

Integrated Chronic Disease Management Fact Sheet

Care Planning with General Practice – FAQs about the use of CDM Medicare Items

A resource for Victorian Primary Care Partnerships

This resource addresses some frequently asked questions regarding integrated chronic disease management, specifically care planning for people with chronic disease and complex care needs that involves working with general practice and the Medicare Benefits Schedule (MBS)'s Chronic Disease Management (CDM) items.

This resource can be read in conjunction with:

- Department of Human Services position statement and resource guide, *Working with General Practice*¹, January 2008;
- *Summary of new MBS item numbers: General practice and allied health flipchart*², November 2008;
- Commonwealth Department of Health and Ageing *Chronic Disease Management (CDM) Medicare Items: Q&As*³; and
- *Client services through Medicare: Opportunities and considerations for community health services*⁴, February 2009.

All quotations below are from the Department of Health and Ageing's document, '*CDM Medicare Items: Q&As*'.

I am a nurse or an allied health professional and I have received a request to participate in a Team Care Arrangement (TCA) from a general practice. What do I have to do?

A TCA is simply a GP-led multidisciplinary care plan. A request from a GP to participate means that the GP believes your services can help the client meet the management goals that have already been agreed between the GP and the client.

Upon receipt of a TCA request, you will need to discuss with the referring GP the potential treatment or services that you will provide to help achieve management goals for the patient, and then provide the agreed services. This communication with the GP needs to be two-way, and preferably oral communication, although it may be in writing (email or fax). **If you are employed by a public health service, you can provide the agreed services as part of your ordinary responsibilities of employment** – you do not have to be registered with Medicare Australia to be a part of the client's TCA.

The Department of Health & Ageing advises that:

"The key points about involvement are that the team members must collaborate with the coordinating GP (they must discuss potential treatment/services they will provide to achieve management goals for the patient). The Collaboration must relate to the specific needs and circumstances of the patient, the treatment of services or services must be ongoing and the collaborating team members must be providing different kinds of ongoing care to the patient."

¹ http://www.health.vic.gov.au/communityhealth/gps/position_statement.htm

² http://www.health.vic.gov.au/communityhealth/downloads/mbs/all_mbs_attachments_for_printing%20.pdf

³ [http://www.health.gov.au/internet/main/publishing.nsf/Content/D1794C87EE43B870CA2573D600833BF6/\\$File/qsandasnov08.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/D1794C87EE43B870CA2573D600833BF6/$File/qsandasnov08.pdf)

⁴ <http://www.health.vic.gov.au/communityhealth/gps/mbs/index.htm#client>

Can health professionals employed by public health services be a part of Team Care Arrangements initiated by a GP?

“Yes. The GP can include a public sector **allied health professional** as part of a TCA. The services provided for the patient by the public sector allied health professional will be provided as part of the public sector allied health professional’s responsibilities.”

The Department of Health & Ageing provide a list of the many allied health professionals, home and community care providers and care coordinators who can be included in a team for the purposes of Team Care Arrangements. Their only stated limitation is that myofascial therapists, massage therapists and naturopaths are generally not regarded as health or care providers and therefore cannot be part of a TCA, unless the GP could be clearly satisfied that the involvement in the client’s care would be regarded by the GP’s peers as appropriate.

Consultant physicians can also be a part of Team Care Arrangements, although only one per TCA. The list of eligible participants in a TCA is, of course, more extensive than the list of allied health professionals to whom a GP can refer patients for the purpose of the five annual Medicare allied health rebates.

Where a **nurse** is providing ongoing care to the patient, or where it is proposed that their ongoing involvement would be beneficial, then a nurse can also be one of the core members of a TCA.

Do I have to be registered with Medicare, or a private provider, to receive or be a part of a Team Care Arrangement?

No. “The GP can include a public sector allied health professional as part of a TCA.”

I am concerned that accepting a TCA will mean that I am ‘double-dipping’.

The term double-dipping is sometimes used to describe a situation where a health or care provider is being paid twice for the provision of a single service – for example, attracting and keeping a Medicare rebate for themselves *and* receiving a salary at the same time.

Agreeing to be a part of GP-initiated TCA does not mean that a provider is double-dipping. Many providers who are salaried by a public health service are part of a client’s TCA and do not attract or keep an MBS rebate. They may work alongside Medicare-registered providers who are also part of the same TCA.

Is there a limited number of services I can provide to a client who has a TCA?

Once a TCA has been established, the client will be eligible for Medicare rebates for five allied health service in the following 12 months. Services not rebated by Medicare, such as allied health services provided by publicly-funded health services, are not included within this limit of five annual services, nor are services rebatable under other Medicare arrangements such as Mental Health Plans.

I work outside of general practice and have identified a client who will benefit from MBS-subsidised allied health services. How can I initiate this?

You should identify the client’s usual general practice and then work with them to ascertain whether or not the client already has a care plan (GP Management Plan or Team Care Arrangements). If not, you should seek to speak with the client’s usual GP regarding the likely benefits of a care plan. It may then be appropriate to request that a GP Management Plan and TCA be considered, and discuss your potential input into the TCA, including your service access model and any waiting periods for access to your services.

When coordinating services in this way, it is important to:

- understand the requirements of relevant item numbers and understand which clients are eligible for these services, including that TCAs must have a minimum of three contributing health or care providers (including the GP);
- ensure that the client’s usual GP is aware of the services being provided or offered to the client in your setting; and
- recognise that the ultimate decision about whether to offer and deliver a GP-led care plan is that of the GP in consultation with the client.

For a client to access MBS-funded allied health services - that is, to be eligible for reimbursement from Medicare for all or part of the fee charged by a private practising allied health professional - there are a range of Medicare rules that apply (see *Summary of new MBS item numbers: general practice and allied health*). Importantly, the services must be provided on referral from a GP, following the initiation of a TCA by the GP in consultation with the client.

A client I am working with already has a care plan that I have developed but would benefit from GP input into the plan. Does the client's GP also have to develop a care plan of their own (eg: GP Management Plan and/or TCA), or can I get the client's GP to be involved in our care plan, paid for by the MBS?

There may be circumstances where you identify that there could be benefits for a client to access MBS-funded allied health services and/or for the client's GP to develop Team Care Arrangements, even where your service has already undertaken a care planning process with the client. This should be discussed with the client and the GP and processes followed as per the previous question.

If you or your organisation plans to initiate a care planning process, or has already developed a care plan, there are several ways for the client's GP to contribute to another provider's care plan and be funded through the MBS for this work:

- GP contribution to a care plan, or review of a care plan, being prepared by another provider (MBS item #729)
- GP contribution to a care plan, or review of a care plan, being prepared by the residential aged care facility (RACF) or hospital from which the resident is being discharged (MBS item #731)

Note that a #729 or #731 cannot be claimed by the GP within 12 months if they have already claimed for a GP Management Plan or TCA for that patient, unless there have been significant changes to the client's condition or circumstances. Similarly, a GP Management Plan or TCA cannot be claimed within 12 months of a #729 or #731 unless there has been a significant change in the client's condition or circumstances (see *Summary of new MBS item numbers: general practice and allied health* document, which summarises these rules).

Case conferencing may also be appropriate as part of a care planning process, and there are a range of MBS items relating to case conferences organised and coordinated by a GP and for GP participation in case conferencing organised and coordinated by another provider such as yourself.

Further resources

Copies of Medicare item descriptors, explanatory notes and a fact sheet are available on the Department of Health & Ageing's website at www.health.gov.au/epc. Questions about items can be sent to epc.items@health.gov.au.

Your local Division of General Practice is also a good resource for you to discuss queries you may have regarding the MBS and general practice.

The Department of Health & Ageing's **Chronic Disease Management (CDM) Medicare Items Qs & As** (updated 1 November 2008) has been used as the key resource for this publication, and provides a range of further information.

For further information about General Practice Engagement in Integrated Chronic Disease Management, please contact your local Division of General Practice or:

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