Optimising GPMPs & TCAs for Improved Health Outcomes

Today We'll Cover

1. The Audit-Proof Care Plan: Medicare requirements for GP Management Plans (GPMPs) & Team Care Arrangements (TCAs).
2. The most effective templates to easily create meaningful care plans.
3. How to simplify referral paperwork and improve communication with AHPs.
4. How to set up an effective system to recruit and engage patients
5. How to use Care Plans to really improve your patients' quality of life.

Why Care Plans?

Table 11.12 shows health expenditure on seven major disease groups. In total, expenditure in these areas in 2004-05 accounted for $25.5 billion (b), equivalent to 48% of allocated health expenditure for the year.

11.12 HEALTH EXPENDITURE BY DISEASE GROUP, 2004-05 ($million)

Selected disease groups	Hospital(a)	Pharmaceuticals(b)(c)	Community and public health(d)	Research	Total
Cardiovascular disease	4 142	1 636	-	164	5 942
Arthritis and other musculoskeletal disease	3 184	680	-	92	3 956
Injuries	3 267	124	-	14	3 405
Mental disorders	1 949	854	1 177	148	4 128
Cancer	2 951	236	222	378	3 787
Diabetes mellitus	659	275	-	55	989
Respiratory disease	2 516	725	-	69	3 310
Total selected disease groups	**18 668**	**4 530**	**1 399**	**920**	**25 517**
Total allocated health expenditure	**36 121**	**8 144**	**1 399**	**1 715**	**52 660**

- nil or rounded to zero (including null cells)
(a) Includes public and private acute and psychiatric hospitals. Also includes medical services provided to private admitted patients in hospital.
(b) Includes all pharmacueticals for which a prescription is needed, inluding benefit paid, private and under copayment prescriptions.
(c) Excludes over the counter medicaments such as vitamins, minerals, patent medicines, first aid and wound care products, analgesics, feminine hygiene products, coldsore preparations and a number of complementary health products that are sold in both pharmacies and other retail outlets.
(d) Comprises expenditure on community mental health services and public health cancer screening programs.
Source: Australian Institute of Health and Welfare, Health Expenditure Australia 2007-08. HWE 46, Canberra.

http://www.abs.gov.au/ausstats/abs@.nsf/0/692C03405807CF0BCA25773700169C87?opendocument

Some of the challenges

GPs	AHPs	Patients
• More paperwork • Complex process • Confusing eligibility and referral criteria • Time consuming • Not sure what services to refer to	• More paperwork • Low rebate • Not enough sessions for adequate treatment	• Confusing system • Not sure how referrals work • Most eligible patients don’t know the scheme exists

Care Plans: Pros & Cons

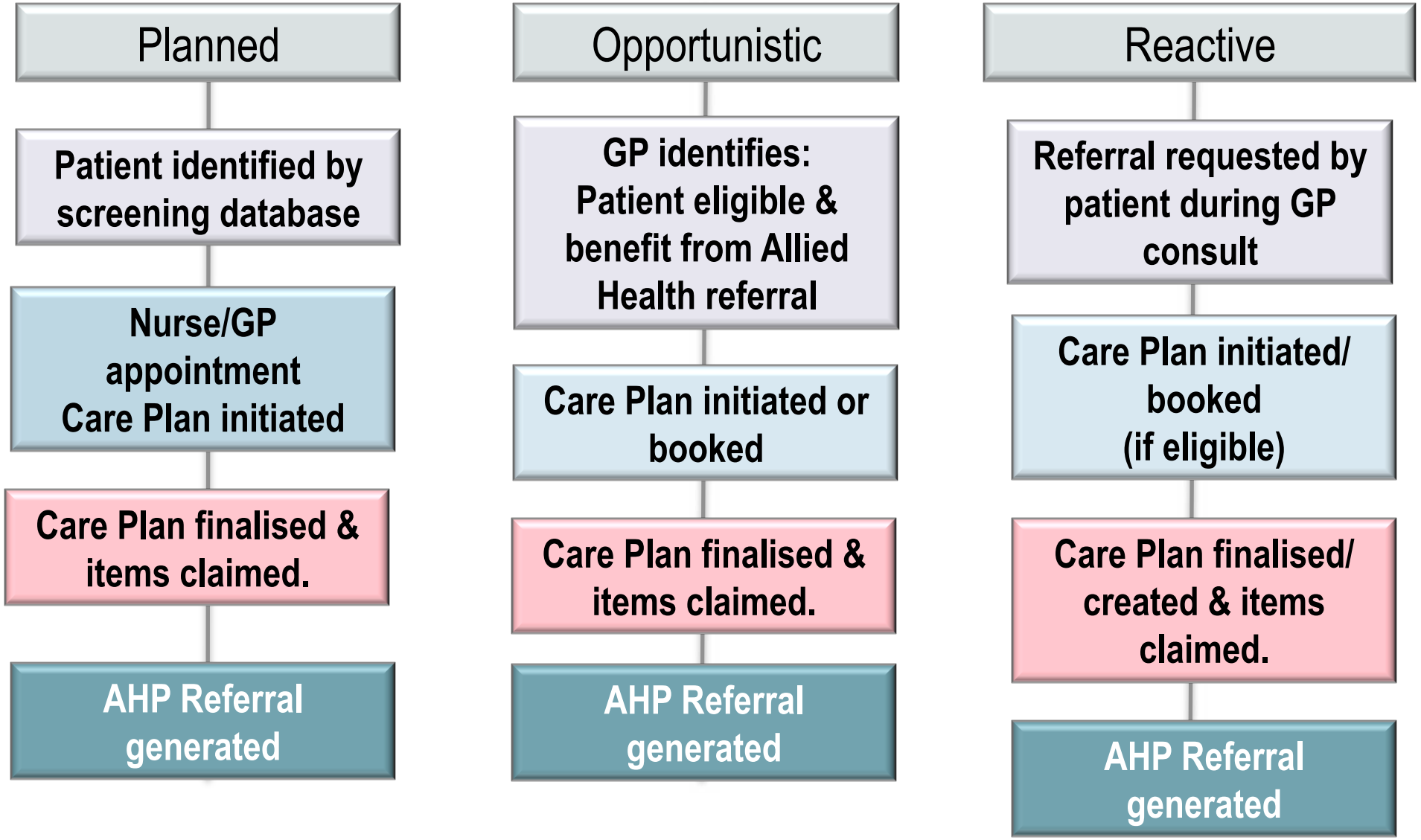
Cons

- Time consuming and I'm already too busy!
- Too much paperwork and red tape
- Too much to keep track of
- Audit risk: Could get in trouble with Medicare
- Ineligible patients demanding plans so they can see their allied health
- Can't find the right allied health providers
- Allied health providers don't write back

Pros

- Better management of patient conditions
- Reduce hospital admissions *(better managed conditions have fewer acute crises/exacerbations)*
- Reduced length of hospital stay (reliable multidisciplinary team arrangements established in the community that can provide follow up care)
- The written plan is a useful central tool the whole team can use for ease of patient management
- ***Revenue generating for providers***
- ***Patients can access subsidised allied health sessions***

Chronic Disease Management Styles in General Practice



GP Management Plans & Team Care Arrangements

GP Management Plan
GPMP (721)

Patient with Chronic Illness
Include: Problems, Goals, Patient Actions, Treatments, Review date

Review in 6 months
(min claiming period: 3 months)

GPMP RW (732)

If **complex condition** requiring a **multidisciplinary team** (at least **2 other providers in addition to the GP)**

Team Care Arrangement
TCA (723)

At least **2 other providers** delivering **different services.**
At least 1 Allied Health Professional: Exercise Physiologist, Podiatrist, Optometrist, Dietitian, Diabetes and Asthma educators, etc.
May include up to 1 Specialist.

Review in 6 months
(min claiming period: 3 months)

TCA RW (732)

2 years
(min claiming period: 1 year)

New GPMP (721)

New TCA (723)

***GPMP+TCA** formerly "EPC"*
721 + 723

5 Nurse support/monitoring services - 10997 (Only GPMP needed)

Allows patient access to
5 AHP services *(in total)* in a calendar year

Questions and answers on CDM items

http://www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-chronicdiseasemanagement-qanda#3_1

Team members could include:

Aboriginal health workers
Audiologists
Chiropractors
Diabetes/asthma educators
Dietitians
Exercise physiologists
Mental health workers
Occupational therapists
Osteopaths
Physiotherapists
Podiatrists
Psychologists
Speech pathologists
Orthoptists, Orthotists or Prosthetists
Social workers
Optometrists
Pharmacists (HMR).

Other providers

Home and community service providers

Meals on wheels

Personal care workers

Probation officers

Workcover Rehabilitation Case Manager

Fitness instructor and personal trainer

if they are contributing to the plan

Specialists

*"**Only one specialist** or consultant physician **can be counted towards the minimum of two** contributing team members who, with the coordinating GP, make up the core TCAs team."*

Australian Government
Department of Health and Ageing

Referral Form for Individual Allied Health Services under Medicare for patients with a chronic medical condition and complex care needs

Note: GPs can use this form issued by the Department of Health and Ageing or one that contains all of the components of this form.

To be completed by referring GP:

Please tick:

☐ Patient has GP Management Plan (item 721 or review item 732) AND Team Care Arrangements (item 723 or review item 732)

☐ GP has contributed to or reviewed a multidisciplinary care plan prepared by the patient's aged care facility (item 731)

Note: GPs are encouraged to attach a copy of the relevant part of the patient's care plan to this form.

Medicare rebates and Private Health Insurance benefits cannot both be claimed for these services.
Patients should be advised that they must choose whether to access one or the other.

GP details

Provider Number ☐☐☐☐☐☐☐☐☐☐

Name

Address Postcode

Patient details

Medicare Number ☐☐☐☐☐☐☐☐☐☐ Patient's ref no. ☐

First Name Surname

Address Postcode

Allied Health Professional (AHP) patient referred to: (Please specify name or type of AHP)

Name

Address Postcode

Referral details – Please use a separate copy of the referral form for each type of service

Eligible patients may access Medicare rebates for up to 5 allied health services (total) in a calendar year. Please indicate the number of services required by writing the number in the 'No. of services' column next to the relevant AHP.

No of services	AHP Type	Item Number
	Aboriginal Health Worker	10950
	Audiologist	10952
	Chiropractor	10964
	Diabetes Educator	10951
	Dietitian	10954

No of services	AHP Type	Item Number
	Exercise Physiologist	10953
	Mental Health Worker	10956
	Occupational Therapist	10958
	Osteopath	10966
	Physiotherapist	10960

No of services	AHP Type	Item Number
	Podiatrist	10962
	Psychologist	10968
	Speech Pathologist	10970

Referring General Practitioner's signature Date signed

The AHP must provide a written report to the patient's GP after the first and last service, and more often if clinically necessary.

Allied health professionals should retain this referral form for record keeping and Medicare Australia audit purposes.

Allied health services funded by other Commonwealth or State/Territory programs are not eligible for Medicare rebates under this initiative.

This form may be downloaded from the Department of Health and Ageing website at www.health.gov.au/mbsprimarycareitems

THE FORM DOES NOT HAVE TO ACCOMPANY MEDICARE CLAIMS

Allied Health Referrals

Questions and answers on CDM items

http://www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-chronicdiseasemanagement-qanda#3_1

Communication between providers:

*"Communication must be **two-way, preferably oral** or, if not practicable, in writing (including by exchange of faxes or email)."*

*"The communication from the collaborating providers **must include advice on treatment and management of the patient."***

*"...a '**blanket agreement' to participate in TCAs would not be sufficient**."*

"A fax form by itself would not meet the requirement** for collaboration **if it does not include the treatment or services to be provided by the provider, matched to the specific needs of the patient."

Questions and answers on CDM items

http://www.health.gov.au/internet/main/publishing.nsf/Content/health-medicare-health_pro-gp-pdf-allied-cnt.htm

Reporting requirements of Allied Health Professionals

"A written report is required after the **first and last** service, or more often if clinically necessary.

Written reports should include any **investigations, tests, and/or assessments** carried out on the patient, any **treatment** provided and **future management** of the patient's condition or problem."

What Care Plans look like

GP Management Plan & Team Care Arrangement

Date of Plan:
Next review date:

Patient details	GP Details
Name: Phone: Date of Birth: Medicare No.:	

Allergies:

Medical History:

Immunisations:

Measurements

BP:

Weight:

GP Management Plan

Informed consent has been obtained from this patient to perform this management plan. This plan has been developed in collaboration with the patient.
A copy of this plan has been offered and provided to the patient.

Needs & Frequency of assessment.	Goals	Patient Actions	Arrangements for treatment / progress

Team Care Arrangement

Agreement to participate in the care of this patient has been obtained from the following providers by means of two-way communication via either phone, secured email, fax or mail correspondence.
With the patient's permission, and where applicable, a copy of this plan has been made available to the following providers.

Provider Details	Role/ Input

GP MANAGEMENT PLAN

Informed consent has been obtained to prepare this plan by <<Doctor:Name>> on <<Date of Plan>>

Patient name:<<Patient Demographics:Full Name>> **Date of birth**: <<Patient Demographics:DOB (long)>>

Allergies:

Identified conditions, problems and needs

<<Clinical Details:History List>>

Management Goals

- Need reliever medication less than 3 times a week
- Minimal limitations on daily activity
- Improved understanding of asthma and asthma management
- Remain free from symptoms
- Adhere to medication regime as discussed with GP

Actions to be taken by patient

- Regular attendance to GP for monitoring
- Identify and avoid triggers
- Spirometry
- Reporting problems with management of condition.
- Promptly report any concerns or questions regarding treatment to GP.

Treatment and services to achieve management goals

- Regular Monitoring by GP.
- Ongoing patient education regarding condition.

Review Date: no later than <<Review date (6+ months)>>

<<Doctor:Name>>
<<Doctor:Provider Number>>

Sample Goals, Patient Actions & Treatments for Common Conditions

Condition	Goals	Actions by patient	Treatment and services to achieve goals.	Possible referral to:
GENERAL (for all plans)	-Minimal interference with daily activities. -Improve understanding of condition and management. -Prevent complications of condition.	-Report to GP with any concern, deterioration or changes in condition. -Adhere to medication regime and treatment as discussed with GP and specialist. -Regular attendance to GP for monitoring. -Report any issues with management of condition.. -Maintain adequate nutrition and level of activity. -Complete cessation of smoking and avoidance of passive smoking. Quitline 131848. -Establishment and maintenance of healthy eating with saturated and trans fatty intake < 8% of total energy Heartline 1300362787 or www.heartfoundation.com.au - Alcohol consumption restricted to a maximum of 4 standard drinks, usually alcohol confined to 1-2 standard drinks per night and abstain from alcohol for 2 nights per week.	-Ongoing review by GP. -Ongoing patient education regarding condition. -Eye check every 1-2 years. -Ongoing review of alternative therapies: physiotherapy, hydrotherapy, acupuncture, etc. -Dental cleaning/checkup every 6-12 months. -Vaccination to prevent Influenza and Pneumococcal disease	
Use goals, actions and treatments from "General" and add the following for the specific illnesses.				
Diabetes	-Maintain Blood Pressure below 130/80mmHg -Maintain HbaIc below 7%. -Maintain Cholesterol within healthy range: Chol <4.0 mmol/L - LDL <2.5 - HDL > 1.0 –trig <2.0 -Maintain Blood Glucose Level (BGL/BSL) below 7mmol/L (4-6 fasting). -Early detection and prevention of eye complications. -Prevention of foot complications. -Prevention of renal complications.	-Regular self-check of feet.	-Annual check of cholesterol. -Annual check of renal function. -Check Blood Pressure every 3-6 months. -Check HbaIc every 3-6 months. -Check condition of feet (by GP, Nurse or Podiatrist) every 6 months. -Optometry review every 12 months.	Dietitian Exercise Physiologist Optometrist Podiatrist Diabetes Educator

Sample Goals, Treatments & Patient Actions for Care Plans

Use goals, actions and treatments from "General" and add the following for the specific illnesses.

Condition	Goals	Actions by patient	Treatment and services to achieve goals.	Possible referral to:
Asthma	-Remain free from asthma symptoms -Need asthma reliever medication less than 3 times a week	- Avoid known asthma triggers.	-Spirometry every 1-2 years. - Review asthma plan every 3-6 months.	Dietitian Exercise physiologist Physiotherapist
Arthritis/Pain	-Optimal pain management with nil to minimal side-effects. -Optimize and preserve mobility. -Minimize joint-specific problems.	-Review should be arranged with symptoms of weight loss, severe night pain, marked morning stiffness, pain with fever or progressive worsening of the pain.	-Ongoing review of need for aids or home modification.	Physiotherapist Osteopath Pain clinic
CHD (Coronary Heart Disease)	-Maintain Blood Pressure below 130/80mmHg. -Maintain Cholesterol within healthy range: (Chol <4.0 mmol/L) – (LDL <2.5) – (HDL > 1.0) – (trig <2.0 -Prevention of renal complications. -Remain free from chest pain.	- Chest pain action plan as discussed with GP.	-Annual check of cholesterol. -Check Blood Pressure every 3-6 months. -Optometry review every 1-2 years.	Dietitian Physiotherapist Optometrist Podiatrist
Dementia	-Minimize changes to routine. -Minimize distractions and control noise.	-Have notes around the house as reminders. -Structure written time tables. -Place identification in a wallet. -Post by every phone a list of emergency numbers. -Have hot water temperatures reduced. -Consider child-proof latches on cabinets that contain dangerous items. -Consider timers for stoves.	-Consider Meals on wheels. -Consider occholocist review for supportive occhotherapy and cognitive behavioral therapy. -Ongoing review to assess if assistance is needed for lifts or transfers.	
Renal/Kidney disease	-Target Hb of 11-12 -Maintain Blood Pressure below 130/80mmHg -Maintain HbaIc below 7%. -Maintain Cholesterol within healthy range: (Chol <4.0 mmol/L) (LDL <2.5) (HDL > 1.0) - (trig <2.0		-Annual check of cholesterol. -Check Blood Pressure every 3-6 months. -If plasma ferritin concentrations below 100 mcg per L, should be given iron supplements.	

PracticeNursing.info

Patients with Type 2 Diabetes (Individual Assessment)

- Assessment for group services (at least 45min long)

Item	Description
81100	Diabetes Educator
81110	Exercise Physiologist
81120	Dietitian

Patients with Type 2 Diabetes (Group Services)

- Group services (at least 60min long)
- Between 2 and 12 persons
- Patients are eligible for a maximum of eight group services per calendar year
- Each service must be at least 60 minutes long
- Up to two group services may be provided consecutively on the same day by the same provider

Aboriginal & Torres Strait Islander Items

http://www.health.gov.au/internet/main/publishing.nsf/Content/health-oatsih-pubs-mbslist

FREQUENTLY CLAIMED MBS ITEMS FOR ABORIGINAL COMMUNITY CONTROLLED HEALTH SERVICES AND OTHER PRIMARY HEALTH CARE PROVIDERS

Benefits are based on the 1 November 2012 Medicare Benefits Schedule

NOV 2012 EDITION

NO.	ITEM	BENEFIT
Consultation Items for VR GPs		
3	Brief Consult Level A	$16.60
4	Brief Home Visit or Consult at an institution (other than a RACF)	Formula
23	Standard Consult Level B, less than 20 min	$36.30
24	Standard Home Visit or Consult at an institution (other than a RACF)	Formula
36	Long Consult level C, 20-40 min	$70.30
37	Long Home Visit or Consult at an institution (other than a RACF)	Formula
44	Prolonged Consult Level D, more than 40 min	$103.50
47	Prolonged Home Visit or Consult at an institution (other than a RACF)	Formula
After-hours Consultation Items for VR GPs		
5000	Brief Consult Level A	$28.45
5003	Brief Home Visit or Consult at an institution (other than a hospital or RACF)	Formula
5020	Standard Consult Level B, less than 20 min	$48.05
5023	Standard Home Visit or Consult at an institution (other than a hospital or RACF)	Formula
5040	Long Consult Level C, 20-40 min	$82.30
5043	Long Home Visit or Consult at an institution (other than a hospital or RACF)	Formula
5060	Prolonged Consult Level D, more than 40 min	$115.45
5063	Prolonged Home Visit or Consult at an institution (other than a hospital or RACF)	Formula
Urgent After-hours Consultation Items VR GPs		
597	Urgent Attendance - after hours (other than between 11pm and 7am)	$127.25
599	Urgent attendance - unsociable hours (11pm-7am)	$150.00
Consultation Items for Non-VR GPs		
52	Brief Consult, less than 5 min at consulting room	$11.00
53	Standard Consult, 5-25 min at consulting room	$21.00
54	Long Consult, 25-45 min at consulting room	$38.00
57	Prolonged Consult, more than 45 min at consulting room	$61.00
58	Brief Home Visit or Consult at an institution (other than a RACF)	Formula
59	Standard Home Visit or Consult at an institution (other than a RACF)	Formula
60	Long Home Visit or Consult at an institution (other than a RACF)	Formula
65	Prolonged Home Visit or Consult at an institution (other than a RACF)	Formula
After-hours Consultation Items Non-VR GPs		
5200	Brief Consult, less than 5 min	$21.00
5203	Standard Consult, 5-25 min	$31.00
5207	Long Consult, 25-45min	$48.00
5208	Prolonged Consult, more than 45 min	$71.00
5220	Brief Home Visit or Consult at an institution (other than a hospital or RACF)	Formula
5223	Standard Home Visit or Consult at an institution (other than a hospital or RACF)	Formula
5227	Long Home Visit or Consult at an institution (other than a hospital or RACF)	Formula
5228	Prolonged Home Visit or Consult at an institution (other than a hospital or RACF)	Formula
Urgent After-hours Consultation Items Non-VR GPs		
598	Non-VR urgent attendance - after hours (other than between 11pm and 7am)	$104.75
600	Non-VR urgent attendance - unsociable hours (between 11pm and 7am)	$124.25

NO.	ITEM	BENEFIT
Prolonged Consults for Management of Life Threatening Conditions		
160	1-2 hours total time per patient on a single occasion	$217.15
161	2-3 hours total time per patient on a single occasion	$361.90
162	3-4 hours total time per patient on a single occasion	$506.50
163	4-5 hours total time per patient on a single occasion	$651.50
164	5 hours or more total time per patient on a single occasion	$723.90
Miscellaneous Diagnostic Tests and Procedures		
11506	Spirometry with printout before and after bronchodilator	85% = $17.50
11700	Twelve-lead electrocardiography, tracing and report	85% = $26.60
11701	Twelve-lead electrocardiography, report only	85% = $13.25
11702	Twelve-lead electrocardiography, tracing only	85% = $13.25
13757	Therapeutic Venesection (polycthaemia/ haemichromatosis or porphyria cutanea tarda)	85% = $62.05
14203	Hormone or Living Tissue Implantation by incision and suture	85% = $43.50
14206	Hormone or Living Tissue Implantation by cannula	85% = $30.30
73805	Microscopy of urine, whether stained or not, or catalase test	85% = $3.90
73806	Pregnancy Test by 1 or more immunochemical methods	85% = $8.65
73811	Mantoux test	85% = $9.55
30003	Dressing of Localised Burns (not involving grafting)	85% = $30.90
30006	Dressing of Extensive Burns without Anaesthesia (not involving grafting)	85% = $39.55
30026	Repair Skin Lac (not Face/Neck) <7cm, superficial	85% = $44.40
30029	Repair Skin Lac (not Face/Neck) <7cm, deep tissue	85% = $76.50
30032	Repair Skin Lac of Face/Neck <7cm, superficial	85% = $70.15
30035	Repair Skin Lac of Face/Neck <7cm, deep tissue	85% = $99.95
30038	Repair Skin Lac (not Face/Neck) >7cm, superficial	85% = $76.50
30041	Repair Skin Lac (not Face/Neck) >7cm, deep tissue	85% = $122.40
30045	Repair Skin Lac of Face/Neck >7cm, superficial	85% = $99.95
30048	Repair Skin Lac of Face/Neck >7cm, deep tissue	85% = $127.30
30061	Superficial foreign body removal (including from cornea or sclera), as an independent procedure	85% = $20.00
30064	Subcutaneous foreign body removal (incision and exploration)	85% = $33.45
30071	Biopsy of Skin or Muc Membranes, as an independent procedure	85% = $44.40
30102	Premalignant skin lesions (including solar keratoses), treatment of, by ablative technique (10 or more lesions)	85% = $33.65
30219	Haematoma, Furuncle, Small Abscess or Similar Lesion - incision with drainage	85% = $25.25
Bulk-Billed Services		
10990	Additional payment for each bulk billed medical service provided to Commonwealth concession cardholders and children under 16 yrs	85% = $6.00
10991	Additional payment for each bulk-billed medical service provided to Commonwealth concession cardholders and children under 16 yrs- specified areas only	85% = $9.10
64990	Radiology bulk billing incentive	85% = $6.00
64991	Radiology bulk billing incentive, (e.g. scans) - specified areas only	85% = $9.10
74990	Pathology bulk billing incentive	85% = $6.00
74991	Pathology bulk billing incentive	85% = $9.10

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NO.	ITEM	BENEFIT
Health Assessments		
701	Brief Health Assessment, less than 30 minutes	$58.20
703	Standard Health Assessment, 30-45 min	$136.20
705	Long Health Assessment, 45-60 min	$186.55
707	Prolonged Health Assessment , more than 60 minutes	$263.55
715	Aboriginal and Torres Strait Islander peoples Health Assessment	$208.10
Follow-up Allied Health Items for people of Aboriginal and Torres Strait Islander descent (linked to Health Assessments)		
81300	Aboriginal Health Worker Service	85% = $52.95
81305	Diabetes Education Service	85% = $52.95
81310	Audiology Service	85% = $52.95
81315	Exercise Physiology Service	85% = $52.95
81320	Dietetics Service	85% = $52.95
81325	Mental Health Service	85% = $52.95
81330	Occupational Therapy Service	85% = $52.95
81335	Physiotherapy Service	85% = $52.95
81340	Podiatry Service	85% = $52.95
81345	Chiropractic Service	85% = $52.95
81350	Osteopathy Service	85% = $52.95
81355	Psychology Service	85% = $52.95
81360	Speech Pathology Service	85% = $52.95
Practice Nurse & Aboriginal and Torres Strait Islander Health Practitioner Items		
10986	Healthy Kids check provided by a Practice Nurse or Aboriginal and Torres Strait Islander Health Practitioner	$58.20
10987	Follow up, for a person who has received an Aboriginal & Torres Strait Islander peoples health assessment (Max 10 services per calendar year)	$24.00
10997	Service for a person with a CPMP, TCA or Multidisciplinary Care Plan (Max 5 services per calendar year)	$12.00
10988	Immunisation provided by an Aboriginal and Torres Strait Islander Health Practitioner	$12.00
10989	Wound Management provided by an Aboriginal and Torres Strait Islander Health Practitioner	$12.00
Practice Incentive Items		
2501	Cervical smear, between 20-69 yrs & more than 4 yrs since last cervical smear (Level B)	$36.30
2504	Cervical smear, between 20-69 yrs & more than 4 yrs since last cervical smear (Level C)	$70.30
2507	Cervical smear, between 20-69 yrs & more than 4 yrs since last cervical smear (Level D)	$103.50
2517	Annual cycle of care for diabetes (Level B)	$36.30
2521	Annual cycle of care for diabetes (Level C)	$70.30
2525	Annual cycle of care for diabetes (Level D)	$103.50
2546	Completion of asthma cycle of care (Level B)	$36.30
2562	Completion of asthma cycle of care (Level C)	$70.30
2558	Completion of asthma cycle of care (Level D)	$103.50

NO.	ITEM	BENEFIT
Chronic Disease Management (CDM) Items (formerly referred to as "EPC" plans) and Case Conferences (CC)		
721	Prepare GP Management Plan	$141.40
723	Coordinate Team Care Arrangements	$112.05
729	Contribution to a Multidisciplinary Care Plan or a Review of a Multidisciplinary Care Plan prepared by another provider	$69.00
731	Contribution to review, prepared by residential aged care facility	$69.00
732	Review of GP Management Plan or Coordinate a Review of Team Care Arrangements	$70.65
739	Organise and coordinate CC 20-40 min	$118.60
743	Organise and coordinate discharge CC more than 40 min	$197.70
747	Member of CC Team 15-20 min	$60.90
750	Contribution to CC Team 20-40 min	$87.25
758	Member of CC Team, more than 40 min	$145.30
Individual Allied Health Items for people with a chronic condition and complex care needs (linked to CDM Items 721 & 723)		
10950	Aboriginal Health Worker Service	85% = $52.95
10951	Diabetes Education Service	85% = $52.95
10952	Audiology Service	85% = $52.95
10953	Exercise Physiology Service	85% = $52.95
10954	Dietetics Service	85% = $52.95
10956	Mental Health Service	85% = $52.95
10958	Occupational Therapy Service	85% = $52.95
10960	Physiotherapy Service	85% = $52.95
10962	Podiatry Service	85% = $52.95
10964	Chiropractic Service	85% = $52.95
10966	Osteopathy Service	85% = $52.95
10968	Psychology Service	85% = $52.95
10970	Speech Pathology Service	85% = $52.95
Antenatal Consults		
16400	Antenatal attendance (midwife, practice nurse or registered Aboriginal and Torres Strait Islander Health Practitioner (RATSIHP))	85% = $23.20
16500	Antenatal attendance	85% = $40.10
16502	Complicated Antenatal attendance (each attendance that is not a routine)	85% = $40.10
55700	Pregnancy ultrasound (less than 12 weeks)	85% = $29.75
55709	Pregnancy ultrasound (dating is 17 to 22 weeks)	85% = $32.30
Medication Management Review		
900	Home medicines review	$151.75

Benefits are based on the 1 November 2012 Medicare Benefits Schedule

PLEASE NOTE: THIS TABLE DOES NOT PROVIDE A COMPREHENSIVE LIST OF MBS ITEMS AND SHOULD BE READ IN CONJUNCTION WITH THE ITEM AND EXPLANATORY NOTES SET OUT IN THE MEDICARE BENEFITS SCHEDULE BOOK AND SUPPLEMENT. THE FULL LIST OF MBS ITEMS IS AVAILABLE AT: www.health.gov.au/mbsonline

For Medicare Claiming enquiries, please phone the Medicare Australia Indigenous Access line on 1800 556 955

For feedback or additional copies, please email OATSIH19.2enquiries@health.gov.au or phone (02) 6289 5291

Diabetes Cycle of Care

Items: 2517 (Level B) - 2521(Level C) - 2525 (Level D)

Measure/Monitor	Frequency
HbA1c	Once every year
Comprehensive eye examination	Once every two years
Weight and height and calculate BMI	At least twice every cycle of care
Measure blood pressure	At least twice every cycle of care
Examine feet	At least twice every cycle of care
Total Cholesterol, Trig &HDL	At least once every year
Test for microalbuminuria	At least once every year
eGFR	At least once every cycle of care
Provide self-care education	At least once every cycle of care
Review diet	At least once every cycle of care
Review levels of physical activity	At least once every cycle of care
Check smoking status.	At least once every cycle of care
Review of medication	At least once every cycle of care

Component	Payment
Sign-on payment	$1.00 per SWPE*
Outcomes payment	$20.00 per diabetic SWPE
Service incentive payment	$40.00 per patient per year

Asthma Cycle of Care

- **Items**:
  2546 (Level B) - 2552(Level C) - 2558 (Level D)
- **Requirements**:
  - At least ***two*** asthma related consultations within 12 months
  - Patient with ***moderate to severe*** asthma
  - Documented diagnosis and assessment of the
  - Patient's level of asthma control and severity
  - Review of the patient's use of asthma medication/devices
  - Written asthma action plan
  - Asthma self-management education
  - Review documented asthma action plan

The PIP Asthma Incentive has two components—the sign-on payment and the service incentive payment.

Table 1: Payments and requirements of the PIP Asthma Incentive

Component	Payment	Activity required for payment
Sign-on payment	$0.25 per SWPE*	One-off payment to practices that: • use a patient register, and a recall and reminder system • agree to use the asthma cycle of care
Service incentive payment	$100 per patient per year	Payment to GPs for each completed cycle of care for patients with moderate to severe asthma.

* Standardised Whole Patient Equivalent (SWPE) is used to measure practice size and includes a weighting factor for the age and gender of patients. As a guide, the average full-time GP has a SWPE value of around 1000 SWPEs annually.

MBS Claiming Scenarios

Thomas

- Original GPMP & TCA in Nov 2016
- Used 5 Podiatry Services in 2016
- Requesting a new referral in January 2017 for more podiatry

➢ Can a referral be made for more sessions?

➢ How many sessions can he have this year?

➢ Is he also eligible for a new plan?

➢ Is he eligible for a review?

MBS Claiming Scenarios

Suzy

- Original GPMP & TCA in April 2016
- Used 3 Physio Services in 2016
- Requesting a new referral in May 2017 for Exercise Physiologist

➢ Can a referral be made for more sessions?

➢ How many sessions can she have this year?

➢ Is she eligible for a new plan?

➢ Eligible for a review?

Patient-Centred Care & Effective Practice Systems

Patient-centred Care

- What does “patient-centred care” mean to you?
- Signs of a patient-centred consult:

_____

_____

_____

_____

_____

Care Plan Consult – Step by Step

Ensure *patient is eligible* today

Answer questions/ clarify what the Care Plan is for. *Gain consent.*

Update history: Allergies, Smoking, Alcohol, Family & Social History.

Ensure *list of conditions is up to date* in patient file

Measurements: Blood Pressure, Weight, etc.

Find out what *other providers or specialists they see* (add to address book)

Patient-centred need "What do you feel is the main issue affecting your health at the moment?"

Patient-centred impact "How is that affecting your everyday life?"

Patient-centred goal "What would be a good outcome/ result for that issue?"

Add additional goals/treatments based on their conditions & guide the patient through these.

Agree on TCA providers & make arrangements to *gain consent & input* from providers. Generate Referrals

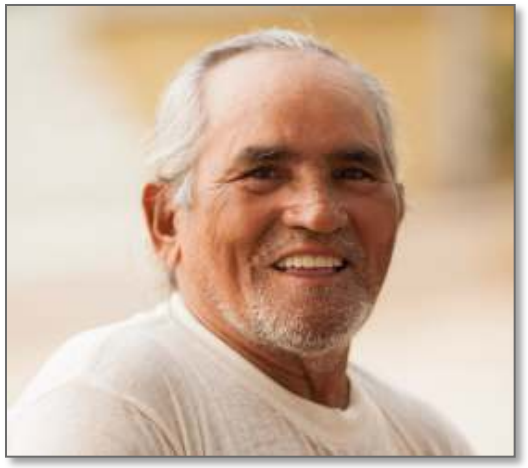
Give a *copy of the plan to the patient*.

Inform the patient that the care plan will need *reviewing in 6 months*

Book in a *progress appointment* before next review (10997), where appropriate.

Bill Items & Add Recall for Review

Francesco: 58yrs Old

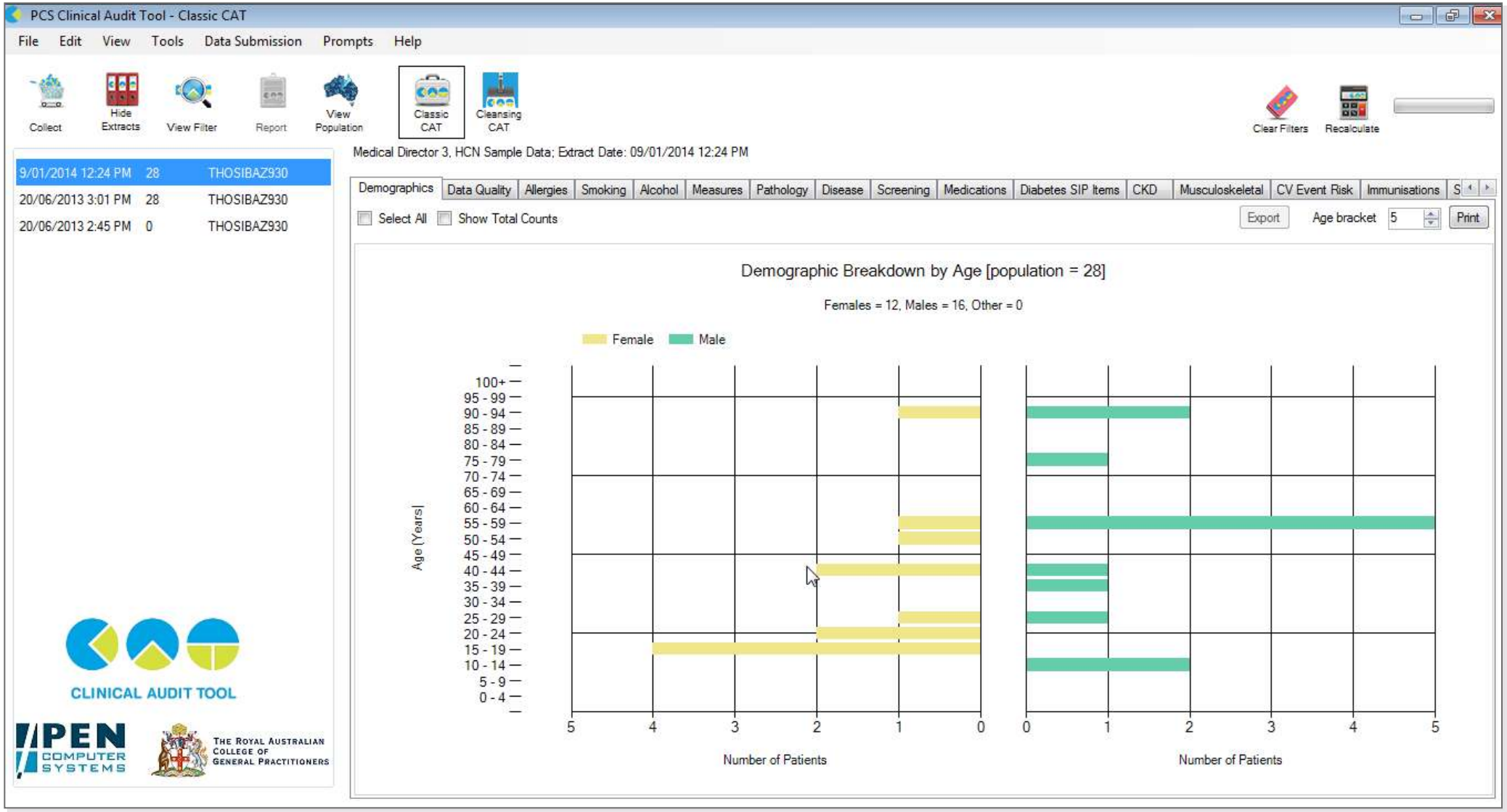


- Newly diagnosed with Type 2 Diabetes
- BMI: 33
- Sees a “Chiro” to help with his “stiff lower back”
- Would like to get fit again, but doesn’t want to make his back worse.
- “The boss” (his wife) cooks all the meals in the house.

- ➢ Any additional information you’d want from Francesco?
- ➢ What services (if any) would you offer/discuss?
- ➢ Would you involve any other providers in his care? If so, who?

Using a Clinical Audit Tool

PEN Clinical Audit Tool (CAT)



The Practice Process - Systems to Recruit & Engage Patients

The practice process (step by step)
12 month plan

1. *Prepare the practice:*

Poster or sign in the waiting room to promote Care Plans

Nurse/GP times and consulting room allocated for Care Plan consults

All staff members are aware of the referral process to Nurse/GP

Templates agreed on and finalised:

- **Invitation letter**
- **Care Plan template**
- **Referral forms (Update Address Book with local Allied Health Providers!)**
- **Poster/waiting room sign**
- **Patient Handouts**

The practice process (step by step)

2. Database search: List of active patients with a chronic condition (i.e. Diabetes)

3. Determine Medicare eligibility of these patients:

Ring Medicare provider line 132 150. (check up to 7 patients/call)

Or Use the Medicare Online portal to check eligibility

Ask if the patient is eligible for item 721 & 723 today.

If NOT eligible then check if eligible for 732 & 732.

4. Flag patient file & recall eligible patients:

Tip! letter followed by phone call the following week works best.

The practice process (step by step)

5. **Book appointment :**
With nurse for 20 or 30 min AND

With GP immediately after nurse to finalise the plan.

Tip! If unable to make nurse and GP appointments on the same day, then let patients know beforehand (in the invitation letter) that the check will take place over 2 consults.

6. **Once patients are seen, add them to recall database for follow up as required.**

7. **Review progress of the 12-month plan and related patient lists at 3, 6 and 9 months.**

8. **Start a new 12-month plan after one year.**

Where to from here?

Access related templates & downloads from the website

Complete the additional course content

Submit the “Practice Reflection Activity” to receive your CPD certificate

Put your knowledge into practice!

Contact us if you need support

We’re only ever an email or phone call away!