# Chronic Condition Management Guide

## Nepean Blue Mountains Primary Health Network (NBMPHN)

*December 2025*

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NEPEAN BLUE MOUNTAINS
An Australian Government Initiative

Wentworth Healthcare
Blue Mountains | Hawkesbury | Lithgow | Penrith

**ACKNOWLEDGEMENTS:**

Wentworth Healthcare acknowledges and thanks the organisations that contributed to the content used in this Guide. They include PHNs, former Divisions of General Practice and Medicare Locals, National Peak Organisations and Commonwealth Agencies.

This resource has been created as part of the National MyMedicare PHN Implementation Program in partnership with National Improvement Network Collaborative (NINCo) Stream 3.

**INTRODUCTION:**

This Guide is intended as a resource to assist general practice staff to effectively coordinate care for their patients with chronic conditions. It provides comprehensive information regarding the MBS items relevant to the management of chronic conditions commonly treated in general practice. For current and comprehensive information about each MBS item number, please refer to the Medicare Benefits Schedule (MBS) at MBS Online. MBS Online is frequently updated as changes to the MBS occur.

**FEEDBACK/COMMENTS:**

If you have any enquiries or would like to provide feedback or comments regarding information provided in this Guide, please contact your Primary Care Engagement Officer on 02 4708 8100.

**DISCLAIMER: whilst every effort has been made to ensure that the information included in this Guide is current and up to date, you should exercise your own independent skill and judgement before relying on it. Refer to MBS Online for current information.**

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# Chronic Condition Management Overview

Chronic Condition Management (CCM) is an integrated care approach to managing illness which includes screenings, check-ups, monitoring and coordinating treatment and patient education.

The Australian Institute of Health and Welfare (AIHW) define chronic condition as “long lasting conditions with persistent effects”. Meaning, conditions that have been, or are likely to be present for at least six months and include but not limited to:

- Arthritis
- Asthma
- Cancer
- Cardiovascular Disease
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes Mellitus
- Mental Health

**Why it is important?**

**Australia is facing a rising burden of chronic conditions**, alongside growing patient expectations and evolving digital tools that support connected, multidisciplinary care**. Among people of all ages, an estimated 15.4 million (61%) were living with at least one long-term health condition in 2022. This ranged from 28% of people aged 0–14 to 94% of people aged 85 and over (AIHW). Living with chronic conditions can have a substantial impact on an individual’s health and requires considerable investment in Australia’s health system.**

**Person-centred care is the foundation of Chronic Condition Management (CCM)**

*‘Healthcare that respects the individual, their family, and carers, and responds to their preferences, needs, and values’* which leads to improved health outcomes. (The Australian Commission on Safety and Quality in Healthcare)


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# Preparation of a GP Chronic Condition Management Plan

# Claiming Workflow – Management Plan (GPCCMP 965 or 92029)

**Patient Eligibility**

**Ensure patient eligibility**

- No age restrictions for patients.
- Patients with a chronic or terminal condition.
- Patients who will benefit from a structured approach to their care.
- Check MyMedicare status.
- Not for public patients in a hospital or patients in a residential aged care home.
- GP Mental Health Treatment Plans (GPMHTP) (item 2700/2701/2715/2717) are available for patients with a mental health condition.

**Develop Plan**

Nurse /AHP may collect information

**GP must see patient**

**Clinical context**

- Explain management plan process and any out-of-pocket costs, gain consent, assess health needs, conditions, health problems, and relevant conditions.
- Set treatment and service goals with the patient including actions to be taken.
- Review plan up to every three months using MBS 967 or 92030.

**Complete Documentation**

**Documentation requirements**

- Record patient's consent to a GPCCMP.
- Patient needs and goals, patient actions, collaborating providers and treatments/services if required.
- Set review date.
- Send copy of relevant management plan information with allied health referrals.
- Offer copy to patient (with consent, offer to carer), keep copy in patient file.

**Claiming**

**Claim MBS item**

- All elements of the service must be completed to claim.
- Requires personal attendance by GP with patient.
- Review using item 967 or 92030 as clinically required.
- Claiming a GPCCMP enables patients to receive five rebated services from allied health (referrals through referral letter).

CCM services may be provided more frequently in exceptional circumstances. Exceptional circumstances exist for a patient if there has been a significant change in the patient's clinical condition or care requirements that necessitates the performance of the service for the patient.



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# Reviewing a GPCCMP

## Claiming Workflow – Management Plan (967 or 92030)

**Patient Eligibility**

**Clinical Context**
- Check MyMedicare status and item has not been billed elsewhere.
- Explain the review process to the patient and gain consent.
- Assess patient's progress, update goals and services, record consent.

**Review**

Nurse /AHP may collect information

**GP must see patient**

**Documentation Requirements**
- Amend the management plan as required.
- Set a new review date.
- Provide a copy of the updated plan to the patient (and carer, with consent); retain a copy in the patient's file.
- Share a copy to My Health Record with consent.

**Claiming**

**Claim MBS item**
- All elements of the service must be completed to claim.
- Requires personal attendance by GP with patient.
- Item 967 or 92030, minimum interval of 3-monthly. Frequency determined by clinical need.

| Name of Item | GP Item Number | Prescribed Medical Practitioner Item Number |
|---|---|---|
| Prepare a GPCCMP – face-to-face | 965 | 392 |
| Prepare a GPCCMP - video | 92029 | 92060 |
| Review a GPCCMP – face-to-face | 967 | 393 |

# Individual Allied Health Services Under Medicare

## Summary

A Medicare rebate is available for a maximum of five services per patient each calendar year.

- If a provider accepts the Medicare benefit as full payment for the services, there will be no out-of-pocket cost. If not, the patient will have to pay the difference between the fee charged and the Medicare rebate.
- **Patients must have a GPCCMP prepared by their GP or be residents of a residential aged care home who are managed under a multidisciplinary care plan.**
- Referrals letters to allied health providers must be from GPs. Allied health providers must report back to the referring GP.
- From 1 March 2024, Aboriginal and/or Torres Strait Islander peoples only need to have either a CCM plan **or** a health assessment to access up to **10** allied health services per calendar year. There will be no requirement to have both services for Aboriginal and/or Torres Strait Islander peoples.
- Residents of a residential aged care home may be eligible if their GP has contributed to a multidisciplinary care plan prepared for them by the aged care home or to a review of the multidisciplinary care plan (item 731).

| Item Number | Allied Health Services | Item Number – First Nations | Allied Health Services for First Nations Patients |
|---|---|---|---|
| **10950** | Aboriginal Health Worker Services | **81300** | Aboriginal Health Worker Services |
| **10951** | Diabetes Educator Services | **81305** | Diabetes Educator Services |
| **10952** | Audiology | **81310** | Audiology |
| **10953** | Exercise Physiology | **81315** | Exercise Physiology |
| **10954** | Dietetic | **81320** | Dietetic |
| **10956** | Mental Health Service | **81325** | Mental Health Service |
| **10958** | Occupational Therapy | **81330** | Occupational Therapy |
| **10960** | Physiotherapy | **81335** | Physiotherapy |
| **10962** | Podiatry | **81340** | Podiatry |
| **10964** | Chiropractic | **81345** | Chiropractic |
| **10966** | Osteopathy | **81350** | Osteopathy |
| **10968** | Psychology | **81355** | Psychology |
| **10970** | Speech Pathology | **81360** | Speech Pathology |
| **93000/93013** | Telehealth Video/Telephone | **93048/93061** | Telehealth Video/Telephone |
| | **Total of 5 per calendar year** | | **Total of 10 per calendar year** |


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# Prescribing / Home Medicines Review

## Domiciliary Medication Management Review (DMMR)

DMMR is targeted at patients living in the community who are likely to benefit from a review and may be at risk of medication misadventure because of risk factors such as:

- Co-morbidities.
- Age or social circumstances.
- Characteristics of their medicines.
- Complexity of their medication regime.
- Lack of skills or knowledge to use medicines to their best effect.

**Examples of risk factors include:**

- Currently taking five or more medications.
- Taking more than 12 doses of medication per day.
- Medications with a narrow therapeutic index or medications requiring therapeutic monitoring.
- Significant changes to medication treatment in the last three months.
- Suspended non-compliance.
- Difficulty managing medication due to literacy difficulties, cognitive difficulties, or physical difficulties.
- Recent discharge from a facility/hospital (in the last four weeks).

**In conducting a DMMR, a medical practitioner must:**

- Assess a patient's medication management need.
- Following that assessment, refer the patient to a community pharmacy or an accredited pharmacist for DMMR.

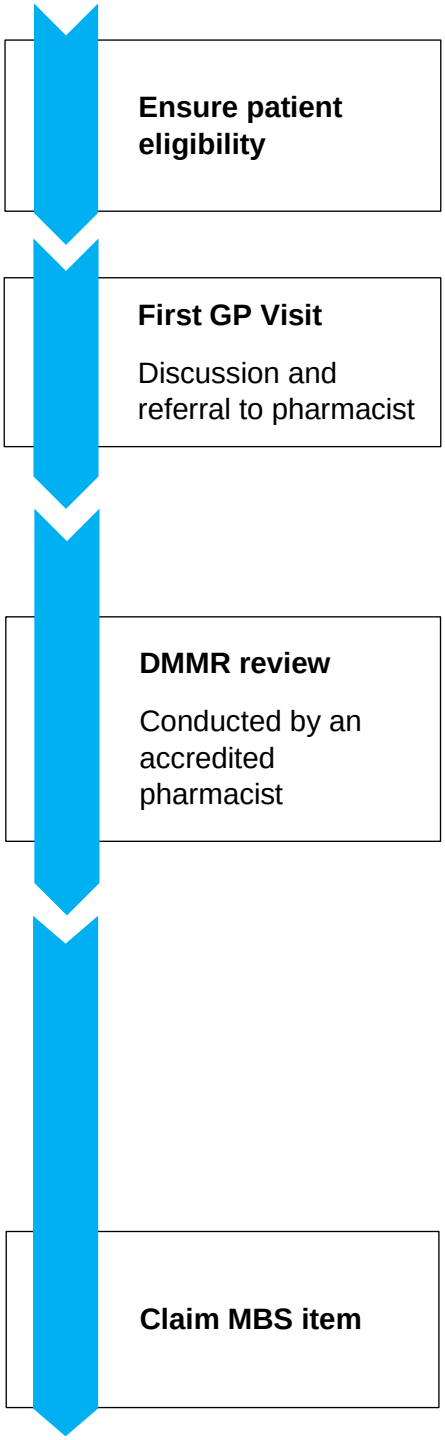
**With the patient's consent, provide relevant clinical information required for the review**

- Discuss with the reviewing pharmacist the results of that review, including suggested medication management strategies.
- Develop a written medication management plan following discussion with the patient.

# Domiciliary Medication Management Review (DMMR)

**Item 900 - DMMR**

**practitioner believes there has been a significant change to a patient's condition or medicine regimen).**




**Eligibility Criteria**

- Patients at risk of medication-related problems or for whom quality use of medicines may be an issue.
- Not for patients in a hospital or residential aged care home.

**GP Initiates Service**

- Explain purpose, possible outcomes, process, information sharing with pharmacist.
- Gain and record patient's consent to DMMR.
- Inform patient of need to return for second visit.
- Complete DMMR referral and send it to a pharmacy or an accredited pharmacist.

**DMMR Interview**

- Pharmacist holds review in patient's home unless prior approval is sought by the pharmacist.
- Pharmacist prepares a report and sends it to the GP covering review findings and suggested medication management strategies.
- Pharmacist and GP discuss findings and suggestions.

**Second Visit**

- Develop summary of findings as part of draft Medication Management Plan.
- Discuss draft plan with patient and offer copy of complete plan
- Send a copy of the completed agreed plan to the Pharmacist.

**Claiming**

- All elements of the service must be completed to claim
- Patient must be seen by the GP at the time of claiming

# Health Assessments - Preventative Health and Screening

Preventive healthcare is an important activity in general practice and a core aspect of many consultations. It includes the prevention of illness, screening activities for the early detection of specific condition/disease, and the promotion and maintenance of health and wellbeing.

## How to Make Health Assessments Work for Your Practice

Take a systematic approach to healthcare in your practice. Designate the task of setting up the health assessment process within the practice:

Obtain a list of appropriate patients (database search) that have been seen by the GP over the last 12 months.

- Ensure all patients are eligible for a health assessment.
- Set up a process for contacting patients (phone, SMS or mail).
- Ensure adequate time is allowed for each assessment.
- Identify and discuss the benefits of a health assessment with each patient.
- Obtain patient consent.
- Findings and outcomes must be discussed with the patient (and carer where appropriate).
- The GP prepares a written summary which that patient signs, including outcomes and recommendations – a copy should be offered to the patient.
- Keep a copy of each assessment in the patient's records.
- Ensure your practice nurse is available & has protected time to help conduct the assessments.

If a third person is undertaking the information collection component, the GP must ensure that this person has suitable skills, experience and qualifications.

# Health Assessment Target Groups

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. The health assessment item that is selected will depend on 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.

**45-49-year-old**
Once only health assessment for patients 45 – 49 years who are at risk of developing chronic disease.

**Type 2 Diabetes Risk Evaluation**
Provision of lifestyle modification advice and interventions for patients aged 40-49 years who score > 12 on the Australian Type 2 Diabetes Risk Assessment Tool (AUSDRISK). Once every three years.

**75 Years and Older**
Health assessment for patients aged 75 years and older. Once every 12 months.

**Comprehensive Medical Assessment**
Comprehensive medical assessment for permanent residents of residential aged care facilitates. Available for new and existing residents. Not more than once a year.

**Heart Health Check** item number 699.

**For Patient with an Intellectual Disability**
Health assessment for patients with an intellectual disability. Not more than once a year.

**For Refugees and Other Humanitarian Entrants**
Once only health assessment for new refugees and other humanitarian entrants, as soon as possible after their arrival (within 12 months of arrival).

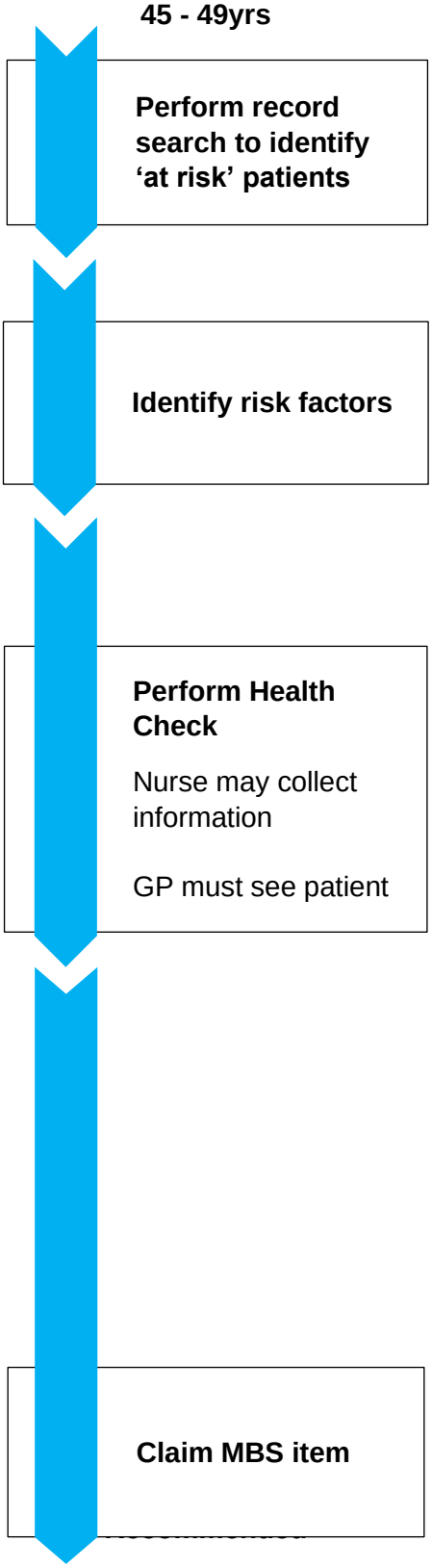
**Former serving members of the Australia Defence Force (ADF)**
The health assessment can be performed at any point after the patient's discharge from the ADF**Menopause and Perimenopause Health Assessment** for eligible patients experiencing signs or symptoms relating to menopause or perimenopause

# Health Assessment for 45 – 49-Year-Olds

**Item 701 / 703 / 705 / 707**
**Health assessment for**

**45 - 49yrs**

**Frequency:** One occasion only




**Eligibility Criteria**

- Patients aged 45 to 49 inclusive.
- Who are at risk of developing chronic disease.
- Not for patients in hospital.

**Risk Factors**

- Lifestyle: smoking, physical inactivity, poor nutrition, alcohol use.
- Biomedical: high cholesterol, high blood pressure, excess weight, impaired glucose metabolism.
- Family history of chronic disease.

**Clinical Content - Mandatory**

- Explain health assessment process and gain consent Information collection - take patient history, examinations and investigations as clinically required.
- Overall assessment of patient's health, including their readiness to make lifestyle changes.
- Initiate interventions and referrals as clinically indicated.
- Advice and information about lifestyle modification programs and strategies to achieve lifestyle and behavior changes.

**Non-mandatory**

- Written patient information resources are recommended.

**Essential Documentation Requirements**

- Record parent's consent to health assessment.
- Record the health assessment and offer the parent a copy.

**Claiming**

- All elements of the service must be completed to claim.
- Requires personal attendance by GP with patient.

# Health Assessment Type 2 Diabetes Risk 40 – 49 Years

**Item 701/703/705/707**
**Health assessment: type 2 diabetes risk evaluation**

**Recommended Frequency:** Once every 3 years


**Eligibility Criteria**

- Non-Indigenous patients aged 40 – 49 years inclusive.
- Patients must score > 12 point on AUSDRISK.
- GP must exclude diabetes via glucose tolerance test.
- Document outcomes.
- Determine if diabetes prevention/lifestyle modification or diabetes management is required based on the outcomes of glucose tolerance test.

# Health Assessment for 75-Years and Older

**Item 701/703/705/707**
**Health Assessment: 75 years and older**

**Establish a patient register and recall when due for assessment**

**Perform Health Check**

Allow 45 – 90 minutes

Nurse may collect information.

GP must see patient. to pharmacist

**Claim MBS item**

**Recommended Frequency:** Once every 12 Months

**Eligibility Criteria**

- Patients aged 75 years and older.
- Patients seen in consulting rooms and/or at home.
- Not for patients in hospital or a Residential Aged Care Facility.

**Clinical Content – Mandatory**

- Explain Health Assessment process and gain patient's/carer's consent.
- Information collection – take patient history, examinations and investigations as clinically required.
- Measurement of BP, pulse rate and rhythm.
- Assessment of medication, continence, immunisation status for influenza, tetanus, and pneumococcus.
- Assessment of physical function including activities of daily living and falls in the last three months.
- Assessment of psychological function including cognition and mood.
- Assessment of social function including availability and adequacy of paid and unpaid help and the patient's carer responsibilities.
- Overall assessment of patient.
- Recommend appropriate interventions.
- Provide advice and information.
- Discuss outcomes of the assessment and any recommendations with the patient.

**Non-mandatory**

- Consider the need for community services, social isolation, oral health and dentition, and nutrition status.
- Additional matters as relevant to the patient.

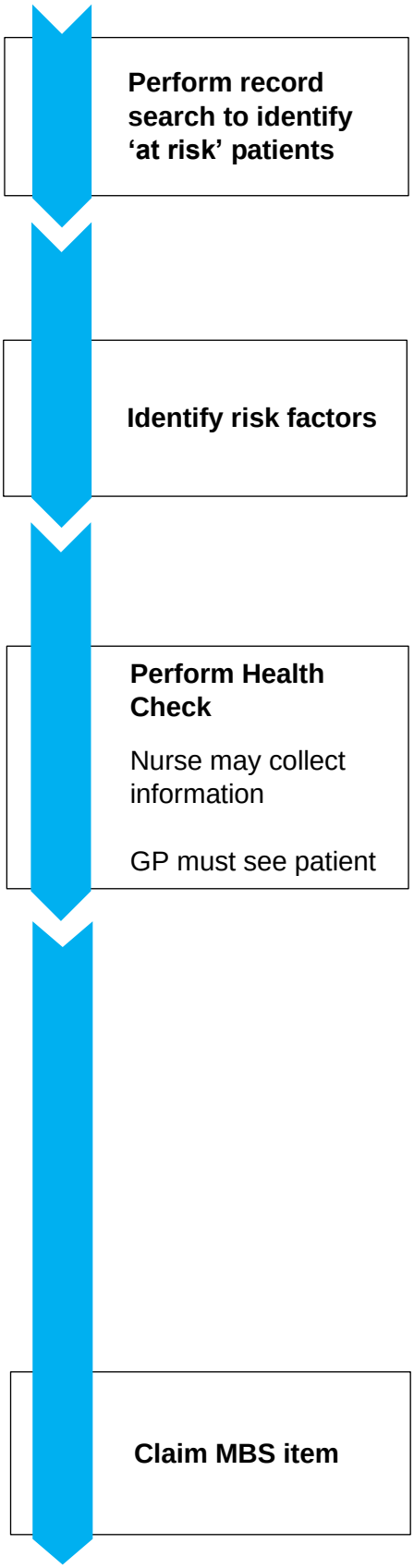
**Claiming**

- All elements of the service must be completed to claim.
- Requires personal attendance by GP with patient.

## Heart Health Assessment

**Item 699**

**Recommended Frequency:** Annually




**Eligibility Criteria**

- Aboriginal and/or Torres Strait Islander peoples who are aged 30 years and above.
- Adults aged 45 years and above.
- The absolute cardiovascular disease risk must be calculated as per the Australian Absolute Cardiovascular Disease Risk Calculator.
- Not for patients in hospital.

**Risk Factors**

- Lifestyle: smoking, physical inactivity, poor nutrition, alcohol use, biomedical, high cholesterol, high BP, impaired glucose metabolism or excessive weight.
- Family history of chronic disease.

**Clinical Content – Mandatory**

- Explain Health Assessment process and gain consent
- Collection of relevant information including taking a patient history that is aimed at identifying cardiovascular disease risk factors, including diabetes status, alcohol intake, smoking status, cholesterol status (if not performed within the last 12 months) and blood glucose.
- A physical examination, which must include recording of blood pressure.
- Initiating interventions and referrals to address the identified risk factors.
- Implementing a management plan for appropriate treatment of identified risk factors.
- Providing the patient with preventative health care advice and information, including modifiable lifestyle factors.

**Non-mandatory**

- Written patient information is recommended.

**Essential Documentation Requirements**

- Record patient's consent to Health Assessment.
- Record the Health Assessment and offer the patient a copy.

**Claiming**

- All elements of the service must be completed to claim.

# Health Assessment for Aboriginal and/or Torres Strait Islander peoples

**Item 715**

**Recommended Frequency:** Every nine months

**Ensure patient eligibility**

**Note:**

It may take several shorter sessions to complete the full health assessment with Aboriginal and/or Torres Strait Islanders peoples. **The practice cannot claim the 715 until all components are completed.**

**Complete Documentation**

**Claim MBS item**

**Eligibility Criteria**

- Aboriginal and/or Torres Strait Islander peoples under 15 years.
- Aboriginal and Torres Strait Islander peoples aged between 15 years and 54 years.
- Aboriginal and Torres Strait Islander peoples aged 55 years and over.

**Clinical Content – Mandatory**

- Explain health assessment process and gain parents'/carers consent.
- Information collection - taking patient history and undertake or arrange examinations and investigations as required.
- Overall assessment of patient.
- Recommended appropriate interventions.
- Provide advice and information.
- Keep a record of the health assessment and offer a copy of the assessment with recommendations about matters covered to the patient and/or carer.

**Non-mandatory**

- Discuss eating habits, physical activity, speech and language development, fine and gross mottos skills, behavior, and mood
- Oher examinations considered necessary by GP/practice nurse

**Essential Documentation Requirements**

- Record parent's/carer's consent to health assessment
- Record the health assessment and offer the parent/carer a copy
- Update parent held child record for children under 5 years of age
- Record immunisations provided. All elements of the service must be completed to claim
- May be completed over several sessions but do not claim 715 until all components are complete
- NB: Once the patient has had a 715 health assessment, they are eligible for ten follow ups by the practice nurse (item number 10987) and five "at risk" allied health visits (separate/additional to the five allied health visits).

## Health Assessments for Government Humanitarian Program

Items 701, 703, 705 and 707 may be used to undertake a health assessment 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 12 months of arrival).

In addition to general requirements for health assessments, the assessments must include development of a management plan addressing the patient's health care needs, health problems and relevant conditions.

The health assessment applied to humanitarian entrants who are residents in Australian with access to Medicare services. This includes refugees, Special Humanitarian Program and Protection Program entrants.

Patients should be asked to provide proof of their visa status and date of arrival in Australia. Alternatively, medical practitioners may telephone Medicare Australia on 132 011, with the patient present, to check eligibility.

The medical practitioner and patient can use the service translator by accessing the Commonwealth Government's Translating and Interpreting Service (TIS) on 131 450.

A health assessment for refugees and other humanitarian entrants may only be claimed once by an eligible patient.

## Health Assessments for People with an Intellectual Disability

Items 701, 703, 705 and 707 may be used to undertake a 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 and would benefit from assistance with daily living activities. Where medical practitioners wish to confirm intellectual disability and a patient's need for assistance with activities of daily living, they may seek verification from a paediatrician registered to a practice in Australia or from a government-provided or funded disability service that has assessed the patient's intellectual function.

The health assessment provides a structured clinical framework for medical practitioners to comprehensively assess the physical, psychological, and social function of a patient with intellectual disability and to identify any medical intervention and preventive health care required.

A health assessment for people with an intellectual disability may be claimed once every 12 months.

## Health Assessments for Former Serving Member of the Australian Defence Force (ADF)

Items 701, 703, 705 and 707 may be used to undertake a health assessment for a former serving member of the ADF, including a former member of permanent and reserve forces.

The health assessment can be performed at any point after the patient's discharge from the ADF. The assessment is available to all former ADF members, whether they are a DVA client or not.

The Former Serving Member of the ADF Health Assessment is intended to promote the early detection and intervention of potential mental or physical health concerns in the veteran population, assisting with access to primary health care, facilitating the establishment of ongoing care with a general practitioner striving to achieve better health outcomes for veterans during their transition to civilian life.

This health assessment must include a personal attendance by a medical practitioner taking the patient's history, including the following:

- Service with the ADF – service type, years of service, field of work, deployments and reason for discharge.
- Social history – relationship status, number of children, current occupation.
- Current medical conditions.

The health assessment should also cover a range of other health domains where these are applicable.

Practice nurses and Aboriginal and Torres Strait Islander health practitioners may assist medical practitioners in performing the health assessment.

Patients should be provided with an explanation of the health assessment process and its likely benefits. Consent to perform the assessment should be obtained and noted in patients' records. Patients should be assured that the information they provide will be treated as confidential.

The health assessment can be performed at any point after the patient's discharge from the ADF. and can only be performed once at a single point in time.

## Health Assessments for Menopause and Perimenopause

Item Number 695 (GP) and 19000 (PMP) have recently been established to encourage health assessments for patients for the assessment and management of menopause or perimenopause.

This includes but is not limited to:

a) Collecting relevant information, including taking a patient history to determine pre-, peri- or post-menopausal status, patient wellbeing and contraindications for management; and

b) Undertaking a basic physical examination, including recording blood pressure, and review of height and weight; and

c) Initiating investigations and referrals as clinically indicated, with consideration given to the need for cervical screening, mammography and bone densitometry; and

   Discussing management options including non-pharmacological and pharmacological strategies including risks and benefits.

d) Implementing a management plan which includes patient-centered symptoms management; and

e) Providing the patient with preventative health care advice and information as clinically indicated, including advice on physical activity, smoking cessation, alcohol consumption, nutritional intake and weight management.

# Residential Aged Care Homes

## Health Assessment Provided as a Comprehensive Medical Assessment (CMA) for Residents of Residential Aged Care Homes

Items 701, 703, 705 and 707 may be used to undertake a Comprehensive Medical Assessment of a resident of a residential aged care home.

This requires an assessment of the resident's health and physical and psychological functioning, and must include:

- Making a written summary of the CMA.
- Developing a list of diagnoses and medical problems based on medical history and examination.
- Providing a copy of the summary to the residential aged care home.
- Offering the resident a copy of the summary.

A residential aged care home is a facility in which residential care services, as defined in the Aged Care Act 1997, are provided. This includes facilities that were formerly known as Nursing Homes and Hostels. A person is a resident of a residential aged care home if they have been admitted as a permanent resident of that facility.

This health assessment is available to new residents on admission. It is recommended that new residents should receive the health assessment as soon as possible after admission, preferably within six weeks following admission into a residential aged care home.

A health assessment for the purpose of a CMA of a resident of a residential aged care home may be claimed for an eligible patient:

- On admission to a residential aged care home, provided that a CMA has not already been provided in another residential aged care home within the previous 12 months.
- At 12-month intervals thereafter.

### Can a GP Charge for a Consultation as well as the CMA?

Medical practitioners should not conduct a separate consultation for any other health-related issue in conjunction with a health assessment unless it is clinically necessary (i.e., the patient has an acute problem that needs to be managed separately from the assessment).

The only exceptions are:

- The CMA, where, if this health assessment is undertaken during the course of a consultation for another purpose, the health assessment item and the relevant item for the other consultation may both be claimed. Practices should refer to MBS Online before claiming.
- Use of a specific form to record the results of the CMA is not mandatory. A Health Assessment provided as a CMA may be claimed annually to an eligible patient.

# Arrangements for GP Residential Aged Care Home (RACH) Services

## Items for GPs and RACH Services

On 1 March 2019, the Government introduced new MBS items for professional services provided by a general practitioner (GP) or medical practitioner at a RACH. The new items include a call-out fee to cover doctors' costs of travel to a RACH (MBS items 90001 and 90002), and new (standard level A to D) attendance items.

The items simplify claims for RACH services and replace the derived fee payment model.

## Call-Out Fee

The call-out items apply to a doctor's initial attendance at a RACH and are billable only for the first patient seen on a RACH visit. Once a call-out item is billed, doctors may then bill an applicable attendance item for each of the RACH patients they see.

| Item number | Fee |
|---|---|
| 90001 | $64.15 |
| 90020 | $20.05 |
| 90035 | $43.90 |
| 90043 | $84.90 |
| 90051 | $125.10 |

## Billing

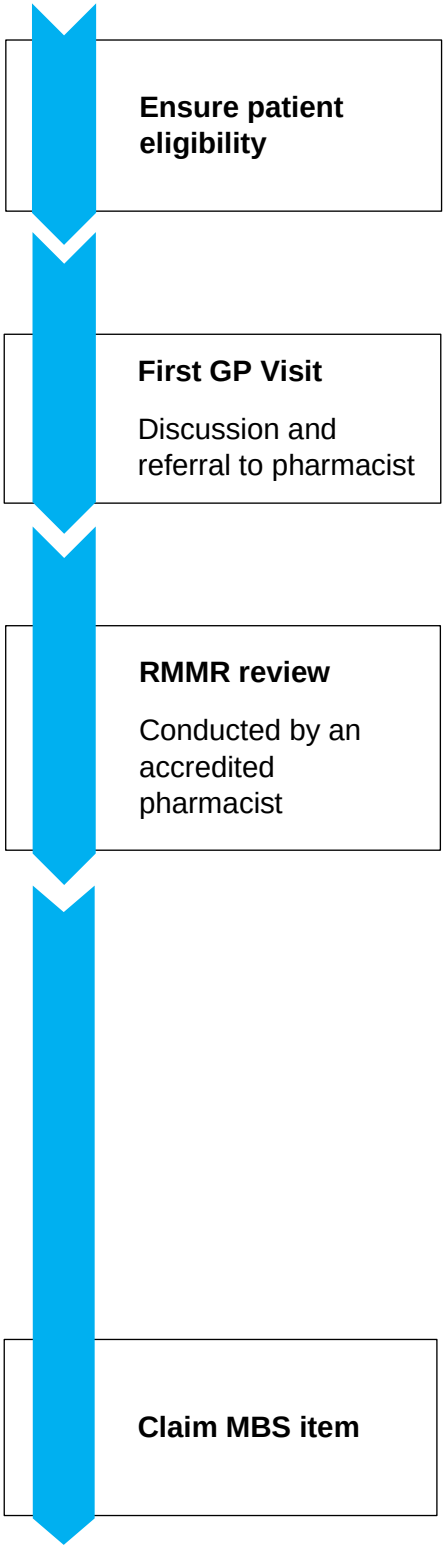
The RACH items are only for Medicare-eligible GP and other medical practitioners providing primary care services in RACHs. Doctors employed by RACHs cannot claim the items, nor can specialists, consultant physicians, nurses and other allied health professionals.

## Item Restrictions

In general, the call-out fee is intended as a one-off payment to help reimburse travel expenses, but if a doctor must return to a RACH, on the same day and the attendances are not a continuation of an earlier episode of treatment, another call-out fee would apply per subsequent RACH visit.

# Residential Medication Management Review (RMMR)

**Item 903**




**Recommended Frequency**: As required (payable once in a 12-month period – unless the medical practitioner believes there has been a significant change to a patient's condition or medicine regimen).

**Eligibility Criteria**

- New residents on admission into a RACH.
- Existing residents on an 'as required' basis every 12 months or if there has been a significant change in medical condition or medication regimen.
- Not for respite patients in a RACH (eligible for Domiciliary Medicines Review when they are living in the community setting).

**GP Initiates Service**

- Explain RMMR process and gain resident's consent.
- Send referral to accredited pharmacist to request collaboration in medication review.
- Provide input from Comprehensive Medical Assessment or relevant clinical information for RMMR and the resident's records.

**Accredited Pharmacist Component**

- Review resident's clinical notes and interview resident.
- Prepare medication review report and send it to GP.

**GP and Pharmacist Post Review Discussion**

- Discuss findings and recommendations of the pharmacist.
- Medication management strategies, issues, implementation, follow up and outcomes.
- If no (or only minor) changes recommended a post review discussion is not mandatory.

**Essential Documentation Requirements**

- Record resident's consent to RMMR.
- Develop and/or revise Medication Management Plan which should identify medication management goals and medication regime.
- Finalie the plan after discussion with resident.
- Provide copy for residents'/carer's records, discuss plan with nursing staff if necessary.

**Claiming**

- All elements of the service must be completed to claim.
- Derived fee arrangement does not apply to

# Veterans' Care

## Coordinated Veterans' Care Program (CVC)

### About the CVC Program

The CVC Program provides proactive care coordination for eligible Veteran Card holders with chronic health conditions and complex care needs. Providers and participants work as a team to improve the participant's health, wellbeing and reduce hospitalisations. It provides new payments to GPs for initial and ongoing care.

### Eligibility

The program is aimed at veterans who are at risk of unplanned admission to the hospital and hold either:

- A Veteran Gold Card and have a chronic health condition.
- A Veteran White Card and have a DVA-accepted mental health condition.

A DVA-accepted mental health condition means DVA has accepted it as being related to a veteran's military service.

GPs can enrol participants in the program if they:

- Pass an eligibility assessment.
- Give their informed consent to be involved in the program.

### Payments for GPs

By participating in the program, GPs can claim the following payments through existing payment arrangements with Medicare Australia:

- Initial assessment and program enrolment (UP01 or UP02).
- Quarterly Care Payments for ongoing care (UP03 or UP04).

**Guide for General Practice**
The DVA has developed a guide to help with the implementation of the CVC. The CVC Program items are DVA only items and do not appear in the MBS.

# Multidisciplinary Case Conferences

Patients with a chronic or terminal medication condition and complex care needs requiring care or services from their usual GP and at least two other health or care providers are eligible for a case conference service. There is no list of eligible conditions, however, the CCM items are designed for patients who require a structured approach and to enable GPs to plan and coordinate the care of patients with complex conditions requiring ongoing care from a multidisciplinary team.

Case conferences can be undertaken for patients in the community, for patients being discharge into the community from hospital and for people living in residential aged care homes.

## When are patients most likely to benefit from a Case Conference?

- When there is a need to develop immediate solutions in response to a recent change in the patient's condition or circumstances, e.g. death of a carer or unexpected event such as a stroke.
- To facilitate ongoing management such as sharing of information to develop or communicate goals for patient care or define relevant provider contributions to care.

## How can a GP be involved in a Case Conference?

Prepare and co-ordinate a case conference:

- For patients living in the community.
- For private patients on discharge from hospital.
- For patients in a residential aged care home; not those receiving nursing home level care.

Participate in a case conference:

- For patients living in the community.
- For public or private patients on discharge from hospital.
- For patients in a residential aged care home; not those receiving nursing home level care.

A case conference can occur face-to-face, by phone or by video conference, or through a combination of these. A minimum of three care providers (including the GP) must be in communication with each other throughout the conference. Examples of persons who may be included in a multidisciplinary care team are:

- Allied health professionals.
- Home and community service providers.
- Care organisers such as education providers, "meals on wheels" providers, personal care workers and probation officers.

| MBS item numbers for Case Conferences | GP Prepares and Co-ordinates | | | GP Participates | | |
|---|---|---|---|---|---|---|
| Community Case Conference | 15-20 mins | 20-40 mins | >40 mins | 15-20 mins | 20-40 mins | >40 mins |
| | 735 | 739 | 743 | 747 | 750 | 758 |
| Discharge Case Conference (At the invitation of the hospital) | For Private Patients | | | For Public and Private Patients | | |
| | 735 | 739 | 743 | 747 | 750 | 758 |
| RACH Case Conference | 735 | 739 | 743 | 747 | 750 | 758 |

# Practice Nurses and Chronic Condition Management

An appropriately skilled practice nurse operating within their scope of practice can deliver some Chronic Condition Management services under the supervision of and on behalf of the GP. Services include:

- Preparation of a GPCCMP.
- A nurse may assist a GP in preparing a GP Chronic Condition Management Plan (GPCCMP). The nurse can collect history, identify needs, goals, and actions, and make arrangements with services.

*The GP must review the plan with the patient before claiming the relevant item/s.*

*Items 965 & 967 apply.*

*Patients being managed under a GPCCMP may receive ongoing support and monitoring from Practice Nurses, up to five times per year, on behalf of the GP who prepared the plan.*

*MBS nurse item 10997 applies.*

- Preparation of a Health Assessment

A suitably qualified nurse can assist the GP conduct a Health Assessment or a Comprehensive Medical Assessment (CMA) for a patient in residential aged care. The nurse can collect information for the patient assessment, provide lifestyle advice and education, as well as facilitate appropriate referral pathways inclusive of a multidisciplinary team. Such assistance must be provided in accordance with accepted medical practice and under the supervision of the GP. The GP must meet all regulatory requirements, personally attend the patient, review, and confirm all elements of assistance provided on their behalf before claiming the relevant item/s.

# Practice Nurse Item numbers

## Chronic condition monitoring and support (MBS item 10997)

Patients being managed under a GPCCMP or a multidisciplinary care plan may receive ongoing support and monitoring from practice nurses between structured reviews of the care plan by the patient's usual medical practitioner.

- A practice nurse provides monitoring and support to an eligible patient consistent with their care plan
- It is provided between structured reviews of the care plan by the patient's usual medical practitioner.

This item can be claimed up to five times per patient per calendar year, and as part of the service, the nurse can check on clinical progress, monitor medication compliance, provide advice and collect information to support the review of the care plan.

## Health Assessment follow-up (MBS Item 10987)

This service can be claimed by the practice nurse for a health assessment follow up on Aboriginal and Torres Strait Islander peoples, including MBS items 228 or 715. This item can be claimed up to 10 times per patient per calendar year and includes patient assessment, identification of patient needs and making arrangements for services.

# APPENDIX A

## Health Assessment Item Numbers

| Item No. | Name | Description/Recommended Frequency |
|---|---|---|
| 699 | Heart Health Check | ≥ 20 mins<br>a. Collection of relevant information, including taking a patient history that is aimed at identifying cardiovascular disease risk factors, including diabetes status, alcohol intake, smoking status, and blood glucose.<br>b. A physical examination, which must include recording of blood pressure and cholesterol status.<br>c. Initiating interventions and referrals to address the identified risk factors.<br>d. Implementing a management plan for appropriate treatment of identified risk factors.<br>e. Providing the patient with preventative health care advice and information, including modifiable lifestyle factors. |
| 701 | Brief Health Assessment | < 30 mins<br>a. Collection of relevant information, including taking a patient history.<br>b. A basic physical examination.<br>c. Initiating interventions and referral as indicated.<br>d. Providing the patient with preventative health care advice and information. |
| 703 | Standard Health Assessment | 30 – 45 mins<br>a. Detailed information collection, including taking a patient history.<br>b. An extensive physical examination.<br>c. Initiating interventions and referrals as indicated.<br>d. Providing a preventative health strategy for the patient. |
| 705 | Long Health Assessment | 45 – 60 mins<br>a. Comprehensive information collection, including taking a patient history.<br>b. An extensive examination of the patient's medical condition and physical function.<br>c. Providing a basic preventative health care strategy for the patient. |
| 707 | Prolonged Health Assessment | > 60 mins<br>a. Comprehensive information collection, including taking a patient history.<br>b. An extensive examination of the patient's medical condition and physical and social function.<br>c. Initiating interventions and referrals as indicated.<br>d. Providing a comprehensive preventative health care management plan for the patient. |
| 715 | Aboriginal and Torres Strait Islander Health Assessment | No designated time or complexity requirements<br>**Aboriginal and/or Torres Strait Islander peoples 0-14 years**<br>Not available to inpatients of a hospital or RACH. Not more than once every nine months.<br>**Aboriginal and/or Torres Strait Islander peoples 15-54 years**<br>Not available to inpatients of a hospital or RACH. Not more than once every nine months. |

# APPENDIX B

## Systematic Care Claiming Rules

For the most up to date information refer to the Medicare Benefits Schedule online at or phone Medicare Australia Schedule Interpretation Team on 132 150.

| | Item No. | Service | Brief Guide | Claim Period |
|---|---|---|---|---|
| Chronic Condition Management | 965 | Preparation of a GPCCMP | Patients with a chronic or terminal medical condition | **2 yearly** (minimum 12 months) |
| | 967 | Review of a GPCCMP | | |
| | 729 | Contribution to care plan or to review the care plan being prepared by the other provider | Not available to patients of RACH | |
| | 731 | Contribution to care plan or to review the care plan for patient of RACH | Plan prepared by such a facility | **6 monthly** (minimum 3 months) |
| | 139 | Assessment, diagnosis and development of a treatment and management plan for a disability | Children aged under 13 years with an eligible disability | **Once only** |
| | 900 | DMMR for patient living in the community setting | Assessment, referral to a community pharmacy | **12 months** except in circumstances with significant change |
| Medication reviews | 903 | RMMR | For new or existing residents of residential aged care home | **12 months** except in circumstances with significant change |
| | 10987 | Monitoring and support for a person who has had a 715-health assessment | 715 health assessment for Aboriginal and Torres Strait Islander people | Maximum 10 per patient per year |
| Practice Nurse | 10997 | Monitoring and support for a person with a chronic condition | Patient must have a GPCCMP or multidisciplinary care plan in place | Maximum of 5 times per patient per calendar year |

**Restrictions of Co-claiming of Chronic Condition and General Consultation Items**
Co-claiming of GP consultation items 3, 4, 23, 24, 36, 37, 44, 47, 52, 54, 57, 58, 59, 60, 63, 65, 597, 598, 599, 600, 5000, 5003, 5020, 5023, 5040, 5043, 5060, 5063, 5200, 5203, 5207, 5208, 5220, 5223, 5227, and 5228 with chronic condition management items 965, 967 **is not permitted for the same patient on the same day.**

*Note: CCM services can also be provided more frequently in circumstances where there has been a significant change in the patient's clinical condition or care circumstances that require a new GPCCMP or review service. You must mark the Medicare claim as "exception circumstances" or "clinically indicated".*

# APPENDIX C

## Information and Resources for Health Professionals

- Prepare a GPCCMP or MHCC - Health professionals - Services Australia
- Practice Nurse Items
- Medicare Benefits Schedule item descriptors and explanatory notes
- Putting Prevention into Practice (Third Edition)
- RACGP About the Red Book
- Nepean Blue Mountains PHN HealthPathways
- Nepean Blue Mountains PHN Chronic Condition Management
- Coordinated Veterans' Care Program
- Coordinated Veteran's Care Program Toolbox
- Correct billing of MBS item 10997

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