

# GP Management Plan (GPMP) 721 & 725

## GP Management Plan

Patient with **chronic condition** that has been or is likely to be present for at least six months or that is terminal (Not necessarily requiring multidisciplinary care).

### GPMP Preparation

#### Item 721

- Claimed by GP with assistance of PN or other
- Every 2 years

### GPMP Review

#### Item 725

- Claimed by GP with assistance of PN or other
- Every 3-6 months, or when clinically required

Practice Staff

- Contact Patient Regarding Care Plan
  - Telephone or send a letter using practice recall system
  - Arrange a time to see the patient for initial assessment
- #### Patient Visit
- Identify and discuss benefits (carer can be present if required).
  - Obtain and record patient consent
  - Check for eligibility and existing care plan– ask patient - check with HIC
  - Eligibility:  
Patient with **chronic condition** that has been or is likely to be present for at least six months or that is terminal.  
(Not necessarily requiring multidisciplinary care).
  - Schedule date for review of plan in 3-6 months time

Health Professional/Nurse

Includes a patient consult with GP

- #### Prepare GPMP with patient
- Assess patient. Identify/ confirm health care needs, problems and relevant conditions.
  - Agree to management goals with patient regarding changes
  - Identify actions for patient to take
  - Identify treatment and services and arrange for the provision and ongoing management.

Health Professional/Nurse

- #### Document GPMP
- Prepare written summary (keep in patient file)
  - Patient signature on plan and copy for patient

GP

- Advise patient/carers of outcomes and recommendations
- #### Claim Item Number- Item 721
- Finalise MBS claim

Could the patient benefit from a Team Care Arrangement in addition to a GP Management Plan?

For steps, refer to the 'blue' page.

Contact the Division on **8396 4511** or email [anedgp@anedgp.com.au](mailto:anedgp@anedgp.com.au)

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Details current as at September 2005

## 721 and 725 List examples

Diabetes

Asthma

Arthritis

- Osteoarthritis
- Osteoporosis
- Rheumatoid Arthritis

Mental Health

AIDS and HIV

Coronary Heart Disease

Stroke

COPD

Lung Cancer

Dementia

Colorectal Cancer

Chronic Kidney Disease

Oral Diseases

Thyroid illness

- Hyperthyroidism
- Hypothyroidism

Prostate cancer

Most cancers (excluding BCC, SCC of skin)

Palliative care

Chronic Renal Impairment

## 721 and 725 Exclusion List

By themselves

**Obesity, Smoking, Unspecified chronic pain**

**Pregnancy, Impaired glucose tolerance**

**Hypercholesterolaemia**

**Hypertension, Syndrome X**

Are not regarded as chronic medical conditions. In many cases a patient may have complications or co-morbidities, that may be a result of, or exacerbated by, such risk factors, making them eligible for CDM services.

If any of the exclusion list are present together, depending on the severity and level of control, the patient may be eligible for a GPMP.

## 721 and 723 Guidelines

- A GPMP and a TCA can both be claimed at the same time provided the two services are delivered as per the Medicare items.
- The TCA does not need to be an entirely separate document to the GPMP preventing unnecessary duplication. Provided the relevant information is documented. The TCA can be included as an addition to the patient's GPMP as an extra page that includes the goals, the collaborating providers, the treatment/services they have agreed to provide, patient actions and a review date.
- A separate standard consultation should not be billed with a GPMP, TCA or review of either service unless it is clinically indicated that a problem must be treated immediately; or the GPMP was not the original purpose of the consultation. Accounts that include both a CDM item and a consultation must be annotated accordingly.

# Team Care Arrangements (TCA) 723, 727, 729 & 731

Have you developed a **GP Management Plan**?

Develop a GPMP using the guide on the **GP Management Plan (GPMP)** page.  
If the patient requires multidisciplinary care, continue with the steps below

## Team Care Arrangement

Patient with **chronic** or terminal condition with complex care needs that **requires multidisciplinary care**

### TCA Coordination

#### Item 723

- Claim with a GP Management Plan
- Claimed by GP with assistance

### TCA Review

#### Item 727

- Claimed by GP with assistance of PN or other
- Every 6 months, or when clinically required

### TCA Contribution

(including on discharge)

#### Item 729

- When TCA prepared by another provider
- Claimed by GP with assistance of PN or other
- Every 6 months, or when clinically required

### Item 731

including on discharge

- Identical to Item 729
- For residents living in aged care facilities

Practice Staff

Same steps as in GP Management Plan replacing eligibility criteria

- Eligibility:  
Patient with **chronic** or terminal condition with complex care needs **requiring multidisciplinary care**
- TCA requires at least two other Health Professionals, as well as the GP, to be included in the plan

#### Contact Other Health Professionals

- Advise professionals involved about patient
- Obtain their agreement to provide services

Health Professional/  
Nurse

#### Prepare TCA with Patient

- Document goals
- Document collaboration with other health professionals
- Document treatment/ services they have agreed to provide
- Document patient actions
- Write referral for services eligible for Medicare rebates

Includes a patient  
consult with GP

- Request and send a copy of relevant information from other health professionals involved in TCA

Health Professional/  
Nurse

GP

- Advise patient and carer of outcomes
- #### Claim Item Number- Item 723
- Finalise MBS claim

GP

#### Contribution to a TCA- Item 729, Item 731

- Record your input to the Allied Health Professional Plan
- Includes inpatients

#### Claim Item Number- Item 729, Item 731

Finalise MBS claim

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