

## **Team Care Arrangements (Medicare item 723)**

### **Important reminders**

The Department of Health and Ageing would like to remind GPs about key requirements of Team Care Arrangements (TCAs – Medicare Item 723). 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](http://www.mbsonline.gov.au)), and the department's web site ([www.health.gov.au](http://www.health.gov.au)) for more information including care planning checklists and templates.

1. The recommended frequency for a TCAs service is once every two years, with regular reviews recommended every six months. This is not mandatory – in general, new TCAs should not be prepared unless and until required by the patient's condition, needs and circumstances.
2. This item is for patients with a chronic or terminal medical condition who require ongoing care from a multidisciplinary team of their GP and at least two other health or care providers.
3. A GP can coordinate team care and claim a TCAs service without the need for a GPMP if the GP considers it appropriate. However, to be eligible for Medicare rebates for the five individual allied health services, a patient must be managed by a GP under both a GPMP and TCAs.
4. Whether or not a patient is eligible for TCAs is essentially a matter for the GP to decide.
5. GPs determine whether the patient's condition would benefit from a chronic disease care plan and allied health services.
6. It is not appropriate for allied health providers to provide part-completed referral forms to GPs for signature, particularly in a way that pre-empts the eligibility of the patient or the GP's decision about the services required.
7. GPMPs and TCAs are designed to improve the quality of patient care and need to be done thoughtfully, with adequate clinical input that seeks to improve a patient's health outcome. TCAs help to coordinate the services and treatment that a patient requires and can be used by the GP as a tool for organising the care a patient needs by collaborating with other health and care providers. They are not designed simply as a mechanism to provide Medicare rebates for allied health services.
8. TCAs are required **by legislation** to include a document that describes:
  - treatment and service goals for the patient
  - treatment and services that collaborating providers will provide to the patient
  - actions to be taken by the patient
  - a date to review these matters.
9. Care coordination during the development of TCAs does not replace a referral.
10. Reviewing TCAs 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.
11. The TCAs item covers the consultation at which the item is undertaken and so, in general, a separate consultation should not be undertaken with TCAs unless it is clinically indicated that the problem must be treated immediately.
12. 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.
13. Patient information materials, that will help GPs to discuss TCAs with their patients, are available on the department's web site.