Australian Government
Department of Human Services

medicare

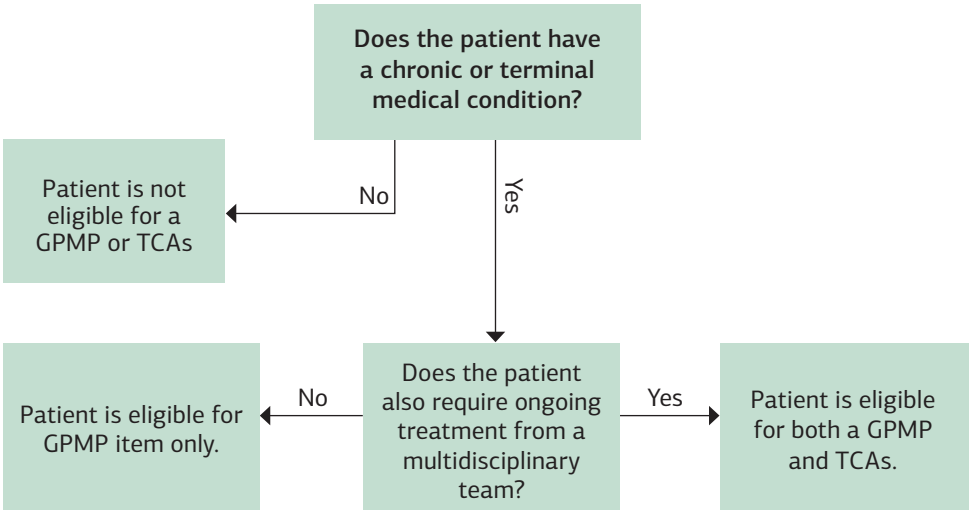
Quick reference guide for general practitioners

GP Management Plan (GPMP—Medicare item 721)

Team Care Arrangements (TCAs—Medicare item 723)

This document should be used as a guide only and should be read together with the Medicare Benefits Schedule (MBS). The Department of Human Services (Human Services) recommends health professionals exercise their own skill and care with respect to its contents.

A chronic medical condition is one that has been, or is likely to be, present for at least six months. Including, but is not limited to: asthma, cancer, cardiovascular disease, diabetes mellitus, musculoskeletal conditions and stroke.



Patient eligibility for items 721, 723

GPMP Item 721 and TCAs Item 723 are available to patients in the community, and private patients who are being discharged from hospital.

Note:

- Items 721 and 723 are not available to public in-patients of a hospital or care recipients in a residential aged care facility.
- Item 731 is available to care recipients in a residential aged care facility.
- GPMP Item 721 by itself is available to patients who have a chronic or terminal medical condition but do not require individual allied health services, which can not be accessed off a GPMP alone. Patients with type 2 diabetes can be referred for group allied health services if a GPMP has been prepared.
- Patients can, on referral, access individual allied health services once the GP has completed both the GPMP and TCAs.

Important: GPMPs and TCAs are not designed simply as mechanisms to provide Medicare rebates for allied health services. They are tools to coordinate the care of people with chronic conditions and help to reduce the need for ad hoc consultations.

GPMP (Item 721) requirements

- Explain to your patient the steps involved in preparing the plan and record their agreement to proceed.
- Assess to identify and/or confirm the patient's health care needs, health problems and relevant conditions.
- Agree management goals and identify actions to be taken with your patient.
- Identify treatment and services for your patient and make any necessary arrangements.
- The GPMP must be a comprehensive written plan describing the above.
- Offer a copy of the plan to your patient and add a copy to the patient's medical record.

TCAs (Item 723) requirements

- Explain to your patient the steps involved in the development of the TCAs and record their agreement to proceed.
- Consult with at least two collaborating providers, who will provide a different kind of treatment/service to the patient.
- Prepare a document describing:
  - treatment and service goals for the patient.
  - treatment and services that collaborating providers have agreed to give.
  - actions to be taken by the patient and specify a date to review the TCAs (MBS item 732—recommended every six months).
- Discuss with the patient the collaborating providers who will contribute to the TCAs and provide treatment/services.
- Offer a copy of the TCAs to the patient, give copies of the relevant parts of the document to the collaborating providers and add a copy of the document to the patient's medical record.

Multidisciplinary team for the purpose of TCAs

A GP plus at least two other collaborating health or care providers, one of whom may be another medical practitioner, who will be providing ongoing treatment/services for the patient.

Each of the health or care providers must be providing a different type of ongoing treatment/services. The non-GP collaborating providers need not be providers of Medicare eligible services.

A patient's informal or family carer does not count as one of the other two health or care providers but can be involved in the process.

Important information

GPMP and TCAs should be undertaken by the patient's usual GP. The patient's usual GP is considered to be the GP, or a GP working in the medical practice, who has provided the majority of care to the patient over the previous 12 months and/or will be providing the majority of GP Services to the patient over the next 12 months.

Claiming frequency

The recommended frequency of GPMP or TCAs is once every two years, with regular reviews (recommended every six months) of the patient's progress against the plan. This should be applied with regard to the patient's requirements. In general, a new GPMP or TCAs should not be prepared unless required by the patient's condition, needs and circumstances. The minimum claiming period is 12 months. Where there has been a significant change in the patient's clinical condition or care circumstances, more frequent claims can be made. If you are unsure whether the patient currently has a GPMP and/or TCAs in place, contact Human Services on **132 150***.

We suggest that practices create a system to call and encourage patients to attend an appointment for a review of their care plan. The MBS review item is 732 for reviewing a GPMP and TCAs. Item 732 can be claimed twice on the same day for a review of a GPMP and for a review of TCAs, as long as the MBS item descriptor and explanatory notes for Item 732 are met.

For more information

Call **132 150***

Online **health.gov.au** then **Programs and campaigns > programs and initiatives > MBS Primary Care Items**

humanservices.gov.au/healthprofessionals then **Doing business with Medicare > Online education services**

* Call charges apply

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