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Chronic Disease Management (CDM) & MBS Item Numbers

Acknowledgment to Country

We are committed to supporting reconciliation between Indigenous and non-Indigenous Australian people. In keeping with the spirit of Reconciliation, we acknowledge the Aboriginal and Torres Strait Islander Peoples as the Traditional Owners of the lands. We wish to pay respect to their Elders – past, present and emerging – and acknowledge the important role Aboriginal and Torres Strait Islander people continue to play within our community.

PHN Acknowledgment

This webinar has been developed by Eastern Melbourne PHN on behalf of the Victorian PHN Alliance, which is the collective platform for the six PHNs in Victoria.

Eastern Melbourne PHN does not take responsibility arising from the use of, or reliance on, this webinar by a third party. Any such use or reliance is the sole responsibility of that party. This webinar does not constitute medical advice. If you require medical advice, please consult an appropriate medical professional.

Information contained in this presentation is current as at February 2017

Learning Objectives

- Describe the definition of chronic disease and eligibility requirements for chronic disease management (CDM)
- Describe GP Management Plans (GPMP) & Team Care Arrangements (TCA)
- Describe the CDM MBS Items and claiming frequency
- Outline the role of the Practice Nurse in assisting the GP with components of CDM
- Outline the role of allied health in CDM

Chronic Disease Management

Australian Government

Department of Health

CHRONIC DISEASE MANAGEMENT

Definition of “Chronic Condition”

- A **chronic medical condition** is one that has been or is likely to be present for six months or longer, including but not limited to, asthma, cancer, cardiovascular disease, diabetes, musculoskeletal conditions and stroke.

Aim of the Chronic Disease Management (CDM) program

- Coordination of services and treatments
- Proactive focus
- Active participation by patient
- Multidisciplinary team care approach

Patient eligibility for CDM

- Determined by the patients usual GP
- GPMP – Patient must have **a chronic or terminal condition** and would benefit from a structured care approach - MBS Item 721
- TCA - Patients must have **a chronic or terminal condition with complex care needs**, requiring ongoing care from a multidisciplinary team – that being at least 3 health or care providers from different disciplines, one of which is the GP - MBS Item 723

Other Medicare CDM service Items

- GPMP & TCA Review - MBS Item 732 – can be claimed X 2 on the same day if both GPMP & TCA were reviewed (must be annotated)

- MBS Item 729 - review or contribute to a multidisciplinary care plan prepared by another health or care provider

- MBS Item 731- contribution or review of a multidisciplinary care plan for a resident of a RACF where the plan was developed by the facility

Claiming frequency

Name	Item number	Recommended claiming	Minimum claiming period
Preparation of a GPMP or TCA	721 723	2 yearly	12 months
Review of a GPMP or TCA	732	6 monthly	3 monthly
Contribution to a multidisciplinary care plan provided by another provider	729	6 monthly	3 monthly
Contribution to a multidisciplinary care plan prepared by a residential aged care facility	731	6 monthly	3 monthly

Patient exclusions

- Medicare Provider Enquiry Line –
  Ring 132 150 to check '**if patient is eligible'** for care planning MBS Item payment before commencing a care plan or a review – can check eligibility of up to 7 patients per call

- Minimal claiming intervals apply except when exceptional circumstances apply

Care plan content

- Relevant conditions and health care needs
- Treatment and services
- Management goals & actions agreed to by patient
- Review date

GPMP Process

- Explanation of care planning process, consent & agreement by patient to participate
- Comprehensive care plan documented in a template
- Copy provided to patient and saved in patient medical record
- Generate recall/reminder for periodic review of goals and actions

TCA Process

- Patient consent for TCA and sharing of information with multidisciplinary team
- Collaboration with a team of 2 or more health or care providers
- Collaborate with team to determine goals, treatments and services
- Copy of care plan to team and patient
- Review date documented & generate recall/reminder

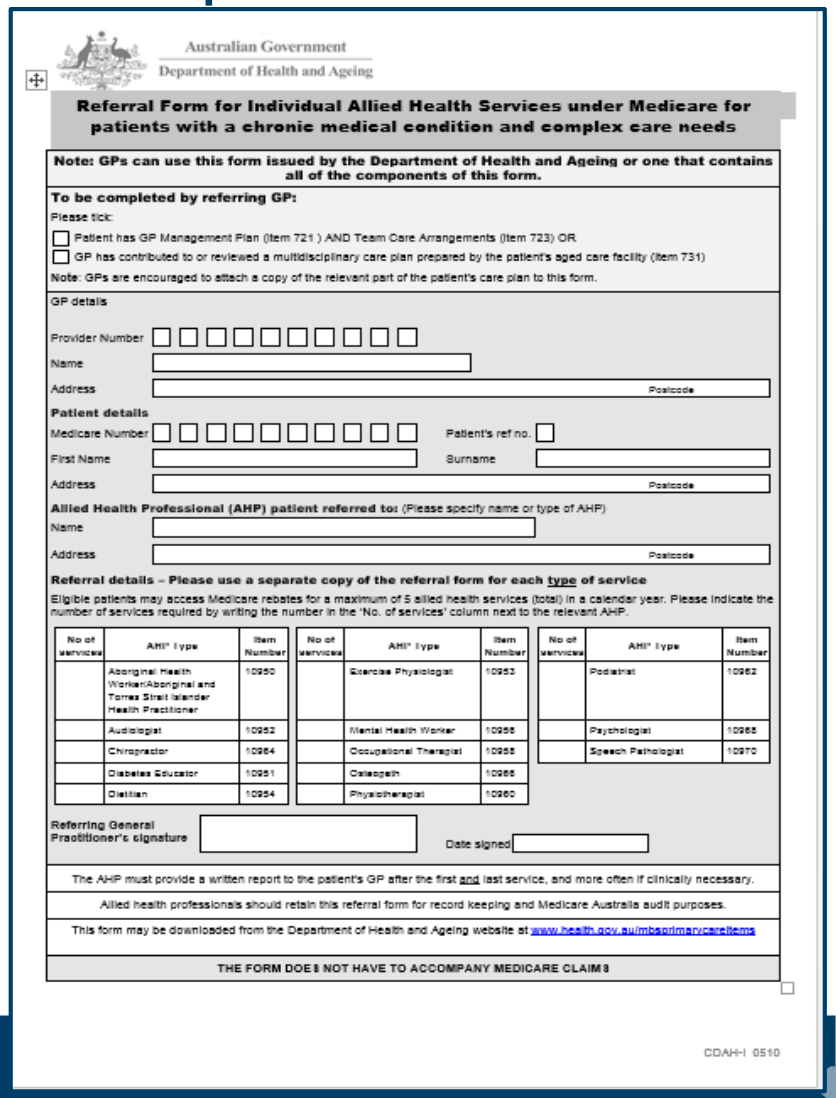
What is meant by collaboration? What does “ongoing involvement with the patient” mean?

- Ongoing involvement means provider contact must be based on more than a one off consultation

Access to Allied health services via TCA

- Directly related to the patients condition and identified in the TCA
- 5 rebated **individual** AHP services per calendar year
- 8 rebated **group** AHP sessions per calendar year- for patients with Diabetes - can be accessed via GPMP only

Referral Form for **Individual** Allied Health Services under Medicare for patients with a chronic medical condition and complex care needs



Australian Government
Department of Health and Ageing

Referral Form for Individual Allied Health Services under Medicare for patients with a chronic medical condition and complex care needs

Note: GPs can use this form issued by the Department of Health and Ageing or one that contains all of the components of this form.

To be completed by referring GP:

Please tick:

☐ Patient has GP Management Plan (Item 721) AND Team Care Arrangements (Item 723) OR

☐ GP has contributed to or reviewed a multidisciplinary care plan prepared by the patient's aged care facility (Item 731)

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

GP details

Provider Number ☐☐☐☐☐☐☐☐☐☐

Name

Address Postcode

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 a maximum of 5 allied health services (total) in a calendar 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
	Aboriginal Health Worker/Aboriginal and Torres Strait Islander Health Practitioner	10950
	Audiologist	10952
	Chiropractor	10954
	Diabetes Educator	10951
	Dietitian	10954

No of services	AHP type	Item Number
	Exercise Physiologist	10953
	Mental Health Worker	10956
	Occupational Therapist	10958
	Osteopath	10966
	Physiotherapist	10960

No of services	AHP type	Item Number
	Podiatrist	10962
	Psychologist	10968
	Speech Pathologist	10970

Referring General Practitioner's signature

Date signed

The AHP must provide a written report to the patient's GP after the first and last service, and more often if clinically necessary.

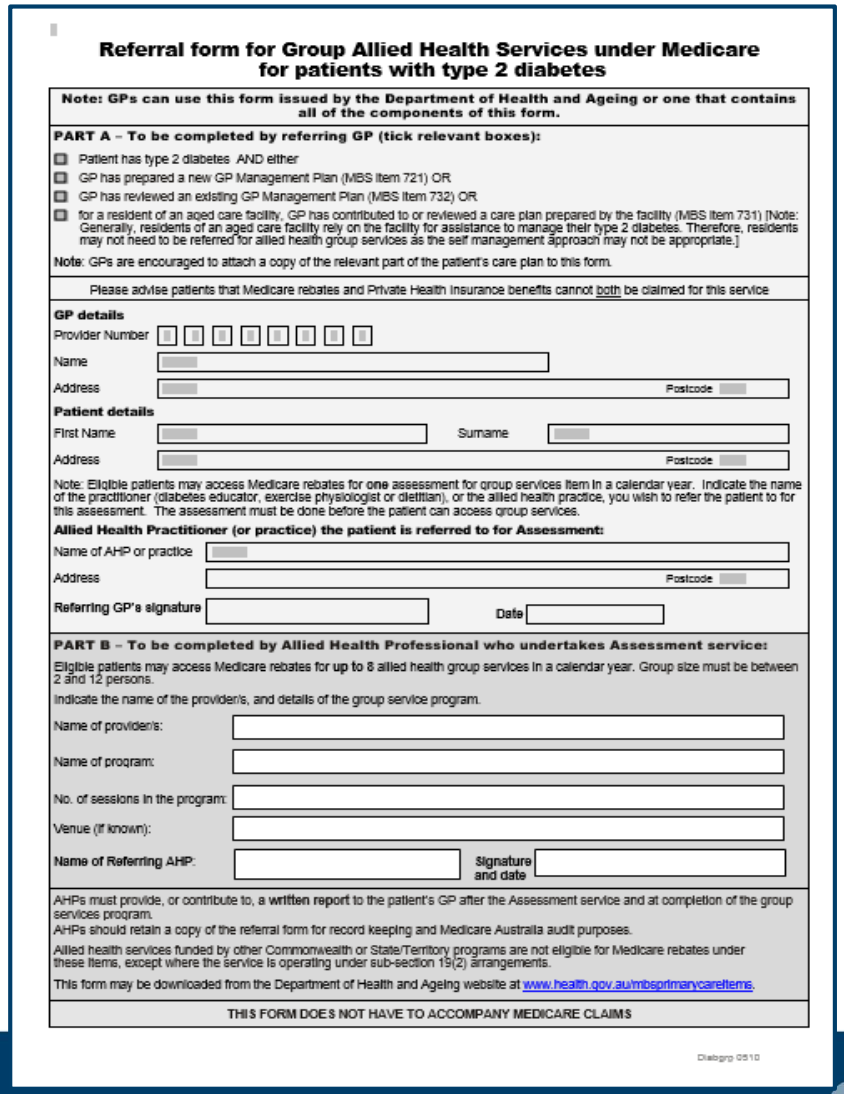
Allied health professionals should retain this referral form for record keeping and Medicare Australia audit purposes.

This form may be downloaded from the Department of Health and Ageing website at www.health.gov.au/mbsprimarycareitems

THE FORM DOES NOT HAVE TO ACCOMPANY MEDICARE CLAIMS

CDAH-I 0510

Referral form for **Group** Allied Health Services under Medicare for patients with type 2 diabetes



Referral form for Group Allied Health Services under Medicare for patients with type 2 diabetes

Note: GPs can use this form issued by the Department of Health and Ageing or one that contains all of the components of this form.

PART A – To be completed by referring GP (tick relevant boxes):

- ☐ Patient has type 2 diabetes AND either
- ☐ GP has prepared a new GP Management Plan (MBS Item 721) OR
- ☐ GP has reviewed an existing GP Management Plan (MBS Item 732) OR
- ☐ for a resident of an aged care facility, GP has contributed to or reviewed a care plan prepared by the facility (MBS Item 731) [Note: Generally, residents of an aged care facility rely on the facility for assistance to manage their type 2 diabetes. Therefore, residents may not need to be referred for allied health group services as the self management approach may not be appropriate.]

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

Please advise patients that Medicare rebates and Private Health Insurance benefits cannot both be claimed for this service

GP details

Provider Number ☐☐☐☐☐☐☐☐

Name

Address Postcode

Patient details

First Name Surname

Address Postcode

Note: Eligible patients may access Medicare rebates for one assessment for group services item in a calendar year. Indicate the name of the practitioner (diabetes educator, exercise physiologist or dietitian), or the allied health practice, you wish to refer the patient to for this assessment. The assessment must be done before the patient can access group services.

Allied Health Practitioner (or practice) the patient is referred to for Assessment:

Name of AHP or practice

Address Postcode

Referring GP's signature **Date**

PART B – To be completed by Allied Health Professional who undertakes Assessment service:

Eligible patients may access Medicare rebates for up to 8 allied health group services in a calendar year. Group size must be between 2 and 12 persons.

Indicate the name of the provider/s, and details of the group service program.

Name of provider/s:

Name of program:

No. of sessions in the program:

Venue (if known):

Name of Referring AHP: **Signature and date**

AHPs must provide, or contribute to, a **written report** to the patient's GP after the Assessment service and at completion of the group services program.

AHPs should retain a copy of the 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 these items, except where the service is operating under sub-section 19(2) arrangements.

This form may be downloaded from the Department of Health and Ageing website at www.health.gov.au/mbsprimarycareitems.

THIS FORM DOES NOT HAVE TO ACCOMPANY MEDICARE CLAIMS

Diabgrp 0510

Reviewing GPMP/TCA - Item 732

GPMP

- Changes must be documented
- Copy of updated plan with new review date for patient

TCA

- Changes must be documented
- Collaboration with the providers on progress against the goals
- Copy of updated plan with new review date for patient & TCA providers

Who can assist the GP?

- Practice nurse, Aboriginal & Torres Strait Islander Health Practitioner, Aboriginal Health Worker or other health professional

- GP must review and confirm assessments and arrangements and see patient when CDM Items are billed

Role of the practice nurse

- The practice nurse assists the GP with any of the following:
- Assessment, identification of patient needs, patient metrics
- ID patient needs and assistance with goal setting
- Arrangements for services / communicating with multidisciplinary team
- Support and education
- Management of reviews
- Data management & record keeping

Practice nurse MBS Item 10997

- MBS Item 10997 x 5 per calendar year for monitoring /support provided to a patient with a chronic condition who has a GPMP and/or TCA in place

- Provided under the supervision of the GP, however GP does NOT have to see patient on the day

Care Planning Templates

- Care Planning templates (generic or for specific chronic diseases) feature in most clinical software
- Peak Bodies also provide care planning templates (eg Health Foundation, Asthma Council, Arthritis Foundation, Diabetes Aust etc)
- Modify templates to suit practice needs
- Must follow specific instructions to import a template so specific patient data auto populates
- GPMP & TCA can be one combined document

Home Medicine Review (HMR) Item 900

- Patient eligibility

https://www.psa.org.au/aprc-home-medicines-review/determine-patient-eligibility

- Frequency is every 24 months unless exceptional circumstances exist (must document)
- GP refers patient for a medication review to an accredited pharmacist, who provides a report back to the GP
- Review of pharmacist report by GP and implementation of findings

Inclusion of National Cancer Screening reminders in care plans

Include reminder in care plan for age specific cancer screening actions

- National Bowel Cancer Screening Program

changing from 5 to 2 yearly by 2019 for 50-74 yo

Females

- HPV Cervical Cancer Screening 5 yearly

for 25-74 yo from May 2017

- Breast Cancer Screening 2 yearly for 50-74 yo

Removal of same day billing

- Effective from November 2014
- **Cannot claim Standard Consultation Item and CDM Item on the same day**

Local clinical and referral pathways

PHN pathways provide access to evidence-based information regarding conditions and symptoms, and localised service and referral information to support patient flow.

PHN	Care Pathways Online Resource
Eastern Melbourne	HealthPathways Melbourne melbourne.healthpathways.org.au
Gippsland	HealthPathways Gippsland gippsland.healthpathways.org.au
Murray	Murray HealthPathways murray.healthpathways.org.au
North Western Melbourne	HealthPathways Melbourne melbourne.healthpathways.org.au
South Eastern Melbourne	Map of Medicine semphn.org.au/resources/pathways.html
Western Victoria	HealthPathways Western Victoria westvic.healthpathways.org.au

Resources

- Department of Health (incl sample GPMP/TCA forms) http://www.health.gov.au/internet/main/publishing.nsf/content/mbsprimarycare-chronicdiseasemanagement

- Chronic Disease Management Question & Answers http://www.health.gov.au/internet/main/publishing.nsf/Content/030C0CED16935261CA257BF0001D39DB/$File/CDM-qandas-feb4.pdf

- MBS online http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Home

Resources

- Referral Form for Individual Allied Health Services under Medicare for patients with a chronic medical condition and complex care needs
  http://www.health.gov.au/internet/main/publishing.nsf/Content/health-medicare-health_pro-gp-pdf-ahs-cnt.htm

- Referral form for Group Allied Health Services under Medicare for patients with type 2 diabetes
  http://www.health.gov.au/internet/main/publishing.nsf/Content/F5D1231CD6096BD1CA257BF0001FEB86/$File/Referral%20form%20Grp%20Allied%20HS%20Medicare%202%20Diabetes.pdf

Frequently Asked Questions

- Can you claim a review for a GPMP & TCA on the same day?
- Can a AHP visits from the previous year roll over to the next year?
- Do DVA gold card holders need a TCA to access rebated allied health visits?
- Can a nurse be 1 of the health care providers in a TCA if they routinely assist and coordinate care plans?

Frequently Asked Questions

- Do you have to list all the service providers on the TCA?
- Can a receptionist of either an AHP or specialist consent on their behalf to participate as one of the team members in a team care arrangement?
- Is it necessary to have a new GPMP or TCA prepared each calendar year in order to access a new referral for eligible allied health services?

Thank you for watching and listening

Feedback or further support regarding this webinar should be directed to your local PHN

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