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INNER NORTH WEST MELBOURNE
Connecting health to meet local needs

Care Planning in General Practice

This guide provides an overview of the Medicare initiatives available to GPs preparing a GP Management Plan and/or Team Care Arrangement for patients with chronic disease.

The guide also assists services - whether publically funded or Medicare registered health providers - wishing to collaborate with GPs on care planning.

This guide was originally developed by Impetus and funded as open IP by the Department of Health

Key to abbreviations

AHP	Allied Health Professional
AHS	Allied Health Service
CDM	Chronic Disease Management
EPC	Enhanced Primary Care
GPMP	GP Management Plan
MBS	Medical Benefits Scheme
SIP	Service Incentive Payment
TCA	Team Care Arrangements

References: Department of Health www.health.gov.au and GPV www.gpv.org.au

Last updated by Inner North West Melbourne Medicare Local November 2013

Chronic Disease Management

Many GP visits occur because a patient has an acute problem, when neither the patient nor doctor can effectively address long-term management of the chronic condition causing the problem.

Evidence shows that chronic disease management (CDM) strategies lead to improved health outcomes for people with chronic conditions. CDM includes planned visits, care coordination, quality links with allied health service, and patient involvement in self-management. A written care plan is a primary tool in this kind of management.

What is a chronic condition?

The criteria for GPs is a condition "...that has been or is likely to be present for at least six months, or is terminal, including but not limited to asthma, cancer, cardiovascular illness, diabetes mellitus, mental health conditions (including dementia), arthritis and musculoskeletal conditions and stroke."

http://www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-chronicdiseasemanagement

What is a CDM care plan?

In general practice a care plan is "a process for setting and achieving goals". This involves:

- assessment of the patient's condition/s in relation to overall health and functionality
- outlining the practitioner's goals for the patient
- addressing the patient/carer's needs and goals
- planning treatments and actions which will meet the goals, and
- planning review steps.

If the GP involves other health and care professionals, the plan will also include:

- collaboration between providers to prepare the plan
- recording of each party's goals and the treatment/care planned to meet those goals, and
- regular review of the team arrangements.

Background

GPs are paid through the Medical Benefits Scheme (MBS) for the preparation of care plans, under a Department of Health program called Primary Care Items 'Chronic Disease Management'.

For Department of Health information go to: **www.health.gov.au/mbsprimarycareitems**

When preparing plans and claiming for these services, GPs must read and comply with all Medicare rules and guidelines related to the item.

For Medicare items and explanatory notes go to: **www.mbsonline.gov.au**

In 1999 Medicare introduced the Enhanced Primary Care (EPC) package, which included an MBS item for preparing care plans for people with chronic and complex needs. This allowed GPs to take time away from acute care, to provide patients with information about their condition and to arrange multidisciplinary care. It gave scope to include the practice nurse in preparing the plan. Medicare rebates for certain allied health services were included in the package.

Since July 2005 there have been two kinds of CDM care-planning services available under Medicare: the GP Management Plan (GPMP) and the Team Care Arrangement (TCA). Together these two types of plan equate to the previous 'EPC' care plan. (Recently the term 'Enhanced Primary Care' was removed.)

GPs can prepare either a GPMP or a TCA or both. It is necessary for the patient to have both a GPMP and a TCA where the patient is referred for Medicare allied health services: see page 4.

For a summary of care planning items see the back page of this Guide.

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GP Management Plan

This is a plan prepared by the GP, for a patient of any age with one or more chronic conditions, outlining the goals, care and service which the doctor and patient agree on together.

A GPMP need not involve any other parties. However, most practices combine it with a TCA and provide a single "combo" plan to all parties.

It is required to make a note on the GPMP of the patient's own needs, the goals they identify and the actions they agree to undertake. It is helpful for all members of the team to be aware of this patient perspective.

Team Care Arrangement

A Team Care Arrangement (TCA) is a plan prepared by a GP in collaboration with other services, for a patient of any age who has one or more chronic conditions and who would benefit from multidisciplinary care. For instance, where routine management is compounded by unstable or deteriorating condition, increasing frailty or dependence, development of complications, co-morbidities or a change in social circumstance.

The TCA outlines the goals, care and services which the multidisciplinary team agree on together, with the consent of the client. It includes the client's contribution, as above.

The team must comprise at least 3 health or care providers (including the preparing GP) and:

- the services must be available within a reasonable time (GP/nurse is responsible for checking)
- each service must provide different & ongoing care
- each team member should make a brief written or verbal contribution to the TCA (or give their ok to the contribution which the GP or nurse has written on their behalf)
- each TCA should be tailored to the individual patient.

See page 9 "Care Planning Team Members"

Teams can be made up of a variety of care types, for example:

- a GP, a teacher and a specialist
- a GP, a community diabetes educator and a community dietician
- a GP, a private Medicare-registered physiotherapist and the local council HACC service.

Both GPMP & TCA:

- should be prepared by the patient's usual GP
- are for patients in the community (not in a residential aged care facility or in hospital).

Recommended frequency is every 2 years; GPs may not claim for preparation of a GPMP/TCA within 12 months of a previous claim, unless exceptional circumstances* apply.

Care plans do not have an 'expiry date'; the GPMP & TCA remain valid as long as the patient's condition warrants and as long they are reviewed periodically. This means that after the minimum or recommended time the GP can prepare a new plan if warranted or s/he can review the original plan on an ongoing basis. Either way, the patient will be entitled to five Medicare allied health services per year – see page 4.

* Exceptional circumstances – where there has been a significant change in the patient's clinical condition, or care arrangements, or ability to function. Examples: hospitalisation; development of co-morbidities; death of a career; onset of depression.

Reviews

The GPMP & TCA should be reviewed regularly by the preparing GP or a GP in the same practice.

Review of a TCA is done in consultation with all services involved, with their contribution noted.

The *minimum* time between MBS review claims is 3 months, although the *recommended frequency* between reviews is 6 months. But a review can be done inside the minimum time in exceptional circumstances*.

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General Practice / Allied Health liaison

Where plans are initiated by general practice...

GPs may have assistance from a Practice Nurse, or other health professional, to gather information and prepare care plan documents. This is done on behalf of the GP who must consult the patient as part of the service and must review the finished plan.

See page 5 "Obtaining Consent" and page 10 "Invitation to Participate" letter.

Allied health may be contacted by a practice manager or practice nurse to:

- invite them to participate in a TCA
- exchange confidentiality agreements
- obtain allied health input to the plan, ie
  - arrange a mutually convenient time to speak to the GP, or
  - submit a draft of the TCA for the allied health provider's approval, or
  - a paragraph (provided verbally or by fax/email) outlining their goals for the client and the care they will provide to meet those goals.

Once the client has seen and approved the finished TCA, the practice must provide all team members with a copy. The TCA should include review dates; reviews will be a similar process to the initial liaison.

In addition to formal feedback on client progress, team members may want to contact each other to discuss a problem. Allied health should send a fax, including name, organisation and discipline, and the client's name. State that you are a member of the TCA for this client, outline the issue that you would like to discuss with the GP and request a return call.

Consider whether an incident (deterioration in condition or change of care circumstances) may warrant a case conference.

Plans initiated by allied health

Publicly-funded or private allied health providers can invite GPs to contribute to their own plan.

However, a request for contribution is not ideal. It is preferable to invite the GP to 'prepare' a care plan. This enables the practice to cover the costs of a practice nurse who plays a significant role in supporting the client. It is also because Medicare rules prohibit the GP from preparing a GPMP/TCA for 3 months after a 'contribution' item claim.

Note, a TCA can exist alongside another organisation's plan and the GP-prepared TCA may be based on information given by that organisation. The ideal end result is a plan containing elements from both parties.

It is in the client's interests to have a *GP-prepared* plan (GPMP + TCA), because this entitles them to access allied health Medicare services in combination with community or council services. See page 4.

Residents in Aged Care Facilities

GPs should be invited to *contribute* to the care plan of a residential aged care facility (RACF). The client can then access private Medicare registered allied health services. (GPs cannot *prepare* a GPMP or TCA for a resident of a facility because this would duplicate the facility's plan.)

GPs can *contribute* to discharge care plans prepared by a hospital for residents being discharged back to the RACF.

A GP can *coordinate* a TCA for a private in-patient being discharged from hospital back to the facility – **but** only where the GP is providing the in-patient care.

See relevant items on back page.

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MBS Item Descriptors & Explanatory notes

When preparing care plans (GPMP and TCA), doctors and practice nurses must follow the rules and eligibility criteria outlined in the current MBS. See www.health.gov.au/mbsonline and search by items numbers 721, 723, 732, 729, 731 and 10997.

Allied health providers should see www.health.gov.au/mbsonline and search by items numbers 10950-10970. Provides who register for the Allied Health Medicare Initiative receive a supplementary MBS booklet from Medicare with details of the item related to their discipline.

For further information see www.health.gov.au/mbsprimarycareitems

Allied Health Medicare Initiative ('EPC')

Patients with a chronic condition can access rebates for some private *Medicare-registered* allied health services.

See page 9 'Care Planning Team Members', for a list of eligible disciplines.

- Before providing a referral to a Medicare allied health service, the GP must first complete *both* a GP Management Plan (GPMP) and a Team Care arrangement (TCA), or contribute to an aged care facility's plan for a resident with a chronic condition.
- Medicare allied health rebates are only available where the requirement for the service has been noted on the TCA (or aged care facility plan) and where a signed referral has been supplied by the GP on the form available from the DH&A website: for a copy phone 132 011 or go to www.health.gov.au/mbsprimarycareitems and from the "in this section" box select Individual Allied Health Services.
- Rebates are limited to 5 allied health visits per year in total (not 5 per service type/discipline).
- The GP may refer the patient for further Medicare allied health visits every calendar year if the GPMP + TCA remains *active**. Phone Medicare on 132 150 to ascertain how many visits the patient has claimed so far that year, and write a referral for more as required, up to a total of 5 per calendar year. It is not necessary to prepare a new care plan, as long as the existing one is active.

* *Active* means that both GPMP & TCA, or Review of both GPMP & TCA, have been claimed in the past 24 months. That is, items 721 + 723, or 732, or 731.

- The initiative is confusing for clients. It helps if both private and community allied health providers and clients understand the scheme. Contact your Medicare Local for clarification if required. Give patients an information sheet: see www.health.gov.au/mbsprimarycareitems
- Allied health providers can suggest that the client talk to their usual GP about eligibility and ask the GP to check whether a GPMP/TCA already exists. AHPs should not offer a rebate until this has been done. AHPs may not fill in a referral form and send it to the GP to sign.
- Note that a gap fee may apply to some private services – GP, nurse or the client should check in each case.
- The rebate can assist clients where a publicly funded service is not immediately available or suitable. For instance, the GP could put the client on the community health waiting list and refer to a private provider for the first service or two. Develop a strategy for communication between providers. Some community health services offer 'MBS clinics' alongside their community funded services, so the client can often move from MBS to community services with the advantage of in-house referral to a suite of chronic disease management services.
- A Team Care Arrangement can include any number of services above the minimum three. New or further services should be added to everyone's copy of the TCA as they are put in place. Reviews should be used to keep the TCA current.

Aboriginal & Torres Strait Islander health practitioners

From July 2012, Aboriginal & Torres Strait Islander health practitioners are eligible to provide allied health services under MBS items 10950 and 81300 and mental health services under item 10956. Refer to the MBS Allied Health Schedule.

Dental Health Initiative

Medicare rebates on dental costs are no longer available for patients who are managed under a GPMP and TCA. For more information go to www.health.gov.au/dental

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Practice team roles in the preparation of a GPMP / TCA

Refer to MBS item descriptors and explanatory notes: "A practice nurse, Aboriginal health worker or other health professional may assist a GP with items 721, 723, and 732 (e.g. in patient assessment, identification of patient needs and making arrangements for services). However, the GP must review and confirm all assessments and arrangements, and see the patient."

Suggested tasks:
Establishment of a database of local allied health services, on clinical software and/or paper.
Initial patient recruitment, eg. database search for eligible patients. Phone or letter contact (an alternative to opportunistic recruitment during GP consults).
Explanation to patient (phone or in person prior to GP consultation) of the purpose of GPMP / TCA, steps, costs, etc as per checklist.
Review of history and current assessments, identification of patient needs and personal goals, discussion of actions to be taken by the patient
Discussion with patient about AH services which could be invited to participate in a TCA (ie. services currently being used by the patient or which the patient will be referred to).
Providing basic lifestyle advice, applying 'health coaching' or 'motivational interviewing' techniques, using Lifescripts or similar. (Where the client requires ongoing self management support, they should be referred to a professional with this expertise.)
Follow-up of outstanding test results and similar information for GP.
Contacting allied health to invite them to participate in a particular TCA; discussing their collaboration on required services/treatments. Arranging face-to-face or phone or fax exchange with the GP is necessary.
Typing / copying / filing of GPMP / TCA proforma.
Making consult appointment with patient, for GP to discuss the draft care plan with patient and obtain patient agreement.
Sending final copy of plan to all parties.
Ensuring the admin staff claim the correct item number.

Note, these tasks are undertaken on behalf of the GP. They do not entitle the nurse to be one of the minimum 3 providers on a Team Care Arrangement. (A practice nurse can only be a team member when they provide specific ongoing care in their own right, eg. where the nurse is a trained diabetes or asthma educator.)

MBS item 10997 for ongoing monitoring of the care plan by a practice nurse can be claimed up to 5 times per year, once the GPMP/TCA is in place.

Obtaining Consent to prepare a GPMP or TCA

The GP must discuss the purpose of the GPMP and/or TCA with the patient. The explanation must include:

- informing the patient that s/he will incur a charge for the service provided by the practitioner for which a Medicare rebate will be payable;
- informing the patient of any additional costs s/he will incur; and
- explaining to the patient the nature of a GPMP and/or TCA and asking the patient whether s/he agrees to it taking place.

In the case of a TCA the explanation must include:

- informing the patient that her/his medical history, diagnosis and care preferences may be discussed with other care providers;
- providing an opportunity for the patient to specify what medical and personal information s/he wants to be conveyed to, or withheld from, the other members of the multidisciplinary care team.

Consent must be noted on the plan. The patient may sign the practice's copy of the document, or the GP may sign on their behalf by annotating the electronic record.

See www.health.gov.au/mbsprimarycareitems for a suitable leaflet about care planning, to provide to the patient.

Verifying patient eligibility

Patients will often be unsure whether they have an active GPMP or TCA in place, or how many Medicare allied health claims they have made in the current calendar year. They can obtain this information from Medicare on 132 011.

The provider may enquire with Medicare on their behalf with client authority: Medicare help line for health professionals: 132 150.

MBS Items Online Checker

The MBS Items Online Checker in Health Professional Online Services (HPOS) lets health professionals, or an authorised delegate, check a patient's eligibility to claim a Medicare benefit for certain MBS items, based on their Medicare history. Checking a patient's ability to claim saves time and reduces rejected claims for your practice.

GP items: 721, 723, 729, 731, 732, 10997

Allied Health items: 10952, 10953, 10954, 10956, 10958, 10960, 10962, 10964, 10966, 10968, 10970

Further information on CDM care planning

GPs and Practice Nurses may request advice or a visit from their Medicare Local (ML).

Information sheets, allied health referral forms, and phone advice are available from MLs or from the sources below.

Allied Health providers working with a GP new to care planning can refer the GP to their local ML for assistance and/or to the sites below. The Department of Health & Ageing advises "only the GP can determine whether the patient's chronic condition would benefit from allied health services. It is not appropriate for allied health professionals to provide a part-completed referral form to a GP for signing, or to pre-empt the GPs decision about the services required by the patient".

Medicare Australia

- Medicare items and explanatory notes: **www.mbsonline.gov.au**
- Medicare **provider line 132 150**.
- Medicare **public line 132 011**
- Health Professional Online Services (HPOS)

Department of Health

- For information on Medicare initiatives, fact sheets, proforma and referral forms, go to **www.health.gov.au/mbsprimarycareitems**
- Email questions to: **askMBS@humanservice.gov.au**

For more information

An electronic copy of this booklet is available from Gillian.Cass@inwmml.org.au

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Checklist for preparing MBS Item 721
GP Management Plan (GPMP)

A GPMP is a "Chronic Disease Management" Primary Care Medicare service. Refer to MBS item 721 explanatory notes; see www.mbsonline.org.au Use of this checklist is not mandatory.

1. Eligibility **Responsible:** **Admin, PN or GP.** **Opportunistically or database search.**	Available to patients in the community and to private in-patients (including residents of aged care facilities) being discharged from hospital (see MBS Notes).	☐	
	For patients with a chronic or terminal medical condition (see MBS Notes).	☐	
	Not available to public in-patients being discharged from hospital or residents living in an aged care facility.	☐	

2. Pre GPMP **Responsible:** **Admin, PN or GP.** **Offer opportunistically or do a database search and letter.** **Explain in person or by phone.** **Patient or GP to note consent to proceed.**	Is there an existing GP Management Plan? *Rebate will not be paid within 12 months of previous GPMP claim, or within 3 months of any other 'EPC' chronic disease management item, unless exceptional circumstances apply. To check if the patient has a GPMP with another doctor, phone Medicare 132 011*	☐	
	Would the patient benefit by having a GPMP?	☐	Mandatory
	Explain steps and any costs involved to the patient.	☐	Mandatory
	Record the patient's agreement to proceed.	☐	Mandatory
	Obtain relevant information (eg from previous care plans or assessments & patient history).	☐	Recommended
3. Management This includes the steps as per MBS Explanatory notes. Responsible: GP, or PN with GP overview and confirmation. Personal attendance with GP is a required part of the service. Patient input required.	Assess the patient – identify and/or confirm health care needs, problems and relevant conditions	☐	Mandatory
	Agree goals with the patient (changes to be achieved by the treatment and actions identified in the plan)	☐	Mandatory
	Identify any actions agreed to be taken by the patient	☐	Mandatory
	Identify GP treatment. Identify services in place or required (if making arrangements for provision of these services, consider also preparing a TCA)	☐	Mandatory
	Document the needs, goals, patient actions, treatment, services and a review date on a GPMP proforma*.	☐	Mandatory
	Offer a copy of the GPMP to the patient (and their carer if the patient consents).	☐	Mandatory
	Add a copy of the GPMP to patient's medical record.	☐	Mandatory
	With patient's agreement, provide copy of GPMP or relevant parts to other providers involved in patient's care.	☐	As appropriate
	Set recall date for review	☐	Recommended

4. Ongoing Management and Review **Responsible:** GP or PN with GP overview. Personal attendance with GP is a required part of the service.	Manage the patient's needs through normal consultations. Review plan 6-monthly using item 732 *A new GPMP is not required if condition remains the same, but may be required following hospitalisation or significant change: annotate Medicare claim if a new GPMP is prepared under 12 months.*	☐	
	Nurse item 10997 for care plan monitoring, up to 5/year	☐	

* GPMP proforma may be paper-based or electronic. If the latter, patient consent to proceed may be noted by the GP on the electronic file. There is no mandated type of proforma. TCA may be combined with GPMP on the same form, providing all parts of both services are completed.

Contacts for further assistance: Medicare claims interpretation for providers: 132 150
Medicare for the public: 132 011 – patient can check if GPMP / TCA, or allied health rebates have been claimed.
Dept of Health EPC information: www.health.gov.au/mbsprimarycareitems
To find local allied health providers, see www.nhsd.com.au or www.cdm.ahpa.com.au

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Checklist for preparing MBS Item 723 – Team Care Arrangements (TCA)

GPs coordinating a TCA should refer to the Medicare Benefits Schedule (MBS) explanatory notes for item 723 before using this checklist. See www.mbsonline.org.au Use of this checklist is not mandatory.

1. Eligibility **Responsible: Admin, PN or GP.** Opportunistically or database search.	Available to patients in the community and to private in-patients (including residents of aged care facilities) being discharged from hospital (see MBS notes)	☐	
	Not available to public in-patients being discharged from hospital or residents living in an aged care facility.	☐	
	For patients with a chronic or terminal medical condition and who could benefit from ongoing care from a multidisciplinary team (ie complex).	☐	
	Patients with both a TCA (item 723) and a GPMP (item 721) are eligible for Medicare rebates under the allied health items; see MBS for details.	☐	If applicable
2. Pre TCA **Responsible: Admin, PN or GP. Offer opportunistically or do a database search and letter. Discuss purpose in person or by phone.** Patient or GP to note consent to proceed.	Is there an existing TCA ? *A rebate will not be paid within 12 months of previous TCA claim, or within 3 months of any other 'EPC' chronic disease management item, unless exceptional circumstances apply. To check if the patient has a GPMP with another doctor, phone Medicare 132 011*	☐	
	Would the patient benefit by having a TCA?	☐	
	Explain steps and any costs to the patient.	☐	Mandatory
	Record the patient's agreement to proceed.	☐	Mandatory
	Obtain relevant information (eg. GPMP, previous care plans, reports from existing services).	☐	Recommended
3. Team Care Arrangements This includes the steps as per MBS Explanatory Notes **See over for team requirements and list of possible team members.** Responsible: GP, or PN with GP overview and confirmation. Personal attendance by patient with GP is a required part of the service.. Patient must hear and agree to the final plan. Patient or GP to sign-off TCA.	Discuss with the patient which treatment/service providers should be asked to collaborate on the TCA.	☐	Mandatory
	Gain the patient's agreement to share relevant information. *If any restrictions, note them on consent section of proforma.*	☐	Mandatory
	Contact the proposed providers and obtain their agreement to participate in TCA. *They may need to see patient or need written / verbal health info before participating.*	☐	Mandatory
	Collaborate with the participating providers to discuss their proposed treatment/services to achieve management goals for the patient. *Two-way communication is required, verbal or by fax/email, on the needs of the individual patient.*	☐	Mandatory
	Document the collaborating providers, the treatment/services they have agreed to provide, patient goals & actions, and a review date, on a proforma*.	☐	Mandatory
	Set recall date for review.	☐	Recommended
	Review final TCA with patient and record agreement.	☐	Mandatory
	Offer a copy of the TCA to the patient (and their carer if the patient consents)	☐	Mandatory
	Give a copy of the TCA, or relevant parts, to the other providers in the team.	☐	Mandatory
	Add copy of the TCA to patient's medical record.	☐	Mandatory
	With patient's agreement, give a copy to any others involved in the patient's care *(ie. other than team members).*	☐	As appropriate
	If referring patients to Medicare registered allied health providers use the specified form	☐	
4. Ongoing Management Responsible: GP or PN with GP overview. Personal attendance by patient with GP is a required part of the service.	Review 3-6-monthly, using item 732 *A new TCA is not required if condition remains the same, but may be required following significant change (annotate Medicare claim if a new TCA is prepared under 12 months because of these exceptional circumstances).*	☐	
	Nurse item 10997 for monitoring, up to 5/year	☐	

* TCA proforma may be paper-based or electronic. Patient consent to proceed and share health information may be noted by GP in clinical software. There is no mandated type of proforma. TCA may be combined with GPMP on the same form, providing all parts of both services are completed.

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Care Planning Team Members

MBS requirement: to develop Team Care Arrangements for a patient, at least two health or care providers / organisations who will be providing ongoing treatment 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.

Each person can be counted only once as a team member, even where they offer more than one different service.

One of the minimum team of three is the GP.

Health providers can include, among others:

- aboriginal health workers
- asthma educators
- audiologists
- consultant physician
- dental therapists
- dentists
- diabetes educators
- dietitians
- drug & alcohol workers
- exercise physiologists
- mental health workers
- occupational therapists
- optometrists
- orthoptists, orthotists or prosthetists
- pharmacists
- physiotherapists
- podiatrists
- psychologists
- registered nurses*
- social workers
- specialist / consultant physician
- speech therapist
- pathologists.

Community service providers can include:

- alcohol & drug support workers
- chaplains
- community care coordinators
- community aged care package coordinators
- disability services coordinators
- education providers (teachers)
- home nursing
- personal care workers (paid)
- probation officers
- HACC service providers, incl meals on wheels & home help.

Health and care providers can be sourced through local community health centres, mental health services, aboriginal health services, shire offices & hospitals. To find a provider, try:

Allied Health Services eligible to register for Medicare rebate scheme:

- Aboriginal Health Worker
- Diabetes Educator
- Audiologist
- Exercise Physiologist
- Dietitian
- Mental Health Worker (eg. psychologist, mental health nurse, some social workers)
- Occupational Therapist
- Physiotherapist
- Podiatrist or Chiropodist
- Chiropractor
- Osteopath
- Psychologist
- Speech Therapist

- A practice nurse can assist in the preparation of a plan and in patient education on behalf of the GP, but is not one of the TCA members in her/his own right.
- A practice nurse can be a team member when they provide specific ongoing care in their own right, eg. where the nurse is a trained diabetes or asthma educator.

- Interpreters & TCA organisers (ie. admin) cannot be counted as team members.

- The patient's informal or family carer may be included on the TCA (contributing a goal and/or action) but does not count as one of the minimum three team members. A paid professional carer may be a team member.

Contacts for further assistance

Medicare claims interpretation for providers:**132 150**

Medicare for the public: 132 011 – patient can check if GPMP / TCA, or allied health rebates have been claimed.

Dept of Health EPC information: **www.health.gov.au/mbsprimarycareitems**

To find local allied health providers, see **www.nhsd.com.au** or www.cdm.ahpa.com.au

www.inwmml.org.au

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"Invitation to Participate" sample letter

CONFIDENTIAL
File this health information securely in the client's record, or destroy if not participating in

(insert general practice details / letterhead including fax number)

Date:

To *(insert allied health provider's details)*

Organisation: ……

Physical address / email address: ……

Fax number: ……

Dear ……

Re: Team Care Arrangement for …… **DOB:** …../…../…..

I am currently developing a Team Care Arrangement (TCA) for the above patient, who has given consent to include you as a member of the team. A TCA is a multidisciplinary care plan for a patient with chronic condition/s.

Attached is a copy of the draft TCA (care plan).

I would be grateful if you could advise me:

a) whether you are available to provide ongoing care to the patient and are willing to be involved in the TCA?

b) whether you are satisfied with the TCA (care plan) or have any suggestions for changes?

Please respond by phone or by completing the details below and faxing this page back to me. When the TCA is completed and you have seen the patient, it is important that we receive your feedback.

We will also ask you to participate in Reviews every 6 months (unless circumstances require more frequently).

Yours sincerely

Block print GP's Name

Communication re Team Care Arrangement

I, ……, have read the proposed TCA for the above patient and
(please tick boxes as appropriate)

☐ am willing to be involved in the TCA / care plan, and I am satisfied with the plan as it is

☐ am willing to be involved in the TCA / care plan, and I would like to make some changes to the plan (if so, please attach your suggested changes).

Signature: …… Date: …../…../…..

Please fax back to above GP at fax number .....

CHRONIC DISEASE MANAGEMENT

GP Management Plan (721) & Team Care Arrangement (723)

Patient's Name: …… **Date of Birth:** ……

Contact Details:
Details:

……..... …….

…… …….

…… …….

Details of Patient's Usual GP:
applicable):

Medicare or Private Health Insurance

Details of Patient's Carer (if

……..... …….

…… …….

…… …….

If the patient has a previous or existing care plan, when was it prepared and what were the outcomes?

……..……..

……

…..……

……..……

Other notes or comments relevant to the patient's care planning:

……..……..

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Medications

……..……

……..……..……

……..……..……

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Allergies

……..……..

……

……..…

www.inwmml.org.au

Level 1, 369 Royal Parade, Parkville, Vic. 3052
PO Box 139, Parkville, Vic. 3052
t 03 9347 1188 **f** 03 9347 7433

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Patient's Name & I.D.:

.....

I have explained the steps and costs involved and the patient has agreed to proceed with the service. The patient also agrees to the involvement of other health providers and to share clinical information without / with restrictions (identify if the latter)

GP's Signature ..... Date .....

Care Plan (GP Management Plan & Team Care Arrangement)			
Problems / needs / relevant conditions	**Goals - changes to be achieved.**	**Proposed activities, treatments or services**	**Service (when, who & contact details)**
Patient			
GP			
Provider 2			
Provider 3			

☐ Copy of plan offered to patient. ☐ Copy / relevant parts of the plan supplied to other providers. ☐ Copy of plan added to the patient's records.

☐ Referral forms for Medicare allied health and dental care services completed, if relevant. [For referral forms call 1800 067 307 or go to www.health.gov.au/mbsprimarycareitems]

Date service was completed: ..... Review Date: .....

Chronic Disease Care Planning Items

MBS fees & item numbers last updated November 2013

Item	Description	MBS Fee	Patient Eligibility	Recommended frequency	Minimum claim	**Task summary.** See also GPMP and TCA checklists, available from INWMML as below
721	**GP Management Plan (GPMP)** Prepared by patient's usual GP*	$141.40	Patient in the community with a chronic or terminal condition. Or, where the preparing GP is providing in-hospital care, a *private* patient with chronic condition being discharged from hospital or back into an aged care facility (in-hospital service @ 75%).	Once every 2 years, supported by regular review	12 mths**	• Explain purpose of plan to patient and record patient's consent and agreement to prepare • Assess patient re health care needs, problems and function • Agree on management goals with patient • Identify any actions to be taken by patient • Identify required GP treatment • Identify services (or do this via a TCA) • Document needs, goals, patient actions, treatment/services and a review date on the plan • Discuss finished plan and provide a copy to patient (and carer).
723+	**Coordination of Team Care Arrangements (TCA)** Prepared by patient's usual GP*	$112.05	Patient in community with a chronic or terminal condition who requires ongoing care from a multidisciplinary team of at least 3 care providers including the GP. Or a *private* in-patient as above.	Once every 2 years, supported by regular review	12 mths**	• Explain purpose of team care to patient and record consent to prepare • Discuss which services are needed (or in place) and gain patient's agreement to share relevant information • Contact proposed providers and request their participation • Collaborate with participating providers re goals & treatments • Document goals, provider details, treatment/services, patient actions and a review date on the TCA form • Discuss finished plan with patient and provide a copy to all parties.
732	**Review** of GPMP and/or Coordination of Review of TCA	$70.65	Patient who has a current GPMP (721) or TCA (723) and requires a review	Once every 6 months	3 mths**	• GPMP : review progress against plan and document any changes • TCA: consult providers on progress against treatment / services. • Document any changes to patient's GPMP and/or TCA • Set next review date
729	**Contribution** by GP to a plan prepared or reviewed by another service, eg CHS	$69.00	Patient in the community with chronic or terminal condition.	Once every 6 months	3 mths**	• Collaborate with the provider preparing or reviewing the plan • Forward a copy of your contribution for their records • Include your contribution to the care plan in patient's records.
731+	**Contribution** by GP to plan prepared by an aged care facility or by a hospital for resident.	$69.00	Patient of residential aged care facility (RACF) with chronic condition.	Once every 6 months	3 mths**	• As for Item 729 • contribute at the invitation of the facility • discuss with facility if Medicare allied health services would benefit patient and provide EPC referral.

* Usual GP, or another GP in the same practice. GP may be assisted by practice nurse or other health professional in the practice; GP must authorise the final document. All above services must include a personal attendance by the GP with the patient, who must review the final plan.

** These services can be provided more frequently in exceptional circumstances, eg. where there has been a significant change in the patient's clinical condition or care circumstances, or where the patient has changed practices (ie. changed services or treatments). Annotate the claim to explain circumstances to Medicare.

\+ Patients who have both a GPMP (721) and a TCA (723) in place (or where GP has claimed item 731) can access Medicare allied health services to a total of 5 services per year.

Chronic Condition: one that has been, or is likely to be, present for at least 6 months, including, but not limited to: asthma, cancer, cardiovascular, diabetes mellitus, musculoskeletal & stroke.

Read the Medicare requirements for each item in full before commencing these services: *go to www.health.gov.au/mbsonline*

To check if GPMP-TCA is currently in place, or number of allied health services claimed by patient, phone Medicare on 132 150.

Go to www.health.gov.au/mbsprimarycareitems for fact sheets, proforma, referral forms and patient brochures.