

CHRONIC DISEASE MANAGEMENT

For a comprehensive explanation of each MBS Item number please refer to the Medicare Benefits Schedule online at www.health.gov.au/mbsonline

| Chronic Disease Management | | |
|----------------------------|--|--|
| Item | Name | Description / Recommended Frequency |
| 721 | GP Management Plan (GPMP) | Management plan for patients with a chronic or terminal condition. Not more than once yearly |
| 723 | Team Care Arrangement (TCA) | Management plan for patients with a chronic or terminal condition and complex needs requiring ongoing care from a team including the GP and at least 2 other health or care providers. Enables referral for 5 rebated allied health services. Not more than once yearly |
| 732 | Review of GP Management Plan and/or Team Care Arrangement | Recommended 6 monthly. Must be performed at least once over the life of the plan |
| 729 | GP Contribution to, or Review of, Multidisciplinary Care Plan | Contribution to, or review of, a multidisciplinary care plan prepared by another provider (e.g. community, home or allied health providers, specialists), for patients with a chronic or terminal condition and complex needs requiring ongoing care from a team including the GP and at least 2 other health or care providers. Not more than once every 3 months |
| 731 | GP Contribution to, or Review of, Multidisciplinary Care Plan prepared by RACF | GP contribution to, or review of, a multidisciplinary care plan prepared by RACF, at the request of the facility, for patients with a chronic or terminal condition and complex needs requiring ongoing care from a team including the GP and at least 2 other health or care providers. Not more than once every 3 months |
| 10997 | Chronic Disease Management by Nurse | Monitoring and support for patients being managed under a GPMP or TCA. Not more than 5, per patient, per year. Can be claimed concurrently with other GP item numbers |

| Diabetes and Asthma Cycles of Care | | |
|------------------------------------|---|--|
| Item | Name | Description / Recommended Frequency |
| 2521 | Diabetes Annual Cycle of Care Level C + SIP | For accredited practices. Used in place of usual attendance item when completing Diabetes Annual Cycle of Care. Once every 11 - 13 months |
| 2552 | Asthma Cycle of Care Level C + SIP | For accredited practices. Used in place of usual attendance item when completing the Asthma Cycle of Care for patients with moderate to severe asthma. Not more than once yearly |
| 11506 | Spirometry | Measurement of respiratory function before and after inhalation of bronchodilator |
| Medication Management | | |
| Item | Name | Description / Recommended Frequency |
| 900 | Home Medicines Review (HMR) | Review of medications in collaboration with a pharmacist for patients at risk of medication related misadventure. Once every 12 months |

ALLIED HEALTH SERVICES

| Allied Health Services for Chronic Conditions Requiring Team Care | | | |
|--|-----------------------------------|--|--|
| <i>GP must have completed a GP Management Plan (721) and Team Care Arrangement (723) or contributed to a Multidisciplinary Care Plan in a Residential Aged Care Facility (731)</i> | | | |
| Item | Name | Description / Recommended Frequency | |
| 10950 | Aboriginal Health Worker Services | <p>5 allied health services per calendar year</p> <p>Can be 5 sessions with one provider or a combination e.g. 3 dietitian and 2 diabetes education sessions</p> <p>Medicare EPC Referral Form for each provider</p> <p>Allied Health Provider must be Medicare registered</p> | |
| 10951 | Diabetes Educator Services | | |
| 10952 | Audiologist Services | | |
| 10953 | Exercise Physiologist Services | | |
| 10954 | Dietitian Services | | |
| 10958 | Occupational Therapist Services | | |
| 10960 | Physiotherapist Services | | |
| 10962 | Podiatrist Services | | |
| 10964 | Chiropractor Services | | |
| 10966 | Osteopath Services | | |
| 10970 | Speech Pathologist Services | | |
| 10956 | Mental Health Worker Services | <p>Use Better Access Mental Health Care items for mental health conditions - 12 sessions and GPMP and TCA for chronic medical conditions - 5 sessions</p> | |
| 10968 | Psychologist Services | | |

DENTAL SERVICES

| Dental Services for Chronic Conditions Requiring Team Care | | | |
|--|---|-----------------------------|---|
| <i>GP must have completed a GP Management Plan (721) and Team Care Arrangement (723) or contributed to a Multidisciplinary Care Plan in a Residential Aged Care Facility (731)</i> | | | |
| Item | Name | \$ | Description / Recommended Frequency |
| 85011-8777 | Dentist, Dental Specialist or Dental Prosthetics Services | Range of services - see MBS | <p>Up to \$4250 over 2 consecutive calendar years</p> <p>Patient's oral health must be impacting on, or likely to impact on their general health.</p> <p>Medicare Dental Referral Form</p> <p>Dentist must be Medicare registered</p> |

ALLIED HEALTH GROUP SERVICES FOR PATIENTS WITH TYPE 2 DIABETES

| Assessment and Provision of Group Services | | |
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| <i>GP must have completed a GP Management Plan (721), or reviewed an existing GPMP (732), or contributed to, or reviewed, a Multidisciplinary Care Plan in a Residential Aged Care Facility (731)</i> | | |
| Item | Name | Description / Recommended Frequency |
| 81100 | Assessment for Group Services by Diabetes Educator | One assessment session only by either Diabetes Educator, Exercise Physiologist or Dietitian, per calendar year Medicare Allied Health Group Services for Type 2 Diabetes Referral Form |
| 81110 | Assessment for Group Services by Exercise Physiologist | |
| 81120 | Assessment for Group Services by Dietitian | |
| 81105 | Diabetes Education Group Services | 8 group services per calendar year, can be 8 sessions with one provider or a combination e.g. 3 diabetes education, 3 dietitian and 2 exercise physiology sessions. Medicare Allied Health Group Services for Type 2 Diabetes Referral Form |
| 81115 | Exercise Physiology Group Services | |
| 81125 | Dietetics Group Services | |
| | | |

Allied Health Group Services Directory available from your Practice Support Officer or visit the professional associations' websites to search for local providers offering Medicare rebated group services:

Diabetes Educators - www.adea.com.au

Dietitians - www.daa.asn.au

Exercise Physiologists - www.essa.org.au

GP MULTIDISCIPLINARY CASE CONFERENCES

| Item | Name | Description / Recommended Frequency |
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| 735 | Organise and coordinate a case conference | 15 - 20 minutes. GP organises and coordinates case conference in RACF or community or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs |
| 739 | Organise and coordinate a case conference | 20 - 40 minutes. GP organises and coordinates case conference in RACF or community or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs |
| 743 | Organise and coordinate a case conference | > 40 minutes. GP organises and coordinates case conference in RACF or community or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs |
| 747 | Participate in a case conference | 15 - 20 minutes. GP participates in a case conference in RACF or community or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs |
| 750 | Participate in a case conference | 30 - 40 minutes. GP participates in a case conference in RACF or community or on discharge. For patients with a chronic or terminal condition complex, and multidisciplinary care needs |
| 758 | Participate in a case conference | > 40 minutes. GP participates in a case conference in RACF or community or on discharge. For patients with a chronic or terminal condition and complex, multidisciplinary care needs |