GPMP and TCAs Reviews (Medicare item 732)
Important reminders

The Department of Health and Ageing would like to remind GPs about the importance and key requirements of reviewing care plans (Medicare Item 732). 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. CDM guidance material in the Medicare Benefits Schedule state that GPMPs and TCAs should be regularly reviewed by the GP. The recommended frequency for these services, allowing for variation in patients' needs, is every six months. This is recommended as an average frequency but should be applied with regard to the patient's requirements.

2. In general, a new GPMP or TCAs 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 TCAs have been prepared.

3. It is recommended that a patient receive around three reviews (item 732) for every care plan (item 721 and/or 723) in a two-year period. Changes to the plans can be made as part of each review. Ongoing management and care can be provided through normal consultation items and the practice nurse item for support and monitoring (item 10997) where applicable.

4. CDM review items are not being claimed by GPs as frequently as recommended. This may be because reviews are being undertaken opportunistically during a normal consultation. However, the Medicare benefit for the CDM review items (Item 732) is set at a level higher than a level C consultation to take account of the additional work required.

5. In particular, if a GP undertakes to coordinate the care of patients with complex care needs (with TCAs), they should undertake to regularly review their care plans.

6. Practices should establish systematic ways of reminding patients to attend for a review of their care plans. GPs who have successfully incorporated the CDM items into their practices advise that team-based care need not be difficult if adjustments are made to practice systems and procedures to efficiently manage the collaborative process.

7. Practice nurses and Aboriginal health workers can play an important role in care planning and free up GP time if they are strategically employed, and patients are made aware of their status. This can include gathering and documenting information, assisting in assessing the patient, identifying the patient's needs and making arrangements for services.

8. 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 once 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.

9. A patient information brochure to help GPs to discuss with patients the need to return for a review service is available on the department's web site.