

Chronic Disease Management (CDM) Items - OVERVIEW

GP Management Plan (GPMP) - Item 721

Preparation of a GP Management Plan by the patient's usual GP (or another GP in the same practice).

Eligibility of patients for GP Management Plan

Patients with a chronic or terminal medical condition who will benefit from a structured approach to management of their care needs.

A chronic medical condition is one that has been or is likely to be present for at least six months, including but not limited to asthma, cancer, cardiovascular illness, diabetes mellitus, mental health conditions (including dementia), musculoskeletal conditions and stroke.

GP Management Plans are available to patients living in the community and also private in-patients being discharged from hospital, where their usual GP (or a GP from the same practice) is providing in-patient care (in this case the GPMP is claimed as an in-hospital service).

What's involved in the preparation of a GP Management Plan

The steps in preparing a GPMP must include:

- a) assessing the patient to identify and/or confirm their health care needs, problems and relevant conditions;
- b) agreeing on management goals with the patient for the changes to be achieved by the treatment and services identified in the plan;
- c) identifying any actions to be taken by the patient;
- d) identifying treatment and services that the patient is likely to need, and making arrangements for provision of these services and ongoing management; and
- e) documenting the patient needs, goals, patient actions, treatment/services and a review date i.e. completing the GPMP document.

The GP may, with the permission of the patient, provide a copy of the GPMP or relevant parts of the GPMP to other providers involved in the patient's care.

How often can you do a GPMP?

The recommended frequency of this service is once every two years (with regular reviews of the patient's progress against the plan), except in the discharge setting, where a new GPMP may be required following separate hospital admissions.

A rebate will not be paid by Medicare within twelve months of a previous claim for a GPMP, within twelve months of a claim for item 720 (preparation of a community care plan – *old item*) or within three months of any other EPC chronic disease management item, other than in exceptional circumstances.

'Exceptional circumstances' apply where there has been a significant change in the patient's clinical condition or care circumstances that require a new GPMP (rather than, for example, amending the existing GPMP). Where a service is provided in exceptional circumstances, the patient's invoice or Medicare voucher (assignment of benefit form) should be annotated to briefly indicate the reason why the service involved was required earlier than the minimum time interval for the relevant item.

Team Care Arrangements (TCA) - Item 723

Coordinating the development of Team Care Arrangements (TCA) by the patient's usual GP (or a GP in the same practice). This service can be provided to patients who have a current GPMP or to those patients whose care is, in the opinion of the providing GP, appropriately managed at the GP level without a GPMP.

Eligibility of patients for Team Care Arrangements

Patients with a chronic or terminal medical condition and who require ongoing care from a multidisciplinary team of at least three health or care providers (including their GP).

Available to patients living in the community and also private in-patients being discharged from hospital, where their usual GP (or a GP from the same practice) is providing in-patient care (in this case the GPMP is claimed as an in-hospital service).

What's involved in coordinating Team Care Arrangements

The steps in coordinating TCA must include:

- a) discussing with the patient which treatment/service providers should be asked to collaborate with the GP in completing TCA;
- b) gaining the patient's agreement to share relevant information about their medical history, diagnoses, GPMP etc (with or without restrictions) with the proposed providers;
- c) contacting the proposed providers and obtaining their agreement to participate, realising that they may wish to see the patient before they provide input but that they may decide to proceed after considering relevant documentation, including any current GPMP;
- d) collaborating with the participating providers to discuss potential treatment/services they will provide to achieve management goals for the patient;
- e) documenting the goals, the collaborating providers, the treatment/services they have agreed to provide, patient actions and a review date i.e. completing the TCA document; and
- f) providing the relevant parts of the TCA to the collaborating providers and to any other persons who, under the TCA, will give the patient the treatment/services mentioned in the TCA.

A TCA should document all the health or care services required to address the patient's needs – this should include services to be provided by people/organisations that are not members of the TCA team.

Who is involved in Team Care Arrangements?

To develop Team Care Arrangements for a patient at least two health or care providers who will be providing ongoing treatment or services to the patient must collaborate with the GP in the development of the TCA. Each of the health or care providers must provide a different kind of ongoing care to the patient. Only one of the service providers collaborating with the GP may be another medical practitioner (normally a specialist or consultant physician but not usually another GP). The patient's informal or family carer may be included in the collaborative process but does not count towards the minimum of three collaborating providers.

What does collaboration mean?

Collaboration between the coordinating GP and participating providers must be based on two-way communication either in person, by telephone, videoconferencing, letters, e-mails or faxes. Communication from providers must include advice on treatment and management of the patient.

How often can you coordinate Team Care Arrangements?

The recommended frequency of this service is once every two years, with regular reviews of the patient's progress against the TCA, however, in the discharge setting a new TCA may be required following separate hospital admissions.

A rebate will not be paid within twelve months of a previous claim for the same item, within twelve months of a claim for item 720 (preparation of a community care plan) or within three months of a claim for a TCA review (item 727), other than in exceptional circumstances.

Examples of other Service Providers who can participate:

| <i>Health Professionals such as:</i> | | |
|--------------------------------------|----------------------------|---------------------|
| Aboriginal health workers | Mental health workers | Physiotherapists |
| Asthma educators | Occupational therapists | Podiatrists |
| Audiologists | Optometrists | Psychologists |
| Dental therapists | Orthoptists | Registered nurses |
| Dentists | Orthotists or Prosthetists | Social workers |
| Diabetes educators | Pharmacists | Speech pathologists |
| Dieticians | | |

| <i>Community Service Providers such as:</i> | |
|---|---|
| Alcohol & Drug support workers | Respite services |
| Chaplain | Home & Community Care (HACC) service providers, e.g. |
| Child care workers | - Meals on Wheels & other meal services |
| Community nurses | - Domestic assistance |
| Community support groups | - Community transport |
| Continence Adviser | - Neighbour Aid (social support) |
| Disability service providers | - Community Options |
| Education providers (teachers) | - Home maintenance & modification |
| Home nursing & home help | - Home Care |
| Personal care workers | Community Aged Care Package (CACP) coordinators |
| Probation officers | Extended Aged Care in the Home Package (EACH) coordinators |
| | Consumer Advocacy Case Workers |

| <i>Medical Specialists/Consultant Physicians such as: (only one specialist or consultant can be included on the team)</i> | | |
|---|---------------------|-----------------------|
| Cardiologist | Ophthalmologist | Radiologist |
| Dermatologists | Orthopaedic Surgeon | Psychiatrist |
| Endocrinologist | Neurologist | Respiratory Physician |
| Gastroenterologist | Paediatrician | Urologist |
| Geriatrician | | |

- A multidisciplinary care plan team includes the GP and at least two other service providers.
- Each of the members of the multidisciplinary care plan team must provide a different kind of care or service to the patient.
- Only one other member of the team may be another medical practitioner (e.g. specialist or consultant physician).

Review of a GP Management Plan - Item 725

This item is for patients who have a current GPMP in place and who will benefit from a review of that GPMP. The GP who prepared the patient's last GPMP (or another GP in the same practice or a new GP where the patient has changed practices) undertakes a systematic review of the patient's progress against the GPMP goals.

What's involved in reviewing a GP Management Plan

The steps in reviewing a GPMP must include:

- a) reviewing the patient's needs and goals, patient actions and treatment/services;
- b) making relevant changes to the documented GPMP; and
- c) adding a new review date;

The GP may, with the permission of the patient, provide a copy of the reviewed GPMP or of relevant parts of the reviewed GPMP, to other providers involved in the care of the patient.

How often can you review a GP Management Plan

The recommended frequency of this service is once every six months. A rebate will not be paid within three months of a previous claim for the same item or within three months of a claim for preparing a GPMP, other than in exceptional circumstances.

Review of Team Care Arrangements - Item 727

This item is for patients who have a TCA in place and who will benefit from a review of the TCA. The GP who coordinated the development of the patient's TCA (or another GP in the same practice or a new GP where the patient has changed practices) coordinates a systematic review of the patient's progress against the TCA goals.

What's involved in reviewing Team Care Arrangements

The steps in coordinating a review of TCA must include:

- a) discussing or confirming with the patient which treatment/service providers should be asked to collaborate with the GP in the review and gaining agreement to share relevant information with them;
- b) collaborating with the participating providers to establish the patient's progress against the previously nominated treatment/service goals, and agreeing on any necessary changes and on the specific treatment/services to be provided by each member of the team;
- c) making necessary changes to the documented TCA; and
- d) providing the relevant parts of the revised TCA (if any) to the collaborating providers and to any other persons who will give the patient treatment/services mentioned in the TCA.

How often can you review Team Care Arrangements

The recommended frequency of this service is once every six months. A rebate will not be paid within three months of a previous claim for the same item or within three months of a claim for coordinating the development of TCA, other than in exceptional circumstances.

Contributing to a Multidisciplinary Care Plan or Contributing to a Review of a Multidisciplinary Care Plan - Item 729

This item is for patients who are having a multidisciplinary care plan prepared or reviewed for them by another health or care provider (i.e. other than their usual GP). Other health or care providers include (but are not limited to) allied health providers, home or community service providers and medical specialists, but not usually other GPs.

This item is claimed once the patient's usual GP (or another GP in the same practice) has contributed to the care plan or to the review of the care plan being prepared by the other provider.

This GP service is available to patients in the community and to both private and public in-patients being discharged from hospital. It is not available to patients who are residents of aged care facilities.

What's involved in contributing to or reviewing a Multidisciplinary Care Plan

The steps involved in contributing to a multidisciplinary care plan or to a review of the care plan must include:

- a) gaining or confirming the patient's agreement for the GP to contribute to the care plan or to the review of the care plan and to share relevant information with the other providers;
- b) collaborating with the person preparing the care plan to set goals and specify treatment/services to be provided by the GP;
- c) adding to the patient's records a copy or notation of the GP's contribution to the plan (either the treatment/services to be provided by the GP or the GP's advice to the person preparing the plan).

How often can you contribute to or review a Multidisciplinary Care Plan

The recommended frequency of this service is once every six months. Other than in exceptional circumstances, a rebate will not be paid within twelve months of a GPMP or TCA claimed by the same practitioner for that patient, within three months of a previous claim for the same item or within three months of a claim for other EPC review or contribution items.

Contributing to a Multidisciplinary Care Plan or Contributing to a Review of a Multidisciplinary Care Plan for a Patient who is a Resident of an Aged Care Facility - Item 731

This item, including the components of the service, is similar to Item 729 except that:

- (a) this service is only available to residents of aged care facilities;
- (b) this service can only be provided to a resident where the multidisciplinary plan is being prepared by the aged care facility or by a hospital from which the resident is being discharged;
- (c) a contribution to a care plan for an aged care resident must be at the request of the aged care facility or the discharging hospital;
- (d) the GP's contribution should be documented in the care plan maintained by the aged care facility or discharging hospital and a record included in the resident's medical record; and
- (e) a rebate will not be paid within three months of a previous claim for the same item or within three months of a claim for other EPC CDM items.

Additional Information

Before proceeding with any EPC CDM service (other than a care plan contribution under items 729 and 731) the GP must ensure that:

- (a) the steps involved in providing the service are explained to the patient and (if appropriate and with the patient's permission) to the patient's carer;
- (b) in the case of TCA and TCA review services, any likely out-of-pocket costs to the patient for the involvement of other providers are explained to the patient; and
- (c) the patient's agreement to proceed is recorded.

Before completing any EPC CDM service (other than a contribution item) and claiming a benefit for that service, the GP must offer the patient a copy of the relevant document and add the document to the patient's record.

Assistance of a Practice Nurse (or Other health Professional)

A practice nurse, Aboriginal Health Worker or other health professional may assist a GP in preparing or reviewing a GPMP or TCA, for example in patient assessment, identification of patient needs and making arrangements for services. This assistance is provided on behalf of the GP, not as part of a separate Medicare Item. The GP must review and confirm all assessments and elements of the GPMP, TCA, reviewed GPMP or reviewed TCA and must see the patient as part of the service.

Allied Health and Dental Services Under Medicare

The allied health initiative allows for some patients to get access to Medicare rebates for services provided by certain allied health professionals.

For patients to be eligible to access rebates under the allied health and dental items they must have both a GP Management Plan and a Team Care Arrangements in place and claimed on Medicare (Items 721 & 723). Unless these items have been claimed for that patient, the patient will not be able to receive a rebate back from Medicare for the allied health and dental services.

Also, where a resident's GP has contributed to a care plan prepared by the aged care facility or discharging hospital for the resident (Item 731), the resident is also eligible to access rebates under the allied health and dental items.

The allied health and dental services need to be mentioned in the TCA document and the patient needs to be referred by their usual GP, using the special referral forms.

For the allied health services under Medicare, a patient can claim up to five allied health services in total in a calendar year. It is not five services per allied health professional, but rather five services in total. This can be from only one allied health professional or a combination of services. For example your patient may use all five services with the podiatrist OR two with the podiatrist, two with the dietician and one with the physiotherapist = five in total.

For dental services under Medicare, a patient can receive up to \$4,250 in Medicare benefits for dental services over two consecutive calendar years.

These services can only be provided by allied health professionals, dentists and dental specialists who are registered with Medicare Australia.