Practice Assist
Strengthening general practice in WA

Fact Sheet

V2 \ July 2018

MBS Item 732
Review, or coordination of a review, of a GP Management Plan or Team Care Arrangements

MBS item number	732
Schedule fee	$72.05[i]
Minimum claiming period	3 months

Regulatory requirements

Chronic Disease Management (CDM) Medicare Benefit Schedule (MBS) items provide rebates for general practitioners to manage chronic or terminal medical conditions by preparing, coordinating, reviewing or contributing to CDM plans. They apply for 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.

CDM MBS item number732 allows for the review of a GP Management Plan (GPMP) or the coordination of a review of a Team Care Arrangements (TCA).

Patient eligibility

In addition to the eligibility requirements listed in the individual CDM item descriptors, the General Medical Services Table mandates the following eligibility criteria:

MBS item number 732 is:

- available to:
  - patients in the community; and
  - private in-patients of a hospital (including private in-patients who are residents of aged care facilities) being discharged from hospital
- not available to:
  - public in-patients of a hospital; or
  - care recipients in a residential aged care facility

Review of a GP Management Plan

When reviewing a GP Management Plan, the medical practitioner must:

- explain to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) the steps involved in the review;
- record the patient's agreement to the review of the plan;
- review all the matters set out in the relevant plan;
- make any required amendments to the patient's plan;
- offer a copy of the amended document to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees);
- add a copy of the amended document to the patient's records; and
- provide for further review of the amended plan by a date specified in the plan.

Practice Assist is an initiative of

WAPHA WA Primary Health Alliance | RURAL HEALTH WEST

WA Primary Health Alliance is supported by funding from the Australian Government under the PHN Program.

Rural Health West is funded by the Australian Government and the WA Country Health Service.

Minimum claiming period

Each service to which MBS item number 732 applies (ie Review of a GPMP and Review of TCA) may be claimed once in a three-month period, except where there are exceptional circumstances arising from a significant change in the patient's clinical condition or care circumstances that necessitates earlier performance of the service for the patient.

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.

Coordination of a Review of Team Care Arrangements

When coordinating a Review of TCA, a multidisciplinary community care plan or a multidisciplinary discharge care plan, the practitioner must:

- explain the steps involved in the review to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees);
- record the patient's agreement to the review of the TCA or plan;
- consult with at least two health or care providers (each of whom provides a service or treatment to the patient that is different from each other and different from the service or treatment provided by the medical practitioner who is coordinating the TCA or plan) to review all the matters set out in the relevant plan;
- make any required amendments to the patient's plan;
- offer a copy of the amended document to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees);
- provide for further review of the amended plan by a date specified in the plan;
- give copies of the relevant parts of the amended plan to the collaborating providers; and
- add a copy of the amended document to the patient's records.

MBS item number 732 can also be used to coordinate a Review of a Multidisciplinary Community Care Plan or to Coordinate Review of a Discharge Care Plan where these services were coordinated or prepared by that medical practitioner (or an associated medical practitioner), and not being a service associated with a service to which MBS item numbers 735-758 apply.

Claiming of benefits

MBS item number 732 can be claimed twice on the same day when a MBS item number 732 for reviewing a GPMP and a MBS item number 732 for reviewing TCA are both delivered on the same day as per the Medicare Benefits Schedule item descriptors and explanatory notes.

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 requirements when MBS item number 732 is claimed twice on the same day

If a GPMP and TCA are both reviewed on the same date and MBS item number 732 is to be claimed twice on the same day, both electronic claims and manual claims need to indicate they were rendered at different times:

1) non-electronic Medicare claiming of MBS item number 732 on the same date:
    - The time that each MBS item number 732 commenced should be indicated next to each item
2) electronic Medicare claiming of MBS item 732 on the same date:
    - Medicare Easyclaim: use the 'ItemOverrideCde" set to 'AP', which flags the item as not duplicate services
    - Medicare Online/ECLIPSE: set the 'DuplicateServiceOverrideIND' to 'Y', which flags the item as not duplicate

Palliative care

The review of GPMP MBS item number732 cannot be claimed by general practitioners when they are a recognised specialist in the specialty of palliative medicine and treating a referred palliative care patient under MBS item numbers 3005-3093. The referring practitioner is able to provide the CDM services.

Who can provide a Medicare Benefit Schedule item number 732?

MBS item number 732 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 CDM service.

A practice nurse, Aboriginal and Torres Strait Islander health practitioner, Aboriginal health worker or other health professional may assist a general practitioner with MBS item 721 number (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.

Patients being managed under the CDM items may also be eligible for:

- individual allied health services (MBS items numbers 10950 to 10970); and/or
- group allied health services (MBS item numbers 81100 to 81125); and/or
- dental services (MBS item numbers 85011-87777).

More information on eligibility requirements can be found in the Medicare Benefits Schedule explanatory note for dental services, individual allied health services and group allied health services.

More information

Advice on the items and further guidance are available at:

http://www.health.gov.au/mbsprimarycareitems

[i] Medicare rebates are paid as a percentage of the Medicare Schedule Fee. Please use the MBS online search to confirm the available rebate.