



Chronic Disease Management (CDM) Medicare Items

The Chronic Disease Management items, on the Medicare Benefits Schedule, 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 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 items replaced the former Enhanced Primary Care (EPC) items for multidisciplinary care planning services.

Overview of the items

The CDM items include a service for 'GP only' care planning (the GP Management Plan) in addition to services for multidisciplinary care planning (Team Care Arrangements).

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 items

There are six CDM items:

Preparation of a GP Management Plan (GPMP - 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 \$127.70
- 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 (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 \$63.85
- 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 \$101.15
- 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 \$63.85
- 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.
- The Medicare fee is \$62.30
- 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 items

Patients who have both a GP Management Plan and a Team Care Arrangements service have access to the allied health services on the Medicare Benefits Schedule.

Similarly, residents of aged care homes whose GP has contributed to a care plan prepared by the aged care home (item 731) will also have access to the allied healthcare items.

Eligible patients can claim a maximum of **5 allied health services per calendar year**.

Patients with a GPMP 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 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 referral form can be found at: http://www.health.gov.au/internet/main/publishing.nsf/Content/health-medicare-health_pro_gp-pdf-epcahs-cnt.htm or ordered by faxing (02) 6289 7120.

Practice Nurse Monitoring and Support

Patients with either a GPMP or a TCA can receive monitoring and support services from a practice nurse or registered Aboriginal health worker on behalf of the GP.

Further information

More detailed information on the CDM items is available at www.health.gov.au – use the A-Z Index to go to 'E' then select the Enhanced Primary Care (EPC) Program. The Chronic Disease Management Medicare items are located in the 'In this Section' box of this EPC web page. Alternatively, contact Medicare Australia on 132 150 (for GPs) or 132 011 (for patients).