Chronic Condition Management (CCM) MBS Changes

Welcome

to

Chronic Condition Management (CCM) MBS Changes Webinar

This activity and resources have been made possible by funding from Gold Coast PHN.

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Learning Objectives

- Key changes in Chronic Disease Management
- How these updates will impact processes in primary care
- Practical tips for integrating these changes smoothly into your practice

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How you may feel now…

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By the end of the webinar…

Chronic Conditions

AIHW, 2024

- 55% of all hospitalisations in Australia were associated with **chronic conditions.**
- Between 89% - 92% of all deaths each year were attributed to **chronic conditions**
- 84.9% of total disease burden contributed by Chronic Disease.
- Chronic disease is on of the main factors **contributing to the gap in life expectancy** between Aboriginal and Torres Strait Islander people and non-Indigenous Australians.

Why MBS Item Changes?

Significant changes in the last **20 years** regarding:

- Burden of chronic disease
- Patient expectations
- Technology to support communication between multidisciplinary care teams and patients

Goals of the MBS Item Changes

- Simplify and streamline
- Promote continuity of care
- Encourage regular review
- Support communications between a patient’s care team
- Ensure existing patients continue access to care

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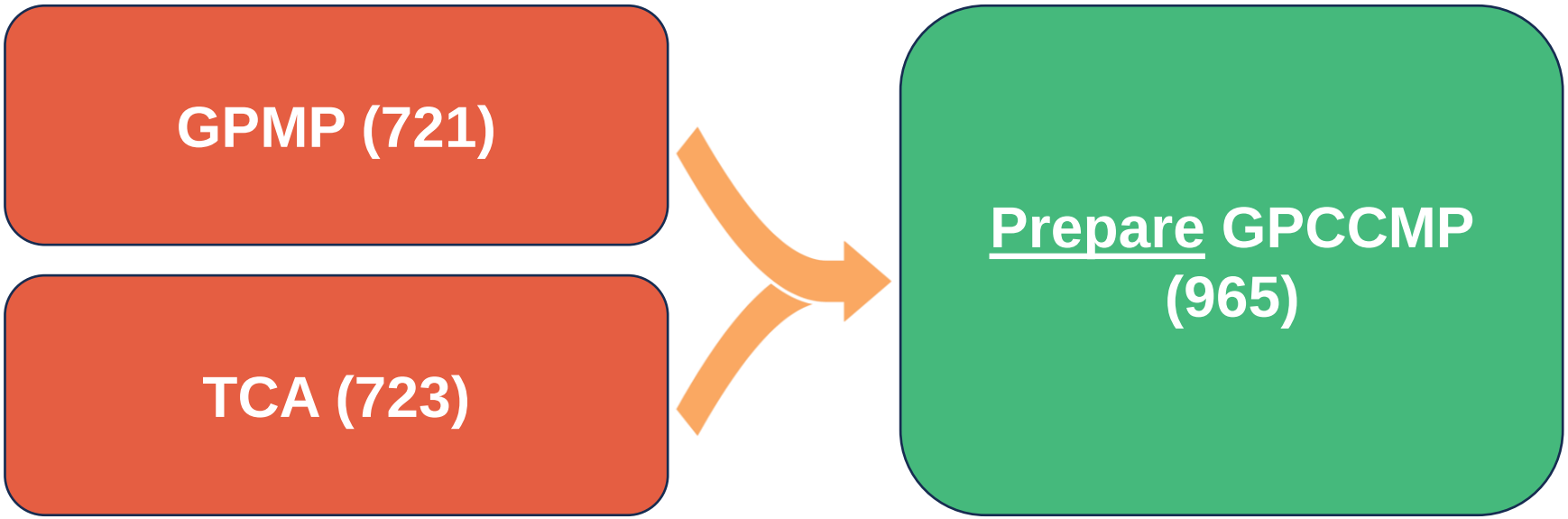
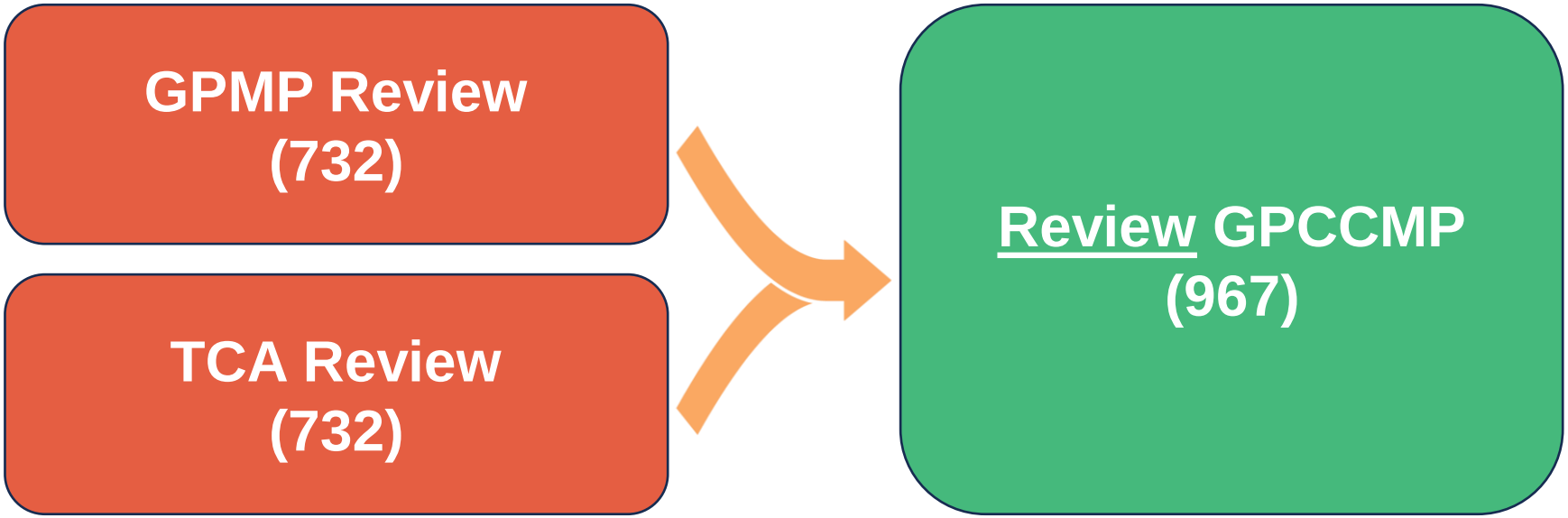
The CDM MBS Item Changes

GP Chronic Condition Management Plan (GPCCMP)



GP Chronic Condition Management Plan Review (GPCCMP Review)



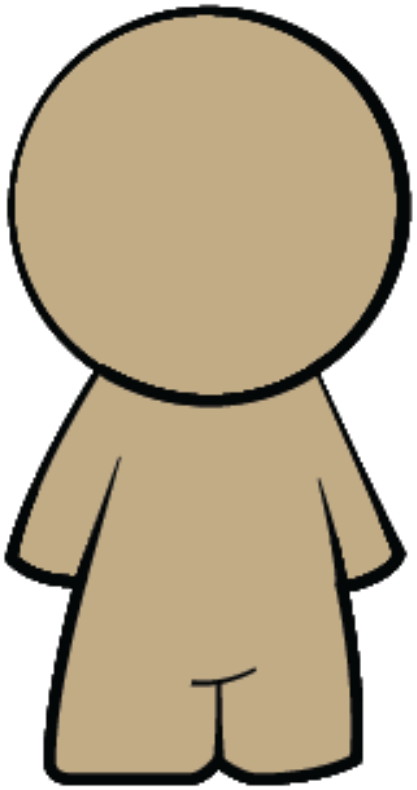
Chronic Condition Management Plan
GP MBS Item Numbers

MBS Item Name	GP Face-to-Face 	GP Video 
Prepare a GP Chronic Condition Management Plan	**965**	**92029**
Review a GP Chronic Condition Management Plan	**967**	**92030**

Chronic Condition Management Plan
PMP MBS Item Numbers

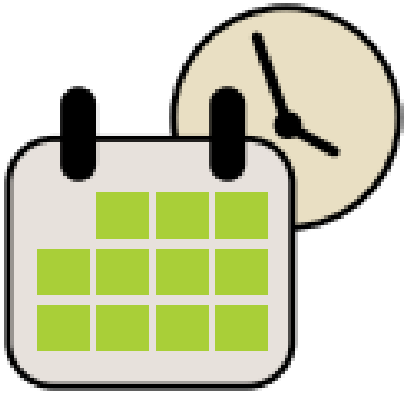
MBS Item Name	PMP Face-to-Face 	PMP Video 
Prepare a GP Chronic Condition Management Plan	**392**	**92060**
Review a GP Chronic Condition Management Plan	**393**	**92061**

GPCCMP Patient Eligibility

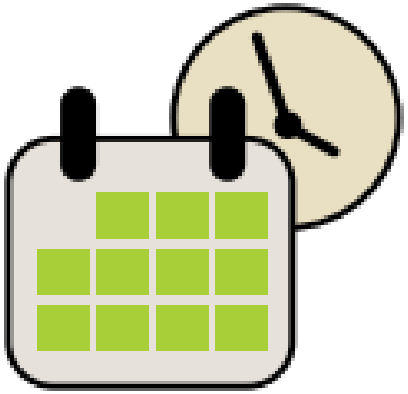


- Patient has at least **ONE** medical condition that has been (or is likely to be) present for at least **6 months** or is **terminal**
- They would benefit from a structured approach to their care
- They are **not** a patient in a residential aged care facility.

GPCCMP Frequency



- A GPCCMP can be **prepared** ONCE every 12 months



- A GPCCMP can be **reviewed** every 3 months

Practice Team
Who Can Assist?

- A Practice Nurse
- Aboriginal Health Worker
- Aboriginal and Torres Strait Islander Health Practitioner

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Medicare

Medicare Rebates
Prepare and Review Equalised

Prepare GPCCMP
MBS Item 965

$156.55

=

Review GPCCMP
MBS Item 967

$156.55

Medicare Rebates
Financial Comparison - Annual

	GPMP	GPMP and TCA	GPCCMP
Preparation of Plan	$164.35	$164.35 + $130.25	$156.55
1st Review	$82.10	$82.10 + $82.10	$156.55
2nd Review	$82.10	$82.10 + $82.10	$156.55
3rd Review	$82.10	$82.10 + $82.10	$156.55
Total	**$410.65**	**$787.20**	**$626.20**

MyMedicare

- Patients registered with MyMedicare **MUST** access GPCCMP Items through their enrolled practice
- Patients not registered with MyMedicare may access their services through their usual GP

Combination Billing
What goes together?

MBS BILLING COMBINATIONS

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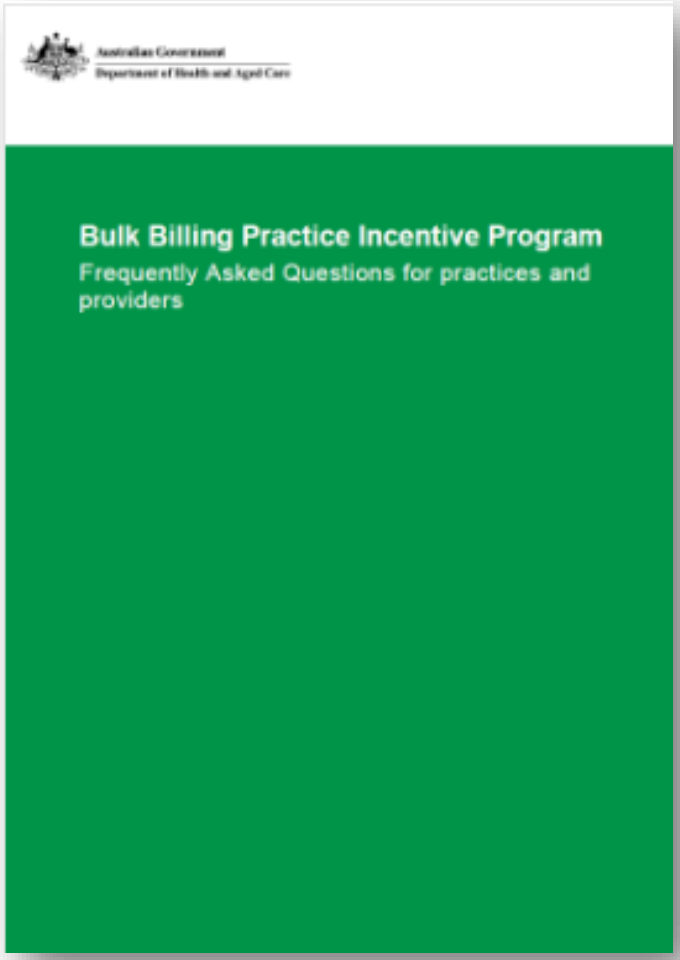
	Consultation 3 23 36 44	Mental Health 2700 2701 2712 2715 2717	GPCCMP 965	GPCCMP Review 967	Home Medicines Review 900	ATSI Health Assessment 715	Health Assessment 701 703 705 707	Heart Health Assessment 699
Consultation 3 23 36 44		✓	X	X	✓	✓	✓	✓
Mental Health 2700 2701 2712 2715 2717	✓		✓	✓	✓	✓	✓	✓
GPCCMP 965	X	✓			✓	✓	✓	✓
GPCCMP Review 967	X	✓			✓	✓	✓	✓
Home Medicines Review 900	✓	✓	✓	✓		✓	✓	✓
ATSI Health Assessment 715	✓	✓	✓	✓	✓			X
Health Assessment 701 703 705 707	✓	✓	✓	✓	✓			X
Heart Health Assessment 699	✓	✓	✓	✓	✓	X	X	
Nurse/AHP 10997	✓	✓	X*	X*	✓	✓	X	✓
Nurse/AHP 10987	✓	✓	✓	✓	✓	X*		✓

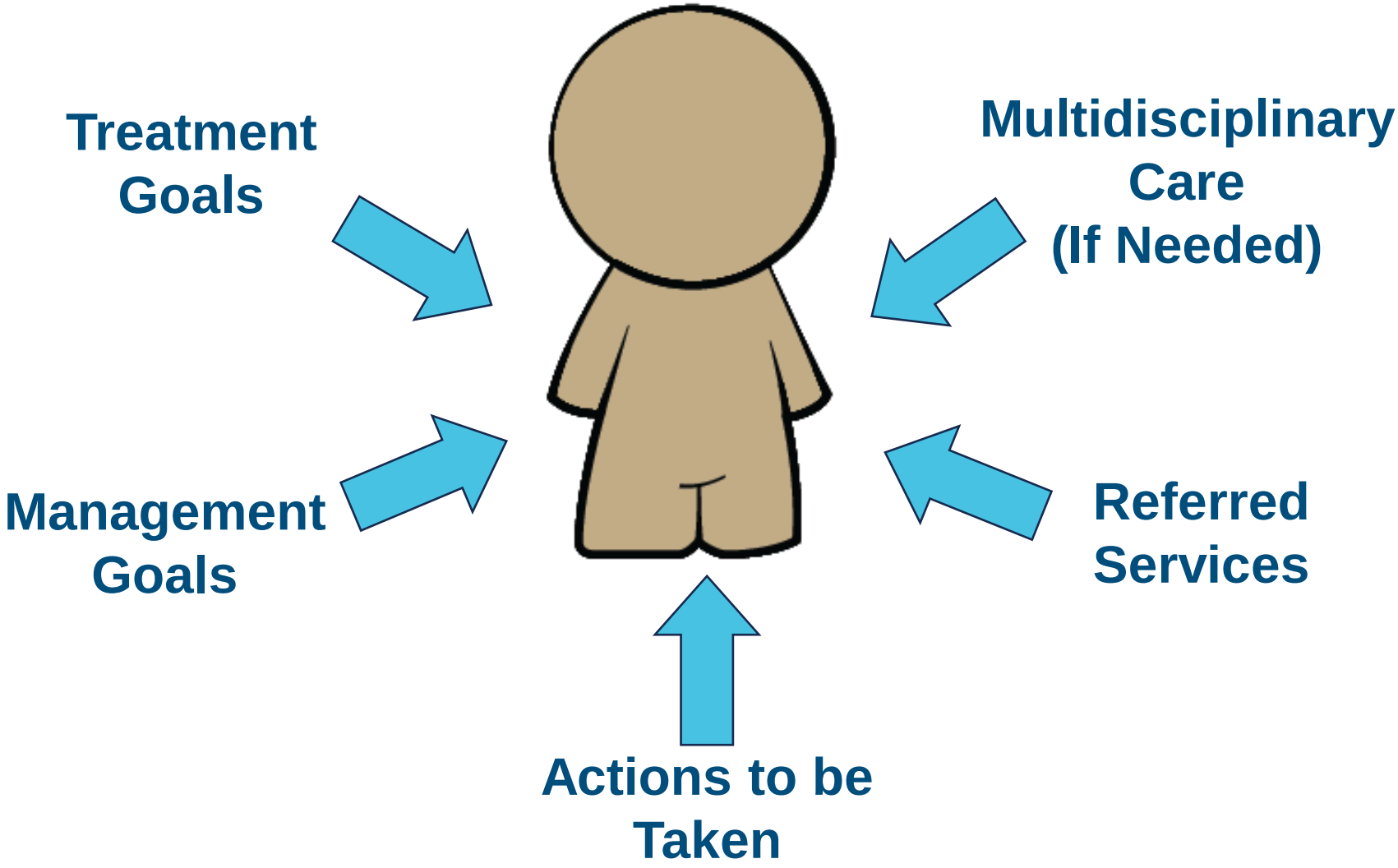
Follow Us SOURCE: Medicare Benefits Schedule *See MBS Online for further guidance MBS BILLING COMBINATIONS | © CDM Plus Pty Ltd

Bulk Billing Incentives



- From Nov 1, 2025, all Medicare-eligible patients will be eligible for bulk billing incentives.
- Practices participating in the Program will receive and additional 12.5% incentive payment on every $1 of MBS benefit earned from eligible services (split between GP/Practice).

GPCCMP Purpose
Patient-Centred Care



GPCCMP
Service Description

A GPCCMP will include:

- Patient's chronic conditions and care needs
- Agreed health and lifestyle goals
- Patient Actions
- Treatment and services likely needed
- MDT and referred services
- Planned review and timeframe

GPCCMP Review
Service Description

A GPCCMP Review will:

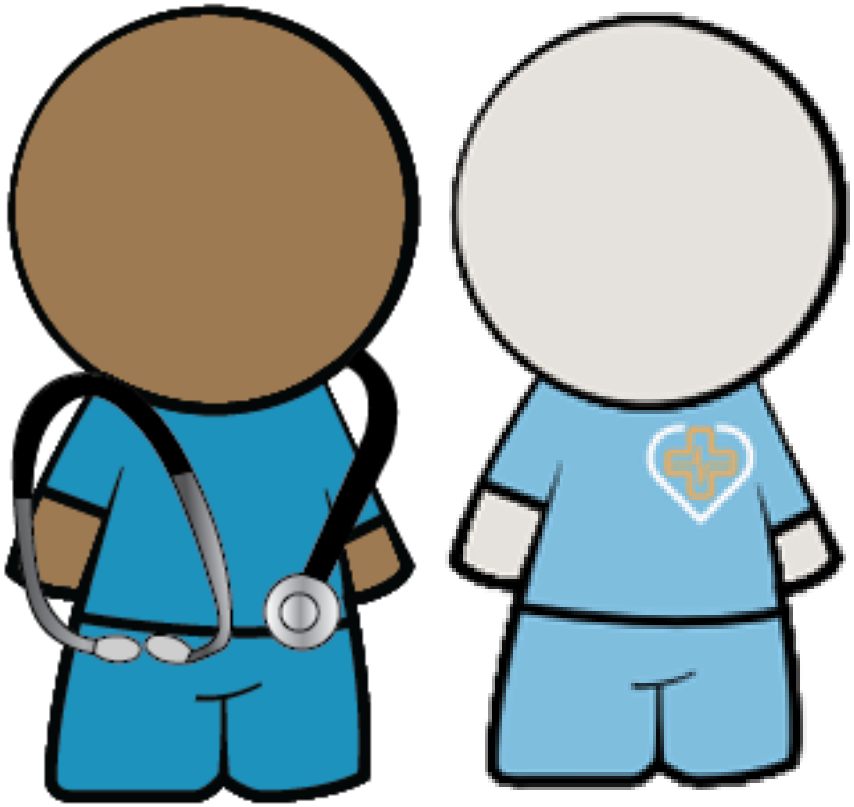
- Document patients **progress** towards goals in GPCCMP
- Update GPCCMP as needed
- Reassess goal relevance & progress
- Note MDT input and patient consent
- Review follow-up arrangements

GPCCMP and GPCCMP Reviews Finalising and Documenting

A GP must also:

- Record the patients consent and agreement to the plan
- Offer a copy of the plan to the patient and carer
- Add a copy of the plan to the medical records

Referring to Multidisciplinary Team (MDT)



If the patient is referred to a member of the MDT, the GP/PMP must:

- Obtain consent to share relevant info
- Provide relevant parts of the plan to the MDT if the patient consents

MDT members do not need to provide services through MBS to be a member of the MDT.

GP Allied Health Referrals

- Consultation with at least 2 collaborating providers is **no longer required**
- Referral **Letters** replace Forms
- GPs can refer patients with a GPCCMP **directly** to relevant services
- GP CCMPs do not expire
- Patients must have CCMP prepared/reviewed in previous 18 months to continue access to allied health services under the plan

GP Allied Health Referrals Minimum Requirements

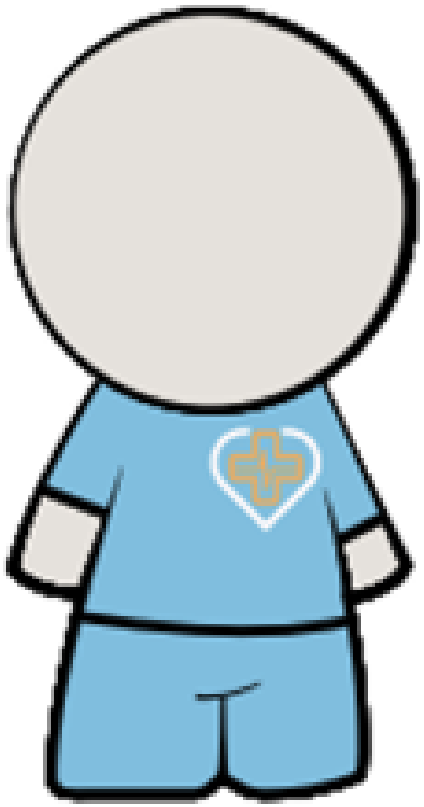
- ✓ Name of **referring** practitioner
- ✓ Address of practice **or** referring practitioner's provider number
- ✓ Date practitioner made referral
- ✓ Be in writing
- ✓ Be signed (can be electronic)
- ✓ Dated
- ✓ Include reasons for referral including information about the patient's condition that the GP considers necessary

GP Allied Health Referrals

Do Not Need to Include:

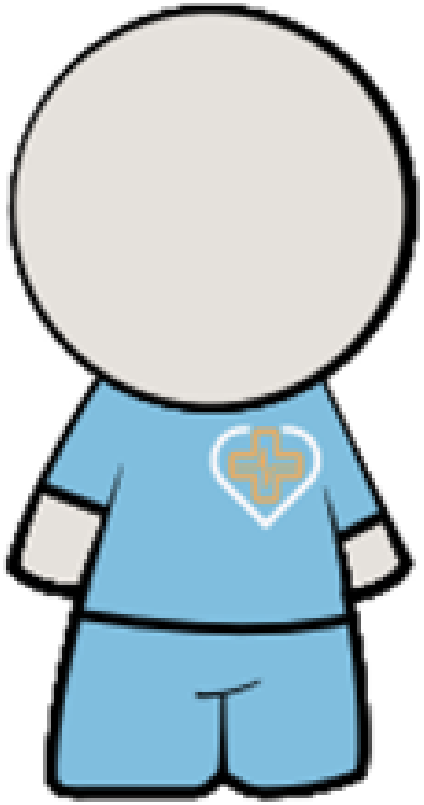
- Name of the allied health provider
- Specify the number of services to be provided.

Allied Health Documentation



- No requirement for allied health providers to confirm acceptance of referral or provide input into the preparation of the GPCCMP.
- Requirements for allied health providers to provide a written report back to the GP after the provision of services (unchanged):
  - After a single service
  - After first and last service
  - When clinically necessary

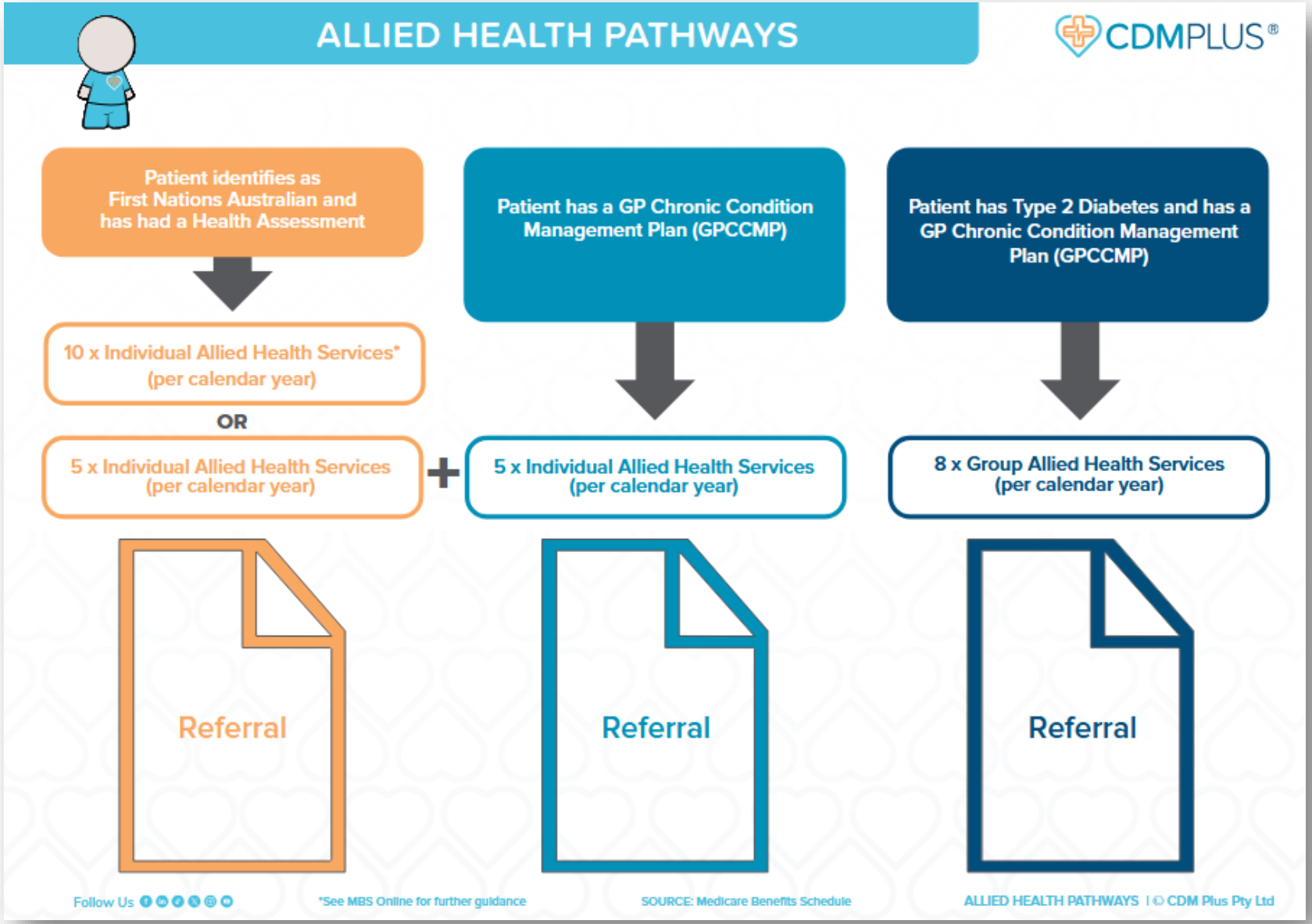
Allied Health Reports



Allied Health Written Reports back to referring practitioner should include:

- Any investigations, tests, and/or assessments
- Any treatment provided
- Future management of the patient's condition or problem

Allied Health Services



Services Provided on Behalf of a Medical Practitioner

- ✓ Patients can **continue to access** services provided through MBS **Item 10997** under existing GPMPs & TCAs until June 30, 2027.
- ✓ Patients can access MBS-supported services when they are consistent with their GPCCMP.
- ✓ Up to 5 services on behalf of GP/PMP by a Practice nurse or Aboriginal and Torres Strait Islander Health Practitioner.

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Transition Arrangements

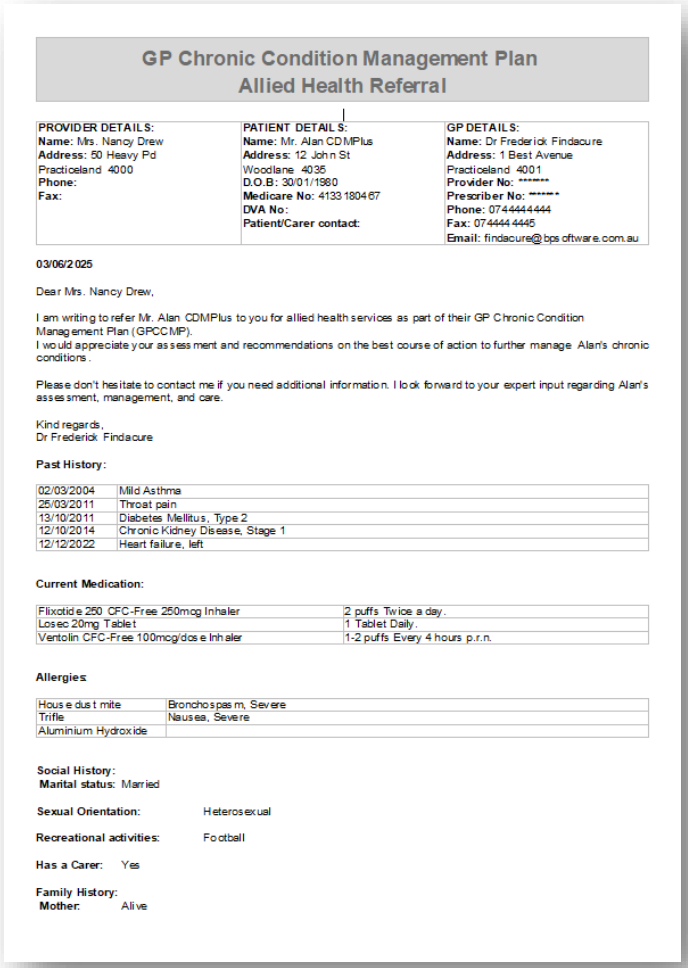
Transitioning to GPCCMPs

- Transition arrangements in place for 2 years
- Patients with GPMP/TCA prior to July 1, 2025, will retain access to services consistent with those plans (for two years).
- The new MBS Items to **REVIEW** a GPCCMP should only be used to review an **existing** GPCCMP.
- If a patient requires a **review of a GPMP or TCA** (that was put in place prior to July 1, 2025) they should be **transitioned to the new arrangements** through preparation of a GPCCMP.

Transitioning to GPCCMPs From July 1, 2025

Current GPMP/TCA No review required	No immediate action required
Current GPMP/TCA Patient requires review	Prepare a GPCCMP MBS Item 965
No existing GPMP/TCA Patient eligible	Prepare a GPCCMP MBS Item 965

Transitioning to Referral Letters From July 1, 2025



GP Chronic Condition Management Plan
Allied Health Referral

PROVIDER DETAILS:	PATIENT DETAILS:	GP DETAILS:
Name: Mrs. Nancy Drew **Address:** 50 Heavy Pd Practiceland 4000 **Phone:** **Fax:**	**Name:** Mr. Alan CDMPlus **Address:** 12 John St Woodlane 4035 **D.O.B:** 30/01/1980 **Medicare No:** 4133 180467 **DVA No:** **Patient/Carer contact:**	**Name:** Dr Frederick Findacure **Address:** 1 Best Avenue Practiceland 4001 **Provider No:** ****** **Prescriber No:** ****** **Phone:** 0744444444 **Fax:** 074444 4445 **Email:** findacure@bpsoftware.com.au

03/06/2025

Dear Mrs. Nancy Drew,

I am writing to refer Mr. Alan CDMPlus to you for allied health services as part of their GP Chronic Condition Management Plan (GPCCMP).
I would appreciate your assessment and recommendations on the best course of action to further manage Alan's chronic conditions.

Please don't hesitate to contact me if you need additional information. I look forward to your expert input regarding Alan's assessment, management, and care.

Kind regards,
Dr Frederick Findacure

Past History:

02/03/2004	Mild Asthma
25/03/2011	Throat pain
13/10/2011	Diabetes Mellitus, Type 2
12/10/2014	Chronic Kidney Disease, Stage 1
12/12/2022	Heart failure, left

Current Medication:

Flixotide 250 CFC-Free 250mcg Inhaler	2 puffs Twice a day.
Losec 20mg Tablet	1 Tablet Daily.
Ventolin CFC-Free 100mcg/dose Inhaler	1-2 puffs Every 4 hours p.r.n.

Allergies:

House dust mite	Bronchospasm, Severe
Trifle	Nausea, Severe
Aluminium Hydroxide	

Social History:
Marital status: Married

Sexual Orientation: Heterosexual

Recreational activities: Football

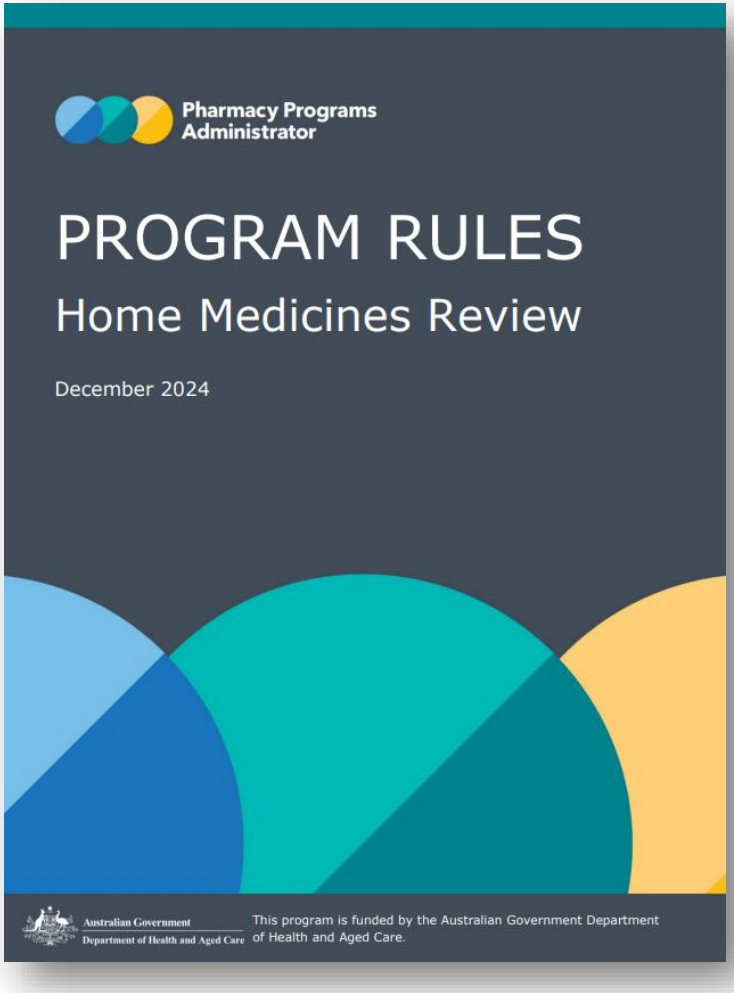
Has a Carer: Yes

Family History:
Mother: Alive

Any **NEW** referral for allied health services after July 1, 2025, should meet the **NEW** referral requirements regardless of whether referral is made under a:

- GPMP (721)
- TCA (723)
- GPCCMP (965)

Other Services



- From July 1, 2027, patients will need a GPCCMP to access a Home Medicines Review (HMR)
- These chronic condition changes do not affect multidisciplinary care plan items such as:
  - 729 – MD Plan
  - 731 – MD Plan (RACF)

GPCCMPs – Let's Get Ready

Admin/Management

- ❑ Meet with team about upcoming changes
- ❑ Promote MyMedicare enrollments
- ❑ Inform MyMedicare registered patients about the changes
- ❑ Remove GPMP/TCA templates
- ❑ Upload new GPCCMP templates
- ❑ Update appointment types and times
- ❑ Adjust any internal billing guides
- ❑ Set up recall system for GPCCMP reviews
- ❑ Ensure Practitioners understand co-claiming restrictions
- ❑ Plan how allied health referrals and reports will be tracked

Clinical Staff

- ❑ Attend relevant training to understand changes and new responsibilities
- ❑ Update Clinical Software Templates
- ❑ Review clinical workflow Nurse-AHP-GP
- ❑ Update Text Shortcuts
- ❑ Review Billing Combinations
- ❑ Review Documentation changes
- ❑ Plan how patient communication will be managed (consider scripts for admin)
- ❑ Remove any educational/promotional GPMP/TCA materials
- ❑ Update Referral Letter for Allied Health

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Case Studies

Case Study #1

It's July 28, 2025, and Stuart, a 42-year-old man has come into the practice for wound care:

- Smoker & Overweight
- History of Asthma & Hypertension
- Previous patient billing information:
  - No Health Assessments
  - No GPMP/TCA (721/723)

Questions:

Is Stuart eligible for a GP Chronic Condition Management Plan (GPCCMP)?

Case Study #1

It's July 28, 2025, and Stuart, a 42-year-old man has come into the practice for wound care:

- Smoker & Overweight
- History of Asthma & Hypertension
- Previous patient billing information:
  - No Health Assessments
  - No GPMP/TCA (721/723)

Question:

Is Stuart eligible for a GP Chronic Condition Management Plan (GPCCMP)?

Answers:

Yes. Stuart has a chronic condition and may benefit from a coordinated approach to his care.

Case Study #1

It's July 28, 2025, and Stuart, a 42-year-old man has come into the practice for wound care:

- Smoker & Overweight
- History of Asthma & Hypertension
- Previous patient billing information:
  - No Health Assessments
  - No GPMP/TCA (721/723)

Questions:

Stuart attends the practice a week later and his GP completes a GPCCMP. What MBS Item will be billed?

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- Previous patient billing information:
  - No Health Assessments
  - No GPMP/TCA (721/723)

Questions:

Stuart attends the practice a week later and his GP completes a GPCCMP. What MBS Item will be billed?

Answers:

MBS Item 965 (GP Chronic Condition Management Plan – Face-to-Face).

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- Smoker & Overweight
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- Previous patient billing information:
  - No Health Assessments
  - No GPMP/TCA (721/723)

Questions

Stuart's GP recommends input from an exercise physiologist (EP). Stuart agrees and the GP includes this in the GPCCMP. Stuart does not currently have any other providers involved in his care. Is Stuart still eligible to access 5 Individual allied health services under Medicare to the EP?

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  - No Health Assessments
  - No GPMP/TCA (721/723)

Questions:

Stuart's GP recommends input from an exercise physiologist (EP). Stuart agrees and the GP includes this in the GPCCMP. Stuart does not currently have any other providers involved in his care. Is Stuart still eligible to access 5 Individual allied health services under Medicare to the EP?

Answers:

Yes. Patients can access 5 individual allied health services under Medicare per calendar year consistent with their GPCCMP.

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- Smoker & Overweight
- History of Asthma & Hypertension
- Previous patient billing information:
  - No Health Assessments
  - No GPMP/TCA (721/723)

Question:

Stuart's GP completes the GPCCMP and has Stuart's consent to complete the referral to the EP. The GP cannot find an allied health referral template, so they just use the old referral form. Will the EP be able to receive the referral?

Case Study #1

It's July 28, 2025, and Stuart, a 42-year-old man has come into the practice for wound care:

- Smoker & Overweight
- History of Asthma & Hypertension
- Previous patient billing information:
  - No Health Assessments
  - No GPMP/TCA (721/723)

Question:

Stuart's GP completes the GPCCMP and has Stuart's consent to complete the referral to the EP. The GP cannot find an allied health referral template, so they just use the old referral form. Will the EP be able to receive the referral?

Answer:

No. Referral forms will no longer be used after July 1, 2025. Referral LETTERS will replace the referral forms.

Case Study #2

Stacey is a 45-year-old woman who presents for preparation of a Chronic Condition Management Plan. Stacey and her GP agree that she would benefit from input from the diabetes educator and dietitian. The GP writes a referral letter to both providers.

- First Nations, Ex-smoker
- Diabetes & Chronic Kidney Disease

Questions:

Does the GP need to wait for confirmation from the diabetes educator and dietitian of their willingness to be involved in Stacey's care to complete the GPCCMP billing today?

Case Study #2

Stacey is a 45-year-old woman who presents for preparation of a Chronic Condition Management Plan. Stacey and her GP agree that she would benefit from input from the diabetes educator and dietitian. The GP writes a referral letter to both providers.

- First Nations, Ex-smoker
- Diabetes & Chronic Kidney Disease

Question:

Does the GP need to wait for confirmation from the DE and dietitian of their willingness to be involved in Stacey's care to complete the GPCCMP billing?

Answer:

No. Consultation with at least 2 collaborating providers is no longer required. GPs can refer patients with a GPCCMP directly to the relevant services.

Case Study #2

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- First Nations, Ex-smoker
- Diabetes & Chronic Kidney Disease

Questions:

Stacey has been attending both the DE and dietitian. She returns for a review of her GPCCMP 3 months after it was prepared. The GP cannot find any allied health reports. When should the allied health providers have been providing reports?

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Stacey is a 45-year-old woman who presents for preparation of a Chronic Condition Management Plan. Stacey and her GP agree that she would benefit from input from the diabetes educator and dietitian. The GP writes a referral letter to both providers.

- First Nations, Ex-smoker
- Diabetes & Chronic Kidney Disease

Question:

Stacey has been attending both the DE and dietitian. She returns for a review of her GPCCMP 3 months after it was prepared. The GP cannot find any allied reports. When should the allied providers have been providing reports?

Answer:

- Single Service – after each
- Multiple Services - After first and last service
- Clinically necessary

Case Study #2

Stacey is a 45-year-old woman who presents for preparation of a Chronic Condition Management Plan. Stacey and her GP agree that she would benefit from input from the diabetes educator and dietitian. The GP writes a referral letter to both providers.

- First Nations, Ex-smoker
- Diabetes & Chronic Kidney Disease

Question:

Since preparation of the GPCCMP the Aboriginal Health Practitioner has seen Stacey three separate times on behalf of the GP. Can the GP use MBS Item 10997 for these services?

Case Study #2

Stacey is a 45-year-old woman who presents for preparation of a Chronic Condition Management Plan. Stacey and her GP agree that she would benefit from input from the diabetes educator and dietitian. The GP writes a referral letter to both providers.

- First Nations, Ex-smoker
- Diabetes & Chronic Kidney Disease

Question:

Since preparation of the GPCCMP the Aboriginal Health Practitioner has seen Stacey three separate times on behalf of the GP. Can the GP use MBS Item 10997 for these services?

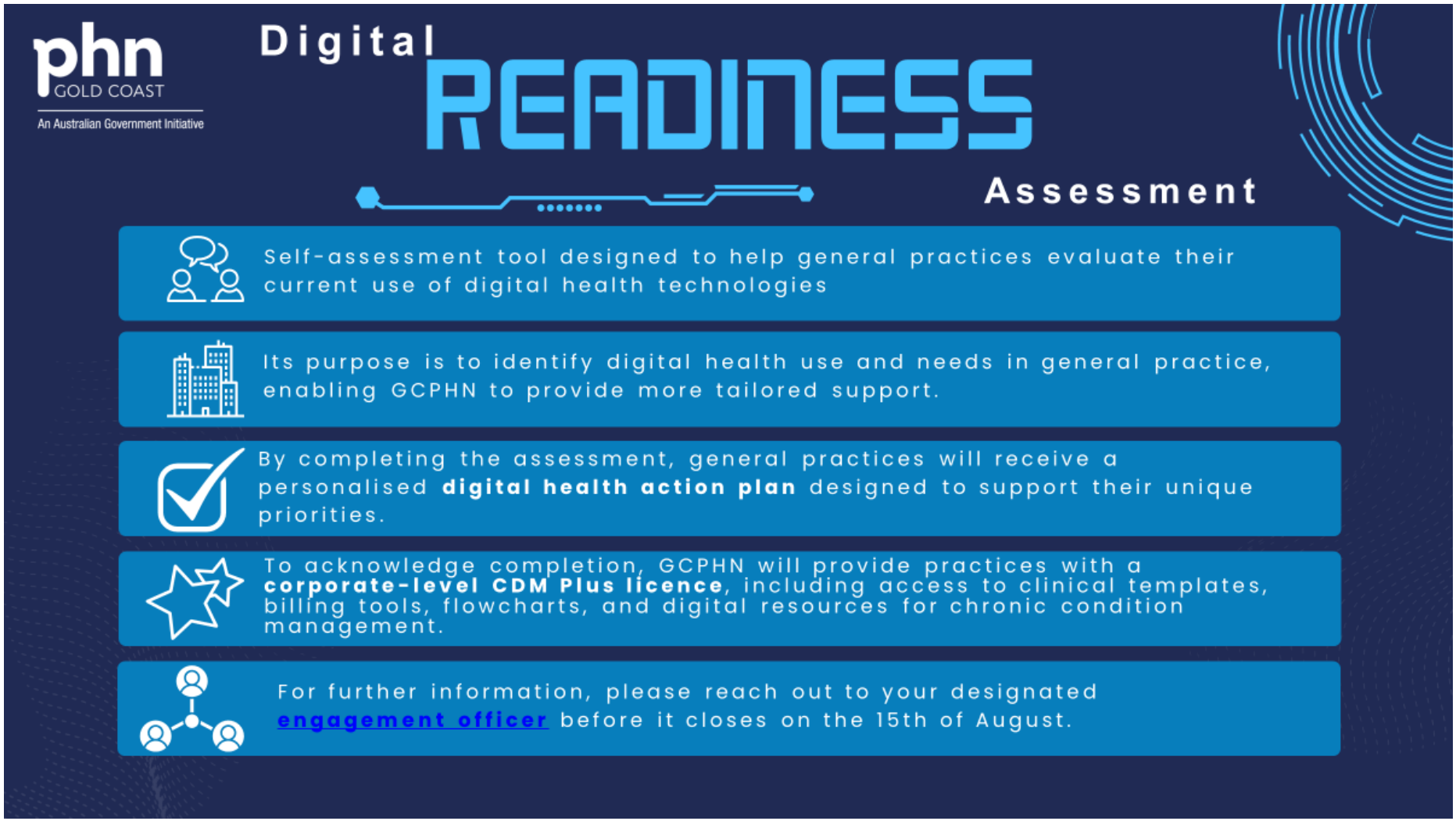
Answer:

Yes. Patients with a GPCCMP can access services from AHPs and nurses (on behalf of a medical practitioner) using 10997, 93201, 93203.

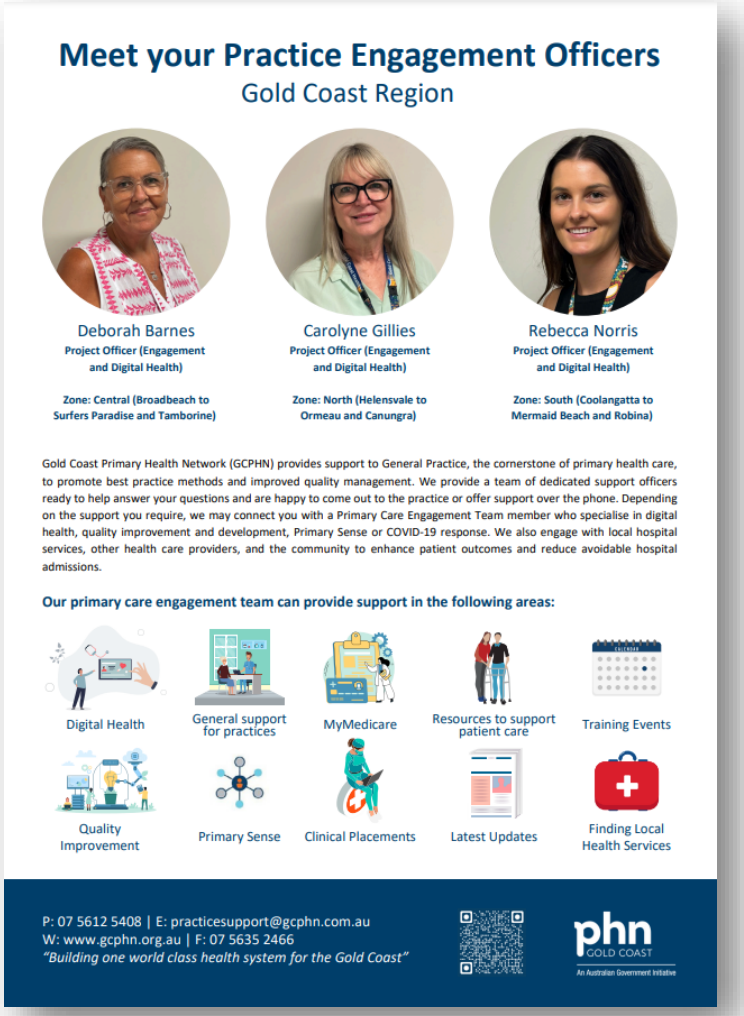
Questions & Feedback Survey

Please scan the QR code to complete a short feedback survey.
Your feedback helps us improve future sessions.

Digital Readiness Assessment



Digital Readiness Assessment



Meet your Practice Engagement Officers

Gold Coast Region

Deborah Barnes
Project Officer (Engagement and Digital Health)
Zone: Central (Broadbeach to Surfers Paradise and Tamborine)

Carolyne Gillies
Project Officer (Engagement and Digital Health)
Zone: North (Helensvale to Ormeau and Canungra)

Rebecca Norris
Project Officer (Engagement and Digital Health)
Zone: South (Coolangatta to Mermaid Beach and Robina)

Gold Coast Primary Health Network (GCPHN) provides support to General Practice, the cornerstone of primary health care, to promote best practice methods and improved quality management. We provide a team of dedicated support officers ready to help answer your questions and are happy to come out to the practice or offer support over the phone. Depending on the support you require, we may connect you with a Primary Care Engagement Team member who specialise in digital health, quality improvement and development, Primary Sense or COVID-19 response. We also engage with local hospital services, other health care providers, and the community to enhance patient outcomes and reduce avoidable hospital admissions.

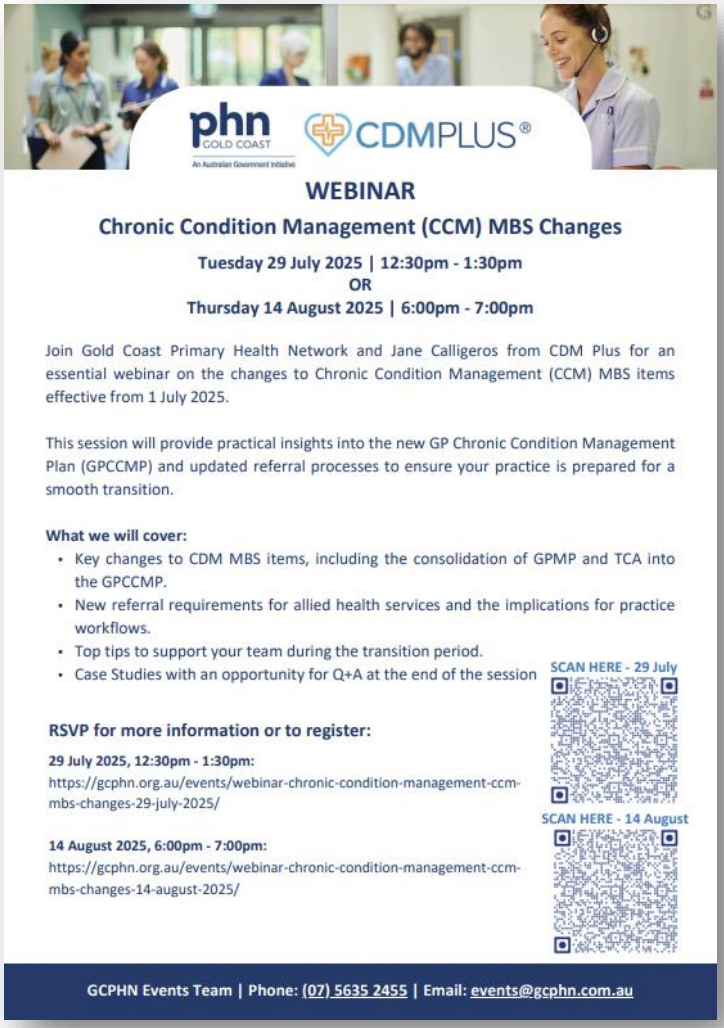
Our primary care engagement team can provide support in the following areas:

Digital Health
General support for practices
MyMedicare
Resources to support patient care
Training Events
Quality Improvement
Primary Sense
Clinical Placements
Latest Updates
Finding Local Health Services

P: 07 5612 5408 | E: practicesupport@gcphn.com.au
W: www.gcphn.org.au | F: 07 5635 2466
"Building one world class health system for the Gold Coast"

- GCPHN will provide practices with a corporate level CDM Plus licence once Digital Readiness Assessment is complete.
- Reach out to your designated Engagement Officer before it closes 15th August.
- practicesupport@gcphn.com.au

Upcoming Webinars



Chronic Condition Management (CCM) MBS Changes

Thursday August 14th 6 pm – 7pm

SCAN HERE - 14 August

Sources & More Information

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