

New CDM Item Numbers Kit

New Medicare Chronic Disease Management items replace Enhanced Primary Care (EPC) care planning items from 1 July 2005



SUTHERLAND DIVISION OF GENERAL PRACTICE

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New Medicare Chronic Disease Management items replace Enhanced Primary Care (EPC) care planning items from 1 July 2005

From 1 July 2005 new items on the Medicare Benefits Schedule will make it easier for GPs to manage the health care of patients with chronic medical conditions, including patients needing multidisciplinary care.

These items have been developed in close consultation with GP organisations. The new Chronic Disease Management items significantly increase care planning options for GPs, as well as expanding patient eligibility and increasing the assistance that practice nurses and others can provide. They also provide more flexibility in who can provide review services.

The new items will replace the existing Enhanced Primary Care items for multidisciplinary care planning services. The superseded items will be retained until 1 November 2005 so that services commenced but not finished by 1 July 2005 can be completed.

Overview of the changes

The new 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).

Patients who have a chronic or terminal condition (without multidisciplinary care needs) can have a GP Management Plan service. Patients who also have complex care needs can have a GP Management Plan, and a Team Care Arrangements service. GPs can be assisted by practice nurses, aboriginal health workers and other health professionals in providing the new CDM items.

The new items

There are six new CDM items:

Preparation of a GP Management Plan (Item 721)

- Provides a rebate for a GP to prepare a management plan for a patient with a chronic or terminal condition (including patients who have multiple chronic conditions and multidisciplinary care needs).
- Recommended frequency is once every two years, supported by regular review services.
- The Medicare fee is \$122.40
- The GP (who may be assisted by their practice nurse or other) assesses the patient, agrees management goals, identifies actions to be taken by the patient, identifies treatment and ongoing services to be provided, and documents these in the GP Management Plan.

Review of a GP Management Plan (GPMP - Item 725)

- Provides a rebate for a GP to review a GP Management Plan (see above).
- Practice nurse or other can assist.
- Recommended frequency is once every six months; can be earlier if clinically required.
- The Medicare fee is \$61.20
- Involves reviewing the patient's GP Management Plan, documenting any changes and setting the next review date.

Coordination of Team Care Arrangements (TCA - Item 723)

- Provides a rebate for a GP to coordinate the preparation of Team Care Arrangements for a patient with a chronic or terminal medical condition who also requires ongoing care from a multidisciplinary team of at least three health or care providers.
- In most cases the patient will already have a GP Management Plan in place but this is not mandatory.
- Recommended frequency is once every two years, supported by regular review services.
- The Medicare fee is \$96.90.
- Involves a GP (who may be assisted by their practice nurse or other) collaborating with the participating providers on required treatment/services and documenting this in the patient's TCA.

Coordination of a Review of Team Care Arrangements (Item 727)

- For patients who have a current TCA and require a review of their TCA.
- Recommended frequency is once every six months; can be earlier if clinically required.
- The Medicare fee is \$61.20
- Involves the GP (who may be assisted by their practice nurse or other) collaborating with the participating providers on progress against treatment/services and documenting any changes to the patient's TCA.

Contribution to a multidisciplinary care plan being prepared by another health or care provider (Item 729)

- For patients who are having a multidisciplinary care plan prepared or reviewed by another health or care provider (other than their usual GP).
- Recommended frequency is once every six months; can be earlier if clinically required.
- Medicare fee is \$42.50
- Involves the GP (who may be assisted by their practice nurse or other) collaborating with the providers preparing or reviewing the plan and including their contribution with the patient's records.

Contribution to a multidisciplinary care plan being prepared by another health or care provider for a resident of an aged care facility (Item 731)

- This is for patients in residential aged care facilities and is otherwise identical to Item 729 (immediately above).

Access to allied health and dental care items

Patients who have both a GP Management Plan and a Team Care Arrangements service (which, together, are broadly equivalent to a current EPC multidisciplinary care plan) have access to the allied health and dental care items on the Medicare Benefits Schedule, as do patients who previously had an EPC care plan (Item 720 or 722).

Similarly, residents of aged care homes whose GP has contributed to a care plan prepared by the aged care home (item 730 or new item 731) will continue to have access to the allied health and dental care items.

Eligible patients can claim a maximum of **5 allied health and three dental care services per 12 month period**.

Patients need to be referred by their GP for services recommended in their care plan on an *EPC Program referral form for allied health services under Medicare*. Where the GP is referring a patient to more than one allied health professional, s/he will need to use a **separate** form for each referral.

The form, which will be amended from 1 July (to refer to the new CDM items) can be found at

www.hic.gov.au/providers/incentives_allowances/medicare_initiatives/allied_health.htm or ordered by calling 1800 067 307.

Patients with pre-1 July 2005 multidisciplinary care plans

In order to review an existing EPC multidisciplinary care plan (Item 720 or 722) from 1 July 2005, a GP can use either a GP Management Plan Review item, item 725, (for review by a GP without team input) or a Team Care Arrangements review item, item 727 (for review with input from a multidisciplinary team).

What to do if an EPC care planning service was commenced but not completed by 1 July 2005

If an EPC care planning service was commenced before 1 July 2005 but not completed and claimed by that date, the service should be completed and claimed for using the pre-1 July EPC item number.

Further information

More detailed information on the CDM items is available at www.health.gov.au - use the A-Z Index to go to chronic disease management, or can be ordered by calling (02) 6289 8735. Detailed information on the allied health items (including information on eligible providers) is available at www.hic.gov.au/providers/incentives_allowances/medicare_initiatives/allied_health.htm

CDM Explanatory Notes November 2005

A.22 Chronic Disease Management Items (Items 721 to 731)

A.22.1 This note refers to new Enhanced Primary Care (EPC) Chronic Disease Management (CDM) items. These new items replace the former items for multidisciplinary care planning services - items 720, 722, 724, 726, 728 and 730.

A.22.2 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 were developed in consultation with GP groups to improve the operation of the EPC items and reduce red tape.

A.22.3 Where patients have existing EPC multidisciplinary care plans, it is not necessary to prepare a new plan using the new items until required by the patient's circumstances. EPC multidisciplinary care plans can be reviewed using the new CDM review items. (See A.22.51 for more information on transitional arrangements).

A.22.4 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.22.5 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;
- 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); and
- 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. 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 and/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.

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 also 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.

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 all of the patient's 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 Depending on variations in patients' needs, a new GPMP may be required around once every two years, with regular reviews (recommended six monthly) of the patient's progress against the plan. In general, a new GPMP should not be prepared unless required by the patient's condition, needs and circumstances, however, the minimum claiming interval for this item is twelve monthly, to allow for completion of a new GPMP where required. This means that a rebate will not be paid within twelve months of a previous claim for a GPMP, within twelve months of a claim for former 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.22.49 and A.22.50).

COORDINATING THE DEVELOPMENT OF TEAM CARE ARRANGEMENTS (TCA) - (Item 723)

A.22.15 This item is for patients with a chronic or terminal medical condition and who require ongoing care from a multidisciplinary team of their GP and at least two other health or care providers. 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, any actions to be taken by the patient 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, 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.

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 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 minimum two 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.22.47).

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 Depending on variations in patients' needs, a new TCA may be required around once every two years, with regular reviews (recommended six monthly) of the patient's progress against the plan. In general, a new TCA should not be prepared unless required by the patient's condition, needs and circumstances, however, the minimum claiming interval for this item is twelve monthly, to allow for completion of a new TCA where required. This means that a rebate will not be paid within twelve months of a previous claim for a TCA, within twelve months of a claim for former 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.22.49 and A.22.50).

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:

- 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 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 patient has changed practices) has coordinated a systematic team-based 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.

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.22.49 and A.22.50).

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;
- (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, arthritis and musculoskeletal conditions;

(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.

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, noting that:

(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.

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 (eg separate consultation clinically required/indicated).

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 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.22.48 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 as appropriate 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.22.49 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.

A.22.50 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 (eg annotated as clinically indicated, discharge, exceptional circumstances, significant change etc).

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

A.22.51 Where a patient was being managed under an active EPC multidisciplinary care plan (former Item 720 or former Item 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 of a GPMP, or a TCA Review item for team-based review of a TCA).

CDM Item Descriptors November 2005

	GROUP A15 - GP MANAGEMENT PLANS, TEAM CARE ARRANGEMENTS, MULTIDISCIPLINARY CARE PLANS AND CASE CONFERENCES
	SUBGROUP 1 - GP MANAGEMENT PLANS, TEAM CARE ARRANGEMENTS AND MULTIDISCIPLINARY CARE PLANS
721	<p>PREPARATION by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) of a GP MANAGEMENT PLAN for a patient (not being a service associated with a service to which items 734 to 779 apply).</p> <p>A rebate will not be paid within twelve months of a previous claim for the same item or former item 720, or within three months of a claim for items 725, 727, 729 or 731, except where there has been a significant change in the patient's clinical condition or care circumstances that requires the preparation of a new GP Management Plan. (See para A.22 of explanatory notes to this Category)</p> <p>Fee: \$122.40 Benefit: 75% = \$91.80 100% = \$122.40</p>
723	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) to COORDINATE the development of TEAM CARE ARRANGEMENTS for a patient (not being a service associated with a service to which items 734 to 779 apply).</p> <p>A rebate will not be paid within twelve months of a previous claim for the same item or former item 720, or within three months of a claim for item 727, except where there has been a significant change in the patient's clinical condition or care circumstances that requires the coordination of new Team Care Arrangements. (See para A.22 of explanatory notes to this Category)</p> <p>Fee: \$96.90 Benefit: 75% = \$72.70 100% = \$96.90</p>
725	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) to REVIEW:</p> <p>(a) a GP MANAGEMENT PLAN prepared by that medical practitioner (or an associated medical practitioner) to which item 721 applies; or</p> <p>(b) a multidisciplinary community care plan to which former item 720 applied, or a multidisciplinary discharge care plan to which former item 722 applied, prepared by that medical practitioner (or an associated medical practitioner); (not being a service associated with a service to which items 734 to 779 apply).</p> <p>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 721, except where there has been a significant change in the patient's clinical condition or care circumstances that requires the preparation of a new review of a GP Management Plan. (See para A.22 of explanatory notes to this Category)</p> <p>Fee: \$61.20 Benefit: 75% = \$45.90 100% = \$61.20</p>
727	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) to COORDINATE a REVIEW of</p> <p>(a) TEAM CARE ARRANGEMENTS coordinated by that medical practitioner (or an associated medical practitioner) to which item 723 applies; or</p> <p>(b) a multidisciplinary community care plan to which former item 720 applied or a multidisciplinary discharge care plan to which former item 722 applied, prepared by that medical practitioner (or an associated medical practitioner); (not being a service associated with a service to which items 734 to 779 apply).</p>

	<p>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, except where there has been a significant change in the patient's clinical condition or care circumstances that requires the coordination of a new review of Team Care Arrangements. <i>(See para A.22 of explanatory notes to this Category)</i> Fee: \$61.20 Benefit: 75% = \$45.90 100% = \$61.20</p>
729	<p>CONTRIBUTION by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) to a multidisciplinary care plan prepared by another provider or to a REVIEW of a multidisciplinary care plan prepared by another provider (not being a service associated with a service to which items 734 to 779 apply).</p> <p>A rebate will not be paid within twelve months of a claim by the same practitioner for item 721 or 723, within three months of a claim for the same item or within three months of a claim for item 725, former item 726, item 727, former item 728 or item 731, except where there has been a significant change in the patient's clinical condition or care circumstances that requires a new contribution to the multidisciplinary care plan. <i>(See para A.22 of explanatory notes to this Category)</i> Fee: \$42.50 Benefit: 100% = \$42.50</p>
731	<p>CONTRIBUTION by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) to:</p> <p>(a) a multidisciplinary care plan for a patient in A RESIDENTIAL AGED CARE FACILITY, prepared by that facility, or to a REVIEW of such a plan prepared by such a facility; or (b) a multidisciplinary care plan prepared for a resident by another provider before the resident is discharged from a hospital or an approved day-hospital facility, or to a review of such a plan prepared by another provider; (not being a service associated with a service to which items 734 to 779 apply).</p> <p>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 721, 723, 725, 727, 729 or former item 730, except where there has been a significant change in the patient's clinical condition or care circumstances that requires a new contribution to the multidisciplinary care plan. <i>(See para A.22 of explanatory notes to this Category)</i> Fee: \$42.50 Benefit: 100% = \$42.50</p>

Checklist for GPs - Coordinating Team Care Arrangements (TCA) - MBS Item 723

- GPs coordinating a TCA should refer to Medicare item 723 and the relevant Medicare Benefits Schedule (MBS) explanatory notes before using this checklist - see www.health.gov.au/chronicdisease.
- Use of this checklist is not mandatory.
- Checklists for all CDM items are available at the above website.

1. Eligibility	
This service is available to patients in the community and to private in-patients (including residents of aged care facilities) being discharged from hospital (see Medicare Item Note A.22.22).	
This service is <u>not</u> available to public in-patients being discharged from hospital or residents living in an aged care facility.	
This service is for patients with a chronic or terminal medical condition <u>and</u> who require ongoing care from a multidisciplinary team. [See Medicare Item Note A.22.15].	
Patients with a TCA (item 723) and a GP Management Plan (GPMP - item 721) are eligible for rebates under the allied health and dental care items (nos. 10950 to 10977) - see Medicare Item note A.22.20 for details.	
2. Pre TCA	
Would the patient benefit by having TCA?	<input type="checkbox"/> Mandatory
Explain the steps and any costs involved in a TCA to the patient	<input type="checkbox"/> Mandatory
Record the patient's agreement to proceed	<input type="checkbox"/> Mandatory
Obtain relevant information (eg GPMP, previous care plans)	<input type="checkbox"/> Recommended
3. Team Care Arrangements (TCA)	
This includes the steps as per Note A22.17 in the MBS:	
• Discuss with the patient which treatment/service providers should be asked to collaborate with the GP in completing TCA	<input type="checkbox"/> Mandatory
• Gain the patient's agreement to share relevant information	<input type="checkbox"/> Mandatory
• Contact the proposed providers and obtain their agreement to participate	<input type="checkbox"/> Mandatory
• Collaborate with the participating providers to discuss potential treatment/services to achieve management goals for the patient	<input type="checkbox"/> Mandatory
• Document the goals, the collaborating providers, the treatment/services they have agreed to provide, patient actions and a review date i.e. complete the TCA document (may be documented as an addition to the patient's GPMP)	<input type="checkbox"/> Mandatory
Offer a copy of the TCA to the patient (and their carer if the patient consents)	<input type="checkbox"/> Mandatory
Provide relevant parts/a copy of the TCA to the other providers in the team	<input type="checkbox"/> Mandatory
Copy of the TCA added to patient's medical record	<input type="checkbox"/> Mandatory
With patient's agreement, provide copy of TCA or relevant parts to other providers involved in the patient's care.	<input type="checkbox"/> As appropriate
Use an EPC Program referral form for allied health services under Medicare when referring patients to allied health professionals.	<input type="checkbox"/> Mandatory (if referring)
4. Ongoing Management and Review	
Manage the patient's needs through normal consultations and regular review, using TCA Review (MBS Item 727) or GPMP Review (MBS Item 725) as appropriate	<input type="checkbox"/> As indicated

CDM Items Questions and Answers to 22 August 2008

Questions and answers previously published on the CDM web page are consolidated below and grouped under the following headings:

INTRODUCTION

CHRONIC CONDITIONS

CONCLUDING A CDM SERVICE

GP MANAGEMENT PLAN SERVICE

TEAM CARE ARRANGEMENTS SERVICE

TCA TEAM MEMBERS

SIPS AND CDM ITEMS

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OTHER CLAIMING ISSUES

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PRACTICE NURSE ETC ASSISTING GPs

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OTHER RESOURCES

INTRODUCTION

What are the benefits of care planning?

Care planning helps in coordinating the services and treatment that a patient requires. It can be used as a tool for organising all of the care a patient needs and can help reduce the need for ad hoc, episodic consultations. It both enables and legitimises GPs in taking a proactive role managing the health care required by their patients, including through regular reviews.

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 by identifying any actions the patient might take to help achieve the goals of treatment.

New research (see report in *Medical Observer*, 20 May 2005) has showed that care plans have a positive impact on patient care and outcomes. Research conducted by the Centre for General Practice Integration Studies, University of NSW, found more patients were managed in line with national diabetes care guidelines in the year following a care plan. It also found there was a significant improvement in HbA1c, blood pressure and total cholesterol levels where a care plan was implemented and where there were at least two other providers involved in the patient's care.

What are the new CDM items?

They are new care planning items which replace the former EPC multidisciplinary care planning items. They apply to a wider range of patients and make it easier for GPs to manage the care of patients with chronic medical conditions, including patients needing multidisciplinary, team-based care.

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

How are the new CDM items different from the EPC care planning items?

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

GPs are able to use their practice nurse, Aboriginal Health Worker or other health professional to assist them in chronic disease management using the new items.

Patients with a chronic or terminal condition without multidisciplinary care needs are eligible for the GP Management Plan items able to be provided by their GP.

Patients with a chronic or terminal condition **and** complex care needs are eligible for both the GP Management Plan items and the add-on Team Care Arrangements items (provided by the GP in collaboration with at least two other providers). This maintains access to the allied health and dental care items introduced in July 2004 as one of the Government's measures to strengthen Medicare.

Restrictions on who can review a care plan have been relaxed, so that a GP Management Plan 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 review services within these minimum time limits if there have been significant changes in the patient's condition or care circumstances.

Are GP Management Plans available to more patients than the current EPC multidisciplinary care plans?

Yes. GP Management Plans are available to all patients with a chronic medical condition - they do not need to have complex care needs (as required for the former EPC care planning items).

Patients with chronic medical conditions and complex needs are eligible for GP Management Plans and the additional Team Care Arrangements item.

What are the new items and fees for the CDM services?

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. For these patients, a GP Management Plan and Team Care Arrangements, together, broadly equate to an EPC multidisciplinary plan.

The Medicare fees for the new items have been settled in consultation with GP organisations and have their unanimous agreement.

Name	Item No	Medicare Fee(100%) Nov 2005	Recommended frequency	Minimum Claiming Period*
Preparation of a GP Management Plan	721	\$122.40	2 yearly	12 months*
Preparation of Team Care Arrangements	723	\$96.90	2 yearly	12 months*
Review of a GP Management Plan	725	\$61.20	6 monthly	3 months*
Coordination of Review of Team Care Arrangements	727	\$61.20	6 monthly	3 months*
Contribution to a multidisciplinary care plan	729	\$42.50	6 monthly	3 months*
Contribution to a multidisciplinary care plan by an Aged Care Facility	731	\$42.50	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.*

Are the new CDM items eligible for 100% Medicare and bulk billing incentives?

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

Where CDM services are bulk-billed for eligible patients (ie Commonwealth concession card holders or children aged under 16), the services also attract the relevant bulk-billing incentive payment.

How do these changes affect access by patients to allied health and dental care items?

Access to allied health and dental care items (Medicare Items 10950 to 10977) will be available to patients who have both a GP Management Plan and Team Care Arrangements in place. A GP Management Plan and Team Care Arrangements together broadly equate to an EPC multidisciplinary care plan.

Similarly, residents of aged care homes whose GP has contributed to a care plan prepared by the aged care home (item 730 or new item 731) will continue to have access to the allied health and dental care items.

This maintains current access arrangements whereby Medicare rebates for certain allied health and dental care services will continue to be targeted to patients with multidisciplinary care needs. No other changes have been made to the Medicare requirements for the allied health and dental care items.

What happened to the EPC care planning items?

The new CDM items replace the existing EPC items for multidisciplinary care planning services - items 720, 722, 724, 726, 728 and 730, which were withdrawn from the MBS from 1 November 2005. GPs should use the new items when preparing, reviewing or contributing to chronic disease management plans.

Where patients have existing care plans it is not necessary to prepare a new chronic disease management plan using the new items until required by the patient's circumstances.

What about patients who already have an EPC multidisciplinary care plan in place?

Their care plans remain in place. They continue to have access to the allied health and dental items. Where patients have existing care plans it is not necessary to prepare a new chronic disease management plan using the new items until required by the patient's circumstances.

A GP who proposes to review an existing EPC multidisciplinary care plan can use either a GP Management Plan Review item, item 725 (for review by a GP without team input) or a Team Care Arrangements review item, item, 727 (for review with input from a multidisciplinary team).

The Overview paragraph in the explanatory notes (A.22.6) refers to contribution to a multidisciplinary care plan or contribution to a review of a multidisciplinary care plan but I understand that Care Plans as such no longer exist; the items are now for Management Plans and Team Care Arrangements. Is this not the case?

A; When a GP contributes to a "multidisciplinary care plan" the person or organisation preparing the 'care plan' will in most cases not be claiming a CDM item rebate for the service, for example, when a hospital is preparing a care plan for a patient being discharged or an aged care home is preparing a care plan for a resident. Other than the requirements from the contributing GP's perspective that these plans are multidisciplinary and prepared for eligible patients, they don't have to necessarily meet MBS requirements (ie the requirements for a TCA or a review of a TCA). This is why they are described as multidisciplinary care plans (which could include TCAs). If these plans were defined only as TCAs, this would restrict the types of care plans that GPs could contribute to.

CHRONIC CONDITIONS

What 'conditions' should be regarded as 'chronic medical conditions' for the purposes of eligibility for GP Management Plans?

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, mental health conditions (including dementia), musculoskeletal conditions and stroke. Patients who also have complex care needs are eligible for Team Care Arrangements.

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.

Recent 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, hypercholesterolaemia, 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 also recognized, 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.

CONCLUDING A CDM SERVICE

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

The MBS notes for the CDM items explain that:

'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.

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.'

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

(In addition to ensuring that the patient's agreement to proceed is recorded, 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 also 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 (in some cases this may involve having to scan the signed page back into the system, reprint it and then offer it to the patient), or whether a printed (ie unsigned) copy of the GPMP and TCA off the system is sufficient.

GP MANAGEMENT PLAN SERVICE

What are the steps in the GP Management Plan Service (Item 721)?

Preparing a GPMP includes:

- assessing the patient to identify and/or confirm 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.

Where a patient has a number of chronic conditions or a combination of chronic and/or terminal conditions, should they have a GPMP for each condition?

Concurrent GP Management Plans are not envisaged under the new arrangements, which is why the claiming restrictions in the item descriptor for item 721 commence with the words "A rebate will not be paid within twelve months of a previous claim for the same item or item 720". A GP Management Plan should address all of the patient's health care needs; it would not be useful or appropriate to prepare separate additional plans for each condition the patient may have.

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.

TEAM CARE ARRANGEMENTS SERVICE

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 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 (eg 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).

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 either the GP Management Plan or TCA Review items as appropriate, and ongoing management and care should be provided through normal consultation items.

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.

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

Does the TCA need to be an entirely separate document to the GPMP or can the additional information that forms the TCA be added onto the GPMP to prevent unnecessary duplication?

Provided the relevant information is documented (see explanatory notes), it can be included as an addition to the patient's GPMP eg 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.

TCA TEAM MEMBERS

Can a pharmacist qualify to be 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 for.)

Under what circumstances can a Practice Nurse be one of the three minimum members of a multidisciplinary TCA team?

If the practice nurse is providing ongoing treatment or services to the patient in her/his own right that is 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 practice nurse is providing general practice services on behalf of the patient's GP, and not independently providing different ongoing treatment or services to the patient in their own right, they would not qualify as one of the three independent members of the team.

SIPS AND CDM ITEMS

Can I use the new CDM items and also claim a Service Incentive Payment (SIP) for the same patient?

The SIPs for asthma and mental health incorporate the development of a plan to help the patient manage their condition. It would not be appropriate to claim both the SIP and an item for preparation of a GP Management Plan for the same patient - GPs should choose which of these two services to provide and claim only one.

Patients with diabetes may benefit from a GP Management Plan. They are likely to also benefit from the best practice annual cycle of care for patients with diabetes (as set out in the guidelines distributed to GPs under the National Integrated Diabetes Program). When completing the annual 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.

Where a patient has complex, multidisciplinary needs that extend beyond the management of their asthma, diabetes or mental health condition as part of the three step process or cycle of care, it may be appropriate to develop a GP Management Plan and a Team Care Arrangements for the patient. In this case, these items can be claimed in addition to the relevant SIP, provided the requirements of both services are met.

Will the current Service Incentives Payments (SIP) under the Practice Incentives Program (PIP) continue?

Current SIP payments for best practice care of patients with asthma, diabetes or mental health will continue to be available. The new 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, diabetes and mental health conditions.

As the new CDM items bed down over the next few years, their impact on management of chronic disease will be assessed, including on the continued need for separate disease specific items. Any change to the current SIP items as a result would be considered in consultation with GPs and other key chronic disease stakeholders.

How can patients with asthma, diabetes or mental health benefit from the new 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, not restricted to practices participating in the PIP that have signed up for the SIPs.

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.

As Medicare items, incentives for chronic disease management using the new items are built directly into the Medicare fee, are transparent to the patient, and are paid 'up-front' as part of the Medicare system.

In web site Q&As it says that you can claim either a CDM items or SIP but not both. Is this true?

In relation to the GP Management Plans and the asthma and mental health SIPs, the 3 step/visit processes both include a planning component and it would not be appropriate to also claim a CDM item for preparation of a GP Management Plan when this work is encompassed in the SIP.

In relation to diabetes it may be appropriate to prepare a GP Management Plan but not to claim both a GPMP review item (item 725) and a diabetes SIP at the same time. Only one and not both of these services should be claimed. If a GP Management Plan is prepared for a patient with diabetes it should set out the care and treatment required for the patient. The review of that plan is an opportunity for a systematic review of progress against the plan, including whether the required treatment and services have been provided. There is a substantial overlap with this service and claiming for completion of a cycle of care through the SIP item, and it would not be appropriate to claim both - GPs should choose either the review item or the SIP trigger item.

Can a GP Management Plan and a Service Incentive Payment (SIP) be claimed for a patient with co-morbidities, eg a patient with both moderate to severe asthma and cardiovascular disease; or a patient with depression and cancer?

While in theory it would be possible to claim both a GPMP and the relevant SIP in such cases, in practice it would involve claiming two items for overlapping services.

If a patient is being managed under a GP Management Plan, the plan should address all of the patient's health care needs, problems and relevant conditions. This should include needs arising from any co-morbidities, and would normally encompass the care to be provided under an Asthma 3+ Visit Plan or a 3 Step Mental Health Process. If a GP chooses to provide managed care for such a patient through a GP Management Plan it would not normally be expected that a SIP item would also be claimed.

If a patient is being managed under a GP Management Plan and Team Care Arrangements to address their complex needs, they may be eligible for the relevant SIP as well. Patients with co-morbidities and complex needs that extend beyond the management of their asthma, diabetes or mental health condition are likely to benefit from a GP Management Plan and Team Care Arrangements. If a GP chooses to provide team-based care in this case, the CDM items can be claimed in addition to the relevant SIP provided the requirements of both services are

met. Note that it would not be appropriate however, to review the GP Management Plan or Team Care Arrangements at the same time as completing/claiming for the SIP. As a guide the SIP item and the GP Management Plan or Team Care Arrangements review item should not be claimed within three months of each other.

Where a GP Management Plan and Team Care Arrangements, and a SIP item, are being provided to an eligible patient, it is not necessary to annotate the patient's invoice/Medicare voucher to indicate this.

Can a GP Management Plan and SIP (for diabetes) be claimed on 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 established 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 (ie as set out in the plan) at twelve months. When completing an annual 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.

If a patient with established diabetes is managed under a GP Management Plan and GPMP reviews, does this trigger SIP payments and associated practice-based diabetes outcomes payments, and generate data for Divisional performance indicators?

No. When completing an annual cycle of care for a patient with established diabetes GPs should choose to use either the relevant diabetes SIP 'trigger' item, or the GP Management Plan review item, but not both. Due to system limitations, the GPMP review item is not able to trigger SIP or associated outcomes payments.

If a patient is being managed through a 3 Step Mental Health Process how long before a GP Management Plan can be prepared for them?

If the 3 Step Mental Health Process has worked successfully for the patient it may be unlikely that a GP Management Plan is also needed. As both interventions aim to achieve substantially the same result, it is unlikely that both will be required, at least in close proximity and barring any significant change in the patient's condition or circumstances - GPs should choose which of the two services is most appropriate in the patient's circumstances.

Can a GP conduct an annual cycle of care and thus complete a diabetes SIP trigger for a patient in the same period of time (ie within the same year) that he/she developed a GPMP, or must they choose one or the other?

Yes, a GP can prepare a GP Management Plan for a patient and then provide an annual 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 either 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.

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 (ie the minimum period for claiming a GPMP review item).

Can't claim SIPs and GPMP on the same day? However, can claim SIP and GPMP/TCA package on same day?

See earlier questions. A GP Management Plan and a diabetes SIP can be claimed on the same day, but only one of either a GP Management Plan review item or a diabetes SIP should be claimed on the same day. For patients with asthma or a mental health condition the GP should choose between preparing a GP Management Plan or using and claiming for the relevant SIP.

Patients with co-morbidities and complex needs that extend beyond the management of their asthma, diabetes or mental health condition are likely to benefit from a GP Management Plan and Team Care Arrangements. In this case, these items can be claimed in addition to the relevant SIP, provided the requirements of both services are met. It is unlikely that the items and the SIPs would be claimed on the same day, however, as the preparation of a GP Management Plan and Team Care Arrangements both involve a number of steps, including collaboration with other providers for the TCA.

CLAIMING COMBINATIONS OF ITEMS

Can a GPMP and a TCA both be claimed at the same time?

By 'the same time' I assume you mean claimed on the same day (and not claiming two items for the same service). Provided the two services are delivered as per the Medicare items and explanatory notes they could be claimed on the same day. However, in most 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, and then documenting the goals, the collaborating providers, the treatment/services they have agreed to provide, patient actions and a review date. Note also that a TCA is intended to be done after a GPMP; where both items are claimed the TCA should be claimed after the GPMP.

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

A: The answer to this question is the same as the one above i.e. the claiming restrictions don't prohibit the two being claimed on the one day but it is unlikely in most cases 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.

If you use Items 721---731, are you able to claim an attendance item at the same time if you satisfy the descriptor in the MBS Schedule book?

See paragraph A.22.44 of the Explanatory Notes:

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

- (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;

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 (eg separate consultation clinically required/indicated).

Can a standard consultation and a GP Management Plan (item 721) be billed for the same patient on the same day?

A separate consultation should not be billed with a GPMP, TCA or review of either service unless it is clinically indicated that a problem must be treated immediately; or the GPMP was not the purpose of the consultation. Accounts that include both a CDM item and a consultation must be annotated accordingly.

CLAIMING TIME PERIODS

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 2005	Recommended frequency	Minimum Claiming Period*
Preparation of a GP Management Plan	721	\$122.40	2 yearly	12 months*
Preparation of Team Care Arrangements	723	\$96.90	2 yearly	12 months*
Review of a GP Management Plan	725	\$61.20	6 monthly	3 months*
Coordination of Review of Team Care Arrangements	727	\$61.20	6 monthly	3 months*
Contribution to a multidisciplinary care plan	729	\$42.50	6 monthly	3 months*
Contribution to a multidisciplinary care plan by an Aged Care Facility	731	\$42.50	6 monthly	3 months*

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, within twelve months of a claim for former 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 CDM MBS notes A.22.49 and A.22.50).

***Exceptional circumstances** - 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.

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 (eg 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.

OTHER CLAIMING ISSUES

Does the A22.14 exclusion of any other chronic disease management item include case conferencing?

No. A chronic disease management item is one of the new items 721, 723, 725, 727, 729 and 731.

Q4. Does the bulk billing incentive apply to a 721 and a 723 service if both are claimed at the same time?

Yes, if the services are provided to eligible patients.

Are the new CDM items eligible for 100% Medicare and bulk billing incentives?

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

Where CDM services are bulk-billed for eligible patients (ie Commonwealth concession card holders or children aged under 16), the services also attract the relevant bulk-billing incentive payment.

Can you please explain if any GP can now do a CDM review how do they check whether one has already been completed (ie if the patient was not totally aware that one had been done or if the patient forgot)?

The reviewing GP, if not the original GP or one from the same practice, needs to 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, the patient (or their representative) can, whilst at the practice, ring the Medicare Enquiry Line 13 2011 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 720 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.

ALLIED HEALTH REBATES

If a GP writes a GP Management Plan and a Team Care Arrangement plan - and refers the patient for five allied health visits - at the end of the 12 month period can the GP refer the patient for another five allied health visits under the Plans that were written in the last 12 month period? - as the recommended frequency for a TCA is only every two years. What triggers the next lot of referrals for AHP?

A GP does not need to prepare a new GPMP or TCA (or both) in subsequent years in order for patients to continue to be eligible in those subsequent years for the allied health items. Once a patient has received an EPC multidisciplinary care planning service (one of the pre 1 July 2005 care plan preparation items), or both a GPMP and TCA, or a GP contribution to a care plan for an aged care resident, they are eligible for the allied health and dental 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 allied health referral forms.

PRACTICE NURSE ETC ASSISTING GPs

The CDM MBS notes provide:

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.

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, not as part of a separate Medicare item. 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 new items should help free up GPs' time by encouraging an expanded role in EPC care planning for practice nurses/other health professionals. The new 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.

Who can actually assist a GP with the CDM items e.g. are there minimum qualifications, can a GP's receptionist provide this assistance?

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. 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 logistics of arrangements etc, it would not be appropriate for a receptionist to assess the patient or identify their health and care needs.

Can the practice nurse, under instructions from the GP, do the collaboration with other providers?

The GP must see the patient as part of the preparation of the TCA. In general the GP is also 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, but noting that the means of communication used must enable privacy to be safeguarded in relation to patient information). 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 judgement of the GP, such that the practice nurse can confidently communicate about them on the GP's behalf with the other providers, then the PN 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.

Is the practice nurse required to see/consult with the patient as part of their role in helping develop the plan or can the nurse examine the medical record and draft a plan for the GP to complete in the presence of the patient?

Activities that a practice nurse or other health professional may undertake in assisting the GP are not prescribed. They could assist, for example, 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.

Can a nurse employed outside the GP's practice play a role in development of GPMPs and TCAs eg. respiratory nurse from the local area health service where the GP is participating in a structured management program for a particular group of patients?

The expectation is that in preparing a GPMP or TCA the GP may be assisted by their practice nurse 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 doesn't 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.

THE FUTURE

Will the CDM items be reviewed?

Yes, there will be a review of the items after an initial period of operation (around 2 years), and a full evaluation after around 4 years. The initial review will include assessing links between the CDM items and the allied health items, and the SIPs.

OTHER RESOURCES

What information is available to help GPs with the new 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 (and use the A-Z Index tool to go to Chronic Disease Management). GPs can also contact the Department of Health and Ageing for these materials on (02) 6289 8735. Questions about the new items can be sent to epc.items@health.gov.au.

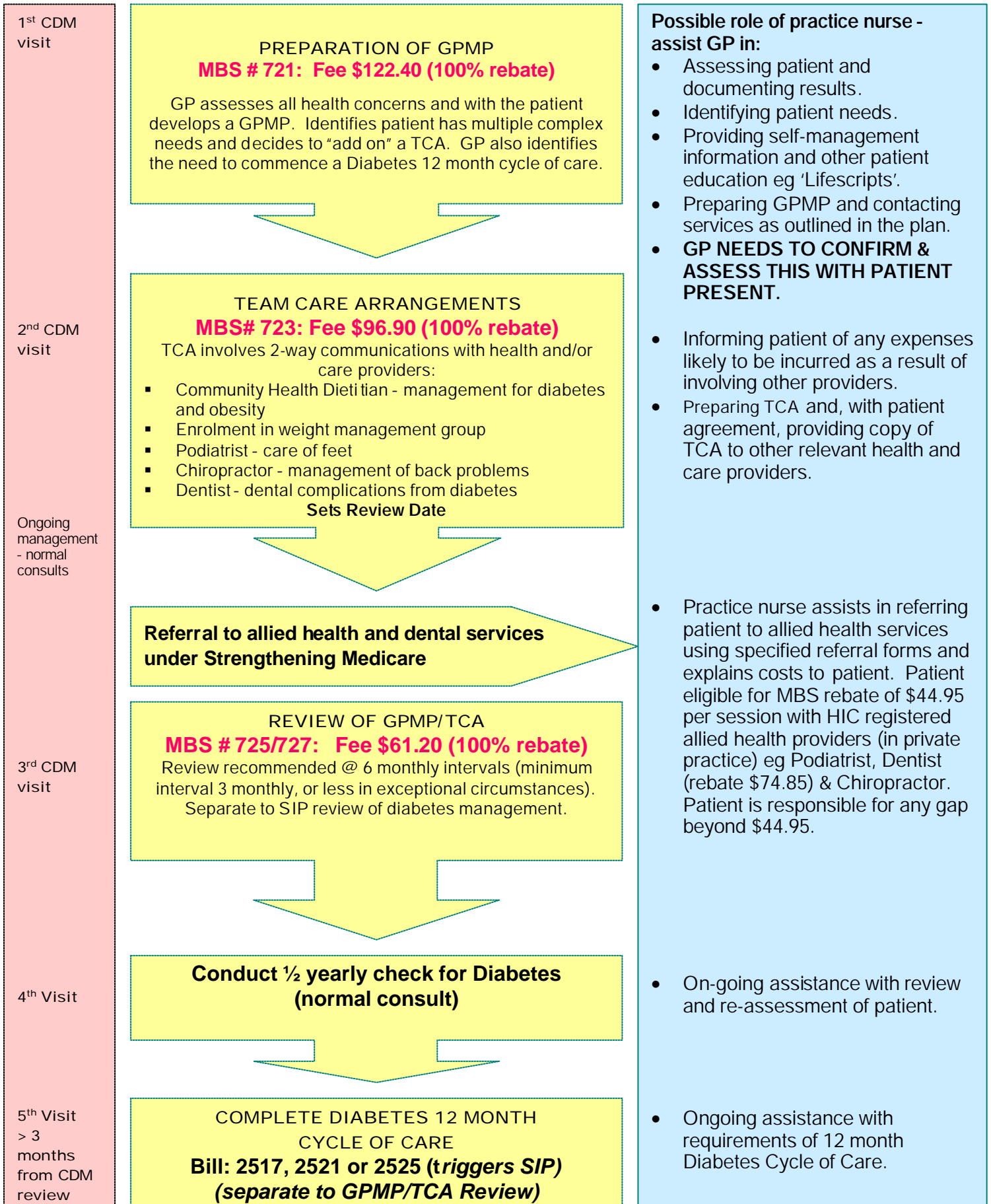
How the new CDM items work for patients

A. Patient with a chronic medical condition (eg diabetes)

1. Mrs Smith is returning to see her usual GP (Dr Jones) after being tested for Diabetes. At the consultation Dr Jones confirms that she has diabetes.
2. Dr Jones suggests Mrs Smith would benefit from a GP Management Plan, as this will outline all the necessary activities that need to be done by both himself and Mrs Smith to ensure she gets the best treatment and management of her Diabetes. He explains what this would involve.
3. After her agreement, her doctor immediately begins the process for a **GP Management Plan**.
 - since Mrs Smith has been seeing Dr Jones for some time, he has a detailed record including past history, social and family history, and is able to quickly complete a thorough assessment of Mrs Smith's needs. If Dr Jones was less familiar with Mrs Smith's history, he might ask his practice nurse to undertake this assessment, which he would then review and confirm with Mrs Smith.
 - they agree that the management goal is to control her diabetes, and this will be measured through a regular blood test done by herself at home and usually with 3 monthly tests done at the pathology laboratory.
 - they discuss the need for her to control her diet, exercise more regularly and monitor her blood sugar level. While Mrs Smith is happy to test her own blood sugar she is unfamiliar with how the testing is done.
 - they agree she should visit a diabetes educator to learn about managing her diabetes, monitoring her sugars and how best to control her diabetes.
 - they agree that they will review the management plan in six months.
 - Dr Jones has used his medical software to document these needs, goals, patient actions, treatment/services and review date, thus completing the GP Management Plan. He prints out a copy for Mrs Smith and either bulk bills or invoices her for the service.
 - If he bulk bills and Mrs Smith has a health care concession card, Dr Jones also claims the relevant bulk billing incentive payment. If the service is not bulk-billed, Mrs Smith goes to the Medicare office and receives **\$122.40** the rebate for the GP Management Plan.
4. Mrs Smith's diabetes is managed normally through her **usual visits** to the doctor (billed as a normal attendance) and further regular reviews of progress against the GP Management Plan (billed against the item for **review of GP Management Plan**, rebate **\$61.20**).
5. After six months, Dr Jones and Mrs Smith review the Management Plan and the impact it has had on control of her diabetes. They agree that the visit to the diabetes educator had been worthwhile but that ongoing support through Diabetes Australia is probably sufficient now. Dr Jones also provides a referral for an ophthalmological review. They also discuss possible future needs:
 - if Mrs Smith's condition changes dramatically before the six months (eg if she is hospitalised for a related reason), Dr Jones might decide to develop a new GP Management Plan.
 - if Mrs Smith's diabetes becomes poorly controlled and she develops complications from it, Dr Jones might consider undertaking **Team Care Arrangements** (see example B below).

B. Patient with a chronic medical condition and complex care needs (eg poorly controlled diabetes)

1. Ms Pappas visits her GP (Dr Jones). At that consultation, Dr Jones confirms that she has diabetes. He also identifies the fact that Ms Pappas' diabetes has gone undetected for some time and she has complications as a result - leg ulcers and numbness from poor circulation. Ms Pappas is 74 and frail, living alone at home, and therefore at risk of falls.
2. After obtaining her agreement, Dr Jones develops a **GP Management Plan** for Ms Pappas in the same way as for Mrs Smith, but he also suggests to Ms Pappas that it would be more effective if he also works with other health providers to manage her diabetes and complications.
3. Dr Jones explains what developing Team Care Arrangements involves and asks if she is happy for other providers to be involved. She agrees, and he initiates the **Team Care Arrangements** service immediately.
 - they agree that a podiatrist and diabetes educator in the local area will be asked to collaborate with Dr Jones in helping her. Ms Pappas agrees to Dr Jones providing them with relevant information.
 - Dr Jones bills Ms Pappas for the GP Management Plan or bulk bills for the service (he has not yet finished the Team Care Arrangements).
 - Before her next visit, Dr Jones asks the practice nurse to send the podiatrist and diabetes educator Ms Pappas' GP Management Plan and discuss with them what services Ms Pappas might need.
 - Dr Jones reviews this information, emails the podiatrist and calls the diabetes educator to confirm the services they will give Ms Pappas, and then includes the agreed arrangements in a Team Care Arrangements document, which can be attached to her GP Management Plan.
4. Ms Pappas visits her GP the next week, as arranged. Dr Jones explains the Team Care Arrangements to Mrs Pappas and gives her a copy of the document and allied health referrals for the podiatrist and for the diabetes educator. Dr Jones decides to bulk bill the Team Care Arrangements item for Ms Pappas (rebate **\$96.90**). Later, she makes an appointment to see the podiatrist.
5. **Allied health services: At the podiatrist**, Ms Pappas gets her feet checked, advice about the right shoes to wear, and advice about how to monitor the condition of her feet herself.
 - The podiatrist completes the referral form and provides it and an invoice for the relevant Medicare item to Mrs Pappas, and emails a report on the service to Dr Jones.
 - Ms Pappas goes to the Medicare office and receives the rebate for an **allied health service (\$44.95)**.
 - Ms Pappas can receive up to 5 allied health services per year as a result of having her condition managed via a GP Management Plan and Team Care Arrangements, so long as Dr Jones completes a referral for the allied health provider. If Ms Pappas had dental problems directly related to that condition, she may also be eligible for up to 3 **dental services** per year.
6. Just as for Mrs Smith, Ms Pappas' diabetes is managed normally through her **usual visits** to the doctor and regular **reviews of progress against the GP Management Plan and (if necessary) the Team Care Arrangements** (rebate \$61.20 for each). If Ms Pappas' condition changes dramatically before the six months (eg if she is hospitalised for a related reason), Dr Jones might decide to develop a new GP Management Plan and/or Team Care Arrangements.



The table below compares key elements of the Enhanced Primary Care (EPC) Multidisciplinary Care Planning items (to be phased out by November 2005) against the new Chronic Disease Management (CDM) items (introduced on 1 July 2005). The information is summarised for illustration purposes only and should not be used for providing care planning services. Clinicians should refer to the relevant Medicare items, descriptors and explanatory notes.

Medicare items under Enhanced Primary Care	EPC Multidisciplinary Care Planning Items	Chronic Disease Management (CDM) Items
Eligibility	<p>Medicare items for EPC Multidisciplinary Care Planning to be withdrawn on 1 November 2005:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> 720 - Preparation of a care plan by a GP. <input checked="" type="checkbox"/> 722 - Preparation of a discharge care plan by a GP. <input checked="" type="checkbox"/> 724 - Review of a care plan by a GP. <input checked="" type="checkbox"/> 726 - Contribution by a GP to a plan or review by another provider. <input checked="" type="checkbox"/> 728 - Contribution by a GP to a discharge plan or review by another provider. <input checked="" type="checkbox"/> 730 - Contribution by a GP to a plan or review by another provider for residents of aged care facilities. 	<p>Medicare items for Chronic Disease Management introduced on 1 July 2005:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> 721 - Preparation of a GP Management Plan by a GP (including on discharge for private patients). <input checked="" type="checkbox"/> 723 - Coordination of Team Care Arrangements by a GP (including on discharge for private patients). <input checked="" type="checkbox"/> 725 - Review of a GP Management Plan by a GP. <input checked="" type="checkbox"/> 727 - Coordination of a review of Team Care Arrangements by a GP. <input checked="" type="checkbox"/> 729 - Contribution by a GP to a plan or review prepared by another provider (including on discharge). <input checked="" type="checkbox"/> 731 - Contribution by a GP to a plan or review by another provider for residents of aged care facilities (including on discharge).
Service delivery	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Mandatory for GPs to collaborate with other care providers in preparing and reviewing multidisciplinary care plans. 	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> GPs can now provide a GP Management Plan to patients with chronic or terminal conditions, without needing to collaborate with other care providers. <input checked="" type="checkbox"/> GPs can still collaborate with other providers if the patient has complex multidisciplinary care needs and would benefit from Team Care Arrangements.
Frequency of services	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Permitted claiming frequency is dependent on the service being provided but is fixed. 	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Minimum time limits apply, but 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.
GP assistance	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> GPs required to perform all tasks without assistance from other clinicians in the practice (eg Practice Nurse). <input checked="" type="checkbox"/> Plans had to be coordinated and reviewed by the same GP (patient's usual GP). 	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> GPs can now be assisted by their Practice Nurse, Aboriginal Health Worker or other health professional. <input checked="" type="checkbox"/> Plans can now be reviewed by the same GP, a GP from the same practice or, in the event that the patient has moved practices, by a GP from the new practice.
Reviews	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> GPs could only review patient's progress using multidisciplinary review item, requiring collaboration with team 	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> GPs can choose most appropriate review item for circumstances of patient - GP review if reviewing alone; Team Care review if reviewing with team input.
Access to allied health and dental care services (MBS Items 10950 - 10977)	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Patients must have a multidisciplinary care plan or, in the case of aged care residents, the GP must have contributed to the resident's multidisciplinary care plan. 	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Patients can access MBS items 10950 - 10977 after their GP has completed their GP Management Plan <u>and</u> Team Care Arrangements or, after the GP has completed their contribution to an aged care resident's care plan. <input checked="" type="checkbox"/> Access also retained for patients who have an EPC multidisciplinary care plan.
Residents in aged care facilities	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> GPs only able to contribute to a care plan prepared by the aged care facility. 	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> GPs can contribute to aged care facility care plans and also contribute to multidisciplinary discharge care plans for aged care residents (public or private patients) being discharged from hospital. <input checked="" type="checkbox"/> GPs can prepare GP Management Plans or coordinate Team Care Arrangements for aged care residents being discharged as private patients from hospital.
Methods of collaboration with other providers.	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Collaboration with other providers can be face to face, in writing, by fax, phone, videoconference or email. 	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Collaboration with other providers for Team Care Arrangement items can be face to face, in writing, by fax, phone, videoconference or email.

Chronic Disease Management (CDM) Items – Forms

It is not mandatory to use these forms. They are samples for assisting GPs and others in completing the services and can be customised to meet the needs of patients and practitioners in your practice.

There are sample forms for the GP Management Plan and for Team Care Arrangements. There is also a combined form for patients requiring both a GP Management Plan and Team Care Arrangements.

If you have any comments on the sample forms, please complete the feedback form and return by email: epc.items@health.gov.au or fax (02) 6289 7120.

The forms are available in two formats on this website address:
<http://www.health.gov.au/internet/wcms/publishing.nsf/Content/pcd-programs-epc-chronicdisease-forms>

SDGP Templates

The Division has developed referral form templates for MD which is attached with this Kit . These forms can also be downloaded on this web address:

<http://www.shiregps.org.au/Default.asp?PageID=146>
and scroll down to Sutherland DGP forms

ACCESS TO CDM ITEMS AND SIPS FOR ASTHMA, DIABETES AND MENTAL HEALTH

KEY:

CDM = Chronic Disease Management Plan (item 721)

GPMP = GP Management

TCA = Team Care Arrangements (item 723)

SIP = Service Incentive Payments Benefits Schedule

MBS = Medicare

Note: The asthma and mental health 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 or mental health 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.	Patients with Mental Health Conditions.
Patient with chronic condition (not requiring team-based care)	GPMP	✓	✓ (1)	✓ (1)
	GPMP Review	✓	✓	✓
	SIP	✓	✓ (2)	✓ (2)
	SIP with GPMP	✓	x	x
	SIP with GPMP Review (3)	Not both at same time	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	Either, as appropriate
	GPMP & TCA plus SIP	✓	✓	✓
	SIP plus GPMP or TCA Reviews (3)	Not both at same time	Not both at same time	Not both at same time

NOTES:

- (1) The GPMP item should not be claimed within 12 months of an asthma or mental health SIP, other than in exceptional circumstances (eg where the patient has/develops a separate chronic condition).
- (2) The asthma and mental health 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.
- (3) The SIP item and the CDM/TCA review items should not be claimed within three months of each other.



Medicare items for allied health services for people with chronic conditions and complex care needs

Medicare rebates are available for a maximum of 5 allied health services per patient in a 12 month period (from the date of the first allied health service).

To be eligible for these rebates, patients need to have a chronic condition and complex care needs which are being managed by their GP under an Enhanced Primary Care (EPC) plan (see **Overview** for requirements). The need for allied health services must be identified in the patient's plan.

Eligible services include those provided by Aboriginal health workers, audiologists, chiropractors, chiropodists, diabetes educators, dietitians, mental health workers, occupational therapists, osteopaths, physiotherapists, podiatrists, psychologists and speech pathologists.

Patients need to be referred by their GP. The GP needs to use an *EPC Program referral form for allied health services under Medicare*. Where a GP is referring a patient to more than one allied health professional, s/he will need to use a **separate** referral form for each referral.

The form can be found on the Department of Health and Ageing website at: www.health.gov.au/strengtheningmedicare or ordered by faxing (02) 6289 7120.

Registration with Medicare Australia

Eligible allied health professionals need to register with Medicare Australia to provide services under this initiative. This includes eligible allied health professionals already registered with Medicare Australia under Department of Veterans' Affairs and Office of Hearing Services programs.

Chiropractors, osteopaths, physiotherapists and podiatrists who were registered with Medicare Australia prior to 1 July 2004, to order diagnostic imaging tests under Medicare, **do not need to re-register** for this measure. However, those who were not registered with Medicare Australia prior to 1 July 2004 need to register for this initiative.

Registration forms are available at the Medicare Australia website at: www.medicareaustralia.gov.au or on request from Medicare Australia on **132 150**.

Overview

Patients need to have in place:

- A GP Management Plan AND Team Care Arrangements (items 721 and 723); OR
- An EPC multidisciplinary care plan (items 720, 722, 730 or 731).

GPs need to use an *EPC Program referral form for allied health services under Medicare* to refer patient.

Allied Health Professionals need to be registered with Medicare Australia.

Maximum of 5 services per patient per 12 month period (from date of first service).

A fact sheet about EPC chronic disease management Medicare items 721, 723 and 731 (and others) can be found at the Department of Health and Ageing website at:

www.health.gov.au/internet/wcms/publishing.nsf/Content/pcd-programs-epc-chronicdisease

A fact sheet about Medicare rebates for **dental care services** also provided under this initiative can be found on the Medicare Australia website at:

www.medicareaustralia.gov.au.

What are the allied health Medicare items?

There are twelve MBS items for allied health services requested by a GP on an *EPC Program referral form for allied health services under Medicare*:

Item 10950 – services provided by an **Aboriginal Health Worker**

Item 10951 – services provided by a **Diabetes Educator**

Item 10952 – services provided by an **Audiologist**

Item 10954 – services provided by a **Dietitian**

Item 10956 – services provided by a **Mental Health Worker** (includes Aboriginal health workers, mental health nurses, occupational therapists, psychologists and some social workers)

Item 10958 – services provided by an **Occupational Therapist**

Item 10960 – services provided by a **Physiotherapist**

Item 10962 – services provided by a **Podiatrist or Chiropodist**

Item 10964 – services provided by a **Chiropractor**

Item 10966 – services provided by an **Osteopath**

Item 10968 – services provided by a **Psychologist**

Item 10970 – services provided by a **Speech Pathologist**

As Aboriginal health workers, occupational therapists and psychologists may provide both services relevant to their discipline and mental health services, they may use **either** the MBS item relevant to their discipline or the mental health item (10956), depending on the type of service provided.

Eligible mental health nurses and social workers may use only the mental health item (10956).

All other eligible allied health professionals may use only the item relevant to their discipline, eg: a physiotherapist may only use item 10960.

Allied health professionals may set their own fees. However for each item, the Medicare schedule fee is \$53.90, with a Medicare rebate of \$45.85.

Conditions for claiming the items

The items can only be claimed where all of the following conditions are met:

- (a) the service is provided by an allied health professional registered with Medicare Australia for this initiative;
- (b) the service is provided on referral from a medical practitioner (including a general practitioner but not including a specialist or consultant physician);
- (c) the service is specified in an EPC allied health referral form;
- (d) the person is being managed under an EPC plan;
- (e) the person is not an admitted patient of a hospital or day-hospital facility;
- (f) the service provided is of at least 20 minutes duration, to an individual patient, in person;
- (g) the allied health professional has provided a written report on the service to the referring practitioner (**NOTE**: where the allied health professional has provided more than one service to a patient under the same referral from the referring practitioner, the allied health professional is required to provide a written report to the referring practitioner on the first and last service only, and more often if clinically relevant);
- (h) the person has not received more than 5 services to which items 10950-10970 apply, within 12 months from the date of the first service; and
- (i) the service has not been funded through other State or Commonwealth programs (see **Other publicly funded programs**).

What information is required in the report to the GP?

Allied health professionals should provide the referring GP with information about, for example:

- any investigations, tests, and/or assessments carried out on the patient;
- any treatment provided; and
- future management of the patient's condition or problem.

Is it necessary for the GP to use the referral form?

Yes, GPs are required to use the referral form. However, from 1 November 2005, signed copies of the form will no longer need to accompany Medicare claims.

A revised form for GP referral use is available on the Department's website at: www.health.gov.au/strengtheningmedicare. GPs may modify this form to suit their practice needs as long as the basic information contained in the form is retained.

Do patients need to obtain a referral for these services every 12 months?

Yes, if they wish to continue to access Medicare rebates every 12 months for a new set of five eligible allied health services recommended in their EPC plan. Patients will need to be referred to an allied health professional for these services by their GP, using the referral form.

Patients should see their GP when the GP is referring the patient for a new set of services. GPs may choose to use this visit to undertake a review of the patient's EPC plan where appropriate, or to manage the process using a GP consultation item, depending on the patient's circumstances and needs.

NOTE: It is not necessary to have a new EPC plan prepared every 12 months just to access a new set of allied health referrals. Patients continue to be eligible for rebates for eligible

allied health services while they are being managed under an EPC plan.

How do patients get a rebate for these services?

When the allied health professional has provided the service s/he may then:

1. seek payment for the service from the patient. The patient then takes the itemised receipt from the allied health professional to Medicare to claim the Medicare rebate. Out of pocket costs will count toward the Medicare safety net; or
2. seek payment for the service directly from Medicare. The patient must first sign an assignment of benefit form and the allied health professional will send that to Medicare for payment. To claim direct payment from Medicare in this way, the allied health professional accepts the value of the Medicare rebate in full payment for the service and will not be able to charge the patient a gap.

The following information must be shown on patients' itemised accounts/receipts:

- patient's name and date of service;
- MBS item number and/or description of service;
- name and practice address or name and provider number of servicing allied health professional;
- name and practice address or name and provider number of referring GP and date of referral; and
- amount charged, total amount paid, and any amount outstanding in relation to the service.

Note: Before a rebate can be paid for the allied health service provided on referral from a GP, either the patient must have already claimed a rebate, or the GP must have already lodged a claim for direct payment from Medicare for the relevant EPC planning item(s).

Allied health professionals may wish to check their responsibilities for Medicare claiming and payment processes with Medicare Australia on **132 150**.

A copy of the MBS booklet *Medicare Benefits for allied health and dental care services provided to people with chronic conditions and complex care needs* is sent to all registered allied health professionals. Updated annually, it contains item descriptors and explanatory notes including information on billing and claiming the items.

Alternatively the Medicare Australia website: www.medicareaustralia.gov.au is a useful resource.

What about patients with private health insurance cover?

Patients need to decide if they will use Medicare or their private health insurance ancillary cover to pay for these services.

Patients with such insurance can either:

1. access rebates from Medicare under the allied health items by following the claiming processes; or
2. see allied health professionals of their choice and claim on their insurance's ancillary benefits. No referral form is required in this case.

Patients cannot use their private health insurance ancillary cover to 'top up' the Medicare rebate.

It is important for patients to check with their health fund which ancillary services are covered and what their out of pocket expenses are likely to be.

Other publicly funded programs

Allied health services funded by other Commonwealth or State programs are not eligible for Medicare rebates. Examples include State government hospital outpatient clinics, the More Allied Health Services (MAHS) program, Commonwealth Hearing Services Scheme or Department of Veterans' Affairs services for veterans.

Where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or State/Territory clinic, the allied health items can be claimed for services provided by eligible allied health professionals salaried by, or contracted to, the service.

Example of the how the Medicare allied health items work

The GP completes a GP Management Plan (GPMP), coordinates Team Care Arrangements (TCA) and bills the relevant EPC CDM items for Ms Jones.

In finalising her TCA, the GP refers her to an eligible podiatrist for 5 services using the 'EPC referral form for allied health services under Medicare'. This enables her to access Medicare rebates for eligible podiatry services recommended under her TCA.

Ms Jones takes the form to the podiatrist who must retain it for Medicare Australia auditing purposes. The podiatrist provides Ms Jones with her first service.

If Ms Jones' podiatrist accepts the value of the Medicare rebate as full payment for this service, s/he will not be able to charge Ms Jones a gap. Ms Jones must first sign an assignment of benefit form and the podiatrist will send that to Medicare for payment.

If the podiatrist charges a fee higher than the Medicare rebate and Ms Jones elects to pay the full amount up front, she will then need to take/send the itemised receipt from the podiatrist to Medicare to claim the Medicare rebate and have her out of pocket costs counted toward the Medicare safety net.

This billing/claiming process is repeated for Ms Jones's 4 subsequent visits under the same referral.

**For more information call Medicare Australia on 132 150
or go to www.medicareaustralia.gov.au**

Eligibility criteria for allied health professionals providing new Medicare services

Aboriginal Health Workers practising in the Northern Territory (NT) must be registered with the Aboriginal Health Workers Board of the NT; in other States and the Australian Capital Territory they must have been awarded a Certificate Level III (or higher) in Aboriginal and Torres Strait Islander Health from a Registered Training Organisation that meets training standards set by the Australian National Training Authority's Australian Quality Training Framework.

Audiologists must be either a 'Full Member' of the Audiological Society of Australia Inc (ASA), who holds a 'Certificate of Clinical Practice' issued by the ASA; or an 'Ordinary Member – Audiologist' or 'Fellow Audiologist' of the Australian College of Audiology (ACAud).

Chiropractors must be registered with the Chiropractors (or Chiropractors and Osteopaths) Registration Board in the State or Territory in which they are practising.

Diabetes Educators must be a Credentialed Diabetes Educator (CDE) as credentialed by the Australian Diabetes Educators Association (ADEA)

Dietitians must be an 'Accredited Practising Dietitian' as recognised by the Dietitians Association of Australia (DAA).

Mental Health Workers 'Mental health' can include services provided by members of five different allied health professional groups. 'Mental health workers' are drawn from the following:

- _ psychologists;
- _ mental health nurses;
- _ occupational therapists;
- _ social workers; and
- _ Aboriginal health workers.

Psychologists, occupational therapists and Aboriginal health workers are eligible in separate categories for these items.

A **mental health nurse** may qualify if they are –

- a registered mental health nurse in Tasmania or the Australian Capital Territory (ACT), if providing mental health services in Tasmania or the ACT; or

**CHRONIC DISEASE MANAGEMENT
721 GP MANAGEMENT PLAN (GPMP)
723 TEAM CARE ARRANGEMENTS (TCA) (if applicable)**

Patient eligibility

- 721 - patients with a chronic or terminal medical condition (existing or likely to exist for 6 months)
- 723 - patients must also have complex needs that require ongoing care from a multidisciplinary team (GP + at least 2 care providers)
- Patients in the community and private in-patients being discharged from hospital
- Patients NOT available to public in-patients being discharged from hospital NOR residents living in an aged care facility

PATIENT DETAILS

DETAILS OF PATIENT'S CARER

(if applicable)

DETAILS OF PATIENT'S USUAL GP

MEDICATIONS

ALLERGIES

PROGRESS NOTES

INVESTIGATIONS

Patient's Name:

721	<input checked="" type="checkbox"/> I have explained the steps and costs involved, and the patient has agreed to proceed with the GP MANAGEMENT PLAN service	(GP's Signature & Date)
723 (if applic)	<input checked="" type="checkbox"/> I have explained the steps and costs involved, and the patient has agreed to proceed with the TEAM CARE ARRANGEMENTS service <input checked="" type="checkbox"/> The patient also agrees to the involvement of other care providers and to share clinical information without / with restrictions (identify)	(GP's Signature & Date)

721 GP MANAGEMENT PLAN and 723 TEAM CARE ARRANGEMENTS (if applicable) (once per 2 years)

Patient problems / needs / relevant conditions	Goals - changes to be achieved	Required treatments and services (including patient actions)	Arrangements for treatments/services (when, who, contact details) <ul style="list-style-type: none"> • 721 - as needed • 723 - mandatory to obtain agreement & collaborate with 2 care providers

Copy offered to patient?	YES / NO	Copy / relevant parts of GPMP/TCA supplied to other providers?	YES / NO / NOT REQUIRED
Copy added to the patient's records?	YES / NO		(Mandatory for 723)
Date GPMP completed:	/ /	Review Date:	/ /
Date TCA completed:	/ /		(6 months)

If both GPMP and TCA are in place and have been claimed, patient may be eligible to be referred to care providers using the Medicare Allied or Dental Health forms
 Web: www.hic.gov.au/providers/forms/medicare.htm MD: blue i icon-Allied Health-Allied Health EPC Referral Form HIC: 1800 067 307

CHRONIC DISEASE MANAGEMENT
725 REVIEW of GP MANAGEMENT PLAN
or 727 REVIEW of TEAM CARE ARRANGEMENTS (if applicable)

PATIENT DETAILS

DETAILS OF PATIENT'S CARER

(if applicable)

DETAILS OF PATIENT'S USUAL GP

MEDICATIONS

ALLERGIES

PROGRESS NOTES

INVESTIGATIONS

Patient's Name:

725 GPMP review OR	<input checked="" type="checkbox"/> I have explained the steps and costs involved, and the patient has agreed to proceed with the REVIEW of the GP MANAGEMENT PLAN	(GP's Signature & Date)
727 TCA review	<input checked="" type="checkbox"/> I have explained the steps and costs involved, and the patient has agreed to proceed with the REVIEW of the TEAM CARE ARRANGEMENTS <input checked="" type="checkbox"/> The patient also agrees to the involvement of other care providers and to share clinical information without / with restrictions (identify)	(GP's Signature & Date)

725 REVIEW of GP MANAGEMENT PLAN <u>or</u> 727 REVIEW of TEAM CARE ARRANGEMENTS	<i>(once per 6 months)</i>
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Goals (from existing GPMP or TCA)	Progress of the planned treatments and services (incl patient actions) in achieving these goals <ul style="list-style-type: none"> • 727 - mandatory to obtain agreement and collaborate with care providers on existing TCA 	Further actions required (if any) (incl any new care providers if necessary)

Copy offered to patient?	YES / NO	Copy / relevant parts of REVIEW of the GPMP/TCA supplied to other providers?	YES / NO / NOT REQUIRED <i>(Mandatory for 727)</i>
Copy added to the patient's records?	YES / NO		
Date review was completed: <i>(note only 725 <u>or</u> 727 to be performed)</i>	/ /	Next Review Date:	/ / <i>(6 months)</i>
If both GPMP and TCA are in place and have been claimed, patient may be eligible to be referred to care providers using the Medicare Allied or Dental Health forms			
Web: www.hic.gov.au/providers/forms/medicare.htm		MD: blue i icon-Allied Health-Allied Health EPC Referral Form	HIC: 1800 067 307



Enhanced Primary Care (EPC) Program Referral form for Allied Health Services under Medicare

To be completed by referring GP:

Please tick the relevant box below:

- Patient has an EPC Multidisciplinary Care Plan in place (MBS item 720, 722, 730 or 731) OR
 Patient has a GP Management Plan and Team Care Arrangements in place (MBS item 721 AND 723)

Note: GPs are encouraged to attach a copy of the relevant part of the patient's care plan to this form.

Medicare rebates and Private Health Insurance benefits cannot both be claimed for these services.
 Patients should be advised that they must choose whether to access one or the other.

GP details

Provider Number

Name

Address Postcode

NOTE: Relevant MBS item(s) above must be BILLED by GP prior to patient receiving their first referred allied health service for Medicare rebate to be payable for that service.

Patient details

Medicare Number Patient's ref no.

First Name Surname

Address Postcode

Allied Health Professional (AHP) patient referred to: (Please specify name or type of AHP)

Name

Address Postcode

Referral details - Please use a separate copy of the referral form for each type of service

Eligible patients may access Medicare rebates for up to 5 allied health services (total) a year. Please indicate the number of services required by writing the number in the 'No. of services' column next to the relevant AHP.

No of services	AHP Type	Item Number	No of services	AHP Type	Item Number	No of services	AHP Type	Item Number
	Aboriginal Health Worker	10950		Dietitian	10954		Podiatrist	10962
	Audiologist	10952		Mental Health Worker	10956		Psychologist	10968
	Chiropractor	10964		Occupational Therapist	10958		Speech Pathologist	10970
	Chiropodist	10962		Osteopath	10966			
	Diabetes Educator	10951		Physiotherapist	10960			

Referring General Practitioner's signature

Date signed

AHP must provide a written report to patient's GP after each service – except where the AHP provides multiple services to a patient under the one referral. In this case, the AHP must provide a written report to the patient's GP after the first and last service, and more often if clinically necessary.

Allied health professionals should retain this referral form for record keeping and Medicare Australia audit purposes.

Allied health services funded by other Commonwealth or State/Territory programs are not eligible for Medicare rebates under this initiative.

This form may be downloaded from the Department of Health and Ageing website at www.health.gov.au/strengtheningmedicare or ordered by faxing (02) 6289 7120.

THIS FORM DOES NOT HAVE TO ACCOMPANY MEDICARE CLAIMS