# Gold Coast Chronic Condition Management

## Continuous Quality Improvement Toolkit

**The Chronic Conditions Management (CCM) QI Toolkit provides a practical guide to help general practices implement continuous Quality Improvement (QI) activities for managing chronic conditions.**

It supports primary care teams in delivering structured, proactive, and person-centred care - enhancing continuity, improving patient outcomes, and increasing efficiency. The toolkit aligns with the revised CCM MBS items and the Strengthening Medicare reforms.

phn NATIONAL IMPROVEMENT NETWORK COLLABORATIVE
An Australian Government Initiative

National MyMedicare PHN Implementation Program

phn COOPERATIVE
An Australian Government Initiative

phn GOLD COAST
An Australian Government Initiative

**Gold Coast Primary Health Network would like to acknowledge and pay respect to the land and traditional practices of the families of the Yugambeh Language region of South East Queensland and their Elders, past, present and emerging.**

***Artwork: Narelle Urquhart. Wiradjuri woman.***
***Artwork depicts a strong community, with good support for each other, day or night. One mob.***


***Acknowledgements***
*This QI toolkit has been developed by Gold Coast PHN and PHN's nationally through the PHN Cooperative, the National Improvement Network Collaborative (NINCo), and the National MyMedicare PHN Implementation Program.*

*This resource was developed with the support of WentWest, Western Sydney Primary Health Network (PHN).*

*We acknowledge that some resources used or referenced within this toolkit are from organisations including the Department of Health, Disability and Ageing (DOHDA), Services Australia, Royal Australian College of General Practitioners (RACGP); Best Practice; and Medical Director. These organisations retain copyright over their original work. Referencing of material is provided throughout.*




## Where to get help?


**Gold Coast Primary Health Network**
07 5635 2455
practicesupport@gcphn.com.au

# Navigating this toolkit

This toolkit includes practical, flexible activities that are **not sequential.** We recommend starting with **Section One – Practice Readiness** to assess your current state.
Use the links below and this icon to navigate directly to each activity section.

Click on the section of interest or scroll through.



Use the **Model for Improvement** and **Plan-Do-Study-Act (PDSA) cycles,** to test changes, drive progress, and embed high-quality chronic condition care aligned with **MyMedicare** and upcoming **MBS reforms.**

# Introduction

**From 1 July 2025, the most significant reforms to chronic disease management in over 20 years**

Major changes to the **MBS framework** for chronic disease management in primary care will come into effect. These changes implement the **recommendations** of the MBS Review Taskforce.

**Chronic conditions affect 61% of Australians**

15.4 million people, including nearly all aged 85+. As demand for connected, multidisciplinary care grows, chronic conditions are driving major pressure on individuals and the health system.

## Key changes

- A **single GP Chronic Condition Management Plan** (GPCCMP) replaces GPMP and TCA.
- All previous items (721, 723, 732, 92024–92028, etc.) **have ceased and replaced.**
- **Equalised fees** for preparation and review of plans ($156.55 for GPs)

## MBS CHANGE ITEM & FEE

| Service | GP Item Number | Fee | Replacing |
|---|---|---|---|
| Prepare plan - face-to-face | 965 | $156.55 | 721 and 723 |
| Prepare plan - video | 92029 | $156.55 | 92024 and 92025 |
| Review plan - face-to-face | 967 | $156.55 | 732 |
| Review plan - video | 92030 | $156.55 | 92028 |

## Other changes

- Patients with at least **one chronic or terminal condition** will be eligible.
- **Practice Nurses,** Aboriginal and Torres Strait Islander Health Practitioners, and Aboriginal Health Workers can now assist in preparing or reviewing a plan.
- A plan can be **prepared once every 12 months,** and **reviews can occur every 3 months.** A new plan each year is not required—existing plans can be reviewed.
- Domiciliary medication management reviews will require a new-style management plan from 1 July 2027.
- Multidisciplinary care plan items (e.g., for aged care) remain unchanged.
- Current plans remain valid during a **2-year transition period** until 30 June 2027.

## MyMedicare

- **Patients registered with MyMedicare** must have plans and reviews provided by their registered practice.
- Unregistered patients can continue to access plans and reviews through their usual GP.

## Referring to Allied Health

- **No need for two collaborating providers to initiate plan** anymore—this requirement has been removed.
- Referral letters will replace existing allied health referral forms.
- Patients must have had a **plan prepared or reviewed within the last 18 months** to access MBS-funded allied health services.


**Refer MBS guide for the frequently used items including Care Planning and incentives. This guide links item number to MBS criteria, descriptor and fact sheets.**

# Tools and Enablers

At GCPHN, we are investing in the best tools and enablers to help health professionals drive CQI. For user access, contact us **practicesupport@gcphn.com.au** or call 07 5612 5408.

| | |
|---|---|
| **Primary Sense** | Primary Sense supports extracting, analysing, and managing general practice data in a confidential and safe way, providing 'real time' reports and medication alerts. |
| **HealthPathways** | Developed by local GPs, specialists, nurses and allied health providers, **Gold Coast HealthPathways** supports health professionals by providing local, relevant information on managing medical conditions and referral options for their patients.<br>*A login is required.* |
| **Smart Referrals** | General practitioners using GP Smart Referrals can request non-urgent clinical advice from specialists and receive a response within 5 business days. This service is only available for patients within the Gold Coast Hospital and Health Service catchment. |
| **Heart Foundation Walking Groups** | The Heart Foundation Walking Groups are free and are effective in encouraging people to increase their physical activity which can help prevent and manage diabetes, cardiovascular, mental health and their weight.<br>**Join a walking group and make every step matter.** |
| **GP Support Tools** | General practitioners using GP Smart Referrals can request **non-urgent clinical advice** from specialists and receive a response within 5 business days. This service is only available for patients within the Gold Coast Hospital and Health Service catchment. |
| **Gold Coast Hospital and Health Service – GP Advice Line** | For services not yet available via the Request for Advice functionality in GP Smart Referrals, or if GP Smart Referrals is not accessible at your practice, general practitioners can request non-urgent clinical advice from the **GP Liaison Unit's GP Advice Line**. Contact via: Phone 1300-004-242 (option 3) or email GCGPLU@health.qld.gov.au. Please ensure you de-identify patient information if sending by email. Only provide the initials of your patient's name and date of birth. Available Monday to Friday, 8am to 4pm. |
| **Mental Health Funded Services** | Gold Coast Primary Health Network commissions a range of primary care and mental health, alcohol and other drugs and suicide prevention services to meet the diverse and growing needs of the Gold Coast region. Our commissioned services are available at no cost to patients. Alternatively, **Initial Assessment and Referral (IAR)** levels support easy referral pathways. |

# Module 1

## Leadership - Preparing your practice

**On completion of this module, you will:**

- Evaluate your practice's readiness to implement MyMedicare and Chronic Condition Management
- Engage the entire practice leadership team to confirm MyMedicare registration status and ensure readiness for the transition

**Activity Navigation**


1.1 Practice Readiness Checklist
1.2 Preparing for CCM QI in action
1.3 Communication Action Plan
1.4 Practice Change (QI) Plan
1.5 Practice Meeting template

# MyMedicare and Chronic Conditions Management (CCM) Foundations

**MyMedicare** is a Voluntary Patient Registration (VPR) model that connects patients with their preferred general practice and care team to promote continuity and comprehensive care.

By choosing a MyMedicare practice, patients formalise where GPCCMP MBS items can be accessed. This connection strengthens relationships and ensures proactive care planning for long-term conditions.

**Eligible Patients registered with MyMedicare can only access GP Chronic Condition Management Plan services (face-to-face or telehealth) at their MyMedicare registered practice location, delivered by any eligible provider (including GP registrars) there, not other practices or locations.**

**Chronic Conditions MBS items** support primary care providers to develop plans and continue to actively manage, monitor, and coordinate ongoing care with other providers working as a multidisciplinary team, for patients diagnosed with a chronic condition that is expected to impact their health for longer than 6 months.

GPCCMP items also support access to allied health and other services for patients that would benefit from multidisciplinary team care to manage their chronic condition.

For more information, refer to the **Services Australia Fact Sheet – Overview of MBS Changes**

## MyMedicare Practice Registration

- Link your organisation in **PRODA** to **HPOS**
- Access the **Organisation Register** in **HPOS** to register your practice and link your eligible health care providers
- Add MyMedicare to 'My Programs' in HPOS
- Ensure practice staff have appropriate delegations to access MyMedicare on HPOS

**Learn more:**

- **Service Australia's MyMedicare**

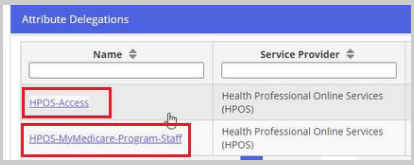
## Practice Resources

- **CDM Changes – Overview**
- **CDM Changes – Transition Arrangements**
- **CDM Changes – Referral Arrangements**
- **CDM Changes – GPCCMP MBS Items**
- **CDM Changes – Allied Health Providers**
- **CDM Changes – Practice nurse, Aboriginal**
- **Health workers and ATSI Health Practitioners**
- **MyMedicare - Service Australia e-learning**
- **RACGP summary of CCM changes**
- **MyMedicare - Translated resources**
- **MyMedicare - GP Communication Toolkit**
- **MyMedicare - Practices and providers**
- **Chronic Condition Management Items Gold Coast Health Pathways**
- **RACGP - Chronic disease**
- **RACGP – Preventive Activities (the Red Book)**

## 1.1 Pre-Activity – Practice Readiness Checklist

Before commencing your activity, evaluate your **practice's readiness to implement MyMedicare and CCM.** Engage your leadership team to confirm registration status and ensure a smooth transition.

| Step 1 | Actions | Assigned to |
|---|---|---|
| Plan the transition | ☐ Nominate a **CCM change lead** and team | |
| | ☐ Document the **change** plan, timeline, patient registers, and team responsibilities<br>*Need help? Contact your* **Gold Coast PHC Engagement Officer** | |
| | ☐ Meet with the team, define team roles, responsibilities, and timelines | |
| | ☐ Conduct **data cleansing and archive** inactive records | |
| | ☐ Set up a shared folder for documentation (e.g. Teams/Google Drive) | |
| | ☐ Coordinate audits and maintain up-to-date patient registers (**Use GCPHN Data Cleansing Toolkit**) | |
| | ☐ Schedule regular team meetings to track progress | |

| Step 2 | Actions | Assigned to |
|---|---|---|
| System & Resource Setup | ☐ Register practice and providers in **PRODA** | |
| | ☐ Assign team in **PRODA organisation account delegations and permissions**   | |
| | ☐ Add MyMedicare to 'My Programs' in **HPOS** | |
| | ☐ Update **workflows,** templates, and policies (if needed) | |
| | ☐ Allocate team time for updates and training | |
| | ☐ Audit existing CDM resources and store centrally for ease of access | |

| Step 3 | Actions | Assigned to |
|---|---|---|
| Prepare your team | ☐ Train the team in MyMedicare **benefits, registration** and **CCM changes** | |
| | ☐ Define roles and workflows (use the **Swim Lane template**) | |
| | ☐ Allocate protected time for each team member's transition role | |
| | ☐ Provide regular updates to the team via internal communication | |
| | ☐ Refer clinicians to **HealthPathways** for the latest guidelines and referral pathways | |
| | ☐ Brief Allied Health providers on upcoming changes (refer to **Referral Arrangements for Allied Health Services**) | |

| Step 4 | Actions | Assigned to |
|---|---|---|
| Patient Engagement & Registration | ☐ Use MyMedicare Communication kit (brochures, posters, videos, website & social media) | |
| | ☐ Ensure reception staff register patients opportunistically and **invite others** (SMS, email, or in-person) | |
| | ☐ Communicate the shift from CDM to CCM to patients | |
| | ☐ Assist patients with **form completion** or digital registration | |
| | ☐ Confirm who will add/invite patients to MyMedicare via PRODA. Make sure to enable **'Auto Accept'** for registrations in MyMedicare Preferences via PRODA. | |
| | ☐ Regularly import registered patient lists into your CMS refer to guides **Best Practice** **Medical Director** **Cubiko** | |
| | ☐ Monitor de-registrations via HPOS – refer activity **Management registration via HPOS** | |

| Step 5 | Actions | Assigned to |
|---|---|---|
| Patient Identification & Recall | ☐ Use Primary Sense Patients with High Complexity 5 & 4 Report to identify eligible patients. | |
| | ☐ Offer GPCCMP plans opportunistically (during consults, HA's, immunisations) | |
| | ☐ Recall existing CDM patients to update them to GPCCMP | |
| | ☐ Support clinicians with referrals, scripts, and bookings | |
| | ☐ Set **automated reminders** (BP/MD, Hotdoc, AutoMed, Healthengine) | |
| | ☐ Establish / review your process for booking reviews & managing missed appointments | |

| Step 6 | Actions | Assigned to |
|---|---|---|
| Monitor, Reflect, and Celebrate | ☐ Use **QI tools to track** CCM transition activities (e.g., PDSAs, data reviews) | |
| | ☐ Monitor registration targets and plan review timelines | |
| | ☐ Regularly review and update all documentation | |
| | ☐ Review your video telehealth setup for MyMedicare (consider using -create a **Healthdirect** account or **login**) | |
| | ☐ Celebrate milestones and successes with your team | |

*Adapted from: Brisbane North PHN and West Vic PHN*

# CALL TO ACTION

Do a PDSA - Team awareness, desire and readiness

The infographic below depicts an example of management planning for a chronic condition patient. Review appointments as clinically relevant support ongoing patient engagement and care continuity.

## CCM Management Plan Review example

**Aims of chronic condition management plans are to provide a framework for personalised, coordinated care that empowers individuals to better self-manage their chronic conditions. Delivery of care should be underpinned by principles of dignity, respect and compassion.**


**Initial Chronic Condition Management Plan.**

Provide updated copy to all care team members and the patient.

Review of management plan **as clinically relevant** up to every 3 months.

**Reasons for review appointments could include:**

- support the patient to understand and self-manage their chronic condition
- monitor symptoms and health,
- review and update medications,
- plan, conduct and review tests and screening
- update treatment plans in response to changes to patient needs, treatment options and evidence.

## 1.2 Activity - Preparing your practice for CCM QI Action

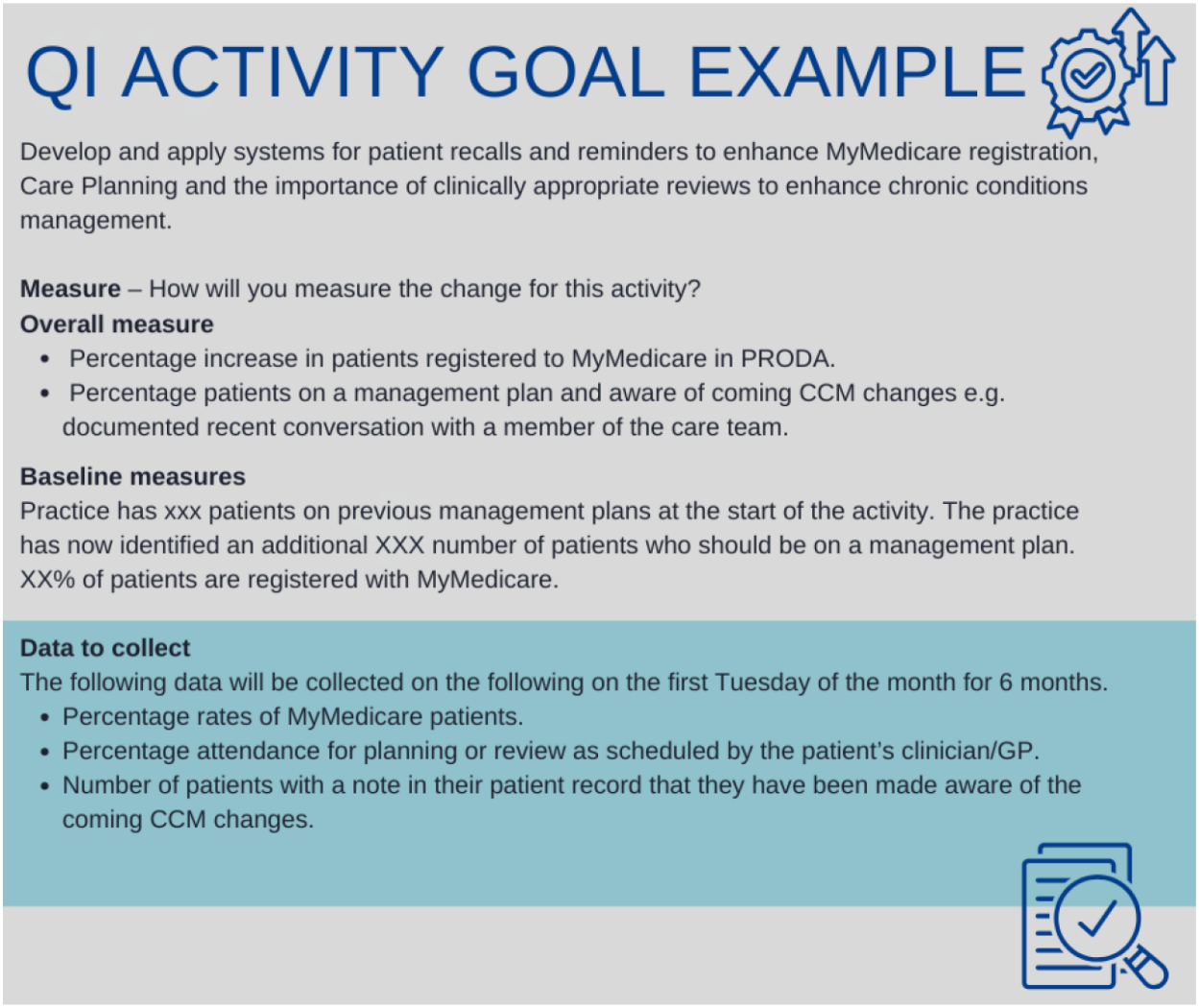
A systematic approach to defining team roles, engaging patients, and quality improvement is necessary for successful Chronic Condition Management (CCM).

Every successful Quality Improvement starts with setting clear goals, underpinned by data and requires ongoing measurement and cycles of new activity in response to your findings. This process engages your primary health care team in assessing progress and tracking if change(s) are leading to an improvement.

Demonstrating the impact of your team's QI actions is essential to maintaining engagement, momentum and building a culture of celebrating success!

It is best to measure at the beginning of the activity (baseline) and then at regular intervals. Use the **Model for Improvement (MFI) framework** to methodically work through identifying a clear problem, and to explore solutions and take action.

The QI Activity Goal below is an example of a clear goal for Chronic Conditions Management and MyMedicare you could adapt to your practice.



# 1.3 Activity – Communication Action Plan

Practice name:

| QI focus area | Why improve this focus area? | QI ideas "What" of the action plan | Resources |
|---|---|---|---|
| **MyMedicare Patient Registration**<br><br>***To increase patient registration for MyMedicare for our General Practice*** | **What are the benefits of undertaking activities in this area?**<br><br>• Opportunity to formalise, establish or enhance our relationship for ongoing coordinated care with patients<br>• To prepare for Chronic Conditions Management (CCM) MBS item changes<br>• To prepare for changes to Better Access Mental Health Treatment Plans | **What ideas can we explore?**<br><br>**Tips for engaging patients:**<br>• Encourage registration as they present to the practice or attend appointments including patient who have:<br>  • attended the practice twice in 24 months<br>  • attend the practice for ongoing care management (e.g. Chronic Disease Management Plans, Mental Health Treatment Plans, Health Assessments and Health Checks)<br><br>**Communication approaches/ideas**<br>• Posters or flyers - waiting room and reception<br>• Website and/or social media<br>• Targeted identification - Search and tag patient records for action when they present or contact the practice<br>• Encourage patients to register through Medicare Online Account<br>• Conversations at appointments including reminder cards, information in clinic rooms.<br>• SMS or email campaign<br>• MyMedicare patient forms offered to patients (notepaper forms submitted through PRODA require additional staff time required to process)<br>• Poster documenting your unique MyMedicare value or key messages | **Clinic resources**<br><br>1. MyMedicare GP Toolkit (includes posters, social tiles, flyers, etc)<br>2. MyMedicare Videos<br>3. Introducing MyMedicare – Fact sheet<br>4. Registering in MyMedicare – Fact sheet<br>5. MyMedicare practice registration – Frequently asked questions<br>6. Registering patients with MyMedicare – Systems overview for practices and providers<br>7. MyMedicare Program Guidelines<br>8. About MyMedicare for health professionals |

# 1.4 Activity – Practice Change (QI) Plan

*Please complete the following table to outline your plan to complete the goal.*

| | | | | |
|---|---|---|---|---|
| Engaged Leadership | **Goal** | **Improve chronic condition management by focusing on MyMedicare registration in *[insert time frame]* from ##% (*## patients*) to ##% (*## patients*) by DD/MM/YYYY.** | | |
| | **Measure/s** | • number of patients MyMedicare registered<br>• number of patients on the chronic conditions register<br>• number of management plans/reviews billed<br>• number of appointments (missed, rebooked) | **Search criteria** | |
| | **QI Lead and Team** | Who will need to be involved? | **Period** | Start date - end date |

| | **Actions** *Tip: Use PDSA cycles to test change ideas* | **Activity** | **Resources** | **Who** | **Period** | **Update** |
|---|---|---|---|---|---|---|
| Data-Driven Improvement | Conduct **data cleansing** to identify and verify patients with MyMedicare status and chronic conditions. | | • Data Cleansing Toolkit | | Start date - end date | Allocated a usual care provider to patients |
| | **Identify your MyMedicare and CCM patients** using Primary Sense and document baseline data | | • Primary Sense | | | |
| Patient Registration | **Find eligible patients that are due for management plan/ review** | | • Primary Sense | | | |
| | Ensure **recall and reminder system** is established for MyMedicare and CCM patients | | • BP Reminder<br>• MD Recalls | | | |
| | **Educate patients** on CCM management plan and review benefits | | | | | |
| | **Communicate and promote** MyMedicare and CCM | | | | | |
| Team-Based Care | Identify **roles and responsibilities** | | | | | |
| | **Map workflows** and upskill team in MyMedicare and CCM | | | | | |
| | Assign a nurse or admin staff to **track and rebook missed appointment** | | | | | |
| | Train clinical staff to enter **coded diagnoses** (no free text) | | | | | |
| | Ensure staff can access **HealthPathways** for the latest chronic conditions assessment, management and referral information | | • Gold Coast HealthPathways | | | |
| | Create **patient-centred goals** with more frequent reviews | | | | | |

| | | |
|---|---|---|
| Reflection | **Outcomes Summary** | As a team, what did you learn? What changes would you make to your practice as a result? |
| | | **RACGP CPD Tip:** utilise the self-reporting feature on Quick Log **mycpd.racgp.org.au** to document reflection. |

# 1.5 Activity – Practice Meeting template

The most common way for practices to build teamwork is to schedule regular meetings where all members of the practice team are encouraged to contribute to discussions. It is a good idea to keep minutes of the meetings and to document the decisions made at team meetings and the names of those responsible for implementing related actions.

A Practice Meeting needs between 2-25 participants (GPs, practice staff and other health professionals) with each meeting lasting at least 30mins, in order to meet CPD activity requirements.

## < Practice Meeting Title>

***Please note:***

- *(C0.0▸C, QI0.0A) is RACGP Standards for General Practices – 5th edition indicator*
- *RACGP CPD type: Educational Activities (EA), Reviewing Performance (RP), Measuring Outcomes (MO)*

| **PRACTICE** | | **Date:** | |
|---|---|---|---|
| **CHAIR (GP/Practice Lead)** | | **Time:** | |
| **Participant names** | | | |
| **Agenda/ Topics** | **Actions/ Summary** – Example | **CPD Type / Duration** | |
| **1. Quality Improvement *(QI1.1 ▸B,C,D)*** | • *This can include updates on QI projects such as MyMedicare,* ***Chronic Condition Management (CCM) change*** *ideas, coming together to discuss changing current processes to improve data, staff feedback on anything relating to the practice.*<br>• *Making quality improvements to the practice's structures, systems and clinical care that are based on the practice's information and data will lead to improvements in patient safety and care.*<br>*Quality Improvement includes:*<br>• *Patient health records quality*<br>• *MyMedicare/CCM project changes to the day-to-day operations of the practice, such as – scheduling of appointments – normal opening hours – record-keeping practices – how patient complaints are handled – systems and processes*<br>• *Responding to feedback or complaints from patients, carers or other relevant parties*<br>• *Responding to feedback from members of the practice team*<br>• *Auditing clinical databases*<br>• *Analysing near misses and errors*<br>• *Practices –what QI is being implemented across the practice*<br>***MyMedicare Practice Registration:***<br>• *MyMedicare practice registration checklist* ***here.***<br>• *Adding GPs as providers to the Organisation Register in PRODA* ***here.***<br>• *Providing practice staff with relevant delegations to view and manage patient registration* ***here.***<br>• *Educating non-clinical staff on the steps involved in patient registration with your practice and preferred GP* ***here.***<br>***MyMedicare Patient Registration:***<br>• *Patient facing resources to formalise the relationship between patient, general practice, and preferred GP* ***here.***<br>• *Patient eligibility and methods of registration* ***here.***<br>• *MyMedicare Patient Registration Form* ***here.***<br>***MyMedicare and CCM Examples meeting resources:***<br>• *Patient registration benefits* ***here.***<br>• *MyMedicare General Practice Communication Toolkit* ***here.***<br>• *CCM MBS item changes – Overview here.* | RP 30mins | |

| | | |
|---|---|---|
| | • *CCM MBS item changes – Transition Arrangements for Existing Patients* ***here.***<br>• *CCM MBS item changes – Referral Arrangements for Allied Health Services* ***here.***<br>• *CCM MBS item changes – MBS Items for GP Chronic Condition Management Plans* ***here.*** | RP 30mins |
| **2. Risk management including Clinical Risk** ***(C3.1 ▸C, QI3.1A)*** | *Have any staff identified any risks in the practice that should be addressed? If mentioned here, they should be placed in the risk register and addressed.*<br>*Examples:*<br>• *Poor record keeping*<br>• *IT system failures*<br>• *Inadequate systems for updating patients' contact details and following up test results*<br>• *Workplace health and safety incidents, as a result of equipment that is not maintained in accordance with the manufacturer's recommendations*<br>• *Inadequate number of practice staff working during busy times*<br>• *Conflicts of interest/ethical dilemmas*<br>• *Updates to or breaches of the IT security system.* | |
| **3. Patient Feedback** *(QI1.2 ▸B)* | *Depending if the practice collects feedback once every three years or on a continual basis will guide this agenda item. Either way this is a good time to address patient feedback and possibly ask the team if they have any solutions.* | |
| **4. WHS** ***(C3.5 ▸A)*** | *Raising issues about the health and safety of the team. For example, are duress alarms required, how to deal with an aggressive patient.* | |
| **5. Clinical Care of patient's** ***(C5.1 ▸A,B)*** | • *When clinical teams discuss clinical care, they must refer to and consider the best available evidence, to ensure their clinical care aligns with best practice. In some instances, 'best practice' may involve doing more than adhering to current clinical guidelines. Each team meeting there could be a new clinical topic, such as referral for a colonoscopy where patient symptomatic and urgency of referral are discussed*<br>• *Specific patient cases can also be discussed at team meetings if patient confidentiality is maintained.* | |
| **6. Other** | • *Ethical dilemmas- These are then to be entered into an ethical dilemma log and the patient's files- C2.1 ▸E*<br>• *Administrative matters- C3.4 ▸A*<br>• *Infection control updates including changes to guidelines and laws.*<br>• *An opportunity to announce local outbreaks and public health alerts - GP4.1 ▸A* | |

# Module 2

## Patient Registration & Engagement

**On completion of this module, you will:**

- Enhance communication strategies to boost patient participation in MyMedicare and CCM.
- Develop effective systems for timely care plan review reminder
- Design resources that educate and encourage active involvement in care planning and review

**Activity Navigation**

## Person-centred care is the foundation of both CCM and MyMedicare

At the heart of both **MyMedicare** and Chronic Conditions Management (CCM) is person centred care — healthcare that aligns with each patient's unique values, needs, and life goals. This approach strengthens engagement, supports continuity, and leads to better health outcomes. Core principles include:

1. Dignity
2. Compassion
3. Coordinated
4. Personalised Care
5. Empowerment for Self-Management

**This often begins by asking *"What matters to you?"* rather than *"What is the matter with you?"* to better understand and incorporate the patient's life goals into care planning. It fosters greater patient engagement in the care planning process and supports tailored, meaningful care.**

Both initiatives promote active patient participation and shared decision-making, moving away from one-size-fits-all models to deliver care that is truly tailored to the individual.

### MyMedicare Practice Registration

1. Medicare online - MyGov Account
2. Paper registration form, submitted in person at our practice. You can pre-fill MyMedicare forms - Refer to Activity

**Tip:** Enable 'Auto Accept' for patient registrations in MyMedicare Preferences via PRODA and pre-fill

**Learn more:**

- Managing MyMedicare registrations – eLearning
- Our MyMedicare Patient Registration Guide
- Our MyMedicare One Page Patient Guide

### Practice Resources

- MyMedicare - DL Brochure
- MyMedicare - Easy Read Brochure
- MyMedicare - Poster 1
- MyMedicare - Poster 2
- MyMedicare - Poster First Nations
- MyMedicare - Community Information kit
- Introducing MyMedicare Video
- Registering in MyMedicare Video
- MyMedicare - Social Media Tile

## 2.1 Activity – Reminders, Registration and Flagging

This activity helps practices implement or enhance reminder and recall systems to improve MyMedicare registration, support care planning, and ensure timely reviews for patients with chronic conditions. By leveraging your clinical software, you can:

- Proactively identify and flag eligible patients
- Pre-fill MyMedicare registration forms (RTF) for individual patients or bulk print them using mail merge
- Automate communication and reminders
- Improve data accuracy and patient engagement

**Patients can then register using these pre-filled paper forms or via the Medicare Online Account**

This enables smoother registration, better continuity of care, and future-ready MBS claiming.

The following steps and screenshots show how to register and flag patients in Best Practice, Medical Director, and My Health Record.

### Software-Based Instructions

#### Best Practice (BP)

BP Spectra will compass all CCM changes including database searches, printable **guides** and **desktop foldout** resources.

- Use **MyMedicare Awareness and BP Comms** to reach eligible patients
- Use **BP database queries to identify eligible patients**
- Tools:
  - **Reminder**
  - **Actions**
  - **Mail merge**
  - **SMS reminders**

**BP MyMedicare** | **bpsoftware.net**
1300 40 1111

#### Medical Director (MD) and Pracsoft

- Use Telstra Health Smart Visual Dashboards to identify eligible patients, Track MyMedicare registrations, Send SMS reminders.
- Tools:
  - **Reminder**
  - **Actions**
  - **Mail merge**
  - **SMS reminders**

**MD MyMedicare** | **medicaldirector.com**
1300 300 161

#### Cubiko (for BP/MD users)

- **GPCCMP home**
  - **Cubiko Insights:** GPCCMP metrics and forecasting dashboard
  - **Cubiko Insights:** CCM Preparation: Actionable metrics My Dashboard
- **Resource pack** including staff room poster, patient handout, flyer and printouts
- **Identify and flag MyMedicare eligible patients**
- **Export/import CSV lists** for targeted outreach

**Cubiko Knowledgebase**
1300 CUBIKO

#### Other Reminder Systems

The following platforms can also be used independently or in conjunction with your clinical software to manage patient recalls and reminders:

- **Pracsoft**
- **Hotdoc**
- **Healthengine**
- **AutoMed**

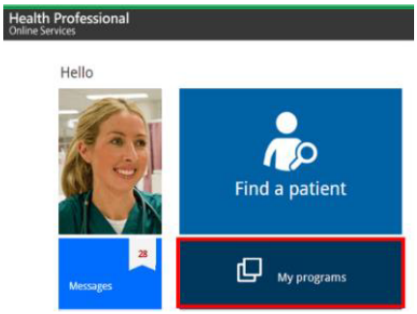
*Note: GCPHN does not provide software licensing for these systems.*

## 2.1.1 Management registration via HPOS

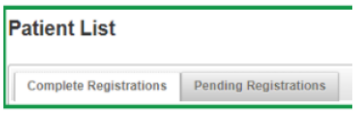
To support your team, access **the Services Australia MyMedicare eLearning modules** for **MyMedicare overview** and **Managing patient registration.**

### Accessing the Patient List in HPOS >MyMedicare program

1. Log in to **PRODA** to use HPOS → Select the organisation to act on behalf of.
2. Got to **My Programs → MyMedicare**
3. Go to **Patient List**

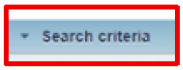


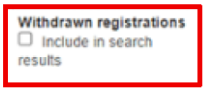






### Viewing Withdrawn or De-registered Patients




4. In the Patient List, use the **Search Criteria** filters.
5. Tick **"Withdrawn registrations"** to include de-registered patients.
6. Look under the **"Date Withdrawn"** column to see when deregistration occurred.

| Date Registered | Date Withdrawn | Initiated By |
|---|---|---|
| 10/10/2023 | 19/05/2025 | Patient |
| 16/10/2023 | 14/05/2025 | Practice |

### Exporting Patient Records

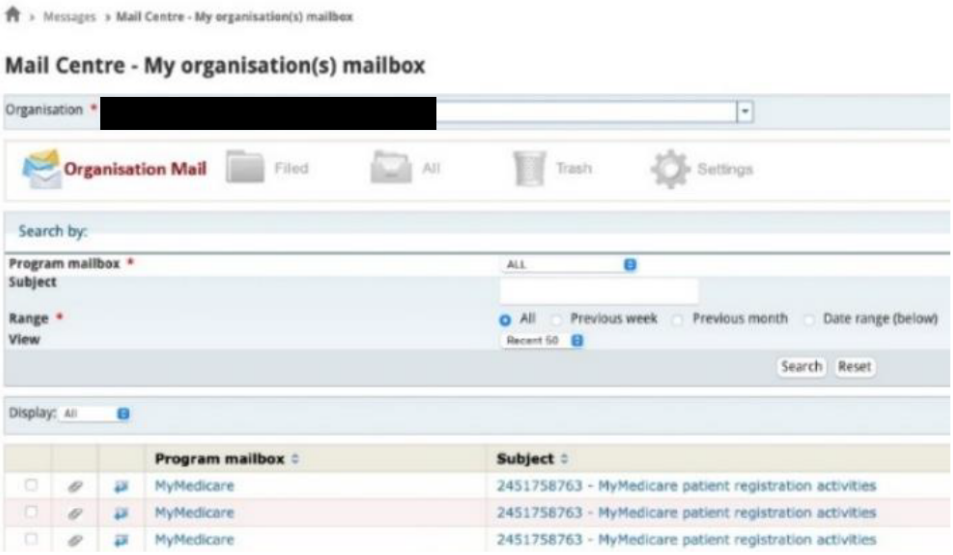
7. Click **Export Complete Registrations List** to download both Complete and Pending lists). Use this list to track deregistered patients and take follow-up action

| MyMedicare patient registation activities | | | | | |
|---|---|---|---|---|---|
| Run Date/Time: 04/06/2025 04:03:03 | | | | | |
| | | | | | |
| Notes: | | | | | |
| This list may contain registrations waiting to be accepted or declined by the practice. | | | | | |
| | | | | | |
| Activity | Activity Date/Time | Decline Reason | Date Cancelled | Date Withdrawn | Withdrawal Reason |
| Complete Registration Created | 03/06/2025 14:21:56 | | | | |
| Complete Registration Created | 03/06/2025 14:25:13 | | | | |
| Preferred GP Amended | 03/06/2025 14:26:21 | | | | |
| Complete Registration Created | 03/06/2025 14:29:20 | | | | |
| Withdrawal Date Added | 03/06/2025 14:52:51 | | | 02/06/2025 | Another practice registered patient |

## Accessing the Patient List in HPOS >MyMedicare program

1. Log in to **PRODA** to use HPOS → Select the organisation to act on behalf of.
2. Go to **Messages → My organisation(s) mailbox.**
3. Select **Settings** → Choose your **email** and **notification frequency** (immediate, daily, weekly)
4. Click **Submit.**

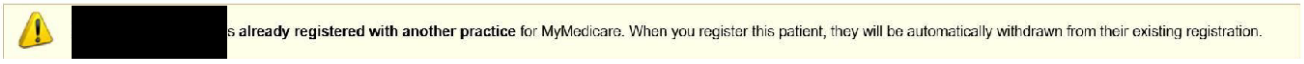
***Here's an example of MyMedicare Patient registration activities***




## Individual patient

1. Log in to **PRODA** to use HPOS → Select the organisation to act on behalf of → **My Programs → MyMedicare**
2. Go to Register a patient → Find a patient
3. Then **Enter details**: Medicare/DVA CARD number, IRN, First name, DOB → tick declaration → click **Find**
4. Select **patient → Register for MyMedicare**
5. Choose: **Practice** (Organisation site) → **Preferred GP**
6. Select **Confirm eligibility** (auto or select reason)
7. Select **Review details** → tick declaration → click **Confirm**
8. For pending registration: choose "Pending" instead of "Complete" on step 4.

***If the patient is registered with another practice, this message will appear:***



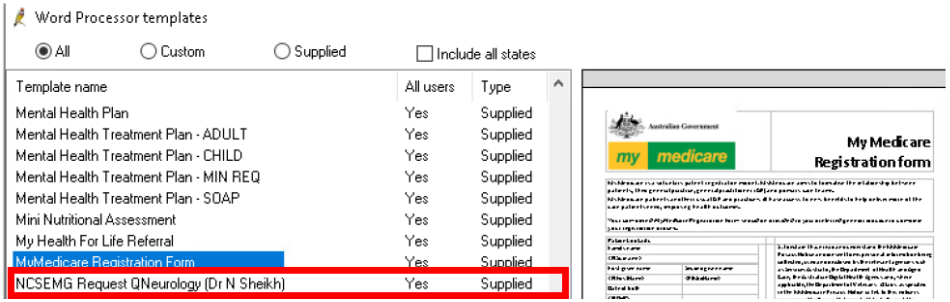
## 2.1.2 Best Practice – CCM, MyMedicare Registration and flagging

**For the latest updates, visit BP Premier Spectra including MyMedicare Medicare Web services (enrolment management and registration check)new templates (GPCCMP and CCMP AHP referral), appointment types, SQL queries and Co-billing logic.**

### MyMedicare Registration Form via Letter writer

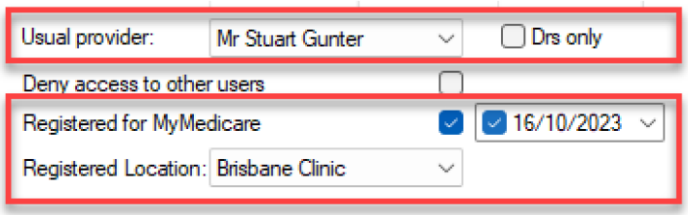
Letter writer (RTF format) will **auto-populate with patient details** ready for patient to provide sign consent.

File → New Letter (F4) → Templates → Use Template → Open




### Individual Patient Registration

File → Open Patient → View → Patient/F2 → View details → Complete the fields listed below → Save

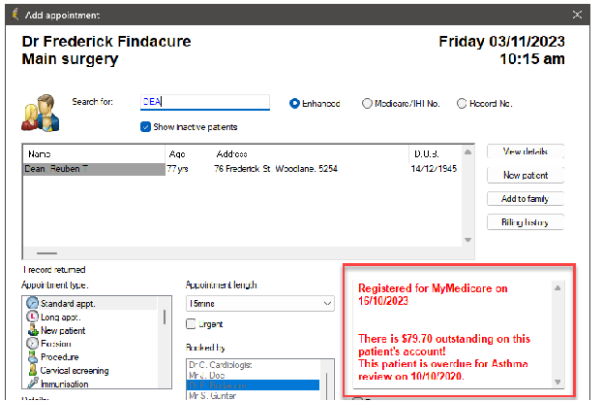



### Flagging MyMedicare registered status

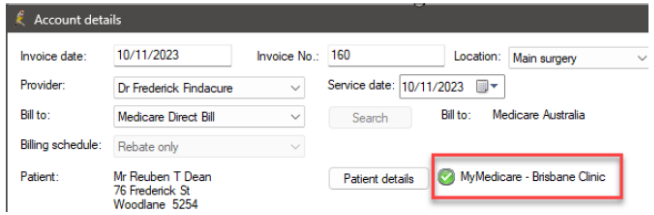
MyMedicare Registered status will be displayed on:

**Patient Record**


**Appointment book**




**Invoices**



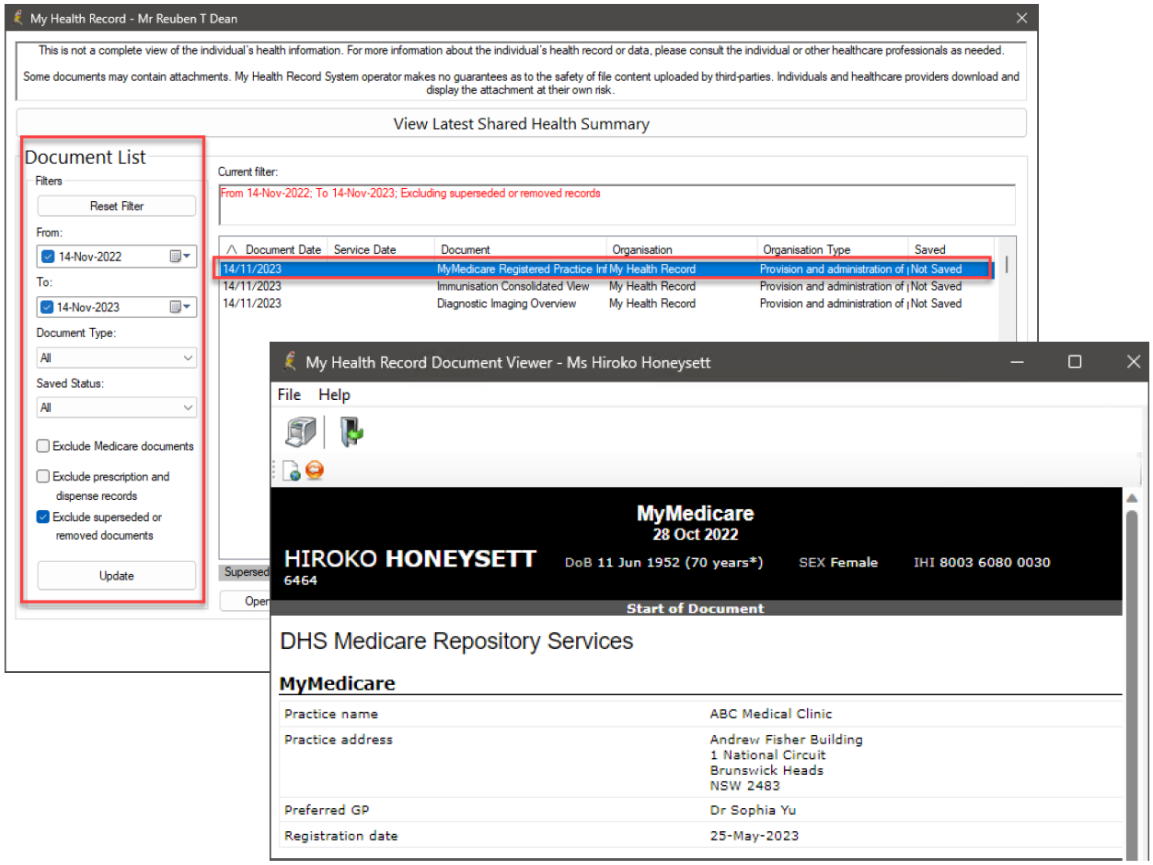

**CALL TO ACTION**

**Bulk import option of MyMedicare: Download exported registration list from HPOS for patient registration status and import list using BP Premier Reporting Tool**

## 2.1.3 Best Practice - My Health Record and MyMedicare Registration

**Retrieve MyMedicare Documents from My Health Record.** MyMedicare information is sourced from Medicare systems operated by Services Australia and includes the patient's Registration date, Practice Name, Practice Address, and preferred GP name, if supplied.

File ⟶ Open Patient, View ⟶ Patient/F2 ⟶ My Health Record ⟶ View Document List ⟶ Filters ⟶ untick the Exclude Medicare documents and Exclude prescription and dispense records ⟶ Update ⟶ select MyMedicare Registered Practice information document ⟶ Open




**To access My Health Record, your staff**

- **must have an *HPI-I* (identifies individual healthcare providers) To obtained via AHPRA account or by calling 1300 419 495, while non-AHPRA staff can apply through HPOS.**
- ***Set User permissions*: Best Practice main screen > Setup > Users > select employee > Edit > Set Permissions > scroll to My Health Record Access > Select 'Allowed' > Save.**


**Please note the My Health Record participation obligations and Security and Access policies – Rule 42 guidance.**

**CALL TO ACTION**

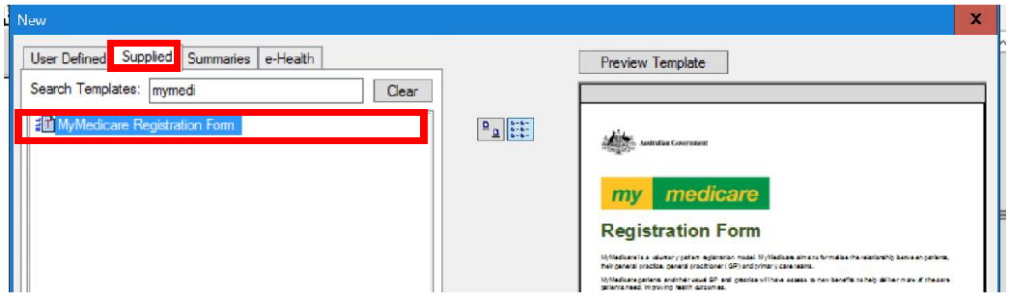
**Save a Document to a Patient Record Please note patent preference to save this document - See Understanding confidentiality and patient notes for more information.**

## 2.1.4 Medical Director – MyMedicare Registration and flagging

### MyMedicare Registration Form via Letter writer

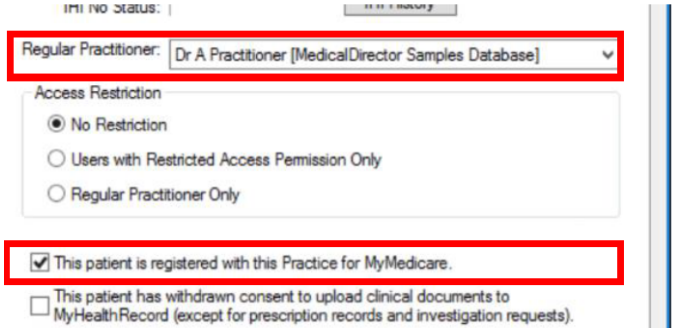
Letter writer (RTF format) will **auto-populate with patient details** ready for patient to provide sign consent.

Patient File → Tools → Letter Writer (F8) or  File → New → Ok




### Individual Patient Registration

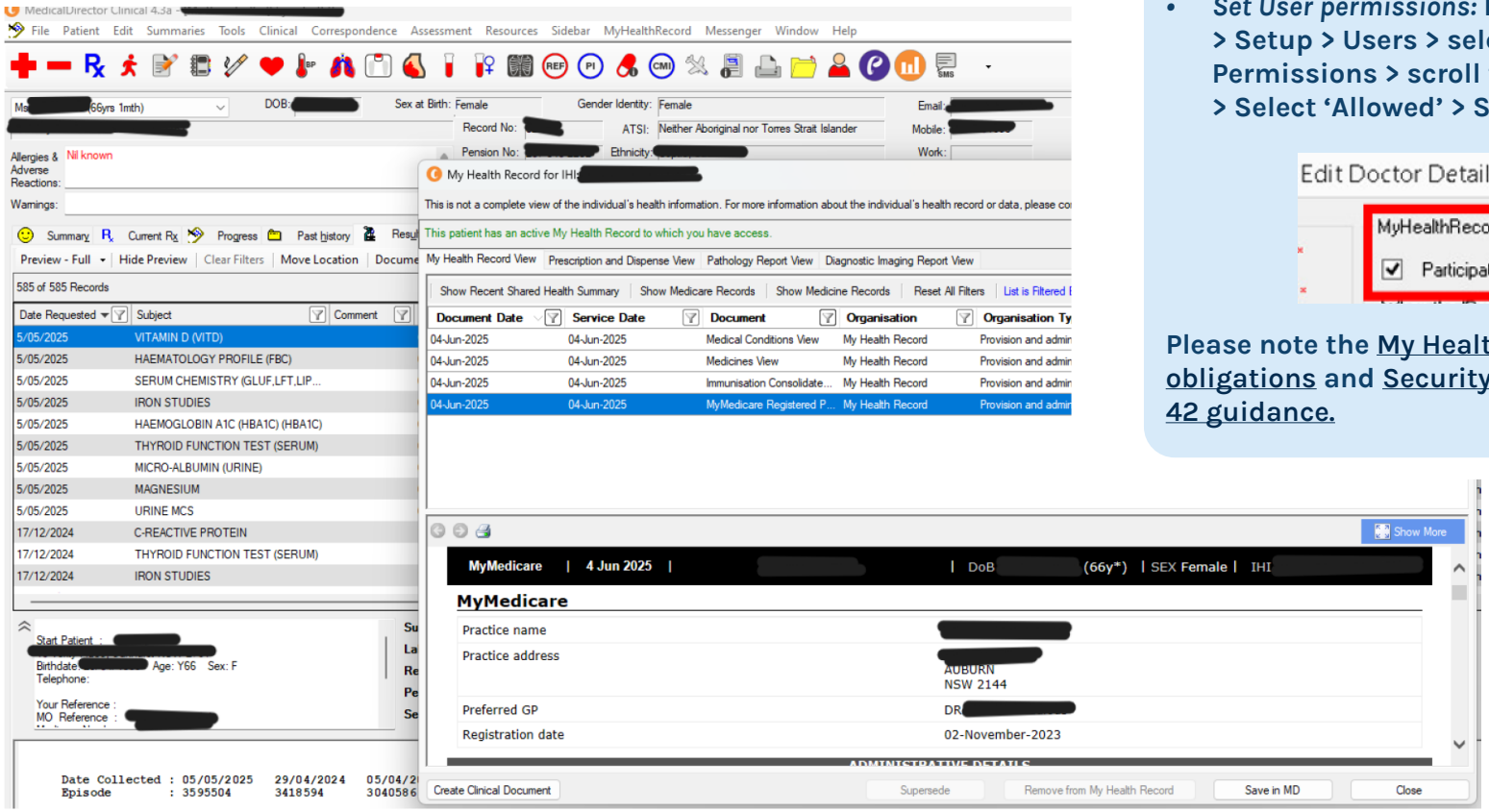
File → Open Patient → View details → tick "This patient is registered with this Practice for MyMedicare" → select Preferred GP = "Regular Practitioner" → Save



## 2.1.5 Medical Director - My Health Record and MyMedicare Registration

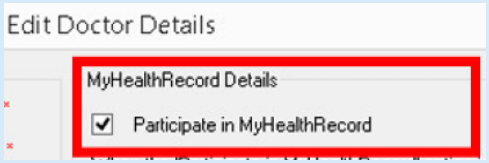
**Retrieve MyMedicare Documents from My Health Record.** MyMedicare information is sourced from Medicare systems operated by Services Australia and includes the patient's Registration date, Practice Name, Practice Address, and preferred GP name, if supplied.

Patient File → My Health Record (or view document list)




**To access My Health Record, your staff**

- **must have an *HPI-I* (identifies individual healthcare providers) To obtained via AHPRA account or by calling 1300 419 495, while non-AHPRA staff can apply through HPOS.**
- ***Set User permissions:* Best Practice main screen > Setup > Users > select employee > Edit > Set Permissions > scroll to My Health Record Access > Select 'Allowed' > Save.**




**Please note the My Health Record participation obligations and Security and Access policies – Rule 42 guidance.**

**CALL TO ACTION**

**Save a Document to a Patient Record Please note patent preference to save this document** ***- See Understanding confidentiality and patient notes for more information.***

## 2.2 Activity – Scripts: phone, SMS, email, and website

Please tailor scripts for **phone, SMS, email, and website** for staff to use when communicating with patients about **Chronic Condition Management Plans** and **MyMedicare.**

### Phone Script (Reception or Nurse Call)

Hi, this is [Your Name] from [Practice Name]. I'm just checking in about your ongoing care.

If you have a health condition that lasts six months or more, you may be eligible for a Care Plan. This supports your health with a clear plan, plus up to 5 subsidised visits per year to allied health providers like a physio or dietitian.

We also recommend registering for MyMedicare, which helps us provide more coordinated care. Would you like to book a longer appointment to get started or get more info?

### SMS Script

Hi [First Name], you may be eligible for a Care Plan and MyMedicare registration with your GP at [Practice Name].

This can support your ongoing care and give access to subsidised allied health visits.
Call [Phone] or book online: [Website]


**Keep it clear, professional, and actionable.**

### Email Script

Subject: **Care Plan & MyMedicare – Supporting Your Health**

Hi [First Name],
If you have a long-term health condition, you may benefit from a Care Plan at [Practice Name]. It helps you and your GP plan and manage your care, and may include up to 5 subsidised allied health visits per year.
We also recommend registering with MyMedicare to make sure your care is continuous and wellcoordinated.
A longer appointment is needed to set up your plan.
You'll check in with your GP every 3-6 months.
Reply to this email, call us on [Phone], or book online at [Website]

### Website Text (Info Page or Pop-up)

**Do you have a long-term health condition?**

We can help you manage it with a Care Plan at [Practice Name]. This includes:
o Your health goals
o How we'll support you
o Up to 5 Medicare-subsidised visits to allied health providers

We also recommend registering for MyMedicare, a free program that links you to us as your regular practice — for more coordinated care.
Longer appointments are needed to set up your plan
You'll check in with your GP every 3–6 months
Ask us today, or [Book Online Now]

**CALL TO ACTION**

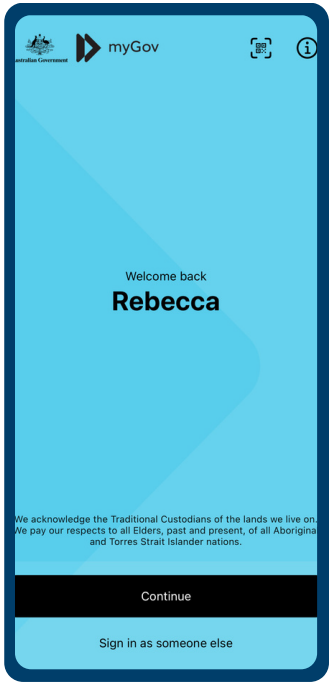
Do a PDSA - Reducing Missed Appointments for Care Plan reviews

# 2.3 Activity – How to check your MyMedicare registration

MyMedicare registration is voluntary. Patients are encouraged to register only with the practice they prefer to see for the management of their health, under the care of their chosen general practitioner.

The following steps can also be completed on the **MyMedicare Express Plus App**.

**Scan the QR code to sign in or create a MyGov account**




## Step 1

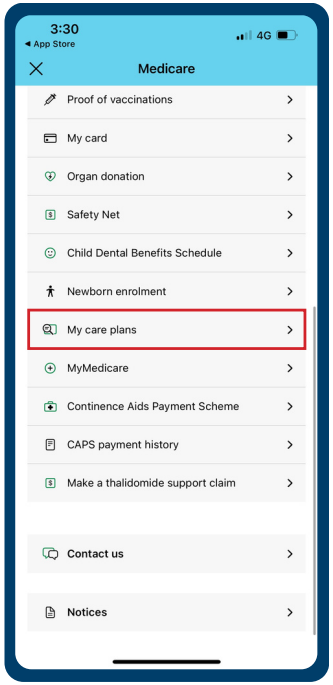
Open and sign into the myGov app on your phone

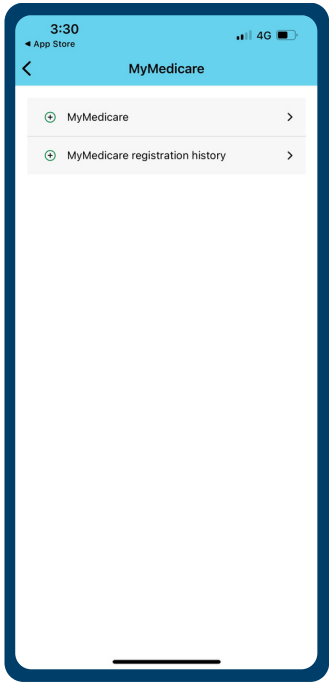

## Step 2

Click Services on the bottom right-hand side of the screen

Select Medicare

Scroll down to MyMedicare



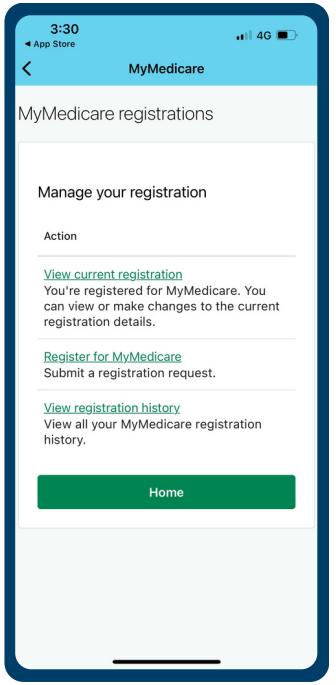

## Step 3

Select MyMedicare registration history

Click View current registration

## Step 4

To change your MyMedicare Registration to your preferred General Practice and Practitioner, click Register for MyMedicare and follow the prompts




***Patients can only register at one practice. Care planning items including GPCCMP can only be completed by the MyMedicare registered practice.***

# Module 3

## Data-Driven Improvement

**On completion of this module, you will:**

- Use Primary Sense – Mastering MyMedicare to drive proactive care. All activities in this module use Primary Sense clinical searches and recipes to help identify, segment, and manage cohorts of patients for MyMedicare registration and chronic condition management.
- Apply data-driven strategies to plan, implement, and review quality improvement (QI) activities.

### RACGP Clinical Audit


**Gold Coast offers a free, CPD-accredited Clinical Audit activity to help practices increase MyMedicare registration for patients with complex health needs. This supports proactive, data-informed care aligned with the 2025 CCM item changes.**

**CPD Outcomes**

Reviewing Performance (RP) — 4 hours

Measuring Outcomes (MO) — 6 hours

**Before You Begin**

- Ensure **Primary Sense** is installed on all desktops and all staff are trained on how to download and export reports.
- Clean your data using Primary Sense Data Cleansing (e.g. archive inactive records, remove duplicates).
- Standardise coding: ensure diagnoses are coded, not free text – use Primary Sense condition mapping.
- Filter by doctor, condition, or age to create a smaller patient list.

**Activity Navigation**

3.1 Activity – MyMedicare patients
3.2 Activity – Patients not registered with MyMedicare
3.3 Activity – All CCM Patients due for a care plan and reviews
3.4 Activity – Patients with a chronic condition eligible for care plan or review

**Track & Reflect**

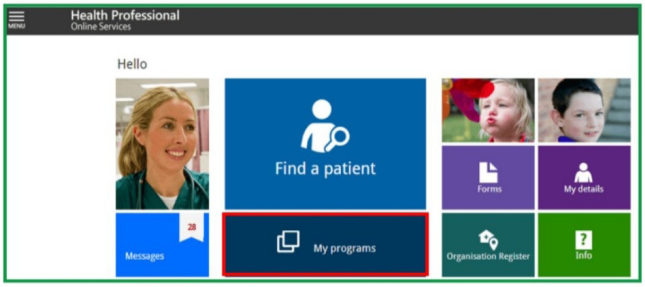
- Download the **audit worksheet** or run chart template
- Record your baseline and follow-up data
- Reflect with your team: What worked? What didn't?
- Completed QI documentation for CPD

## 3.1 Activity – MyMedicare patients

**Activity Goal:** Identify patients who are MyMedicare registered at your practice.

### Starting point

Log into HPOS → My programs → MyMedicare





### Export Complete Registration List

1. Under '**Patient Status**' tab → tick '**Registered with MyMedicare**'


2. Import patient list into your practice software

The Patient List is separated into two separate lists - **Complete Registrations** and **Pending Registrations**. You need to manage each Patient List separately. (Refer to each button to see further information about each list).

**Complete Registrations** | **Pending Registrations**

**Note**: Parent/Guardian item added to the **Registration initiated by** drop-down in the Search criteria area and the **Initiated By** search results column.

These items have been added to reflect the fact that parents/guardians can now register a child under 14 years of age via Medicare online services.

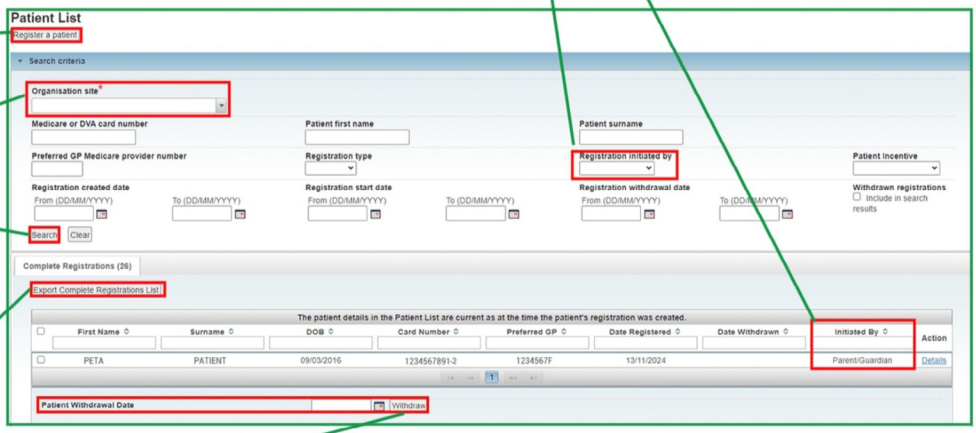
**Register a Patient** - will take you to the Find a patient in HPOS screen.

**Organisation site** - if the organisation has multiple sites, you must select which site you wish to view the Patient List by selecting the applicable practice from the Organisation Site drop-down box.

**Search** - the list allows you to locate a patient by using one or more of the below Search criteria fields.

To obtain a full list of Complete and Pending registrations, you can select **Search** without entering information into the Search criteria fields.

**Export Complete Registration List** - generates a spreadsheet with patient details based on which tab you are in (Complete or Pending).



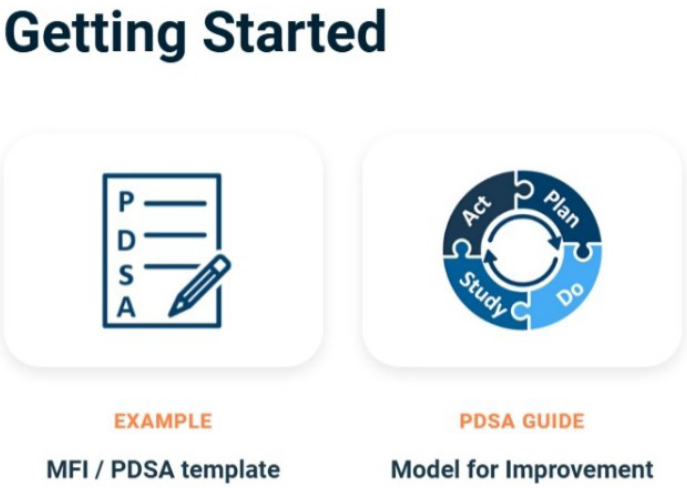

**Patient Withdrawal Date** - will allow you to withdraw one or more patients from MyMedicare.

## 3.2 Activity – Patients not registered with MyMedicare

🎯 **Activity Goal:** Identify patients who may be eligible for **Voluntary Patient Registration** at a general practice, based on having had at least two face-to-face visits in the past two years or who are active based on RACGP definition of 3 visits in the past 2 years. Optionally, exclude patients without a Medicare card.

**Starting point**
Log into Primary Sense → Reports → load '**Voluntary Patient Registration report**' → Export to Excel

**Complete a PDSA using the below templates**



## 3.3 Activity – All CCM Patients due for a care plan and reviews

**Please contact your Engagement Officer for further support - 07 5612 540 practicesupport@gcphn.com.au**

**Activity Goal:** Enhance care plan delivery for MyMedicare-enrolled patients managing chronic conditions.

**Starting point**

Log into Primary Sense → Reports → load '**Patients with High Complexity 5 & 4 report**' → Export to Excel

**Start your PDSA**

Download template.

| **AIM** | **1. What are we trying to accomplish?** | | |
|---|---|---|---|
| *By answering this question, you will develop your **GOAL** for improvement. It important to establish a S.M.A.R.T (Specific, Measurable, Achievable, Relevant, Time bound) and people-crafted aim that clearly states what you are trying to achieve.* | | | |
| **Our Family Medical aims to increase the proportion of RACGP active patients with high complexity (level 5 & 4) who are registered for MyMedicare from 10% to 50% by the end of March 2025** | | | |
| **MEASURE(S)** | **2. How will we know that a change is an improvement?** | | |
| *By answering this question, you will develop the **MEASURE(S)** you will use to track your overarching goal. Record and track your baseline measurement to allow for later comparison.*<br>*Tip: Use a Run Chart to plot trends.* | | | |
| **Outcome Measure:** % of active patients with high complexity (5 & 4) who are registered for MyMedicare<br>**Tool:** ***Patients with High Complexity Level 5 & 4*** Primary Sense report<br>**Frequency:** Monthly<br>**Numerator:** # of active patients with high complexity (level 5 & 4) registered in MyMedicare (A)<br>**Denominator:** # of active patients with high complexity (level 5 & 4) (B)<br><br>The proportion of active patients with high complexity (level 5 & 4) registered in MyMedicare (A divided by B) | | | |
| **Baseline:** | 10% of active patients with high complexity (5&4) are registered in MyMedicare | **Baseline date:** | 03/02/2025 |
| **CHANGE IDEAS** | **3. What changes can we make that will result in improvement?** | | |
| *By answering this question, you will develop **IDEAS** for change.*<br>*Tip: Engage the whole team in formulating change ideas using tools such as brainstorming, driver diagrams or process mapping. Include any predictions and measure their effect quickly.* | | | |
| **Idea 1** | Identify active patients with high complexity (5 & 4) who are not registered in MyMedicare. | | |
| **Idea 2** | Recall active patients with high complexity (5&4) who are not registered in MyMedicare and due for a care plan. | | |
| **Idea 3** | Review the current CDM patient journey to identify how and when MyMedicare enrolment will be discussed. | | |
| **Idea 4** | Provide MyMedicare registration training to receptionist, Nurse and GPs | | |
| **Next steps:** | *Each idea may involve multiple short and small PDSA cycles.* | | |

# 3.4 Activity – Patients with a chronic condition eligible for care plan or review

🎯 **Activity Goal:** Enhance care plan delivery for MyMedicare-enrolled patients managing chronic conditions.

**Please contact your Engagement Officer for further support - 07 5612 540 practicesupport@gcphn.com.au**

**Starting point**
Log into Primary Sense → Reports → load '**Patients with Moderate Complexity 3**' → Export to Excel

**Start your PDSA**
Download template.

| **AIM** | **1. What are we trying to accomplish?** | | |
|---|---|---|---|
| *By answering this question, you will develop your **GOAL** for improvement. It important to establish a S.M.A.R.T (Specific, Measurable, Achievable, Relevant, Time bound) and people-crafted aim that clearly states what you are trying to achieve.* | | | |
| **Our Family Medical aims to increase the proportion of RACGP active patients with high complexity (level 5 & 4) who are registered for MyMedicare from 10% to 50% by the end of March 2025** | | | |
| **MEASURE(S)** | **2. How will we know that a change is an improvement?** | | |
| *By answering this question, you will develop the **MEASURE(S)** you will use to track your overarching goal. Record and track your baseline measurement to allow for later comparison.*<br>*Tip: Use a Run Chart to plot trends.* | | | |
| **Outcome Measure:** % of active patients with high complexity (5 & 4) who are registered for MyMedicare<br>**Tool:** ***Patients with High Complexity Level 5 & 4*** Primary Sense report<br>**Frequency:** Monthly<br>**Numerator:** # of active patients with high complexity (level 5 & 4) registered in MyMedicare (A)<br>**Denominator:** # of active patients with high complexity (level 5 & 4) (B)<br><br>The proportion of active patients with high complexity (level 5 & 4) registered in MyMedicare (A divided by B) | | | |
| **Baseline:** | 10% of active patients with high complexity (5&4) are registered in MyMedicare | **Baseline date:** | 03/02/2025 |
| **CHANGE IDEAS** | **3. What changes can we make that will result in improvement?** | | |
| *By answering this question, you will develop **IDEAS** for change.*<br>*Tip: Engage the whole team in formulating change ideas using tools such as brainstorming, driver diagrams or process mapping. Include any predictions and measure their effect quickly.* | | | |
| **Idea 1** | Identify active patients with high complexity (5 & 4) who are not registered in MyMedicare. | | |
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| **Idea 3** | Review the current CDM patient journey to identify how and when MyMedicare enrolment will be discussed. | | |
| **Idea 4** | Provide MyMedicare registration training to receptionist, Nurse and GPs | | |
| **Next steps:** | *Each idea may involve multiple short and small PDSA cycles.* | | |

# Module 4

## Team-based care approach

**On completion of this module, you will:**

- Optimise care plan reviews to boost efficiency, outcomes and practice performance.
- Allocate team tasks to ensure clarity and ownership of each member's role.

**Activity Navigation**

# Revised structure for chronic disease management items

From 1 July 2025, there is a revised structure for items for chronic disease management. The changes simplify, streamline, and modernise the arrangements for health care professionals and patients. These changes primarily affect medical practitioners, however, allied health professionals providing MBS services should be aware of the changes to the plan and referral requirements. Transition arrangements will be in place for two years to ensure current patients don't lose access to services.

Items for GP management plans (229, 721, 92024, 92055), team care arrangements (230, 723, 92025, 2056) and reviews (233, 732, 92028, 92059) will cease and be replaced with a new streamlined GP chronic condition management plan (GPCCMP). Table below - Chronic Condition Management items commencing 1 July 2025.

| Name of Item | GP item number | PMP item number | Frequency of Claiming | Fee |
|---|---|---|---|---|
| **Prepare a GP chronic condition management plan – face to face** | 965 | 392 | Every 12 months if clinically relevant | GPs - $156.55<br>PMPs - $125.30 |
| **Prepare a GP chronic condition management plan - video** | 92029 | 92060 | Every 12 months if clinically relevant | GPs - $156.55<br>PMPs - $125.30 |
| **Review a GP chronic condition management plan – face to face** | 967 | 393 | Every 3 months if clinically relevant | GPs - $156.55<br>PMPs - $125.30 |
| **Review a GP chronic condition management plan – video** | 92030 | 92061 | Every 3 months if clinically relevant | GPs - $156.55<br>PMPs - $125.30 |

The purpose of this resource is to support General Practices to plan their delivery of care for patients with chronic conditions and provide examples of how to use MBS items to provide regular care and review for patients in line with the intent of the MBS items.

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

This resource demonstrates the potential use of MBS items related to CCM, for a full explanation of each MBS item please go to MBS online. https://www.mbsonline.gov.au/

# 4.1 Activity – Business Optimisation for CCM

The Chronic Conditions Management MBS changes support general practices to undertake proactive care planning, quarterly reviews, team-based follow-up and early intervention. General practices should consider, how best to support their chronic condition patients with self-management and care to improve outcomes for their chronic conditions whilst effectively claiming to optimise practice Medicare revenue.

## Approach

As a practice or as a team (GP, practice nurse, AHP, NP etc.), determine the approach you will take to GPCCMP and optimising both  atient outcomes and revenue.

- **Annual GPCCMP:** Developed and shared with the patient and care team.
- **Quarterly Reviews:** Assess goals, progress, symptoms, and update care as clinically required.
- **Nurse/AHP Follow-up Services:** Delivered ***up to 5 times annually*** to reinforce care plans and patient actions.

Nurses or AHP may provide support and follow up at the time of the management plan/ review appointment.

Alternatively, an approach may be for the nurse or AHP to provide a follow up phone call and support/ touch point with the patient to check in, confirm care plan goals, assist with allied health or any other referral pathways.

Either option the nurse or AHP can claim the MBS item 10997.

Revenue of one patient,
attending all review appointments

| Service | Times/ Year | Annual amount billed/ patient | Annual amount billed/ patient |
|---|---|---|---|
| GPCCMP MBS 965 or 92029 | 1 | $156.55 | |
| GPCCMP Review MBS 967 or 92030 | 3 | $469.65 | |
| Nurse/ AHP follow up 10997 or 93203 | 3-5 | $42.00 - $70.00 | $667.15 - $691.45 |

## Why Review

- Use **Care Planning Claiming workflow** to explore care plan contents.
- Care plan reviews enable timely adjustments to medications, referrals, and self-management strategies.
- Ultimately, working in partnership with patients for better outcomes leads to reduced hospital admissions.
- Working together, with your team and patient to provide planned care across a 12-month cycle of care, will have an improved revenue impact.

## Operational Tips

- **Examine practice data -** know who your CCM patients are.
- **Determine a target -** % of patients rebooked for review appointments (include missed appointments and DNAs)
- **Engage your patients** so they are well informed and aware of the reason/s for their review appointment and what will happen at the next appointment.
- **Recall -** utilise practice systems to automate appointment reminders and recalls.
- **Flexibility -** ensure your practice is able to provide patient's access (flexibility may be key), face to face and/or telehealth may be required.

**Refer MBS guide for the frequently used items including Care Planning and incentives This guide links item number to MBS criteria, descriptor and fact sheets**

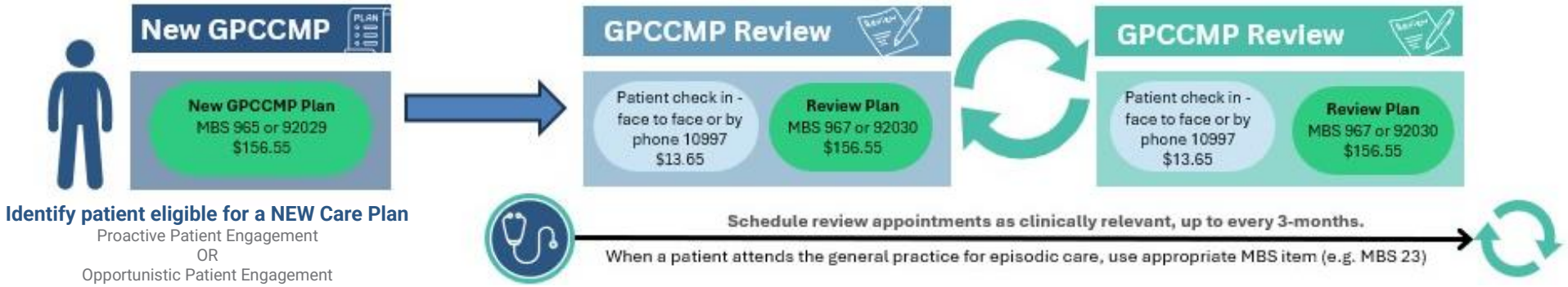
***Bulk Billing Incentive & Bulk Billing Practice Incentive Program***

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

- **From 1 November 2025, all Medicare-eligible patients will be eligible for bulk billing incentives.**
- **The CCM MBS items are eligible for Bulk Billing Incentive and Bulk Billing Practice Incentive Program items which attract additional payments.**
- **For more information on Bulk Billing Incentive changes click here**

## 4.2 Activity – CCM Claiming Annual Cycle of Care

Refer to the Chronic Conditions Management MBS User Guide for examples of how CCM management planning items can be used and claimed by general practices.




### New GPCCMP

**1. Patient Eligibility**

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

**2. Develop the Management Plan** ***- GP must see patient***

***Practice Nurse, Aboriginal Health Workers, Practitioners may contribute to preparing the plan***

- ☐ Explain the management plan process, gain informed consent, and collaboratively identify the patient's conditions, 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 Review

- ☐ Review existing GPCCMPs every 3 months if clinically appropriate.
- ☐ Use MBS item 967 (face-to-face) or 92030 (video)
- ☐ Assess patient progress, update goals and services, obtain and record consent
- ☐ Share updates with other providers (if applicable)
- ☐ Schedule the next review.

## 4.3 Activity – Allied Health Referrals and other GPCCMP considerations

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. More info, visit **HealthPathways**

### 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

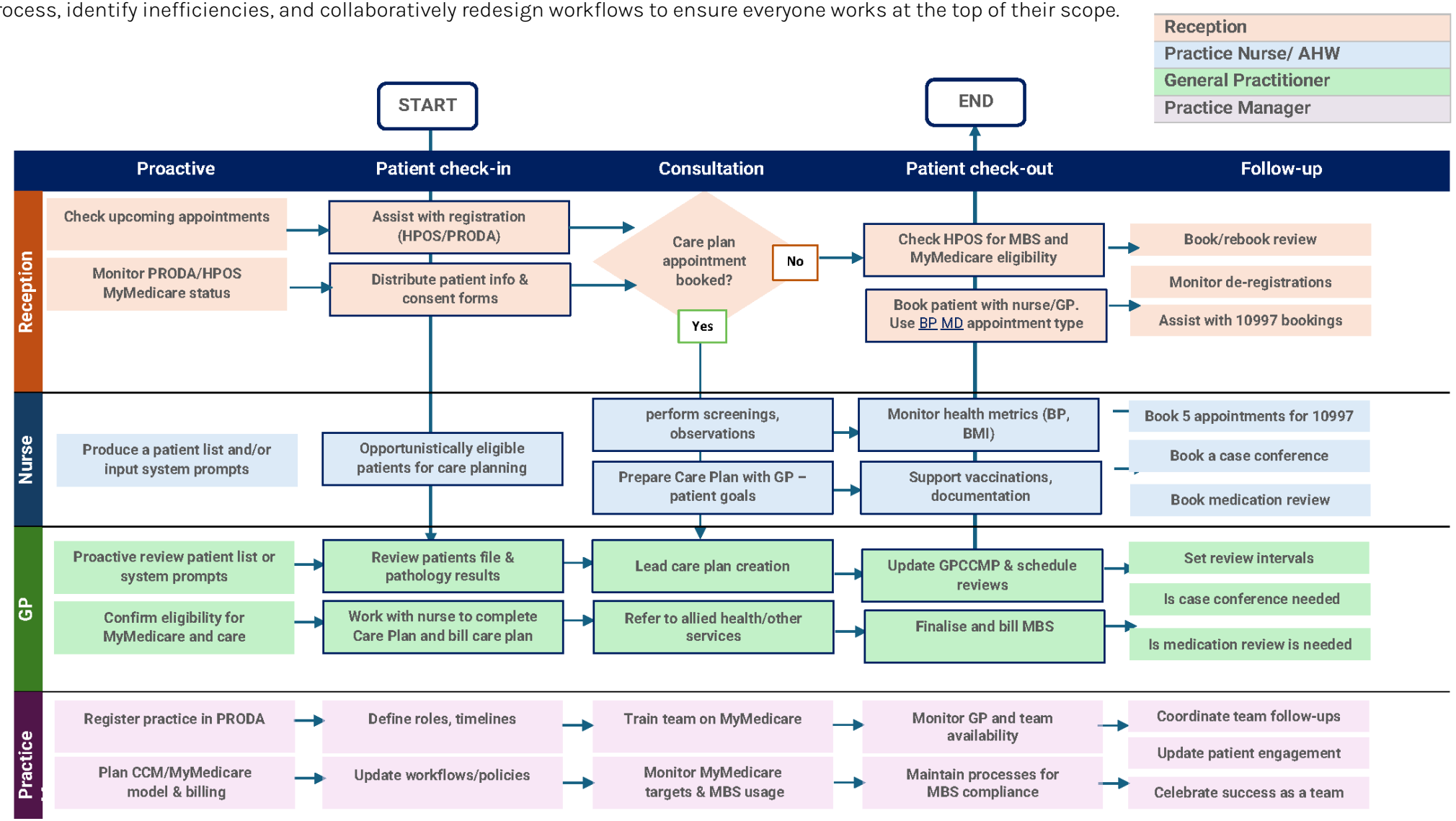
**Social Work Referral**
Consider this where there is social issues where additional support would benefit chronic condition outcome.

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

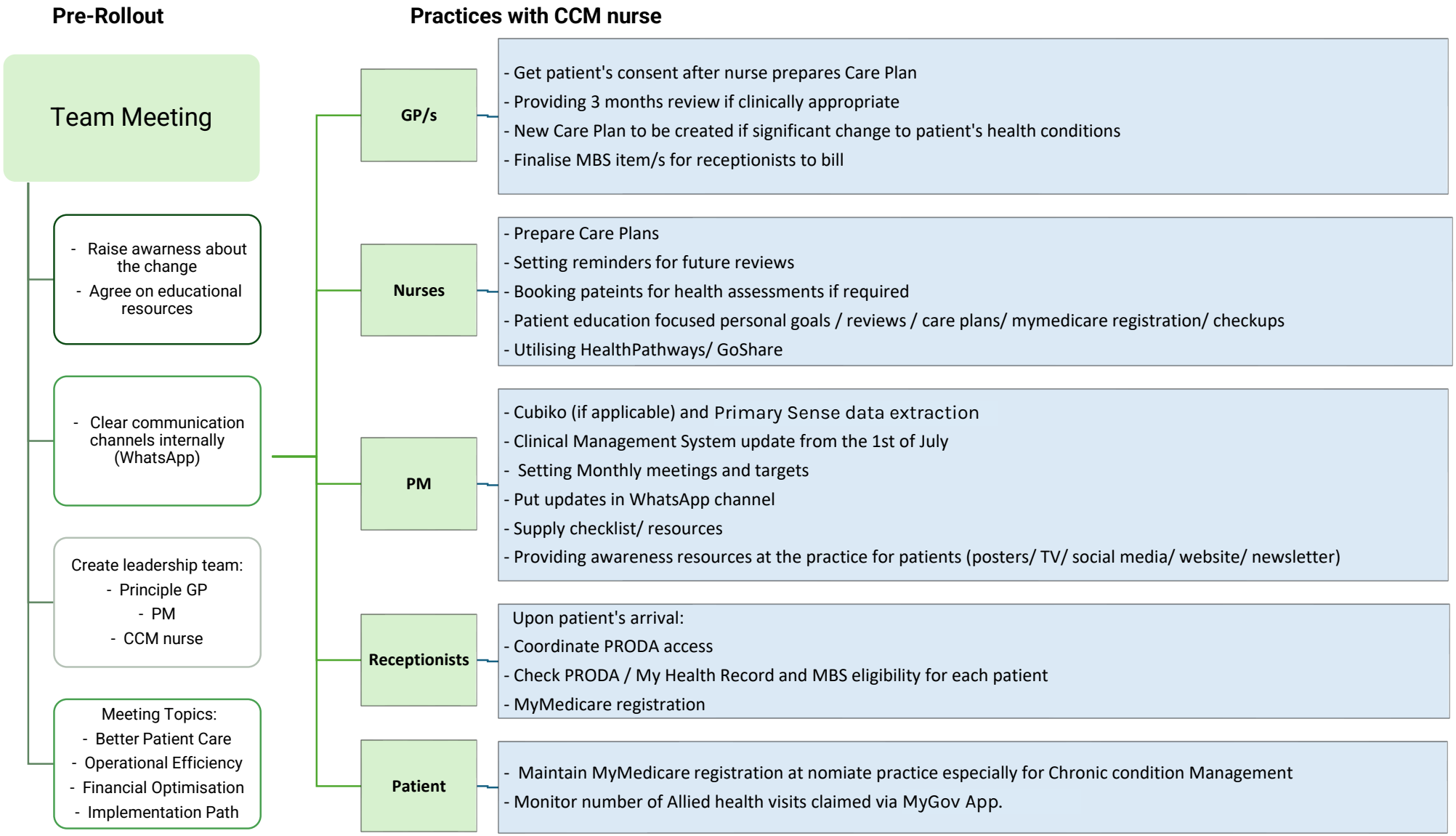
**Social supports**
Consider social support in home environment, social connectedness, community connections and linkages

## 4.4 Activity – Roles and Responsibility (Swim Lane workflow)

Use this swim lane process map to visually clarify team members roles and responsibilities and who performs each task in the care process, identify inefficiencies, and collaboratively redesign workflows to ensure everyone works at the top of their scope.



## 4.5 Activity - Sample workflows



# Appendices

Navigation

# 5.1 Quality Improvement documentation

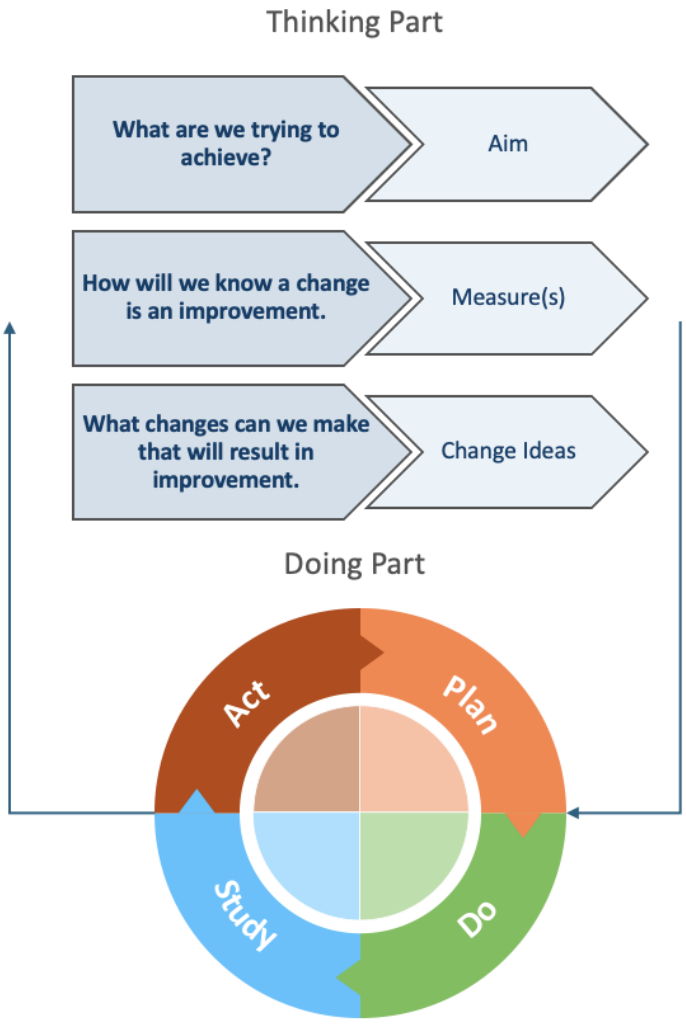
Start by documenting your **practice QI team** and define your problem and specified a robust ***Problem Statement.***

| | | | |
|---|---|---|---|
| **Practice name:** | *Add your primary healthcare service name here* | **Date:** | Start date |
| **QI team:** | *List the team members involved* | | |
| **Problem:** | *Describe why this work is strategically important. What problem is the team addressing? What does our data indicate about it, and what are the causes?* | | |
| **Problem Statement:** | *Document your succinct problem statement here* | | |

Next, move onto the **Model for Improvement (MFI)**, the **'Thinking Part'** focuses on the overall improvement strategy, while the **'Doing Part'** implements changes through the **Plan-Do-Study-Act (PDSA) cycle**. This model uses PDSA cycles to test changes, ensuring measurable and sustainable improvements. Watch short video on MFI and PDSA's.

## Step 1: Model for Improvement (Thinking Part)

1. **Goal / Aim:** What are we trying to accomplish? Develop a S.M.A.R.T. (Specific, Measurable, Attainable, Realistic, Time-bound) and people-crafted Aim Statement.
2. **MEASURE:** How will we know that a change is an improvement? Identify what good looks like and develop a measure(s) of success.
   ***Tip:*** *Use a* ***Run Chart*** *to plot trends*
3. **CHANGE IDEAS:** What changes can we make that will result in an improvement? Engage the whole team in formulating change ideas *using* ***Institute for Healthcare Improvement QI tools*** such as brainstorming, ***driver diagrams*** or ***process mapping***
   **Each change idea may involve multiple small rapid PDSA cycles.**




## Step 2: Plan-Do-Study-Act (PDSA) (Doing Part)

1. **PLAN:** Describe the change idea (what, who, when, where). Predict outcomes and define the data to collect.
2. **DO:** Carry out the plan. Collect data. Consider what worked well and why? Document any unexpected observations, events or problems.
3. **STUDY:** Analyse results, compare them to predictions, and reflect on what you learned.
4. **ACT:** Based on what you learned from the test, consider what you will do next (e.g., adopt, adapt or abandon)? How does this inform the plan for your next PDSA?

**For guidance, download template or for support on conducting quality improvement in your primary healthcare services, please contact your Primary care Deliver team on practicesupport@gcphn.com.au**

*Source: Langley, G., Nolan, K., Nolan, T., Norman, C. & Provost, L. 1996, The Improvement Guide, Jossey-Bass, San Francisco, USA*

# QI ACTIVITY GOAL EXAMPLE

Develop and apply systems for patient recalls and reminders to enhance in MyMedicare registration, Care Planning and the importance of frequent reviews to enhance chronic conditions management.

**Measure** – How will you measure the change for this activity?

**Overall measure**

- Percentage increase in patients registered to MyMedicare in PRODA.
- Percentage patients on a care plan and aware of coming changes e.g. documented recent conversation with a member of the care team.

**Baseline measures**

Practice has xxx patients on previous care plans at the start of the activity. Following this activity and in preparation for the changes to CCM now have identified an additional XXX number of patients who should be on a care plan. XX% of patients are registered with MyMedicare.

**Data to collect**

Data will be collected on the following on the first Tuesday of the month for 6 months.

- Percentage rates of MyMedicare patients.
- Number of patients who are coming in for new CCM Care Plan or review to previous care plan?
- Number of patients with a note in their patient record that they have been made aware of the coming CCM changes.

# 5.2 PDSA – Team awareness, desire and readiness

## Model For Improvement (MFI)

| AIM | 1. What are we trying to accomplish? |
|---|---|
| **To increase awareness and understanding among the practice team about MyMedicare and Chronic Conditions Management (CCM) changes, while defining and documenting each team member's roles and responsibilities. This will help build readiness for change and support sustainable implementation.** | |
| **MEASURE(S)** | **2. How will we know that a change is an improvement?** |
| • **Team members can describe the purpose and benefits of MyMedicare and CCM changes.**<br>• **Documented and agreed team roles and responsibilities.**<br>• **Feedback from the team shows increased confidence and clarity.**<br>• **Team reflects on the process and adapts based on shared learnings.** | |
| **CHANGE IDEAS** | **3. What changes can we make that will result in improvement?** |
| **Idea 1** | Hold a team meeting or lunch catch-up to communicate MyMedicare and CCM changes |
| **Idea 2** | Share updates via email or in the staff room. |
| **Idea 3** | Use talking points to explore MyMedicare benefits. |
| **Idea 4** | Facilitate discussion around CCM changes and training needs. |
| **Idea 5** | Define, document, and review team roles and responsibilities regularly. |
| **Next steps:** | *Each idea may involve multiple short and small PDSA cycles.* |

## Plan-Do-Study-Act (PDSA)

| Idea | Plan | Do | Study | Act |
|---|---|---|---|---|
| 1.1 | raise awareness about MyMedicare across the practice team.<br>• Organise a 15–30 min team meeting or informal lunch session.<br>• Share talking points and benefits of MyMedicare beforehand.<br>• Pose open questions for discussion.<br><br>Who: Practice manager and GP lead<br>When: Week 1<br>Where: Staff meeting room | Held the meeting, provided handouts, and facilitated discussion on MyMedicare benefits and how it may impact the practice. | • Team showed interest but had questions about patient eligibility and enrolment.<br>• Some team members unaware of how it aligns with the practice's current strategy.<br>• Quick post-meeting feedback collected showed 80% of attendees found the session useful. | • Plan a follow-up FAQ session.<br>• Add a MyMedicare summary to the practice resource folder.<br>• Ensure key updates are emailed post-session. |
| 1.2 | Clearly define and document each team member's role in CCM and MyMedicare.:<br>• Use provided role template.<br>• Hold short 1:1 discussions with each staff member or in a small team huddle.<br>• Document and share consolidated roles with the team.<br>Who: Practice manager<br>When: Week 2–3<br>Where: In-practice meetings | Met with all team members. Used the role template to draft roles and responsibilities. Shared draft with staff via email for feedback. | • Most team members appreciated the clarity.<br>• A few roles needed adjusting after real-world testing.<br>• Team identified gaps in CCM training during reflection. | • Schedule 4-week check-in to reflect on roles.<br>• Organise a short training session on CCM planning.<br>• Update and re-share finalised roles document. |

# 5.3 PDSA – Identifying Active Patients and Linking to MyMedicare Program

## Model For Improvement (MFI)

| AIM | 4. What are we trying to accomplish? | | |
|---|---|---|---|
| Improve the accuracy of active patient identification and ensure 10% of eligible active patients are registered for the MyMedicare program within the next six months. | | | |
| **MEASURE(S)** | **5. How will we know that a change is an improvement?** | | |
| Percentage of active patients identified who are successfully registered with MyMedicare. | | | |
| **Baseline:** | 4000 active patients and 50 registered with MyMedicare | **Baseline date:** | 10/11/2023 |
| **CHANGE IDEAS** | **6. What changes can we make that will result in improvement?** | | |
| **Idea 1** | Hold a team meeting or lunch catch-up to communicate MyMedicare and CCM changes | | |
| **Idea 2** | Share updates via email or in the staff room. | | |
| **Idea 3** | Use talking points to explore MyMedicare benefits. | | |
| **Idea 4** | Facilitate discussion around CCM changes and training needs. | | |
| **Idea 5** | Define, document, and review team roles and responsibilities regularly. | | |
| **Next steps:** | *Each idea may involve multiple short and small PDSA cycles.* | | |

## Plan-Do-Study-Act (PDSA)

| Idea | Plan | Do | Study | Act |
|---|---|---|---|---|
| 1.1 | Practice Manager to extract a list of patients flagged as active patients who are not registered for MyMedicare by 1/11/23. **Prediction:** there will be patient that are inactive. | Conduct the first round of active patient verification for 50 patients and 10 were inactive as predicted. 15 were enrolled but MyMedicare status was missing. Update records to correct status and register them for MyMedicare. | • Conduct a bulk archive of inactive patients. Bulk import MyMedicare enrolments to PMS instead of manual/ per patient. Incorporate MyMedicare enrolment discussions during patient contact and pre-plan for upcoming appointments | Practice Manager to extract a list of patients flagged as active patients who are not registered for MyMedicare by 1/11/23. **Prediction:** there will be patient that are inactive. |
| 1.2 | Conduct a bulk archive of inactive patients **Prediction**: need to this regularly. | Conduct the first round of active patient verification for 50 patients and 10 were inactive as predicted. 15 were enrolled but MyMedicare status was missing. Update records to correct status and register them for MyMedicare. | • Conduct a bulk archive of inactive patients. Bulk import MyMedicare enrolments to PMS instead of manual/ per patient. Incorporate MyMedicare enrolment discussions during patient contact and pre-plan for upcoming appointments | Practice Manager to extract a list of patients flagged as active patients who are not registered for MyMedicare by 1/11/23. **Prediction:** there will be patients that are inactive. |

# 5.4 PDSA – CCM and MyMedicare

## Model For Improvement (MFI)

| AIM | 1. What are we trying to accomplish? |
|---|---|
| **Improve the completion of management plans for MyMedicare-registered patients with chronic conditions by 20% in the next 3 month.** | |
| **MEASURE(S)** | **2. How will we know that a change is an improvement?** |
| **Proportion of chronic condition patients who are registered with MyMedicare and have an active care plan.** | |
| **CHANGE IDEAS** | **3. What changes can we make that will result in improvement?** |
| Idea 1 | Display MyMedicare posters in waiting areas and train all staff to engage patients in conversations about MyMedicare. |
| Idea 2 | Use data tools (e.g. Primary Sense) to identify patients with chronic conditions who are not yet registered with MyMedicare. |
| Idea 3 | Send SMS or letters to identified patients, outlining the benefits of MyMedicare and management plan eligibility. |
| Idea 4 | Flag eligible patients in the practice management system to prompt MyMedicare discussions during appointments. |
| **Next steps:** | *Each idea may involve multiple short and small PDSA cycles.* |

## Plan-Do-Study-Act (PDSA)

| Idea | Plan | Do | Study | Act |
|---|---|---|---|---|
| 1.1 | Practice Nurse to flag patient files of those likely to benefit from MyMedicare registration. Practice Manager to ensure all staff are trained and equipped with key messages for patient conversations. ***Prediction:*** *Flagging and staff messaging will increase MyMedicare registrations.* | Begin flagging eligible patients in the system. When these patients attend appointments, GPs initiate discussions about MyMedicare. Share informational materials via email or print. | Monitor staff feedback and patient responses. Record the number of patients flagged, engaged, and successfully registered. Identify any challenges or missed opportunities. | Adjust flagging or scripting processes as needed. Refine communication methods (e.g. SMS vs. in-person). Plan next PDSA cycle to build on what worked well. |
| 2.1 | Conduct a **data cleansing** exercise using Primary Sense to identify patients with diagnosed or potentially undiagnosed chronic conditions. ***Prediction:*** *improved patient identification* | Reviewed 50 patient records (e.g. diabetes cohort) to verify diagnoses and uncover inconsistencies or missing coding. | There may be some discrepancies or missing data points in the initial search results, particularly if the chronic conditions are under-diagnosed or not appropriately coded (see **Indicated Diagnoses report)** . This will require follow-up with clinicians to ensure correct data entry and comprehensive patient records. | Standardise coding practices within the PMS. Use Primary Sense condition **Data Mapping**<br><br>Train staff to enter coded diagnoses (no free text) and use provisional diagnosis fields appropriately. Scale this activity to broader cohorts. |
| 2.2 | Train clinical staff on accurate coding procedures using Primary Sense, Best Practice, and Medical Director tools. Prediction: improved management plan eligibility identification. ***Prediction:*** *Training will improve coding accuracy and management plan eligibility.* | Delivered staff training sessions. Provide resources and visual guides. Introduce standardised coding templates. | Track updates in chronic disease coding and increases in accurately coded diagnoses. Review feedback from clinicians. | Continue refining training materials. Monitor coding trends monthly. Use coding data to trigger management plan reminders and patient recalls. |
| 3.1 | Use Primary Sense to identify MyMedicare-registered patients due for a GPMP/TCA. Aim to optimise both management planning and MBS claiming. ***Prediction:*** *Recalls will boost attendance* | Review a sample list of 50 patients with diabetes. Initiate recalls via SMS, phone, or opportunistic prompts during visits. | Assess how many patients responded to recalls and completed management plans. Document process issues or patient feedback. | Refine recall messaging and intervals. Introduce automated reminders and integrate review scheduling into routine workflows. |

# 5.5 PDSA – Reducing Missed Appointments for Management plan reviews

## Model For Improvement (MFI)

| AIM | 1. What are we trying to accomplish? |
|---|---|
| Reduce missed chronic condition management plan review appointments by 20% in the next 3 month. | |
| **MEASURE(S)** | **2. How will we know that a change is an improvement?** |
| ➢ Reduction in missed chronic condition review appointments (target: 25% reduction over 6 weeks).<br>➢ Increase in rebooked review appointments.<br>➢ Increase in patient engagement with digital education materials (e.g., GoShare).<br>➢ Number of patients with documented personalised care goals. | |
| **CHANGE IDEAS** | **3. What changes can we make that will result in improvement?** |
| Idea 1 | Implement structured follow-up processes (calls, letters) for missed appointments using tracking tools like BP, Pracsoft, or Cubiko. |
| Idea 2 | Assign a nurse or designated team member to track and rebook missed reviews. |
| Idea 3 | Use GoShare or similar platforms to re-engage at-risk patients through videos and resources. |
| Idea 4 | Introduce personalised, patient-centred goals into management planning to boost motivation and follow-up rates. |
| **Next steps:** | *Each idea may involve multiple short and small PDSA cycles.* |

## Plan-Do-Study-Act (PDSA)

| Idea | Plan | Do | Study | Act |
|---|---|---|---|---|
| 1.1 | Develop a structured follow-up workflow using BP and Cubiko to identify and act on missed chronic condition reviews. Create standard letter and call templates. ***Prediction:*** *A consistent follow-up process will reduce missed appointments by at least 20% within 6 weeks.* | Trial the process for 4–6 weeks with admin staff using the templates to follow up with patients who missed reviews. | Monitor reduction in missed appointments. Cubiko showed a 25% reduction over 6 weeks. Staff reported more confidence in consistency of follow-up. | Adopt the follow-up process as policy. Train all admin staff. Automate reporting and follow-up tracking in Cubiko or equivalent system. |
| 2.1 | Test whether having a nurse or admin staff responsible for tracking missed reviews improves rebooking outcomes. ***Prediction:*** *Assigning a nurse to manage rebooking will improve review attendance rates compared to ad hoc admin follow-up.* | Trial with rotating admin and nursing staff for 4 weeks. Track rebooked patients. | Nurse-led follow-up achieved higher rebooking rates compared to admin-only. Fewer patients were lost to follow-up. | Assign this task permanently to nursing staff, with admin backup. Document responsibilities in staff workflows. |
| 2.2 | Use GoShare to send targeted educational videos/resources to patients who have missed reviews or show signs of disengagement. ***Prediction:*** *Sending GoShare resources will re-engage at least 40% of patients who previously missed their review appointment.* | Send GoShare resources to at-risk patients. Monitor engagement using platform analytics. | ~45% engagement rate. Patients who interacted with content were more likely to rebook and attend their next appointment. | Expand GoShare use to other cohorts (e.g. mental health, lifestyle conditions). Develop SOPs for using digital resources when disengagement risk is flagged. |
| 3.1 | Introduce patient-centred goal-setting (e.g. weight, activity, mental health) during care plan reviews to improve follow-through. ***Prediction:*** *Patients with documented personal goals will be more likely to attend follow-up reviews and report higher satisfaction.* | Implement this with a small cohort of patients during routine reviews. Document goals in the care plan. | Patients with personalised goals showed improved motivation and better follow-up attendance. Positive feedback was noted from nurses.. | Incorporate personalised goals into all care plan templates. Use Primary Sense reports to monitor patient progress monthly. |

## 5.6 Measuring Outcomes – Audit Worksheet

1. Choose the QI activity measure that aligns with your practice goal
2. Enter a practice target and baseline for each QI activity measure in the table below
3. Track your progress over time by entering a result for reporting period.
4. Use run chart to plot results over time.

| Measure: | Practice Target | Baseline date | Result 1 date | Result 2 date | Result 3 date | Result 4 date |
|---|---|---|---|---|---|---|
| *Example PIPQI* | # (%) | % | # (%) | # (%) | # (%) | # (%) |
| MyMedicare registered patients | | | | | | |
| MyMedicare registered and CCM patients | | | | | | |
| Patients due for CCM or review | | | | | | |
| Patients with 'Diabetes' | | | | | | |
| Patients with a billed Care Plan in the past 12 months | | | | | | |
| Insert QI activity measure | | | | | | |
| Insert QI activity measure | | | | | | |
| Insert QI activity measure | | | | | | |

** Per RACGP, an active patient has 3+ visits in 2 years. This filter may exclude new or at-risk patients who don't see their GP regularly*

## 5.7 Group reflection – after completing activities

| **As a team, analysis and review baseline data results and discuss change ideas and actions.<br>Use PDSA cycles to test and measure change ideas** | |
|---|---|
| The degree to which the learning needs were met:<br>Not met<br>Partially met<br>Entirely met | To what degree this activity was relevant to your practice:<br>Not met<br>Partially met<br>Entirely met |
| **What did you learn? What changes would you make to your practise as a result?** | |
| For example,<br>• Has patient engagement increased through education efforts?<br>• Which educational strategies were most effective?<br>• Have MyMedicare registrations improved following engagement efforts?<br>• Do relevant team members know how to send out GoShare patient resources, videos and apps?<br>• What barriers were encountered in patient engagement? | |
| **RACGP CPD: utilise the self-reporting feature on Quick Log mycpd.racgp.org.au to document reflection.** | |

## 5.8 Useful contacts

| | |
|---|---|
| **Gold Coast PHN** | 07 5612 5408 \| practicesupport@gcphn.com.au<br>www.gcphn.org.au<br>Engagement Officer flyer |
| **Provider Digital Access (PRODA) PRODA** | 1800 700 199 (option 1) \| proda@servicesaustralia.gov.au<br>PRODA Information<br>Training: PRODA eLearning |
| **Health Professional Online Services (HPOS)** | 132 150 (option 6)<br>HPOS Access<br>Training: HPOS eLearning |
| **Medicare Provider Enquiries (Medicare Programs)** | Phone: 132 150 (Option 2 - Claiming, payment, Provider Registration, MyMedicare and Organisation Register enquiries) |
| **Services Australia Incentive Program** | 1800 222 032<br>Incentive Program Information<br>Training: Incentive Programs eLearning |
| **MBS** | 13 21 50 \| askmbs@health.gov.au<br>MBS online<br>Training: MBS Training eLearning |
| **Healthdirect** | 1800 580 771 \| videocallsupport@healthdirect.org.au<br>Registration Form Video Call<br>Video Call |
| **Australian Immunisation Register** | 1300 650 039<br>air@humanservices.gov.au |
| **Department of Veteran Affairs** | 1800 550 457 |
| **Services Australia eBusiness** | 1800 700 199<br>ebusiness@humanservices.gov.au |
| **Primary Sense** | 07 5612 5476 \| primarysense@gcphn.com.au<br>www.primarysense.org.au |
| **Medical Director** | 1300 300 161<br>www.medicaldirector.com |
| **Best Practice** | 1300 40 1111 \| support@bpsoftware.net<br>www.bpsoftware.net |
| **Translating and Interpreting Service (TIS National)** | 131 450 |
| **My Aged Care** | 1800 200 422 |
| **MyGov help desk** | 132 307 - option 1 |
| **eRx** | 1300 700 921 |
| **Healthlink** | 1800 125 036 |
| **My Health Record** | 1800 723 471 |
| **Gold Coast Hospital and Health Service – GP Advice Line** | 1300-004-242 (option 3) \| GCGPLU@health.qld.gov.au<br>*- please ensure you de-identify patient information if sending by email. Only provide the initials of your patient's name and date of birth. Available Monday to Friday, 8am to 4pm.* |
| **Gold Coast Public Health Unit** | (07) 5667-3200 \| GCPHU@health.qld.gov.au *(do not include any patient information)*<br>For after hours health advice, phone 13 HEALTH (13 43 25 84) |
| **Medicare Urgent Care Clinic** | Southport 07 5680 0040 \| Oxenford 07 5573 1122<br>www.gcphn.org.au/medicare-urgent-care-clinic |

## 5.9 MBS Quick Guide

This guide outlines the frequently used Medicare Benefits Schedule (MBS) items with each item number linked MBS criteria, descriptor and fact sheets. **Click here** for a full list of MBS items.

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
- Gold Coast HealthPathways - MBS Items

| CHRONIC CONDITIONS MANAGEMENT (CCM) | Face to Face | Telehealth* |
|---|---|---|
| **GP chronic condition management plan**** (EVERY 12 MONTHS if clinically relevant) | 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 chronic condition** (5 PER YEAR) | 10997 | Phone 93203<br>Video 93201 |
| **Practice Nurse/Aboriginal Health Practitioner follow-up services for Aboriginal and Torres Strait Islander patients** (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 | |
| † MyMedicare registered patients can only access these services at their MyMedicare general practice<br>*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.<br>(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.)<br>**Patients with a General Practitioner Chronic Disease Management Plan/Review can access the following MBS services:<br>• Allied Health Services: Up to 5 individual sessions per year (10 for Aboriginal or Torres Strait Islander patients).<br>• Nurse or Health Practitioner Services: Up to 5 services annually, provided on behalf of a doctor.<br>• Type 2 Diabetes Care: If eligible, up to 8 yearly group sessions for dietetics, education, or exercise. | | |

| CASE CONFERENCING | | | |
|---|---|---|---|
| **Case Conference GP organises** (MAX. 5 TIMES PER PATIENT PER CALENDAR YEAR) | 735 | 739 | 743 |
| **Case Conference GP participating** (MAX. 5 TIMES PER PATIENT PER CALENDAR YEAR) | 747 | 750 | 758 |

| BULK BILLING INCENTIVES (BBI) | |
|---|---|
| BBI (**MBS MN.1.1**) can be claimed when you bulk bill a child under 16 or a **Commonwealth Concession Card** holder. Expanding eligibility for **Medicare bulk billing incentives** takes effect 1 Nov, 2025. | |
| **MyMedicare enrolled patients only at their enrolled practice**<br>• **Level C, D, E (Telehealth*)**<br>• **Level C, D (Telephone*)** | 75880† |
| • **Level B, C, D, E (Face to Face)**<br>• **Level B (Telehealth*, Telephone*)** | 75870 |
| **All other eligible services not covered below** (refer MBS MN.1.1) | 10990 |

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

phn
NATIONAL IMPROVEMENT NETWORK COLLABORATIVE

An Australian Government Initiative

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