Australian Government

Department of Health and Ageing

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The superseded items will be retained until 1 November 2005 so that services commenced but not finished by 1 July 2005 can be completed.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 $120.00
- 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 $60.00.
- 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 $95.00.
- 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 $60.00.
- 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 $41.65
- 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 similar 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, she/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/chronicdisease* 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.*