GPDV GENERAL PRACTICE DIVISIONS VICTORIA

Published Feb '06

Enhanced Primary Care & Chronic Disease Management Medicare Items in General Practice

Better Capacity Better Care

Annual Health Assessment For patients over 75 yrs living at home Min claiming period = 12 mths	In Consulting Room	At Patients Home
75years & over	**Item 700**	**Item 702**
Aboriginal & Torres Strait Islanders 55 & over	**Item 704**	**Item 706**
100% rebate & MBS Fee	$164	$232
115% DVA	$188.60	$266.80

Other Health Assessment Items	Aboriginal and Torres Strait Islander Health Check ATSI people 15 to 55 yrs Min claiming period = 18 mths	Comprehensive Medical Assessment For new residents and for existing residents as required Min claiming period = 12 mths
Item	**710**	**712**
100% rebate & MBS Fee	$195.50	$183.80
115% DVA	$224.82	$211.37

GP Management Plan (GPMP)

Patients with a chronic medical condition present or likely to be present for 6 mths or longer or a terminal illness.

For patients in the community or on discharge for private patients Recommended Frequency = 2 yrs Min claiming period = 12 mths	Plan Item 721	Review Item 725
100% rebate & MBS Fee	$122.40	$61.20
115% rebate for DVA plus veterans' access payment	$138	$70.38

Multidisciplinary Team Care Items

Patients with a chronic medical condition present or likely to be present for 6 months or longer or a terminal illness and **complex care needs** requiring ongoing care from a multidisciplinary team involving the patients GP and at least 2 other health or care providers

Team Care Arrangements (TCA)

For patients in the community or on discharge for private patients Recommended Frequency = 2 yrs Min claiming period = 12 mths	Plan Item 723	Review Item 727
100% rebate & MBS Fee	$96.90	$61.20
DVA 115% plus veterans' access payment	$111.43	$70.38

Contribution to a Care Plan/Review

Residential Aged Care Facility Recommended Frequency = 4 times per yr Min claiming period = 3 mths	**Item 731**
In the Community or on Discharge from Hospital both private and public patients	**Item 729**
100% rebate & MBS Fee	$42.50
DVA 115%	$48.87

Allied Health & Dental Care Items

Patients with a GPMP Item 721 and TCA Item 723 or Item 731 may access up to 5 AH & 3 Dental Care Medicare rebate-able services per calendar year.

Dental Care Items

MBS items	10975, 10976, 10977
MBS Fee	$89.80
85%	$76.35

Allied Health Items

MBS items	10950 10951 10952 10954 10956 10958 10960 10962 10964 10966 10968 10970
MBS Fee	$53.90
85%	$45.85

Case Conference Items

Organise & Coordinate Case Conference

Time	**15-30 min**	**30-45 min**	**>45 min**
In the community not for in-patient of hospital or day hospital or RACF	**Item 740**	**Item 742**	**Item 744**
In Aged Care Facility (RACF)	**Item 734**	**Item 736**	**Item 738**
100% rebate & MBS Fee	$82.05	$123.05	$164.00
115% rebate for DVA	$94.35	$141.50	$188.60
On Discharge Once per hospital admission	**Item 746** $82.05	**Item 749** $123.05	**Item 757** $164
85% Rebate	$69.74	$104.59	$139.40
∆ **75% Rebate** for service provided to private hospital patient	$61.55	$92.30	$123.00

Participate in a Case Conference

Time	**15-30**	**30-45**	**>45 min**
In the community not for in-patient of hospital or day hospital or RACF	**Item 759**	**Item 762**	**Item 765**
In Aged Care Facility (RACF)	**Item 775**	**Item 778**	**Item 779**
100% rebate & MBS Fee	$58.55	$93.75	$128.85
115% rebate for DVA	$67.35	$107.80	$148.20
On Discharge Once per hospital admission	**Item 768** $58.55	**Item 771** $93.75	**Item 773** $128.85
85% Rebate	$49.80	$79.70	$109.55
∆ **75% Rebate** for service provided to private hospital patient	$43.95	$70.35	$96.65

† Examples of complex care needs, where routine management is compounded by one of the following
- Unstable or deteriorating condition
- Increasing frailty or dependence
- Development of complications including falls or incontinence
- Co-morbidities
- 2 or more hospital admissions in the past six months

∆ Items 746,749,757 relate to private in-patients only provided by the medical practitioner who is providing in-patient care, usually the GP.
75% rebate apply to services provided to patients in Private Hospitals.

Quality Improvement Council

EPC Flow chart developed by General Practice Divisions—Victoria. Based on PASS at Knox Division '02 EPC flow chart.

GPDV GENERAL PRACTICE DIVISIONS VICTORIA

Better Capacity Better Care

EPC Health Assessment Items

Annual Health assessment (Items 700, 702, 704, 706) are available for patients 75 years and over and Aboriginal and Torres Strait Islander patients who are 55 years or older who are living at home and not in hospital or a residential aged care facility. The health assessment is an assessment of the patient's health and physical, psychological and social function and whether preventative health care and education should be considered. It includes:

- Measurement of blood pressure, pulse rate and rhythm;
- Medication review, (inc. OTC's, prescriptions from others);
- Continence assessment;
- Immunisation status (influenza, tetanus & pneumococcus);
- Physical function (including ability to transfer between bed, chair & toilet, bathe, dress, shop, etc.) and whether or not patient has had a fall in the last 3 months;
- Psychological function, including cognition & mood (which should be measured with a recognised tool);
- Social function (including availability and adequacy of paid and unpaid help), & if patient is caring for another person.

The information collection component of the Annual Health Assessment may be undertaken by a nurse or other assistant in accordance with accepted medical practice, acting under GP supervision. The other components must include a personal attendance by a medical practitioner.

The annual health assessment should not take the form of a health screening service, generally should not include category 5 (diagnostic imaging) or category 6 (pathology) services, however they may be ordered if clinically relevant.

The assessment must also include keeping a written record of assessment, signed by patient, and provision of a written report to the patient with recommendations about matters covered.

In addition to the annual health assessment items there are 2 other health assessment items; Aboriginal and Torres Strait Islander Adult Health Check (Item 710) is available for ATSI people aged 15 to 55 years (once every 18 months) and the comprehensive medical assessment item CMA is for new residents or existing residents as required (once every 12 months).

Chronic Disease Management Care Plans

The Chronic Disease Management care planning items replace the EPC multidisciplinary care planning items (which cease 1st November 05). They apply to a wider range of patients with chronic medical conditions, including patients needing multidisciplinary care. Chronic Disease Management Care Plans (GPMP) and Team Care Arrangement (TCA) should be provided by the patient's usual GP or another GP from the same practice.
A practice nurse, Aboriginal Health Worker or other health professional can assist a GP in preparing or reviewing a GPMP or TCA. The GP must review and confirm all assessments and elements of the service and must see the patient as part of the service.

It is recommended that a GP prepares a GPMP or TCA once every 2 years but can claim the item every 12 months. In exceptional circumstances a GP may claim a GPMP prior to 12 months.
The GPMP is a 'GP only care plan' and is available for all patients with a **chronic medical condition** that has occurred or is likely to occur for 6 months or longer or a terminal condition.

Item 721 GP Management Plan (GPMP)#

Patients with a chronic medical condition present or likely to be present for 6 mths or longer receive a structured approach to the management of their care needs from their 'usual GP' or GP in the same practice.

Step by Step GPMP

1. Gain Patient consent▲ and confirm eligibility
2. Assess the patient to identify and/or confirm their health care needs, problems and relevant conditions;
3. Agree on management goals with the patient for the changes to be achieved by the treatment and services identified in the plan;
4. Identifying any actions to be taken by the patient;
5. Identifying treatment and services that the patient is likely to need, and making arrangements for provision of these services and ongoing management; and
6. Document the patient's needs, goals, patient actions, treatment/ services and a review date i.e. completing the GPMP document.

Item 723 Team Care Arrangements

The TCA provides a funding stream for GP to coordinate Team Care Arrangements. GP prepares a management plan for a patient with a chronic or terminal condition who has **complex care needs** and requires ongoing care from a multidisciplinary 'team'* of the GP and at least two other health or care providers.

Step by step TCA

1. Identify and confirm with the patient which other treatment or service providers will be involved in completing the TCA and what information can be shared with them;
2. collaborate with the participating providers to discuss potential treatment/services they will provide to achieve management goals for the patient; and
3. Documenting the goals, the 'team members', the treatment/services they have agreed to provide, patient actions and a review date i.e. completing the TCA document.

Item 725 GPMP Review & Item 727 TCA Review

It is recommended that the GP reviews the GPMP and or the TCA on 6 monthly basis. Can be used at 3 months if required. In exceptional circumstances a GP may claim a review of a GPMP prior to 3 months.

Item 731 GP Contribution to Residential Aged Care Plan #A Care Plan is developed by the Aged Care Home for every resident. This practice recognizes the chronic and complex nature of the medical conditions that have contributed to their need for residential care.

Item 729 GP Contribution to Care Plan GP may contribute to a multidisciplinary Care Plan being prepared by another health or care provider in the community and to both private and public in-patients being discharged from hospital. The recommended frequency of items 731 and 729 is once every six months but can be claimed after three months.

 # Allied Health & Dental Care items

Patients with chronic medical conditions and complex care needs who are being managed through an EPC multidisciplinary care plan have had access to Medicare rebates for a maximum of 5 allied health services and 3 dental visits a year when referred by their GP to HIC registered allied health providers and dentists. One if the following EPC care plan items **must** be claimed through Medicare for the patient to be eligible to access the new allied health items:

Item 721 GP management plan & Item 723 and Team Care Arrangements

Item 731 or GP Contributes to a care plan or review of the care plan in a residential aged care facility

For more information visit DoHA website: http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/health-medicare-consumers-booklet4.htm

Case Conferences

In addition to multidisciplinary care planning the patient's GP can be involved in case conferencing activities with the multi-disciplinary team (although both items cannot be claimed in respect of the same service). The eligibility and make up of the team is the same as for care planning. A case conference is a discussion where members of the team must be communicating at the one time for the whole of the conference, either face-to-face, by telephone, video link, or a combination. The case conference involves the multi-disciplinary team undertaking the following activities:

- Discuss the patient's history.
- Identify patient's multi-disciplinary care needs.
- Identify outcomes to be achieved by members of the case conference team giving care to the patient.
- Identify tasks that need to be undertaken in order to achieve outcomes and allocate tasks to team members.
- Assess whether previously identified outcomes have been achieved.

A GP can organise or participate in a case conference, in the community, aged care home or for a private patient in hospital. A GP may only participate in a case conference conducted on discharge from public hospital.

The GP is required to obtain and record patient consent▲ when organising or participating in a case conference.

When organising or participating in a case conference the GP is required to; record day, times, names of participants, matters discussed (history, care needs, outcomes, tasks etc); and provide a summary to patient and team members. It is expected that a patient would not require more than **five** case conferences in a

**May include Aboriginal health care workers, audiologists, dental therapists, dietitians, occupational therapists, optometrists, pharmacists, physiotherapists, podiatrists, psychologists, registered nurses, social workers, speech pathologists. May also include home and community care providers, education providers, "meals-on-wheels", personal care workers, etc.*

▲ Obtaining patient and carer's (where appropriate) consent is a requirement of both care planning and case conferencing items. The GP needs inform the patient of the members of the multi-disciplinary team; that their medical history, diagnosis and care preferences will be discussed with other providers, and provide an opportunity for them to specify what may be conveyed or withheld from others; Patients should be informed that they may incur a charge for this service, for which a Medicare rebate will be payable. Exceptional circumstances are when there has been a significant change in the patient's clinical condition or care circumstances such as deteriorating condition, illness/death of a carer.

Quality Improvement Council

The purpose of this flow chart is to provide an overview or introduction to the MBS Items, it should not be used instead of the Medicare Benefits Schedule. It is recommended that GPs refer to the MBS explanatory notes A.20, A.21, & A.22 for a definitive guide, www9.health.gov.au/mbs/