A Guide to Chronic Condition Management

Part 1—Enhanced Primary Care / Chronic Disease Management Items

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Quick Guide to MBS Items for Enhanced Primary Care

Changes usually occur in May and November annually. For the most up to date information please check the Medicare Online website at: http://www9.health.gov.au/mbs or telephone Medicare on 132 150.

	Item Number	Service	Brief Guide	Claim Period	MBS Payment (as at 20/01/09)
Health Assessments	**701**	**Brief Health Assessment**	A brief health assessment is used to undertake simple health assessments. The health assessment should take no more than 30 minutes to complete	**Depends on age/category (see specific health assessment below)**	**$55.00**
	MBS A24 - http://www9.health.gov.au/mbs/search.cfm?q=701&sopt=S				
	703	**Standard Health Assessment** **MBS A24**	A standard health assessment is used for straightforward assessments where the patient does not present with complex health issues but may require more attention than can be provided in a brief assessment. The assessment lasts more than 30 minutes but takes less than 45 minutes	**Depends on age/category (see specific health assessment below)**	**$127.80**
	705	**Long Health Assessment** **MBS A24**	A long health assessment is used for an extensive assessment, where the patient has a range of health issues that require more in-depth consideration, and longer-term strategies for managing the patient's health may be necessary. The assessment lasts at least 45 minutes but less than 60 minutes	**Depends on age/category (see specific health assessment below)**	**$176.30**
	707	**Prolonged Health Assessment** **MBS A24**	A prolonged health assessment is used for a complex assessment of a patient with significant, long-term health needs that need to be managed through a comprehensive preventive health care plan. The assessment takes 60 minutes or more to complete	**Depends on age/category (see specific health assessment below)**	**$249.10**
	715	**Aboriginal and/or Torres Strait Islander Health Assessment**	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) at consulting rooms or in another place other than a hospital or Residential Aged Care Facility	**Not more than once in a 9 month period**	**$196.65**
	MBS A32 - http://www9.health.gov.au/mbs/search.cfm?q=715&sopt=S				
	0-14 years – A.33 - http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=A33&qt=noteID				
	15-54 years – A.34 - http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=A34&qt=NoteID				
	55+ years – A.35 - http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=A35&qt=NoteID				
	701-707	**Kids Health Check** for 3-5 year olds at time of four year old immunisation	Items 701, 703, 705 and 707 may be used to provide a Health Kids Check for children aged at least 3 years and less than 5 years of age, who have received or who are receiving their 4 year old immunisation.	**Once only to eligible patient**	**Time Based as above**
	MBS A25 - http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=A25&qt=noteID&criteria=701				

Health Assessments					
	10986	**Kids Health Check** for 3-5 year olds at time of four year old immunisation	Assessment in GP Surgery by Practice Nurse or Registered Aboriginal Health Worker	**Once only to eligible patient**	**Time Based as above**
	MBS M12.3 - http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=M12.3&qt=noteID&criteria=701				
	701-707	**Health Assessment** for people aged 75 years and older	A health assessment for people aged 75 years and older is an assessment of a patient's health and physical, psychological and social function for the purpose of initiating preventive health care and /or medical interventions as appropriate.	**Annually to an eligible patient**	**Time Based as above**
	MBS A28 - http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=A28&qt=noteID&criteria=701				
	701-707	**Comprehensive Medical Assessment** (CMA) of a permanent resident of residential aged care facility (RACF)	Comprehensive Medical Assessment at RACF or consulting rooms	**Annually to an eligible patient**	**Time Based as above**
	MBS A29 - http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=A29&qt=noteID&criteria=701				
	701-707	**Type 2 diabetes** risk evaluation for a patient who is 40-49 years of age (inclusive)	At a place other than a hospital and for those with a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool	**Once every 3 years to an eligible patient**	**Time Based as above**
	MSB A26 - http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=A26&qt=noteID&criteria=701				
	701-707	**Health Assessment provided for refugees and other humanitarian entrants**	The purpose of this health assessment is to introduce new refugees and other humanitarian entrants to the Australian primary health care system, as soon as possible after their arrival in Australia (within twelve months of arrival). Check MBS A31 for criteria	**Once only to an eligible patient**	**Time Based as above**
	MBS A31 - http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=A31&qt=noteID&criteria=701				
	701-707	**45-49 year Health Check** for a patient between the age of 45-49 (inclusive) at risk of developing Chronic Disease	For the purposes of this health assessment, a patient is at risk of developing a chronic disease if, in the clinical judgement of the attending medical practitioner, a specific risk factor for chronic disease is identified.	**Once only to an eligible patient**	**Time Based as above**
	MBS A27 - http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=A27&qt=noteID&criteria=701				
	701-707	**Health Assessment** – for people with an intellectual disability	A person is considered to have an intellectual disability if they have significantly sub-average general intellectual functioning (two standard deviations below the average intelligence quotient [IQ]) and would benefit from assistance with daily living activities.	**Annually to an eligible patient**	**Time Based as above**
	MBS A30 - http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=A30&qt=noteID&criteria=701				

	Item	Service	Eligibility	Frequency	Fee
Chronic Disease Management	**721**	Preparation of a **General Practitioner Management Plan (GPMP)**	Patients with a Chronic or terminal medical condition are eligible	**2 yearly** (minimum 12 months)	**$133.65**
	MBS A36 - http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=A36&qt=noteID&criteria=721				
	723	Coordination of a **Team Care Arrangement (TCA)** **MBS A36**	Patients with complex Chronic disease who require ongoing care from a multidisciplinary team	**2 yearly** (minimum 12 months)	**$105.90**
	732	**Review** of a General Practitioner Management Plan (GPMP) **MBS A36**	Systematic review of the patient's progress against the GPMP goals (can be charged together with a review of a TCA)	**6 Monthly** (Minimum 3 months)	**$66.80**
	732	**Review** of a Team Care Arrangement (TCA) **MBS A36**	Systematic team-based review of the patient's progress against TCA goals (can be charged together with a review of a GPMP)	**6 Monthly** (Minimum 3 months)	**$66.80**
	729	**Contributed to care plan or to review the care plan** being prepared by the other provider **MBS A36**	Not available to patients of RACF	**6 Monthly** (Minimum 3 months)	**$65.20**
	731	**Contributed to care plan or to review the care plan** for patient of RACF **MBS A36**	Plan prepared by such a facility	**6 Monthly** (Minimum 3 months)	**$65.20**
Mental Health	**2710**	**GP Mental Treatment Plan**	A GP who has completed mental health skills training undertakes early intervention, assessment and management of patients with mental disorders	**12 Months**	**$160.45**
	MBS A46 - http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=A46&qt=noteID&criteria=2710				
	2712	**Reviewing a GP Mental Health Plan** **MBS A46**	Review of patient's progress once a GP Mental Health Treatment Plan has been prepared	A rebate will not be paid within three months of a previous claim for the same item or within four weeks following a claim for item 2702 or 2710, except where there has been a significant change in the patient's clinical condition or care circumstances that requires the preparation of a new review of a GP Mental Health Treatment Plan.	**$106.95**
	2713	**GP Mental Health Care Consultation** **MBS A46**	Consultation for mental disorder & lasting at least 20 minutes (not being service associated with **items 2710 or 2712)**	**Unrestricted**	**$70.60**

Category	Item	Service	Description	Frequency	Fee
	2721-2727	**Focussed Psychological Strategies**	Provided to patients by a Credentialed medical practitioner and are time limited; being deliverable, in up to 12 planned sessions comprising two groups of up to 6 sessions	**See each item for time required**	**$85.95-$147.05**
	MBS A47 - http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=A47&qt=noteID&criteria=2721				
Medicine Reviews	900	**Domiciliary Medication Management Review (DMMR)** for patients living in a community setting	Assessment, referral to a community pharmacy	**12 Months** Except in circumstances with significant change	**$143.40**
Medicine Reviews	**MBS A42 - http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=A42&qt=noteID&criteria=900**				
Medicine Reviews	903	**Residential Medication Management Review (RMMR)** for a permanent resident of a residential aged care facility **MBS A42**	For new or existing residents of RACFs	**12 Months** Except in circumstances with significant change	**$98.20**
Practice Nurse	10987	**Follow up by a PN or AHW for Indigenous person who has had a health check**	Provided by a Practice Nurse or AHW on behalf of the medical practitioner	**Maximum of 5 times** per patient per calendar year	**$22.70**
Practice Nurse	**MBS M12.4 - http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=M12.4&qt=noteID&criteria=10987**				
Practice Nurse	10993	**Immunisation** provided to a person by a practice nurse	Provided by a Practice Nurse on behalf of the medical practitioner	**Claimed only once per patient visit**	**$11.35**
Practice Nurse	**MBS M2.1 - http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=M2.1&qt=noteID&criteria=10993**				
Practice Nurse	10994	**Pap Smear and preventative check** **MBS M2.1**	Pap Smear and at least one preventative check taken by Practice Nurse on behalf of the medical practitioner	All Practice Nurses taking Pap Smears & other preventative checks should have undertaken an accredited training course	**$22.70**
Practice Nurse	10995	**Pap Smear and preventative check** **MBS M2.1**	The patient is between the ages of 20 and 69 inclusive, has not had a Pap Smear in the last 4 years	Claimed when **no Pap Smear** in 4 years	**$22.70**
Practice Nurse	10996	**Treatment of a person's wound** (other than normal wound care) **MBS M2.1**	Provided by a Practice Nurse	Claimed **only once** per patient visit	**$11.35**

	Item	Service	Description	Conditions	Fee
	10997	**Monitoring and support for a person with a Chronic Disease** **MBS M2.1**	To provide checks on progress, monitor meds, self-management & collection of info to support GP reviews and Care Plans	**Maximum of 5 times** per patient per calendar year	**$11.35**
	10998	**Pap Smear only** **MBS M2.1**	Taken by a Practice Nurse on behalf of the medical practitioner		**$11.35**
	10999	**Pap Smear only** **MBS M2.1**	The patient is between the ages of 20 and 69 inclusive, has not had a Pap smear in the last 4 years		**$11.35**
	11506	**Measurement of Respiratory Function**	Before or after inhalation of bronchodilator	**Claimed only once per patient visit**	**$16.50**
	http://www9.health.gov.au/mbs/search.cfm?q=11506&sopt=S				
	11700	**Twelve-lead Electrocardiography**	A full 12-lead ECG is performed & report	**Claimed only up to three times per day**	**$25.10**
	MBS D1.18 - http://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&q=11700&qt=item&criteria=11700				
	11702	**Twelve-lead Electrocardiography**	Tracing only		**$12.50**
	http://www9.health.gov.au/mbs/search.cfm?q=11702&sopt=S				
Service Incentive Payments	2501 2504 2507	**Cervical Smear** **B** **C** **D**	In surgery Consultation for patient between the ages of 20 and 69 years inclusive	**Patient who has not had a smear in the last 4 years**	**$34.30** **$65.20** **$95.95**
	MBS A43 - http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=A43&qt=noteID&criteria=2501				
	2517 2521 2525	**Diabetes Annual Cycle of Care** **B** **C** **D**	Minimum requirements of care needed to be completed	**Only paid once every 11-13 month period per patient**	**$34.30** **$65.20** **$95.95**
	MBS A44 - http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=A44&qt=noteID&criteria=2517				
	2546 2552 2558	**Asthma** **B** **C** **D**	Completion of minimum the Asthma Cycle of Care within 12 months for a patient with moderate to severe asthma	**1 Asthma Cycle of Care for each eligible patient per 12 months per period**	**$34.30** **$65.20** **$95.95**
	MBS A45 - http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=A45&qt=noteID&criteria=2546				

TGPN gratefully acknowledges the support of GP partners Adelaide in the adaptation of the Chronic Disease Resource Manual. Update by Townsville General Practice Network in June 2010.

Chronic Condition Management Systems

Systematic Chronic Condition Management aims to manage patients with chronic conditions by preventing complications and maintaining health. By planning regular consultations, a reduction in acute problem presentations can be achieved.

The following outcomes are achievable for patients and practices when Chronic Condition Management is systematic:

- Patients become involved in their own care
- Teamwork is of a multidisciplinary kind
- Ad hoc consultations are decreased
- Care becomes coordinated and more effective

Principles to be followed in implementing CCM are:

- A team based whole practice approach with all team members involved and informed
- Improved care needs to be system based
- Utilization of the entire staff skills base
- Responsibilities of staff identified
- Protected time for the practice nurse and other staff to do CCM
- Practice Nurse responsible for chronic condition management skills and education
- Communication between all the team members to be effective
- Awareness of community resources and available contacts

Assessing your practice's capacity for CCM.

The following checklist will assist you in reviewing your current systems for CCM.

Issues	Key Questions	☑	Page
Demographic Issues	What is the patient profile? Are there many patients with specific Chronic Disease?	☐	73
	What can a Practice Health Atlas or Clinical Audit Tool data analysis tell us?	☐	73
	Can we identify our patients with Chronic Disease, diabetes etc.?	☐	73
	What % of female patients has been screened more than four years ago?	☐	73
	Are there many patients requiring Mental Health Care?	☐	73, 9
	Can we identify those asthma patients with moderate to severe asthma?	☐	73
	Which Chronic Disease initiatives could be utilised for this practice population?	☐	6
	Can we identify the patients who may benefit from HMR?	☐	73, 33
	What one area will we address initially?	☐	57

Issues	Key Questions	☑	Page
Clinical Issues ***For GPs and Nurses***	Do I know about the Asthma Cycle of Care?	☐	18
	Do I know about the Diabetes Annual Cycle of Care?	☐	17
	Do I know about the Better Access to Mental Health process?	☐	87
	Can our practice utilise other staff members in managing Chronic Disease?	☐	35
	What new roles and skills are required in the practice to improve our CDM?	☐	35, 54, 57
	Do I know about Medicare Chronic Disease Management (CDM) initiatives?	☐	6
	Do we know who we can refer to for Team Care Arrangements?	☐	21
	What Allied Health Professionals do we have onsite?	☐	15
	Do we need to set aside blocks of time for care planning?	☐	19, 42
	Am I implementing Quality Use of Medicines/best-practice guidelines in the treatment of patients?	☐	87
	What is the role of the Practice Nurse in CDM?	☐	41
	What can be claimed through MBS for PN work?	☐	6
Administration Issues	Is this Practice registered for Practice Incentive Payments?	☐	6
	Do we know when we can claim for PIPS/SIPS?	☐	17
	Do we have good clinical data and record keeping?	☐	72-81
	Is the patient database "clean"? Are active", "inactive", "deceased, patient details and diagnosis" coded correctly?	☐	72-81
	Do I have a Diabetes register for diabetes patients?	☐	73
	Do I have a patient recall/reminder system?	☐	82
	Am I registered with Medicare Australia for diabetes, asthma or cervical screening Service Incentive Payments?	☐	6, 17
	Do we have appropriate templates for care planning on the system?	☐	85, 87
	Do we know how to import other templates into our system from websites?	☐	85, 87
	Do we have all the forms required and do we need electronic forms?	☐	85, 87
	Who will be involved in identifying patients who would benefit for care planning and who will send letters to patients and maintain records of responses?	☐	40, 51, 52
	Does the Practice need to consider re-deploying and/or training existing staff and/or employing a Practice Nurse?	☐	40, 51, 52
	Do staffs have appropriate resources to perform duties? Does the Practice Nurse have access to computer and a room to consult patients?	☐	40
	For HMR – does the practice have access to relevant resources/patient information? Has the practice established links and communication processes with relevant service providers?	☐	33
	Do staffs know how to complete billing and item number process?	☐	6, 40, 51, 52

Issues	Key Questions	☑	Page
Patient Issues	How do we inform the patients that the practice is implementing new Chronic Disease Management Processes (e.g. letters, phone calls, posters, handouts, practice newsletter)?	☐	82
	Who will decide which patient group to target?	☐	37, 38
	Booking appointments – check with whom and the amount of time to be allocated?	☐	40, 51, 52
	Do we want to have specific patient clinics for established diseases?	☐	42
	Are all missed recall appointments followed up? How is this recorded?	☐	82
Getting Started	Take a continuous improvement approach in implementing CDM within the practice. Use the PDSA approach! Plan, Do, Study & Act **PLAN:** Plan your goals so you know where you are going, What, who, when, where, predictions & data to be collected. Start small. **DO:** Undertake activities that you have planned. Document any unexpected problems or outcomes. **STUDY:** Have you achieved your targets and goals? Review and reflect on results. What feedback have you obtained along the way to improve what you do next time? **ACT:** What will you take forward from this cycle? Based on the feedback at the "Study" stage, make improvements; reset the goals and targets.		

TGPN gratefully acknowledges the support of GP partners Adelaide in the adaptation of the Chronic Disease Resource Manual.

Chronic Condition Management (CCM) MBS Item Numbers

In July 2005, new Chronic Condition Management (CCM) items were introduced to the MBS to provide rebates for GPs to manage chronic conditions by coordinating, reviewing or contributing to CCM plans.

The chronic condition management items are for:

- Preparation by a GP of a GP Management Plan (GPMP)
- Coordination by a GP of Team Care Arrangements (TCA)
- Review by a GP of a GPMP
- Coordination by a GP of a review of TCA
- Contribution to a multidisciplinary care plan or contribution to a review of a multi-disciplinary care plan (for patients who are not residents of aged care facilities)
- Contribution to a multi-disciplinary care plan or contribution to a review of a multi-disciplinary care plan (for residents of aged care facilities)

These CCM items apply to the treatment of people with asthma, diabetes, mental illness and other chronic conditions. An advanced/registered practice nurse may work in conjunction with a GP in undertaking the requirements of the CCM items.

The Chronic Condition Management item numbers:

If used effectively, the CCM Items can finance a nurse led chronic condition clinic in general practice, which will result in:

- an increase in the services available to patients through the practice
- an improvement in the quality of care for patients through better use of clinical pathways and the annual cycle of care
- additional income for the practice and potentially an increase in profit

GP Network staff, practice staff and GPs must familiarise themselves with the descriptors and requirements of the CCM items. Further information can be obtained from the Medicare Benefits Schedule Book or from the following link www.health.gov.au/epc.

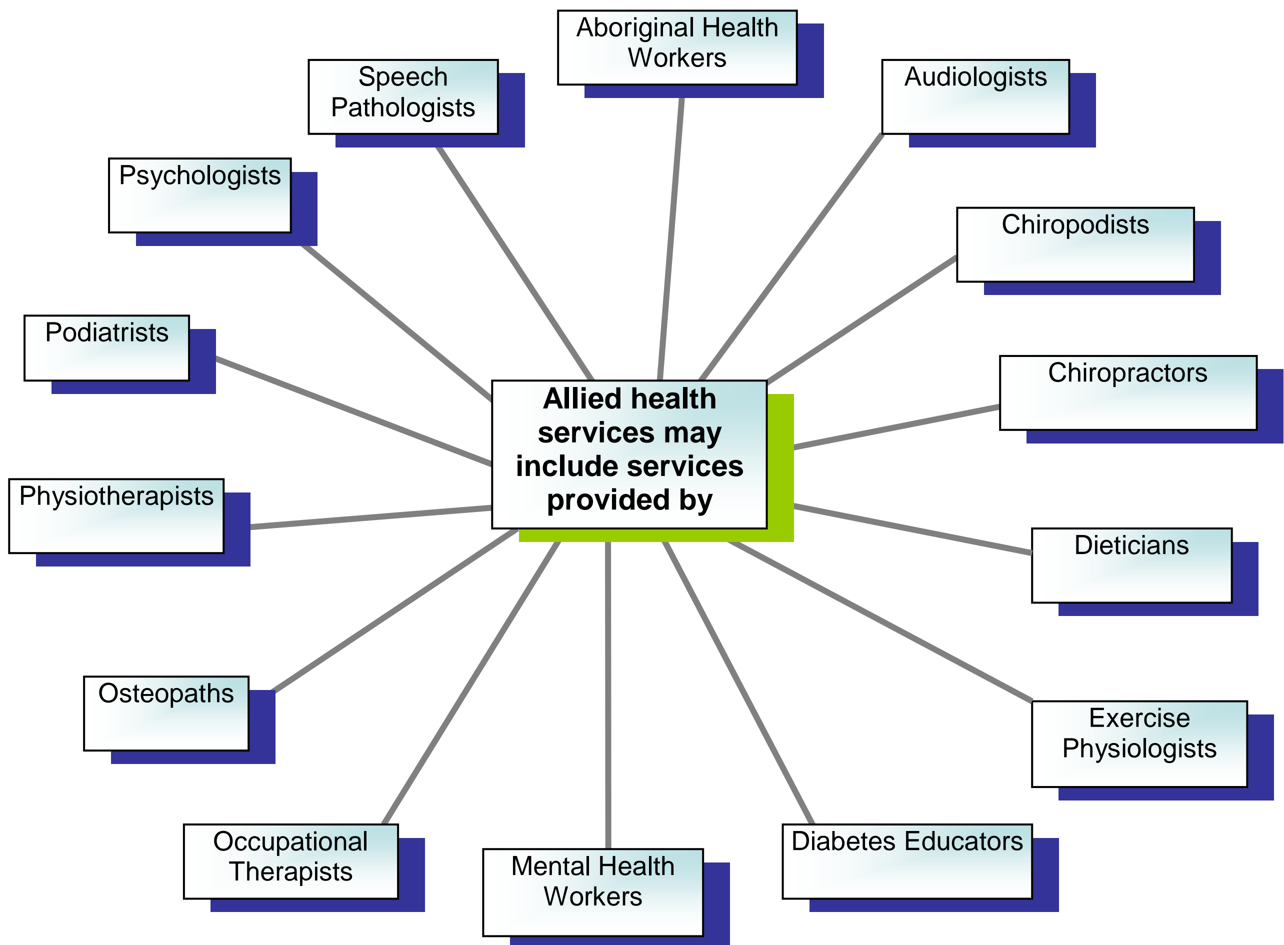
Allied Health and Dental Services MBS Items

The Allied Health and Dental Services MBS items provide for Medicare benefits to be paid for certain services provided by eligible allied health professionals, dentists and dental specialists to people with chronic conditions and complex care needs who are being managed by a GP under an Enhanced Primary Care (EPC) plan.

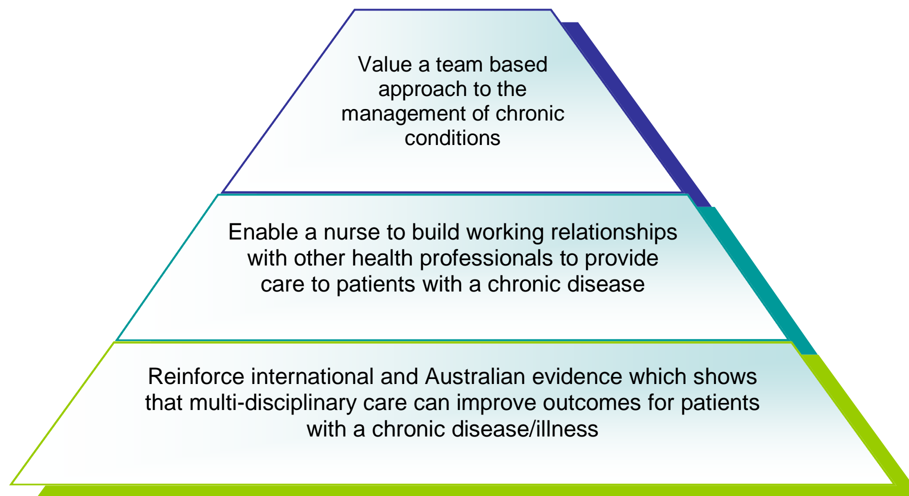
The following groups of allied health professionals are currently eligible to provide services under the Medicare Allied Health and Dental Care initiative. Allied health professionals must meet the provider eligibility requirements and be registered with Medicare Australia.

There must be three health services providers (including the GP) participating in the arrangement.

Medicare benefits are available for up to five private health services per eligible patient, per calendar year. The five allied health services can be made up of one type of service (e.g. five physiotherapy services) or a combination of different types of services (e.g. One dietetic and four podiatry services). Where a practice employs a credentialed diabetes educator, allied health referrals can be made to this position, if the services are required by the patient.



The Allied Health and Dental Services items:



GPs and nurses must familiarise themselves with the descriptors and requirements of the Allied Health and Dental Services items.

Further information can be obtained from the Medicare Benefits Schedule or from the following links http://www.medicareaustralia.gov.au/ and http://www.health.gov.au/

Service Incentive Payments (SIP)

The Service Incentive Payment (SIP) is intended to remunerate individual GPs for services. This payment is made in addition to the Medicare rebate for consultation, and is paid quarterly via Practice Incentive Payments (PIP). The two SIP payments most relevant to supporting and financing chronic condition management in a GP clinic are the:

1. Diabetes SIP
2. Asthma SIP

1. Diabetes SIP

The Diabetes SIP is part of the Chronic Condition Initiative commenced by the Federal Government in late 2001. It is a monetary incentive to encourage GPs to provide a least a minimum annual cycle of care for patients with Diabetes. The requirements are based on the current guidelines Diabetes Management in General Practice produced by Diabetes Australia and the Royal Australian College of General Practitioners.

The minimum requirements of care for the Diabetes SIP are:

Assess diabetes control by measuring HbA1c	At least once every year
Ensure that a comprehensive eye examination is carried out	At least once every two years
Measure weight and height and calculate BMI	At least twice every cycle of care
Measure blood pressure	At least twice every cycle of care
Examine feet	At least twice every cycle of care
Measure total cholesterol, triglycerides and HDL cholesterol	At least once every year
Test for microalbuminuria	At least once every year
Provide self-care education	Patient education regarding diabetes management
Review diet	Reinforce information about appropriate dietary choices
Review levels of physical activity	Reinforce information about appropriate levels of physical activity
Check smoking status	Encourage cessation of smoking (if relevant)
Review of Medication	Medication review

The Diabetes SIP can be used to fund the delivery of the annual cycle of care, but a GP must claim the SIP to benefit financially.

2. Asthma SIP

The Asthma SIP initiative rewards GPs for improving the quality of clinical care provided to people with moderate-to-severe asthma through the completion of the Asthma cycle of care and the development of an Asthma Plan.

At a minimum the Asthma cycle of care must include:

- At least 2 asthma related consultations within 12 months for a patient with moderate to severe asthma (at least 1 of which (the review consultation) is a consultation that was planned at a previous consultation),
- Documented diagnosis and assessment of level of asthma control and severity of asthma,
- Review of the patient's use of and access to asthma-related medication and devices,
- Provision to the patient of a written asthma action plan (if the patient is unable to use a written asthma action plan, discussion with the patient about an alternative method of providing an asthma action plan, and documentation of the discussion in the patient's medical records),
- Provision of asthma self-management education to the patient, and
- Review of the written or documented asthma action plan.

The Asthma SIP can be claimed by a GP once a year.

GPs and nurses must familiarise themselves with the descriptors and requirements of the Diabetes and Asthma SIP items.
Further information can be obtained from the Medicare Benefits Schedule or from the following links
http://www.medicareaustralia.gov.au/ and http://www.health.gov.au/

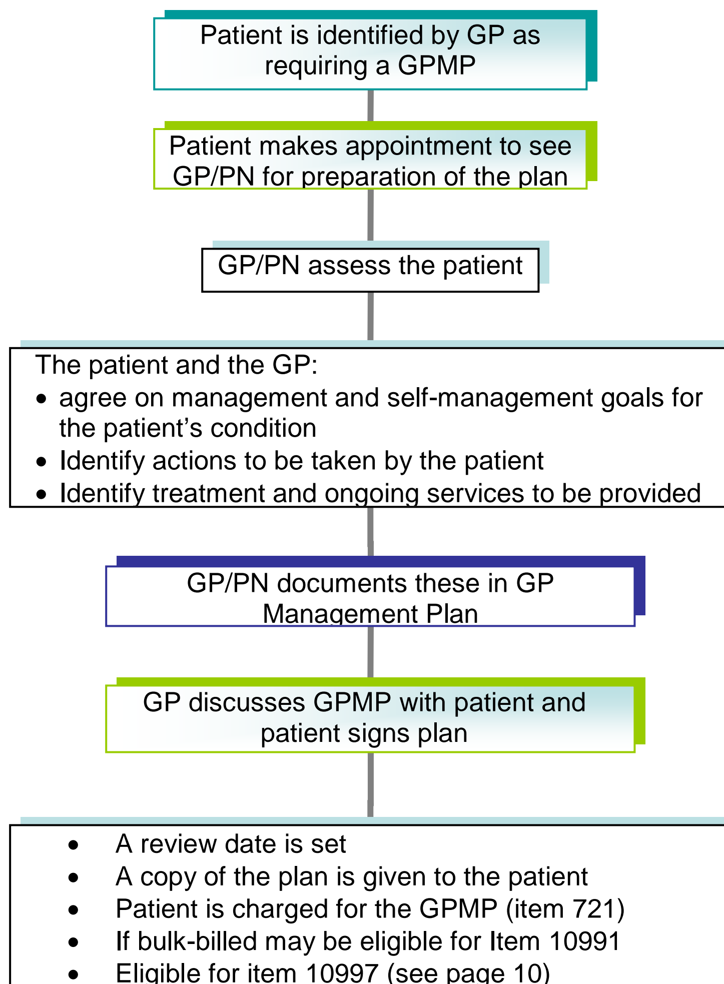
GP Management Plans (Item 721)

GP Management Plan (GPMP)

Eligibility:

- Patient must have a chronic condition which will be present for 6 months e.g. asthma, arthritis, heart disease, diabetes, cancer.
- Recommended frequency is 2 years with a review recommended 6 monthly or sooner if condition changes.
- Practice Nurse can assist in the preparation of the plan

THE GPMP Process



Explanation Item 10991 – website - please check the medicare description for this item number
http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=M1.1&qt=noteID&criteria=10991

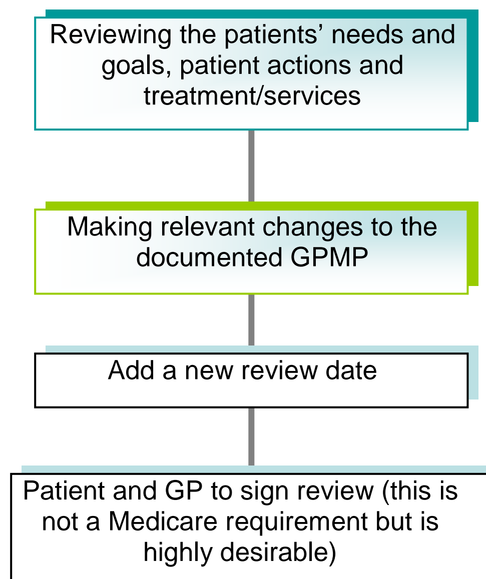
This item number can be charged with each bulk-billed item for patients under 16 years or who have a concession card. It can be charged with each other item number on the medicare form e.g. if the patient is charged for a 721 and 723 you can charge two 10991s on the same bulkbilling form.

GP Management Plan Review - GPMP Review - (Item 732)

This is for patients who have a current GPMP in place and who will benefit from a review of the GPMP. A review is the principal mechanism for ensuring the continued appropriateness of the GPMP and the management of the patient's chronic condition.

A rebate can be claimed once 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) has undertaken a systematic review of the patient's progress against the GPMP goals, completing the 4 steps below recording the patients agreement to proceed, explaining any out of pocket expenses that the patient will have and give the patient a copy of the review.

Steps in reviewing a GPMP

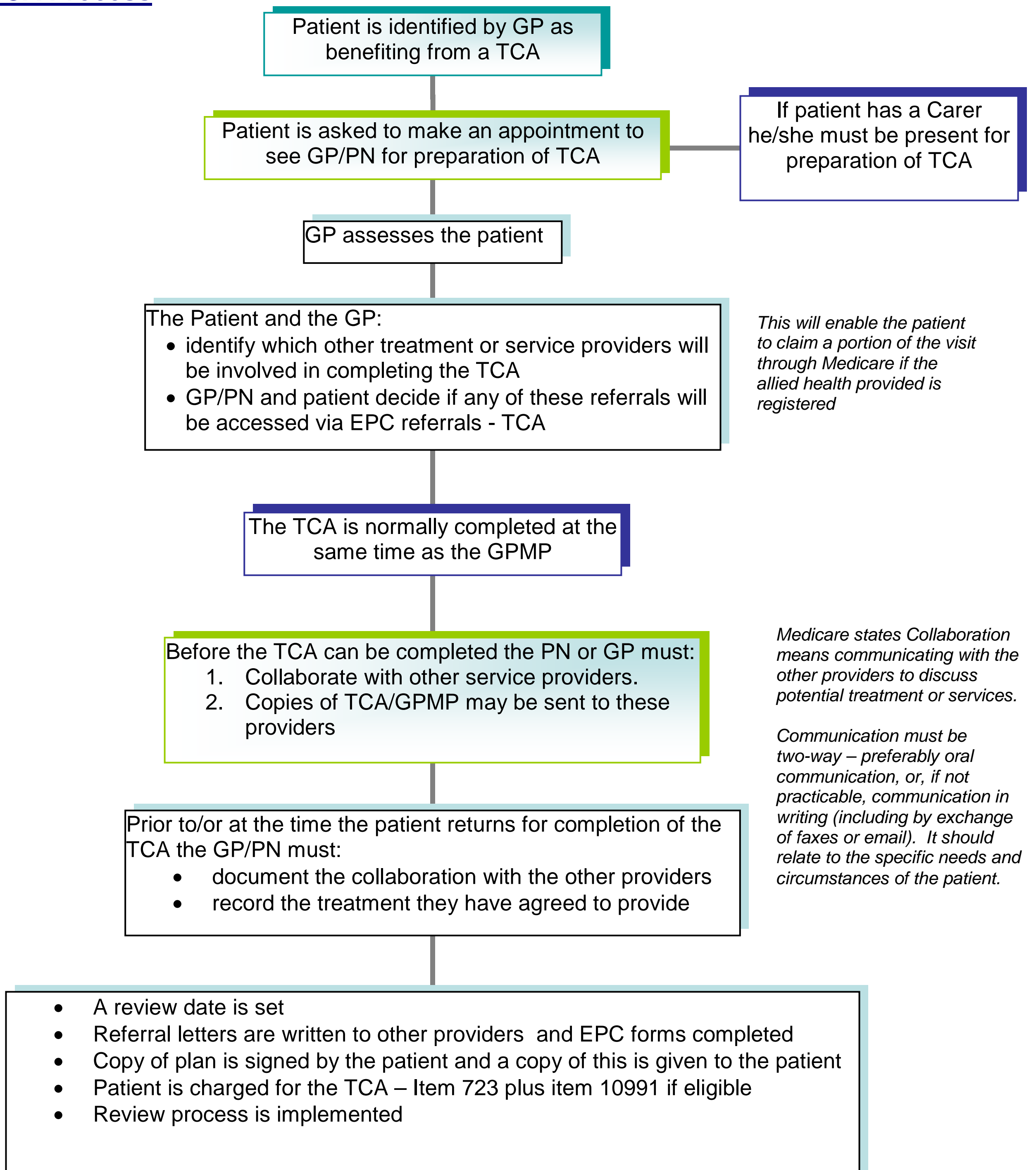


Coordination of Team Care Arrangements (723)

Eligibility:

- Patient must have a chronic condition or terminal medical condition which also requires ongoing care from a multidisciplinary team of at least 3 health or care providers including their GP
- Patient must have a current GP Management Plan if they are to claim Allied Service Medicare rebates.
- Recommended frequency is 2 years with a review recommended 6 monthly
- Practice Nurse can assist in the preparation of the plan and the review process

THE TCA Process



TCA Review with input from a Multidisciplinary Team (Item 732)

Recommended frequency for review is 6 monthly

1. Discuss/confirm with the patient which treatment/service providers should be asked to collaborate with the GP in the review
2. Collaborate with the providers to establish the patient's progress against the previously nominated treatment goals
3. Agree on any necessary changes and provide the concerned providers with copies of the review and requests for any changes to treatment
4. Select TCA Plan 732 ($66.80 plus item 10991 if eligible)
5. Complete any new referral letters, etc that are required
6. Copies of review can be sent to other providers if necessary
7. Set new review date and do recall
8. Patient and GP sign review (this is not a Medicare requirement but is desirable)
9. Patient is given a copy of review

Team Care Arrangements Feedback Form

Name and Address of Allied Health Provider

Dear ……………..,

Re: Team Care Arrangements for ………………………..,

The Commonwealth Government through the Enhanced Primary Care Initiative aims to improve coordination of care and provide a more systematic approach to the care of patients with chronic conditions and complex care needs. One component of this initiative provides GPs with an opportunity to develop multidisciplinary Team Care Arrangements for these patients.

I am currently developing Team Care Arrangements for the above patient who has given consent to include you as a member of the team. Attached is a copy of the plan.

I would be grateful if you could advise me:

a) Whether you are willing to be involved in the Team Care Arrangements for this patient?
b) Whether you are satisfied with the plan or have any suggestions for changes to the Team Care Arrangements?

I would appreciate your feedback either by phone or by completing the details below and faxing this page back to me. If you are happy with the plan all you need to do is fax this page back and send feedback as per usual after you have seen the patient.

Yours sincerely

Dr …………

Communication re team care arrangement

I, ……………….., in reference to the Team Care Arrangements for this patient

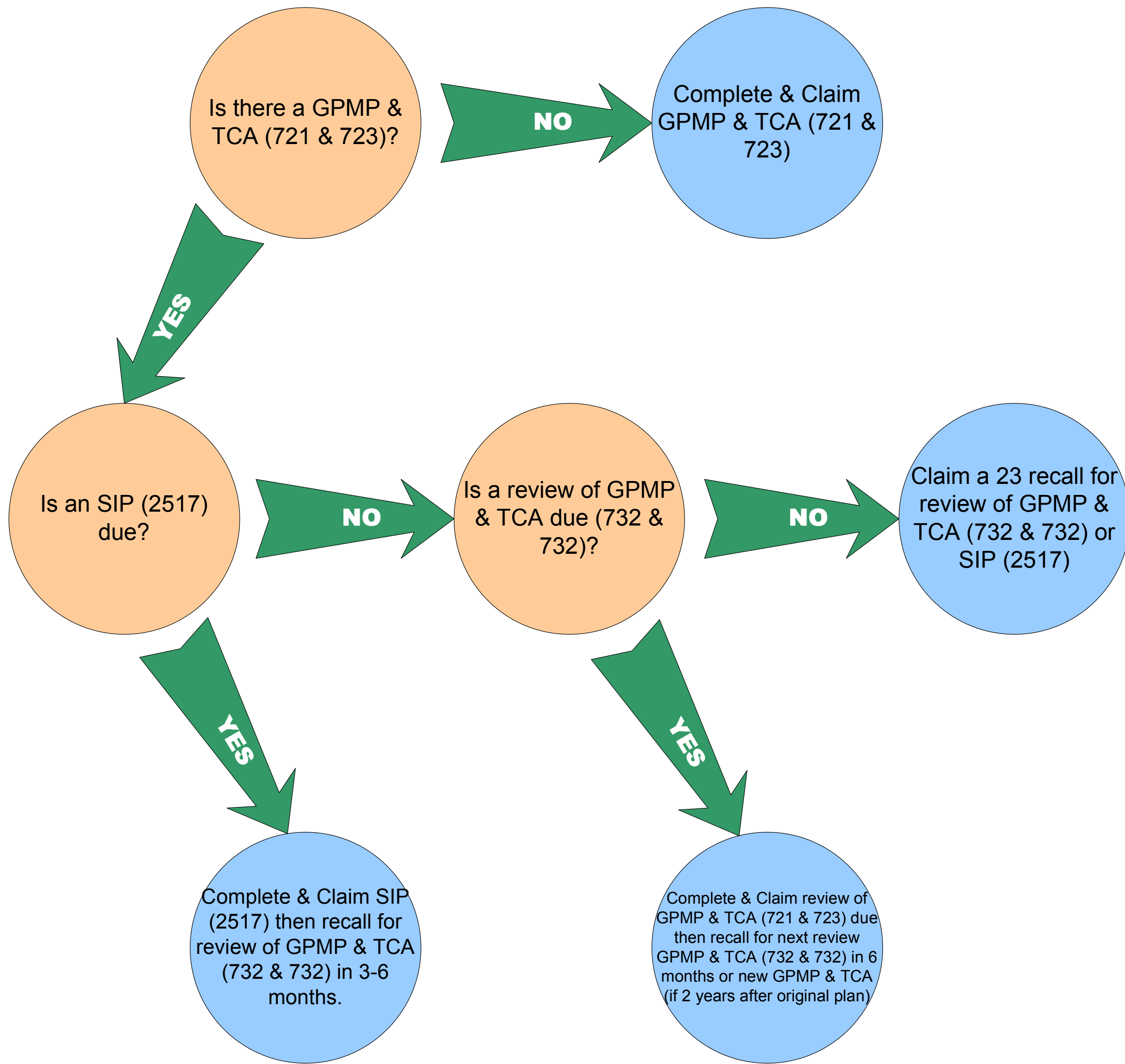
(*Please tick boxes as appropriate*)

☐ I am willing to be involved in the Team Care Arrangements, and I am satisfied with the plan as it is.

☐ I am willing to be involved in the Team Care Arrangements, and I would like to make some changes to the plan (*please attach your suggested changes*).

Signature:…………………………. Date:……/……/……

DIAGRAM 1 – Example Decision Making Tree for Diabetes Item Numbers



Enhanced Primary Care (EPC) Medicare Item Numbers – Preventative Care

Health Assessments – (MBS Items 701 to 707)

The MBS Health Assessment items represent a cross-section of the Australian Government's initiatives in the area of primary health care. The Health Check items allow a medical practitioner to undertake a more comprehensive assessment of a patient. Health checks also permit the needs of specific groups (Aboriginal and Torres Strait Islander people, refugees and aged care residents) to be addressed in a targeted and culturally appropriate manner.

There are four time-based health assessment items, consisting of brief, standard, long and prolonged consultations.

Brief Health assessment (MBS Item 701)

A brief health assessment is used to undertake simple health assessments. The health assessment should take no more than 30 minutes to complete.

Standard Health Assessment (MBS Item 703)

A standard health assessment is used for straightforward assessments where the patient does not present with complex health issues but may require more attention than can be provided in a brief assessment. The assessment lasts more than 30 minutes but takes less than 45 minutes.

Long Health Assessment (MBS Item 705)

A long health assessment is used for an extensive assessment, where the patient has a range of health issues that require more in-depth consideration, and longer-term strategies for managing the patient's health may be necessary. The assessment lasts at least 45 minutes but less than 60 minutes.

Prolonged Health Assessment (MBS Item 707)

A prolonged health assessment is used for a complex assessment of a patient with significant, long-term health needs that need to be managed through a comprehensive preventive health care plan. The assessment takes 60 minutes of more to complete

Medical Practitioners may select one of the MBS health assessment items to provide a health assessment service to a member of any of the target groups listed in notes below. The health assessment item that is selected will depend on the time taken to complete the health assessment service. This is determined by the complexity of the patient's presentation and the specific requirements that have been established for each target group eligible for health assessments.

The time period includes the time taken by the doctor and the practice nurse to undertake a health assessment.

MBS Items 701, 703, 705 and 707 may be used to under take a health assessment for the following target groups:

Target Group	**Frequency of Service**
A Healthy Kids Check for children aged at least 3 years and less than 5 years of age, who have received or who are receiving their 4 year old immunisation	Once only to an eligible patient
A type 2 diabetes risk evaluation for people aged 40-49 years (inclusive) with a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool	Once every three years to an eligible patient
A health assessment for people aged 45-49 years (inclusive) who are at risk of developing chronic disease	Once only to an eligible patient
A health assessment for people aged 75 years and older	Provided annually to an eligible patient
A comprehensive medical assessment for permanent residents of residential aged care facilities	Provided annually to an eligible patient
A health assessment for people with an intellectual disability	Provided annually to an eligible patient
A health assessment for refugees and other humanitarian entrants	Once only to an eligible patient

45-49 Year Health Check – (MBS Item 701 - 707)

Information has been taken from the Medicare Australia website:
http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&qt=NoteID&q=A.28

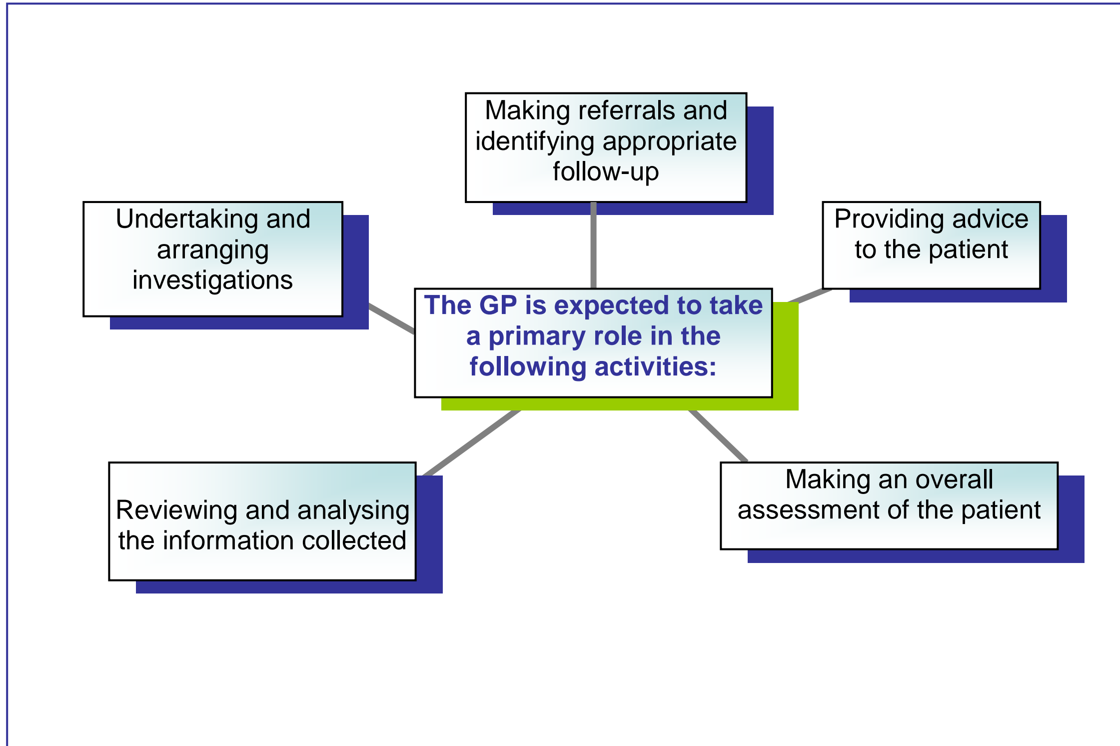
The purpose of this item is to support General Practitioners to focus on the health needs of their patients 45 years of age who are at risk of developing a chronic condition. The aim of the health check is to assist with detection and prevention of chronic conditions and enable early intervention strategies to be put in place where appropriate.

The health check is targeted at people who are between 45 and 49 years of age (inclusive) who are at risk of developing a chronic condition.
A patient must be at risk of developing a chronic condition. A chronic 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, arthritis and musculoskeletal conditions.
The decision about whether an individual is at risk of developing a chronic condition rests with the clinical judgment of the GP, but a specific risk factor must be identified.
Factors that the GP may consider include, but are not limited to: Lifestyle risk factors, such as: • Smoking; • physical inactivity; • poor nutrition or alcohol misuse; Biomedical risk factors, such as: • high cholesterol; • high blood pressure; • impaired glucose metabolism or excess weight; Or family history of a chronic condition.
A Medicare rebate is payable for this item only once for any eligible patient. This item is not an annual health check. If a GP is unsure whether a patient has already received this service, they may call Medicare Australia, with the patient present, on 132 011.

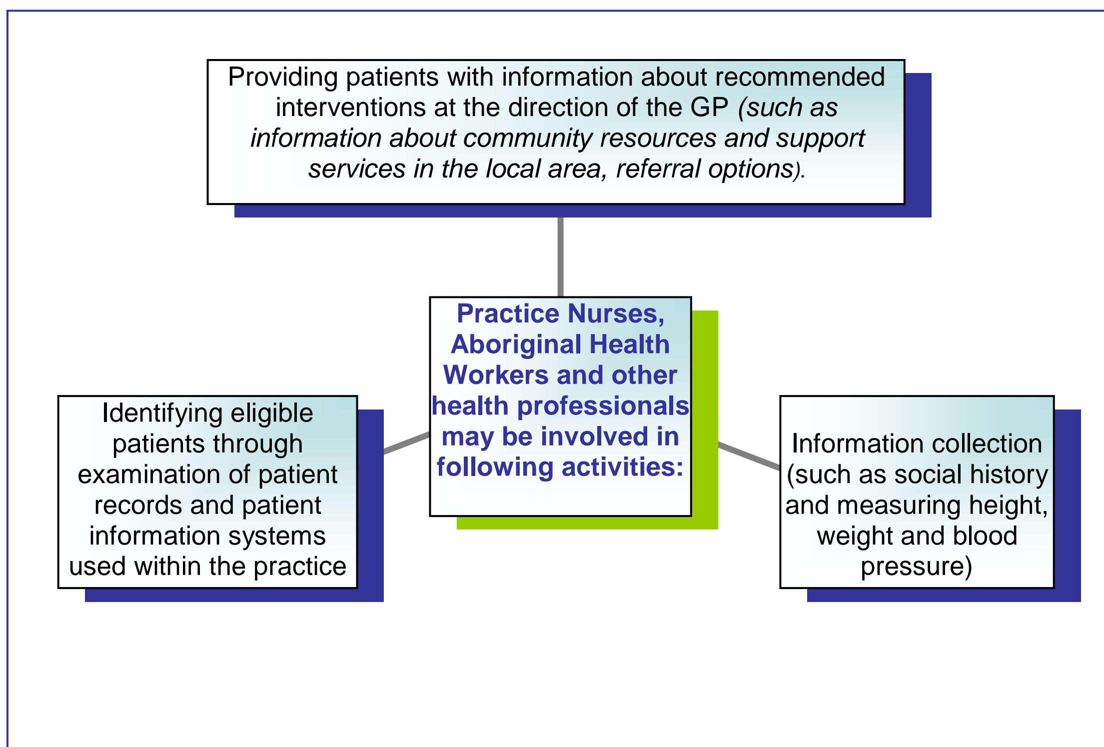
The health check must include:

- Information collection, including taking a patient history and undertaking examinations and investigations as required;
- Making an overall assessment of the patient;
- Interventions as indicated; and
- Providing advice and information to the patient.

The GP is responsible for the overall health check provided to the patient.



Practice Nurses, Aboriginal Health Workers and other health professionals may assist GPs in performing the health check, in accordance with accepted medical practice and under the supervision of the GP.



Check Medicare Online for MBS Rebates for Item 717 http://www9.health.gov.au/mbs

40-49 Year Type 2 Diabetes Check - (MBS Item 701 - 707)

The purpose of this item is to support GPs to address the health needs of patients 40 to 49 years of age who are at '*high risk*' of developing type 2 Diabetes. The 'high risk' score will be determined following the patient's completion of the Australian Type 2 Diabetes Risk Assessment Tool (Ausdrisk). The aim of this item is to review the factors underlying the 'high risk' score identified by the Ausdrisk tool to instigate early interventions, such as lifestyle modification programs, to assist with the prevention or delay of type 2 diabetes.

Eligibility

Eligible patients must be:

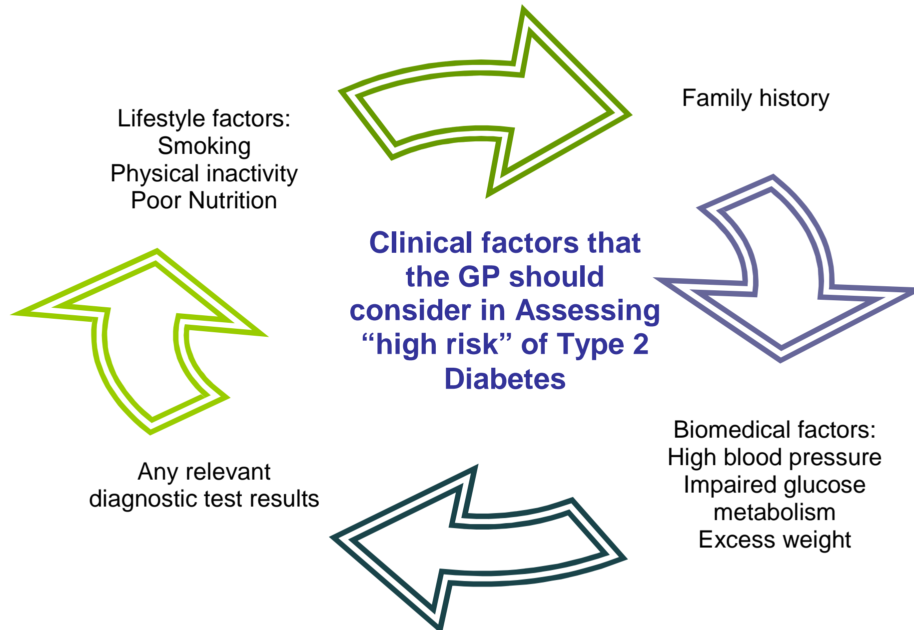
- aged 40 to 49 years (inclusive) ***and***
- at high risk of developing type 2 diabetes (as determined by the Ausdrisk tool)

Patients with newly diagnosed or existing diabetes are not eligible for this item.

Assessing a 'high risk' score and conducting a type 2 Diabetes Risk Evaluation

The type 2 Diabetes Risk Evaluation is a review of the factors underlying the 'high risk' score identified by the Ausdrisk Tool.

http://www.health.gov.au/internet/main/publishing.nsf/Content/diabetesRiskAssessmentTool



The Role of other Health Professionals

Practice Nurses, Aboriginal Health Workers and other health professionals may assist GPs in performing the type 2 Diabetes Risk Evaluation under the supervision of the GP.

The Role of the GP

- Reviewing and analysing the information collected;
- Making an overall assessment of the risk factors that contributed to the "high risk" score of the patient and their readiness to make lifestyle changes to address identified factors;
- Undertaking and arranging relevant investigations;
- Making relevant referrals and identifying appropriate follow-up;
- Providing information and advice to the patient, (e.g.: Lifestyle modifications, Lifescript resources.)

The Townsville General Practice Network offers the following to assist you:
(Please see the *How Townsville General Practice Network can Assist* section of this guide.)

ATSI Health Checks - (MBS Items 715)

These health checks are Medicare services for Aboriginal and Torres Strait Islander Australians. The aim of the health checks is to help ensure that Aboriginal and Torres Strait Islander people receive primary health care matched to their needs, by encouraging early detection, diagnosis and intervention for common and treatable conditions that cause considerable morbidity and early mortality. The Aboriginal and Torres Strait Islander Medicare health checks provide a clinical framework to assess a person's physical, psychological and social function and identify treatment or services he or she may require.

The three aged brackets for Aboriginal and Torres Strait Islander Medicare Health Checks all have the same Item No:

Age Bracket	Name of Health Check	Item Number
(0 – 14 years)	**The child health check** An annual health assessment for children from birth to 14 years of age	**Item 715**
(15 – 54 years)	**The adult health check** A bi-annual assessment for people aged between 15 and 54 years	**Item 715**
(55 years plus)	**The older person's health check** An annual health assessment available to Aboriginal and Torres Strait Islander people over 55 years of age	**Items 715**

Check Medicare Online for MBS Rebates for each Item at http://www9.health.gov.au/mbs/search.cfm

Comprehensive Medical Assessments – (MBS Item 701 - 707)

The following information has been taken from the Medicare website
http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=A29&qt=noteID&criteria=701

The Comprehensive Medical Assessment complements other Medicare Benefits Schedule (MBS) items for services that medical practitioners (including general practitioners but not including specialists or consultant physicians) can provide to residents, including:

(a) normal consultations;
(b) EPC items for contribution to a care plan and for case conferencing

Patient Eligibility:

- This item applies to residents of a Residential Aged Care Facility.
- It does not apply to inpatients of a hospital.
- It is strongly recommended that RACF residents have a CMA within 6 weeks of admission
- CMA's can only be performed 12 monthly except if there has been a significant change in the resident's condition in the past 3 months
- A CMA is a voluntary service, the resident's consent to a CMA should be obtained as per normal practice for obtaining consent to medical services

For more information on MBS Items for Residential Care facilities please contact the Aged Care Program at the Townsville General Practice Network.

Multidisciplinary Case Conferencing – (MBS Items 735-758)

The following information has been taken from the Medicare website:
http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=A38&qt=NoteID

Items	Apply to:	Patient Eligibility:
735, 739, 743	A service to **organise and coordinate**, a multidisciplinary case conference for patients in the community or patients being discharged into the community from hospital or people living in RACF.	**An in-patient of a Residential Aged Care Facility or a Community Case Conference or a Discharge Case Conference**
747, 750, 758	A service to **participate**, in multidisciplinary case conference for patients in the community or patients being discharged into the community from hospital or people living in RACF.	**An in-patient of a Residential Aged Care Facility or a Community Case Conference or a Discharge Case Conference**

A case conference team includes a medical practitioner and at least two other members, who participate in the case conference, each of whom provides a different kind of care or service to the patient, and one of whom may be another medical practitioner (normally a specialist or consultant physician).
See the MBS Online website for specific details for each item number.
http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=A38&qt=NoteID

How does a GP document participation in case conferences?

Is it adequate to place a note in the patient's file recording the necessary information?

A note in the patient's record is sufficient but must be included in the patient's clinical records. It should include:

- A record of the patient's agreement to the medical practitioner participating in the case conference;
- A record of the day on which the conference was held, and the times at which the conference started and ended;
- A record of the names of the participants;
- A record of the matters mentioned in clause A.32.4 of the Medicare Benefits Schedule, in so far as they relate to the GP's participation in the case conference (to be cross referenced with the patient's medical records); and
- A summary of the case conference (a copy of which should be given to the patient).

Immunisation for older Australians – (Nurse MBS Item No: 10993)

The following information has been taken from the Department of Health & Ageing website http://www.immunise.health.gov.au/

"People aged 65 years and older, and Indigenous people aged 50 years and over, are at high risk from influenza and pneumococcal disease and the complications of these conditions, with the great majority of deaths from these conditions occurring in these age groups. The Australian Government funds vaccines for older Australians in order to provide greater protection against these diseases."

Pneumococcal vaccination program for older Australians	• This program provides **FREE** pneumococcal vaccine to adults aged 65 years or older. • Adults aged 65 years or over are at higher risk of contracting pneumococcal disease than the rest of the population, with the majority of deaths from this disease occurring in this age group.
Flu vaccine	• The Influenza vaccine program for older Australians provides FREE flu vaccine for all Australians aged 65 and older.
Vaccines for older Indigenous people	• The National Indigenous Pneumococcal and Influenza Immunisation Program (NIPII) provides free vaccines for Indigenous people aged over 50 years, and • Those aged 15 to 49 years who are at high risk from these diseases and their complications. • For more information please contact the Immunisation Coordinator at the Townsville General Practice Network.

Home Medicines Review – HMR

(Also known as Domiciliary Medication Management Review DMMR)

What is the goal of Home Medicines Review?

To maximise an individual patient's benefit from their medication regime through a team approach involving the general practitioner and the patient's preferred community pharmacy, with the patient as the central focus.

Who is eligible to receive a Home Medicines Review?

People who are living in the community setting for whom quality use of medicines may be an issue or who may be at risk of medication related adverse events. A HMR may be conducted once every 12 months (unless there has been a significant change in the patient's condition or regime).

Which patients are most likely to benefit from a Home Medicines Review?

Patients at risk of medication related problems because of:

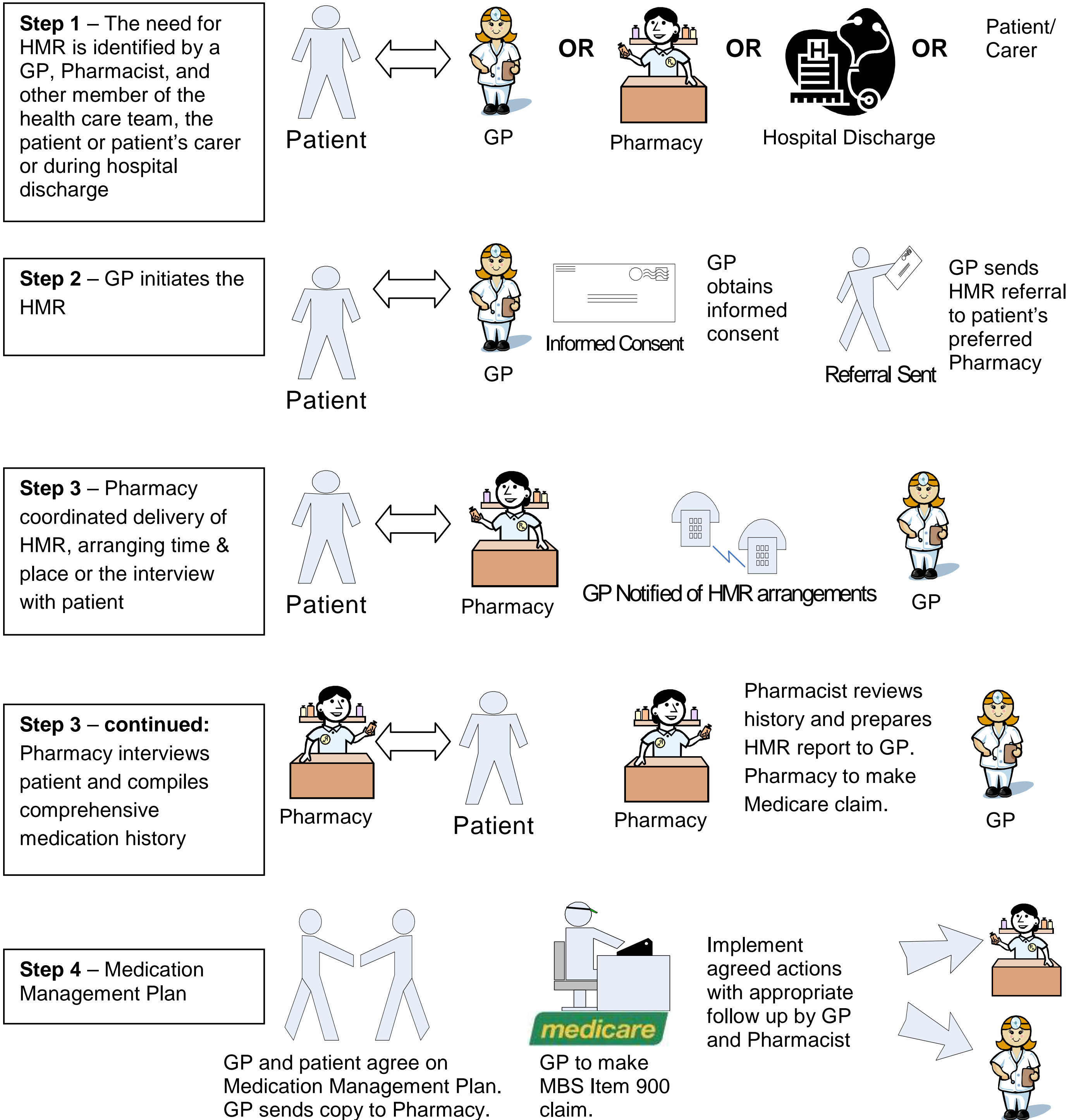
• The complexity of their medication regime	– Taking 5 or medications – Taking more than 12 doses of medication/day – Significant changes to medication in the last 3 months
• The characteristics of their medicines	– Medication with a narrow therapeutic index – Medication requiring therapeutic drug monitoring – Symptoms suggestive of an adverse drug reaction – Sub-therapeutic response to treatment with medicines
• Difficulty managing their own medications	– Literacy or language difficulties – Dexterity problems – Impaired sight – Dysphagia – Confusion, dementia or other cognitive difficulties – Suspected non-compliance
• Social circumstances	– Living alone – Attending a number of different doctors, both GPs and specialists
• Recently discharged from hospital	
• Consider if it is clinically appropriate to add a HMR to a Health Assessment	
• GP Management Plan or Asthma Cycle of Care	

What is the outcome of a Home Medicines Review?

Patients with a plan for their medication management that:

- Utilised communication between the patient, their GP and pharmacist
- Acknowledges their knowledge and attitude towards their medication
- Encourages safe and effective use of medication

DIAGRAM 2 - STEPS in a HMR



Payment for HMR services For GPs:

- MBS Item 900
- Includes completing the referral form, developing the medication management form and the follow up consultation when the medication management plan is discussed and agreed with the patient.

For more information on HMR check the MBS explanatory notes:
http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=A42&qt=noteID&criteria=900

Websites

Department of Health & Ageing – Chronic Disease Management (CDM) Medicare Items	http://www.health.gov.au/internet/main/publishing.nsf/Content/pcd-programs-epc-chronicdisease
Townsville General Practice Network	http://www.tgpn.com.au/
RACGP Clinical Resources – A-Z	http://www.racgp.org.au/clinicalresources/
Chronic Disease Management EPC	http://www.drsref.com.au/epc.html
Dandenong Casey General Practice Association – Chronic Disease Management Program	http://www.dcgpa.com.au/programs/Chronic_Disease_Management
Medicare Benefits Schedule	http://www9.health.gov.au/mbs/search.cfm
North East Valley Division of General Practice	http://www.nevdgp.org.au/?content=14
Zedmed Clinical Templates	http://www.zedmed.com.au/index.php?pageID=82
Adelaide North East Division of General Practice	http://www.anedgp.com.au