



Preparation of A GP Management Plan (GPMP) Item Number 721

Key Points:

Patient Eligibility criteria

1. > 6 months chronic medical condition/terminal illness.
 2. Not an inpatient of Hospital or Commonwealth funded aged care facility
- Recommended frequency 2 yearly with minimum claiming period of 12 months
 - Comprehensive written plan including:
 1. Patients health care needs, problems & conditions
 2. Patient agreed management goals and actions
 3. Treatments & services and arrangements for provision of these
 4. Specified date to review plan (MBS Item 725-recommended every 6 months)
 - A copy should be offered to the patient
 - Practice Nurse can assisted the GP in preparing the plan and Practice Nurse MBS Item 10997 applies for monitoring & support activities in between GP-led reviews of the care plan.
 - GPMP and TCA must be claimed before the patient is able to claim MBS rebates for Allied Health Services (Items 10950-10970)

Contents:

- [Fact Sheet Medicare Australia](#)
- [Quick Reference Guide Medicare Australia](#)
- [Important reminders](#)
- [Role of the GP & Nurse](#)

Other Resources/Links:

- **Electronic templates to Import into your software:**
<http://www.monashdivision.com.au/resources/templates.htm>
- **DoHA Information on Chronic Disease Management (CDM) items**
<http://www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-chronicdiseasemanagement>

For more information or support please contact the program support staff at Dandenong Casey General Practice Association on 8792-1900

Note, all efforts are made to keep this information accurate and up to date however Medicare may change their policies with little or no notice. You are advised to search the specific item explanatory notes at <http://www9.health.gov.au/mbs/search.cfm>

Reviewed January 2010



Australian Government
Department of Health and Ageing

Chronic Disease Management (CDM) Medicare Items

This fact sheet must be read in conjunction with the item descriptors and explanatory notes for items 721-731 (as set out in the *Medicare Benefits Schedule*).

The Chronic Disease Management (CDM) Medicare items are for GPs to manage the health care of patients with chronic or terminal medical conditions, including patients with these conditions who require multidisciplinary, team-based care from a GP and at least two other health or care providers.

Eligibility

Patients who have a chronic or terminal medical condition (with or without multidisciplinary care needs) can have a GP Management Plan (GPMP) service.

Patients with a chronic or terminal medical condition *and* complex care needs requiring care from a multidisciplinary team can have a GPMP and Team Care Arrangements (TCAs).

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 disease, diabetes mellitus, musculoskeletal conditions and stroke.

These items are designed for patients who require a structured approach to their care.

Overview of the items

There are six CDM items that provide rebates for GPs to manage chronic or terminal medical conditions by preparing, coordinating, reviewing or contributing to CDM plans.

The CDM items are intended to be provided by the patient's usual GP, that is, the GP who 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.

A review item is the key component for assessing and managing the patient's progress once a GPMP or TCAs have been prepared.

GPMPs and TCAs can be reviewed by a GP from the same practice or, if the patient changes practices, by their new GP.

Using the CDM items, GPs can contribute to other provider's multidisciplinary care plans and to a review of these plans.

GPs can be assisted by practice nurses, Aboriginal health workers and other health professionals in preparing and reviewing the CDM items.

The items

Preparation of a GP Management Plan (GPMP - item 721)

- Provides a rebate for a GP to prepare a management plan for a patient who has a chronic or terminal medical condition with or without multidisciplinary care needs.
- The recommended frequency is once every two years, supported by regular review services.
- Involves the GP assessing the patient, agreeing management goals with the patient, identifying actions to be taken by the patient, identifying treatment and ongoing services to be provided, and documenting these and a review date in the GPMP.

Review of a GP Management Plan (Item 725)

- Provides a rebate for a GP to review a GP Management Plan (see above).
- Recommended frequency is once every six months; can be earlier if clinically required.
- Involves reviewing the patient's GP Management Plan, documenting any changes and setting the next review date.

Coordination of Team Care Arrangements (TCAs - item 723)

- Provides a rebate for a GP to coordinate the preparation of TCAs for a patient who has a chronic or terminal medical condition and 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 GPMP in place (but this is not mandatory).
- Recommended frequency is once every two years, supported by regular review services.
- Involves the GP collaborating with the other participating providers on required treatment/services, agreeing the arrangements with the patient, documenting the arrangements and a review date in the patient's TCAs, and providing copies of the relevant document to the collaborating providers.

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.

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.

- 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 in the patient's records.

Contribution to a multidisciplinary care plan being prepared 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 items

Patients who have both a GPMP (item 721) and TCAs (item 723) have access to the allied health individual services on the Medicare Benefits Schedule.

Similarly, residents of aged care homes whose GP has contributed to a care plan prepared by the residential aged care facility (item 731) may also have access to these allied health items.

Eligible patients can claim a maximum of **five (5) allied health services per calendar year** (MBS items 10950-10970).

Patients with a GPMP (item 721) and type 2 diabetes can also access Medicare rebates for allied health group services (MBS items 81100 to 81125).

Patients need to be referred by their GP for services recommended in their care plan, using the referral form issued by the Department that can be found at: <http://www.health.gov.au/mbsprimarycareitems> or a form that contains all the components of the Department's form.

Practice Nurse Monitoring and Support

Patients with either a GPMP or TCAs can also receive monitoring and support services from a practice nurse or registered Aboriginal health worker on behalf of the GP (MBS item 10997).

Further information

More detailed information on the CDM items is available at www.health.gov.au – use the A-Z Index to go to 'C' and select 'Chronic Disease Management Medicare items'.

Alternatively, contact Medicare Australia on 132 150 (for GPs) or 132 011 (for patients).



Australian Government

Department of Health and Ageing

Medicare item 10987 for follow up services provided by a practice nurse or registered Aboriginal Health Worker, on behalf of a GP, for an Indigenous person who has received a health check.

From 1 November 2008, an item for practice nurses and registered Aboriginal Health Workers will be introduced that will allow Indigenous people who have received any Medicare health check item to access Medicare rebates for certain follow up services provided by a practice nurse or registered Aboriginal Health Worker, on behalf of a GP.

Item 10987

Follow up service provided by a practice nurse or registered Aboriginal Health Worker, on behalf of a GP, to an Indigenous person who has received a health check, if:

- a) the service is provided on behalf of and under the supervision of a GP; and
- b) the person is not an admitted patient of a hospital; and
- c) the service is consistent with the needs identified through the Health check.

A maximum of 5 services per patient is available in a calendar year.

Who is eligible?

Indigenous people who have received any health check item under Medicare (Items 700 to 719), or a Child who has received a health check as part of the Northern Territory Emergency Response (NTER), are eligible for follow up services under item 10987.

What is a practice nurse or registered Aboriginal Health Worker?

A practice nurse is a registered or enrolled nurse, employed by, or whose services are retained by, a general practice. The general practice may be either accredited or non-accredited.

A registered Aboriginal Health Worker is a person in the Northern Territory who is registered as an Aboriginal Health Worker under the *Health Practitioners Act 2004* (NT), who is employed, or whose services are retained by, a general practice.

Item 10987 only applies where:

- a claim has been made to Medicare Australia for an Indigenous patient in respect of any health check in the last three years; and
- the GP under whose supervision the follow-up services to a health check are provided retains responsibility for the health, safety and clinical outcomes of the person.

Who can claim item 10987?

Item 10987 can only be claimed by a GP for a health check follow up service provided to an Indigenous person by a practice nurse or registered Aboriginal Health Worker, on behalf of a GP.

All vocationally registered and non-vocationally registered GPs are eligible to claim item 10987.

Where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Organisation or a State/Territory Government Health Clinic, item 10987 may be claimed for services provided by a practice nurse or registered Aboriginal Health Worker on behalf of a GP.

What qualifications and training are required for a practice nurse or registered Aboriginal Health Worker to provide follow-up services to a patient who has received an Indigenous health check?

In all cases, the GP (who is responsible for the health, safety and clinical outcomes of the patient) must be satisfied that the practice nurse or registered Aboriginal Health Worker is appropriately qualified and trained to provide follow-up services to a health check.

The practice nurse or registered Aboriginal Health Worker must also comply with any relevant legislative or regulatory requirements.

Quality assurance and continuing professional development

Continuing professional development is recommended for nurses and Aboriginal Health Workers providing these services.

General practices, where practice nurses or registered Aboriginal Health Workers provide follow up services to an Indigenous person who has received a health check, should also have a written clinical risk management strategy covering issues like clinical roles, pathology follow-up and patient consent.

Must the GP see the patient or be present in order to claim item 10987?

As the service is being provided on behalf of, and under the supervision of the GP, the GP retains responsibility for the health, safety and clinical outcomes of the patient.

However, this does not mean that the GP is required to see the patient or be present with the practice nurse or registered Aboriginal Health Worker during the service, to claim item 10987. Supervision of the practice nurse or registered Aboriginal Health Worker at a distance is recognised as an acceptable form of supervision. However the GP should be able to be contacted if required.

Where a consultation takes place with the patient, the GP is only eligible to claim a Medicare item for the length of time that the GP spends with the patient. The time the practice nurse or registered Aboriginal Health Worker spends with the patient to follow up on a health check is claimed separately under this item.

What level of medical indemnity insurance is required?

The GP who claims item 10987 will need to ensure that their medical indemnity insurance covers circumstances where a practice nurse or registered Aboriginal Health Worker follows up on a health check on their behalf.

What is the level of the Medicare rebate for item 10987?

The Medicare rebate for item 10987 is paid at 100% of the schedule fee. The Medicare rebate as at November 2008 is \$22.20.

Can item 10987 be claimed in conjunction with the bulk billing incentive items 10990 and 10991?

Yes, as long as the follow-up is provided to a Commonwealth concession card holder, or person under the age of 16, and the service is bulk billed.

Can item 10987 be claimed in conjunction with other allied health and practice nurse/registered Aboriginal Health Worker items?

Yes, item 10987 can be claimed in addition to the allied health items for people receiving Indigenous health checks (Items 81300 to 81360).

Where a person has a chronic condition and has a GP Management Plan and Team Care Arrangements under Medicare, they can also access the allied health Enhanced Primary Care (EPC) items (items 10950 to 10970).

Item 10987 may also be claimed in addition to the practice nurse and registered Aboriginal Health Worker chronic disease monitoring and support item (item 10997) for people with a chronic disease care plan.

Item 10987 may be claimed in addition to the practice nurse and registered Aboriginal Health Worker items for immunisation and wound management.

Can the GP monitor how many services have been claimed under this item for a patient?

Yes, a GP may check by ringing Medicare Australia, with the patient present, on whether a health check is in place for an Indigenous patient and how many practice nurse/registered Aboriginal Health Worker follow up services have already been provided under this item.

Further information

For further information, visit the Department of Health and Ageing website at http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-medicare-health_pro-gp-index.htm or the Medicare Australia website at <http://www.medicareaustralia.gov.au/medicareinitiatives> or call Medicare Australia on **132 011**.

GP Management Plans (Medicare item 721)

Important Reminders

The Department of Health and Ageing would like to remind GPs about key requirements of GP Management Plans (GPMP – Medicare Item 721). This list provides a brief summary only. Practitioners should refer to the latest Medicare Benefits Schedule (MBS) for full details of the items (www.mbsonline.gov.au), and the department's web site (www.health.gov.au) for more information including care planning checklists and templates.

1. The recommended frequency for a GPMP is once every two years, with regular reviews recommended every six months. This is not mandatory – in general, a new GPMP should not be prepared unless and until required by the patient's condition, needs and circumstances.
2. To be eligible for a GPMP, a patient must have a chronic (or terminal) medical condition - one that has been or is likely to be present for 6 months or longer, including, but not limited to asthma, cancer, cardiovascular illness, diabetes mellitus, musculoskeletal conditions and stroke.
3. Whether or not a patient is eligible for a GPMP is essentially a matter for the GP to decide.
4. The GP is responsible for the GPMP, which is a plan of action that a GP has agreed with the patient for the management of the chronic condition.
5. GPMPs are designed to improve the quality of patient care and must be done thoughtfully, with adequate clinical input that seeks to improve a patient's health outcome.
6. A GPMP is required by legislation to be a **comprehensive written plan** that describes:
 - the patient's health care needs, health problems and relevant conditions
 - management goals with which the patient agrees
 - actions to be taken by the patient
 - treatment and services the patient is likely to need
 - arrangements for providing these treatment and services
 - a date to review these matters.
7. Reviewing a GPMP is an important part of the planning cycle, where the GP and the patient check that goals are being met and agree on any changes that might be needed.
8. The GPMP item covers the consultation at which the item is undertaken and so, in general, a separate consultation should not be undertaken with a GPMP unless it is clinically indicated that the problem must be treated immediately.
9. All CDM items should be provided by the patient's usual GP. The term 'usual GP' would not generally apply to a practice that provides a one-off service to a patient. Any services designed to prevent or manage chronic illness are best provided by the GP or practice that will be responsible for the patient's long term care.
10. Patient information brochures to help GPs to discuss GPMPs with their patients are available on the department's web site.

Care planning and case conferencing: summary of MBS item numbers

Service type ▶▶▶	Care planning by a GP ¹⁶ Chronic disease management (CDM) items		Case conferencing organised and coordinated by a GP				GP contribution to a care plan prepared by another provider Chronic disease management (CDM) items		GP participation in case conferencing organised and coordinated by another provider				Practice nurse or registered Aboriginal health worker monitoring and support
	Client eligibility ▶▶▶	Client has a chronic or terminal medical condition and is living in the community ¹⁷	Client has a chronic or terminal medical condition and complex care needs and is living in the community	Client has a chronic or terminal medical condition and is living in the community	Client has cancer and is living in the community	Client is a resident of a Commonwealth funded residential aged care facility (RACF)	Client is an in-client being discharged from a hospital or day hospital facility into the community	Client is not a resident of a Commonwealth funded residential aged care facility (RACF)	Client is a resident of a Commonwealth funded residential aged care facility (RACF)	Client has a chronic or terminal medical condition and is living in the community	Client has cancer	Client is a resident of a Commonwealth funded residential aged care facility (RACF)	
Relevant MBS item number ▶▶▶	GP Management Plan (GPMP) #721 Review of GP Management Plan #725	Team Care Arrangements (TCA) #723 Review of Team Care Arrangements #727	Organise and coordinate a community case conference 15-30 mins #740 30-45 mins #742 >45 mins #744	Lead and coordinate a case conference of at least 10 mins duration where there are at least four medical practitioners from different areas of practice and, in addition, allied health providers #871	Organise and coordinate a case conference in a RACF 15-30 mins #734 30-45 mins #736 >45 mins #738	Organise and coordinate a discharge case conference 15-30 mins #746 30-45 mins #749 >45 mins #757	Contribution to a care plan, or a review of a care plan, being prepared by another provider ¹⁸ #729	Contribution to a care plan, or a review of a care plan, being prepared by the RACF or hospital from which the resident is being discharged #731	Participation in a case conference 15-30 mins #759 30-45 mins #762 >45 mins #765	Participation in a case conference of at least 10 mins duration and where there are at least four medical practitioners from different areas of practice and, in addition, allied health providers #872	Participate in a case conference in a RACF 15-30 mins #775 30-45 mins #778 >45 mins #779	Participate in a discharge case conference 15-30 mins #768 30-45 mins #771 >45 mins #773	Provision of monitoring and support for people with a chronic disease, on behalf of a GP #10997

16 Note: A GP may also refer a patient with at least two morbidities to a consultant physician (other than in psychiatry) to undertake a comprehensive assessment develop a treatment and management plan (#132 and #133).

17 Item 721 and 723 are also available to private in-patients (incl. residents of aged care facilities) being discharged from hospital, where their usual GP is providing in-patient care.

18 Note: If a community health service seeks to engage a GP in a community health-led care coordination plan, it may be better to request input through a #721 (GPMP) and #723 (TCA) (or a review of these items—#725 or #727) rather than a #729, because clients on a #729 are not eligible for MBS-subsidised (private) allied health services.

Care planning and case conferencing

GP care planning: summary of web links and explanatory notes

	Care planning prepared by a GP				Practice nurse and Aboriginal health worker provision of monitoring and support #10997
	GP Management Plan (GPMP) #721	Review of GP Management Plan #725	Team Care Arrangements (TCA) #723	Review of Team Care Arrangements #727	
Steps that must be taken to claim the Medicare item	<ul style="list-style-type: none"> Assessing the client to identify and/or confirm needs, problems and conditions Explaining the service and any associated costs with the client, and gaining and recording consent to proceed Agreeing on management goals with the client for changes to be achieved by the treatment and services identified in the plan Identifying required client actions Identifying treatment and services that the client is likely to need, and making arrangements for them Services and ongoing management Preparation of a comprehensive written plan describing the client's needs, goals, client actions, treatment/services and a review date Offering a copy of the plan to the client and adding it to medical records 	<ul style="list-style-type: none"> Explaining the service and any associated costs with the client, and gaining and recording consent to proceed Reviewing the client's needs and goals, client actions and treatment/services Making relevant changes to the documented GPMP Adding a new review date Offering a copy of the plan to the client and adding it to medical records 	<ul style="list-style-type: none"> Explaining the service and any associated costs with the client, and gaining consent to proceed Discussing with the client which providers should collaborate with the GP (each of whom must provide a different kind of ongoing care), gaining client consent to share information Contacting the proposed providers, obtaining their agreement to participate, and providing them with relevant information or allowing time for them to see the client, if necessary Collaborating with the other providers to discuss potential treatments/ services to be provided to achieve client goals Preparing a document that describes treatment and service goals, providers involved, client actions and that nominates a review date Providing copy of the TCA document to other providers (with consent), offering a copy to client/ carer, and adding it to the medical records 	<ul style="list-style-type: none"> Explaining the service and any associated costs with the client, and gaining and recording consent to proceed Discussing with the client which providers should collaborate in the review Collaborating with the providers to establish client progress against care plan goals and reviewing the plan Documenting any changes to the plan Providing a copy to other providers (with consent), offering a copy to client/ carer, and adding it to the medical records 	<ul style="list-style-type: none"> Assisting clients on an EPC Care Plan who require access to ongoing care, routine treatment and ongoing monitoring and support between the more structured reviews of the care plan by the client's usual GP. Note: Cannot be claimed at the same time as GP Care Planning items #721, #723, #725, #727, #729 or #731.
Medicare rules relating to frequency of service	Maximum of once per client in a 12-month period. The recommended frequency is one #721 every 2 years (if required) with 6-monthly reviews.	Maximum of once per client in a 3-month period. The recommended frequency is every 6 months.	Maximum of once per client in a 12-month period. The recommended frequency is one #723 every 2 years (if required) with 6-monthly reviews.	Maximum of once per client in a 3-month period. The recommended frequency is every 6 months.	A maximum of 5 services per client per calendar year.
Role of the GP	The GP has ultimate responsibility for delivery of the service, which must include a personal attendance by a single medical practitioner with a single client (the consultation may include the client's carer or representative as necessary)				The GP retains responsibility for the outcomes
Roles that can be performed by practice nurses or Aboriginal health workers on behalf of and under the supervision of a GP	<ul style="list-style-type: none"> Assist in aspects of client assessment, identification of client needs, and making arrangements for services Managing review appointments system Assistance to clients as per #10997 	<ul style="list-style-type: none"> Recalling the client for the care plan review Other tasks as per GPMP column 	<ul style="list-style-type: none"> Assist in aspects of client assessment, identification of client needs, and making arrangements for services Managing review appointments system Assistance to clients as per #10997 	<ul style="list-style-type: none"> Recalling the client for the care plan review Other tasks as per TCA column 	<ul style="list-style-type: none"> All tasks Check web link for examples of specific services
Main information web links	GP items: www.health.gov.au/internet/main/publishing.nsf/Content/pod-programs-epc-chronicdisease Practice nurse item: http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=M2.1&q=noteid				