Practice Assist
Strengthening general practice in WA

Fact Sheet

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Chronic Disease Management
Medicare Benefits Schedule Items

What is a chronic disease?

For the purposes of the Medicare Benefits Schedule (MBS) a patient who suffers from at least one medical condition that has been present (or is likely to be present) for at least six months or is terminal is regarded as having a chronic disease.

What is a chronic disease management plan?

The MBS provides a series of Medicare item numbers which provide rebates for medical practitioners to manage chronic or terminal medical conditions by preparing, coordinating, reviewing or contributing to chronic disease management plans (CDMP).

There are five MBS item numbers in the chronic disease management items list. See next page for descriptions.

Who can provide a chronic disease management plan under the Medicare Benefits Schedule?

CDMPs should generally be undertaken by the patient's usual medical practitioner. The patient's 'usual general practitioner' means the general practitioner, or a general practitioner working in the medical practice, who has provided the majority of care to the patient over the previous twelve months and/or will be providing the majority of general practitioner services to the patient over the next twelve months. The term 'usual general practitioner' would not generally apply to a practice that provides only one specific chronic disease management service or only provides after-hours services.

A practice nurse, Aboriginal and Torres Strait Islander health practitioner, Aboriginal health worker or other health professional may assist a general practitioner with items 721, 723, and 732 (eg in patient assessment, identification of patient needs and making arrangements for services). However, the general practitioner must meet all regulatory requirements, review and confirm all assessments and see the patient.

Allied health services

Patients being managed under the chronic disease management items may also be eligible for:

- individual allied health services (items 10950 to 10970); and/or
- group allied health services (items 81100 to 81125).

More information on eligibility requirements can be found in the explanatory notes for individual allied health services and group allied health services.

Minimum claiming periods

- Each CDMP item number has a minimum claiming period of 3 to 12 months.
- Each service to which the item number applies can only be claimed once in the listed claiming period.
- CDM services may be provided more frequently in exceptional circumstances 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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- 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.

Medicare Benefits Schedule chronic disease management items

MBS item number	Description	Fee	Minimum claiming period
721	Preparation of a GP Management Plan (GPMP).	Schedule fee: $144.25 Rebate: (100%) $144.25	12 months
723	Coordination of Team Care Arrangements (TCA).	Schedule fee: $114.30 Rebate: (100%) $114.30	12 months
729	Contribution to a Multidisciplinary Care Plan (MDCP), or a review of a MDCP, for a patient who is not a care recipient in a residential aged care facility (RACF).	Schedule fee: $70.40 Rebate: (100%) $70.40	3 months
731	Contribution to a MDCP, or a review of a MDCP, for a resident in a RACF	Schedule fee: $70.40 Rebate: (100%) $70.40	3 months
732	Review of a GPMP or coordination of a review of a TCA	Schedule fee: $72.05 Rebate: (100%) $72.05	3 months

More information

More detailed explanatory notes on these items is available at:
http://www.health.gov.au/mbsprimarycareitems