MBS GUIDELINES

Chronic Disease Management

phn COUNTRY SA
An Australian Government Initiative

There are six MBS Chronic Disease Management Items (that may be claimed under five unique numbers):

Item 721 – Preparation of a GP Management Plan

- Provides a rebate for a GP to prepare a management plan for a patient with a chronic or terminal condition (including patients who have multiple chronic conditions and multidisciplinary care needs).
- Recommended frequency is once every two years, supported by regular review services.
- The GP (who may be assisted by their practice nurse or other) assesses the patient, agrees management goals, identifies actions to be taken by the patient, identifies treatment and ongoing services to be provided, and documents these in the GP Management Plan.

Item 723 – Coordination of Team Care Arrangements

- Provides a rebate for a GP to coordinate the preparation of Team Care Arrangements for a patient with a chronic or terminal medical condition who also requires ongoing care from a multidisciplinary team of at least three health or care providers (including the GP).
- In most cases the patient will already have a GP Management Plan in place but this is not mandatory.
- Recommended frequency is once every two years, supported by regular review services.
- Involves a GP (who may be assisted by their practice nurse or other) collaborating with the participating providers on required treatment/services and documenting this in the patient's TCA.

Item 732 – Review of a GP Management Plan

- Provides a rebate for a GP to review a GP Management Plan.
- Practice nurse can assist.
- Recommended frequency is once every six months; can be earlier if clinically required.
- A review of a GPMP involves reviewing the patient's GP Management Plan, documenting any changes and setting the next review date.

Item 732 – Coordination of a Review of Team Care Arrangements

- Provides a rebate for a GP to coordinate a review of their Team Care Arrangement.
- Practice nurse can assist.
- Recommended frequency is once every six months; can be earlier if clinically required.
- Coordinating a review of a TCA involves the GP (who may be assisted by their practice nurse or other) collaborating with the participating providers on progress against treatment/services and documenting any changes to the patient's TCA.

Item 729 – Contribution to a multidisciplinary care plan being prepared by another health or care provider)

- For patients who are having a multidisciplinary care plan prepared or reviewed by another health or care provider (other than their usual GP).
- Recommended frequency is once every six months; can be earlier if clinically required.
- Involves the GP (who may be assisted by their practice nurse or other) collaborating with the providers preparing or reviewing the plan and including their contribution with the patient's records.

Item 731 – Contribution to a multidisciplinary care plan for a Resident of an Aged Care Facility

- Contribution by a GP to a care plan being prepared by another health or care provider for a resident of an Aged Care Facility.
- For patients in residential aged care facilities and is otherwise identical to Item 729 (above).

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Summary of the Claiming Periods for CDM items			
CDM Item	**Item Number**	**Recommended Frequency**	**Minimum Claiming Period**
Preparation of a GP Management Plan	721	2 yearly	12 months
Coordination of Team Care Arrangements	723	2 yearly	12 months
Review of a GP Management Plan	732	6 monthly	3 months*
Coordination of Review of Team Care Arrangements	732	6 monthly	3 months*
Contribution to a multidisciplinary care plan prepared by another provider	729	6 monthly	3 months
Contribution to a multidisciplinary care plan by a residential aged care facility	731	6 monthly	3 months

* Each service to which item 732 applies (i.e. Review of a GP Management Plan and Review of Team Care Arrangements) may be claimed once in a three-month period, except where there are exceptional circumstances. Item 732 can be claimed twice on the same day providing an item 732 for reviewing a GP Management Plan and another 732 for reviewing Team Care Arrangements (TCAs) are both delivered on the same day as per the MBS item descriptors and explanatory notes.

Medicare Claiming for a Review of a GPMP and TCA on the same day

If a GPMP and TCA are both reviewed on the same date and MBS Item 732 is to be claimed twice on the same day, both electronic claims and manual claims need to indicate they were rendered at different times.

Non electronic Medicare claiming of items 732 on the same date:

The time that each item 732 commenced should be indicated next to each item.

Electronic Medicare claiming of item 732 on the same date:

Medicare Easyclaim – use the 'ItemOverrideCde" set to 'AP', which flags the item as *not duplicate services.*
Medicare Online/ECLIPSE – set the 'DuplicateServiceOverrideIND' to 'Y', which flags the item as *not duplicate.*

Exceptional Circumstances

CDM services can be provided more frequently in ‘exceptional circumstances’ where there has been a significant change in the patient’s clinical condition or care circumstances (such as development of co-morbidities or complications, deteriorating condition etc) that require a new GPMP or TCA or review service.

Where a service is provided in exceptional circumstances, the patient’s invoice or Medicare voucher should be annotated to indicate the reason why the service was required earlier than the minimum time interval for the relevant item e.g. “clinically indicated” or “exceptional circumstances”.