# GP Chronic Conditions Management (GPCCM) MBS User Guide

National MyMedicare PHN Implementation Program

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The purpose of this resource is to support general practices to effectively use GPCCM MBS items to deliver comprehensive, proactive care for patients with chronic conditions (a medical condition likely to be present for ≥6 months, or terminal); including regular review of management plans.

The new framework for CCM from 1 July 2025 both simplifies and streamlines the arrangements for health care professionals and patients. To enhance continuity of care, **patients registered with MyMedicare must access GPCCMP items through the practice where they are registered for MyMedicare.** Patients that are not MyMedicare registered may access CCM services through their usual GP. There is no list of eligible chronic conditions; it is up to GP clinical judgment to determine if an individual patient's chronic condition is likely to last for more than 6 months and would benefit from a GPCCMP.

Previous Chronic Disease Management MBS items for GP management plans (229, 721, 92024, 92055), team care arrangements (230, 723, 92025, 92056) and reviews (233, 732, 92028, 92059) will cease and be replaced with the new CCM MBS items. Transition arrangements will be in place for 2 years to ensure current patients don't lose access to services under CDM plans prepared prior to 1 July 2025.

**Chronic Condition Management items from 1 July 2025**

| Name of Item | GP item number | Prescribed Medical Practitioner item number | Frequency of Claiming | Fee |
|---|---|---|---|---|
| **Prepare a GP chronic condition management plan – face to face** | 965 | 392 | Initial plan development. New plan only if clinically necessary. | GPs - $156.55<br>PMPs - $125.30 |
| **Prepare a GP chronic condition management plan - video** | 92029 | 92060 | Initial plan development. New plan only if clinically necessary. | GPs - $156.55<br>PMPs - $125.30 |
| **Review a GP chronic condition management plan – face to face** | 967 | 393 | Up to every 3 months if clinically relevant | GPs - $156.55<br>PMPs - $125.30 |
| **Review a GP chronic condition management plan – video** | 92030 | 92061 | Up to every 3 months if clinically relevant | GPs - $156.55<br>PMPs - $125.30 |

Disclaimer: *This resource provides examples of how GPCCM MBS Items can be used by general practices and should be used as a guide only. General practices or Aboriginal Community Controlled Health Organisations (ACCHO) should consider their model of care, clinical judgement and team structure to inform their application of GP Chronic Condition Management MBS items. All MBS billings must be for clinically relevant services. GPs should use their clinical judgement in relation to what individual patients require.* Please refer to MBS online for the most current and detailed information on all MBS items. https://www.mbsonline.gov.au/

# MBS Quick Guide

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## MBS ONLINE

- Search for Item Number
- Fact Sheets
- Updates (XML Files)
- MBS News

## Eligibility

Ensure patient meets billing criteria.

- HPOS MBS checker
- My Health Record

## More information

- www.mbsonline.gov.au
- Contact MBS 13 21 50 askMBS@health.gov.au

To ensure your practice software applies the **correct Bulk Billing Incentives**, make sure MyMedicare status is updated regularly.

| CARE MANAGEMENT AND HEALTH ASSESSMENT SERVICES | Face to Face | Telehealth |
|---|---|---|
| **GP chronic condition management plan**** (Initial plan, then only if clinically neccesary) | 965† | 92029† |
| **GP chronic condition management plan Review**** (EVERY 3 MONTHS if clinically relevant) | 967† | 92030† |
| **Practice Nurse /Aboriginal Health Practitioner follow-up services for a patient with a GPCCMP** (5 PER YEAR) | 10997 | Phone 93203<br>Video 93201 |
| **Practice Nurse/Aboriginal Health Practitioner follow-up services for Aboriginal and Torres Strait Islander patients** (only available to patients with a 715-health assessment) (10 PER YEAR) | 10987 | Phone 93202<br>Video 93200 |
| **Domiciliary Medication Management Review (DMMR)** (ANNUALLY) | 900 | |
| **GP contribution to multidisciplinary plan – Community** (EVERY 3 MONTHS) | 729 | 92026* |
| **GP contribution to multidisciplinary plan (MCP) – RACF** (EVERY 3 MONTHS) | 731 | 92027* |
| **Residential Medication Management Review (RMMR)** (ANNUALLY) | 903 | |

**Patients with a General Practitioner Chronic Disease Management Plan/Review can access the following MBS services:

† MyMedicare registered patients can only access these services at their MyMedicare general practice

*Telehealth (Video Consults) and *Telephone (Phone Consults) available to Medicare-eligible patients with an established practice relationship who have attended in-person within the past year can access services. (Exceptions include children under 12 months, COVID-19 isolation, natural disaster areas, Aboriginal Medical Services, urgent after-hours care, homelessness, or services for blood-borne viruses, sexual/reproductive health, or TOPIC. The 30/20 rule applies to telephone items.)

- Allied Health Services: Up to 5 individual sessions per year (10 for Aboriginal or Torres Strait Islander patients).
- Nurse or Health Practitioner Services: Up to 5 services annually, provided on behalf of a doctor.
- Type 2 Diabetes Group Services: Initial assessment to determine suitability, and up to 8 yearly group sessions for dietetics, education, or exercise.

| GP CASE CONFERENCING ITEMS | | | |
|---|---|---|---|
| **Case Conference GP organises** | 735 | 739 | 743 |
| **Case Conference GP participating** | 747 | 750 | 758 |

# Chronic Condition Management Plans and Reviews

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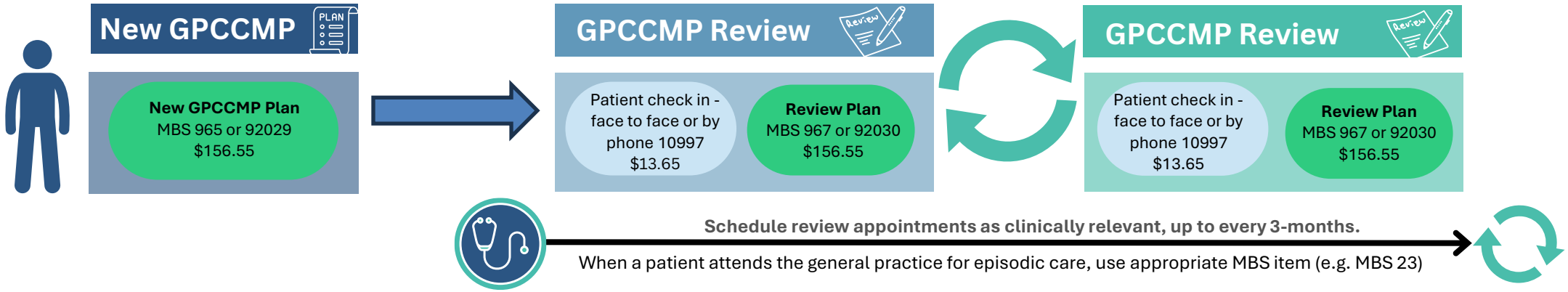


## New GPCCMP

### 1.Patient Eligibility

☐ Must have at least **one chronic condition** (≥6 months). No age restrictions.
☐ **MyMedicare status checked. Discuss MyMedicare patient registration to support care continuity with your practice.**

### 2. Develop Management Plan: Practice Nurse, Aboriginal Health Workers or Practitioners may contribute to preparing the plan - GP must see patient

☐ Explain the management plan process, gain informed consent, and collaboratively identify patient, goals, actions, and required services.
☐ Discuss review visit frequency and importance.
☐ Refer to other providers as needed (**referral letters,** not TCAs).

### 3. Complete the Plan

☐ Record consent and provide copy of plan to patient and carer.
☐ **Set review timeline**— As clinically appropriate, up to **every 3 months**
☐ Share plan with referred providers (with consent)
☐ Encourage upload to My Health Record (with consent)

### 4. Claiming

☐ Use correct item numbers (e.g. 965 for plan, 967 for review)
☐ All plan elements must be complete to claim
☐ Claiming unlocks up to 5 Medicare-rebated allied health visits

General Practitioner and prescribed medical practitioner (PMP) items

Practice nurse/Aboriginal and/or Torres Strait Islander Health Practitioner items

Chronic condition management is an **ongoing care process** including regular management plan reviews as clinically required.

## GPCCMP Reviews

☐ Review GPCCMPs up to every 3 months if clinically appropriate
☐ Use MBS item 967 (face-to-face) or 92030 (video)
☐ Assess patient progress, update goals and services, record consent
☐ Review letters from other providers and note updates in patient file
☐ Provide an updated copy to the patient and carer
☐ Share updates with other providers (if applicable)
☐ Encourage upload to My Health Record (with consent)
☐ Consider future review appointments

# Allied Health Referrals and other GPCCMP Considerations

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## Allied Health Referrals

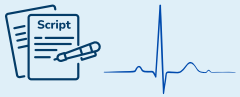
Consider any allied health care your patient may require have when writing the management plan with them.

**Referral letters to allied health providers,** documenting the care required, consistent with the referral process for medical specialists.

**Allied health providers are required to provide a written report back to the GP** after the provision of services (e.g., the first service under a referral).

**Referrals are valid for 18 months** (unless stated otherwise by referring GP).

## Other Management Plan Considerations




**Blood Tests and other periodical tests**

**Scripts & other disease specific testing e.g., ECG, Peak Flow etc.**

**Medical Specialist referral if required**

**Specialist Nurse supports such as:** Breast Care Nurse, Continence Nurse, Renal Nurse, Respiratory, Cardiac etc.

**Case Conference with care team**
MBS 735, 739, 743, 747, 750, 758

**Type 2 Diabetes Group Services Referral** for Diabetes Education, Dietetics or Exercise Physiology

**Self Management or Support Groups** relevant to chronic condition

**Family Support**
Consider if family members/ carers require any supports.

**Mental Health Support**
Consider mental health needs for individual especially if a new diagnosis

**Social Work Referral**
Consider this where there is social issues where additional support would benefit chronic condition outcome.

**Social Prescribing**
Consider if social prescribing may be appropriate for this patient.

**Social supports**
Consider social support in home environment, social connectedness, community connections and linkages

There are a wide range of services and considerations that can enhance management plans**. Consider your patient's unique wellbeing needs and lifestyle goals.**

Refer to HealthPathways for evidence based clinical decision support to inform management planning for each chronic condition. **Western Victorian Community Pathways**