once every six months or less if clinically required.
 - A review of a GPMP/TCA involves the GP (who may be assisted by a Practice Nurse) reviewing the patient's GPMP/TCA (in the case of a TCA, with the collaborating providers), documenting any relevant changes and setting the next review date.
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MBS Item 729 - GP contribution to care plans

- This item is for patients with a chronic medical condition who are having a **multidisciplinary** care plan prepared or reviewed for them by another health or care provider.
 - Recommended frequency is once every six months.
 - The contribution involves the GP (who may be assisted by their practice nurse or other) confirming the patient's agreement for the GP to contribute to the plan, collaborating with the person preparing or reviewing the plan and including the GP's contribution in the patient's records.
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MBS Item 731 - contribution to care plans for residents of aged care facilities

- This item is for a GP to contribute to a **multidisciplinary** care plan for a resident of an aged care facility at the request of the facility.
 - Recommended frequency is once every six months.
 - Where a GP has contributed to an aged care resident's multidisciplinary care plan, the resident is eligible for Medicare rebates for up to five individual allied health services and eight type 2 diabetes group items each calendar year.
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CDM Items and Service Incentive Payments

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


* The GPMP item should not be claimed within 12 months of an asthma SIP, other than in exceptional circumstances.

** 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 GPMP 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.




Advantages of CDM Items

- Easy to use with simple MBS requirements
 - Enhanced role for practice nurses and AHWs
 - GPMP is widely accessible for patients with chronic or terminal conditions
 - GPs can prepare care plans without having to collaborate with other providers, but MBS funds collaboration where required
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Advantages of CDM Items (cont)

- Flexibility in claiming frequency
 - Access to allied health (individual and group) services
 - GPs can prepare (for private patients) or contribute (public & private patients) to discharge plans, including for aged care residents
 - The items support the use of templates, checklists and best practice models.
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MBS Item 10997 - Practice Nurse & Aboriginal Health Worker monitoring & support

- This covers the provision of monitoring and support to people with a chronic disease by a practice nurse or registered Aboriginal health worker, on behalf of a GP.
 - The item is available to people with a chronic disease who have a GPMP, TCA, or Multidisciplinary Care Plan.
 - A maximum of 5 services can be claimed per patient per year.
 - The item may be used to provide:
 - Checks on clinical progress;
 - Monitoring medication compliance;
 - Self management advice; and
 - Collection of information to support GP reviews of Care Plans.
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MBS Items 10950 to 10970 - Allied health items

- These items are for patients who have both a GPMP and TCA in place (item 721 or 725; *and* item 723 or 727).
 - Aged care residents can access allied health items where their GP contributes to their multidisciplinary care plan.
 - The items provide access to five individual allied health services per calendar year (Medicare rebate of \$47.85 per service).
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MBS items 81100 to 81125 - Type 2 diabetes

- These items are for patients who have type 2 diabetes and have in place:
 - A GPMP (item 721) or a review (item 725); or
 - For aged care residents, a multidisciplinary care plan to which the GP has contributed (or contributed to its review) (item 731).
 - They provide access to one assessment and up to eight group services (provided by a diabetes educator, exercise physiologist or dietitian) each calendar year.
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MBS Item 713 - Type 2 diabetes risk evaluation

- The Council of Australian Governments (COAG) has announced a Type 2 Diabetes Prevention Program.
 - The Commonwealth's contribution to this agenda includes the introduction of a new Medicare Benefits Schedule (MBS) item number for people aged 40-49 years who are at high risk of developing type 2 diabetes.
 - Subsidised Lifestyle Modification Programs will also be available for patients at high risk.
 - Item 713 commenced on 1 July 2008.
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Further information

- Key information is available at:
 - www.health.gov.au (follow the A-Z index and 'C' for 'Chronic Disease Management')

