Practice Assist
Strengthening general practice in WA

Fact Sheet

V2 \ July 2018

MBS item 721
Preparation of a GP Management Plan

MBS Item Number	721
Fee	$144.25[1]
Minimum claiming period	12 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 number 721 allows for the preparation of a General Practice Management Plan (GPMP).

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:

A GPMP is available to:

- patients in the community
- private in-patients of a hospital (including private in-patients who are residents of aged care facilities) being discharged from hospital

A GPMP is not available to:

- public in-patients of a hospital
- care recipients in a residential aged care facility

Who can provide a GP Management Plan?

MBS item 721 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 numbers 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.

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

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.

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

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

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

Written plan

A comprehensive written plan must be prepared describing:

- the patient's health care needs, health problems and relevant conditions;
- management goals with which the patient agrees;
- actions to be taken by the patient;
- treatment and services the patient is likely to need;
- arrangements for providing this treatment and these services; and
- arrangements to review the plan by a date specified in the plan.

In preparing the plan, the provider 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 preparing the plan; and
- record the plan; and
- record the patient's agreement to the preparation of the plan; and
- offer a copy of the plan to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees); and
- add a copy of the plan to the patient's medical records.

Minimum claiming period

The minimum claiming period for a GPMP is once every twelve months. However, a GPMP may be provided more frequently should exceptional circumstances exist for a patient. For example, 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.

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.

Palliative care

The GPMP MBS item number 721 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.

More information

Advice on the items and further guidance are available at:

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