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Medicare Australia

Final APS Ref.: FPM03/08
Date of effect: 31/03/2009

Administrative Position Statement

Medicare benefits are payable for an MBS Item 10997 service rendered on the same day as an Item 721, 723, 725, 727, 729 or 731 service if the person has a GP Management Plan (GPMP), Team Care Arrangements (TCA) or Multidisciplinary Care Plan (MCP) in place.

Background Information

The following is relevant to APS FPM03/08. (Please note that the information contained in this section is supportive of but does not constitute the Administrative Position Statement.)

Issue

Can MBS Item 10997 be billed on the same day as MBS items 721, 723, 725, 727, 729 or 731?

The use of MBS Item 10997 may be open to interpretation. On one hand, the MBS refers to the use of MBS Item 10997 services between reviews. This implies that an interval of a number of days or months might be expected between a MBS Item 10997 service and a review. On the other hand, elsewhere in the MBS it refers to the collection of information when using a MBS Item 10997 service to support the review of a care plan—support could be assumed to occur in the rendering of a review of a care plan, on the same day.

What does the item descriptor say? (As at 1 February 2009)

Item 10997

“Service provided to a person with a chronic disease by a practice nurse or registered Aboriginal Health Worker if:

- a) the service is provided on behalf of and under the supervision of a medical practitioner; and
- b) the person is not an admitted patient of a hospital; and
- c) the person has a GP Management Plan, Team Care Arrangements or Multidisciplinary Care Plan in place; and
- d) the service is consistent with the GP Management Plan, Team Care Arrangements or Multidisciplinary Care Plan

to a maximum of 5 services per patient in a calendar year

(See para M2.1 of explanatory notes to this Category)”

The MBS does not specify a time interval between the rendering of a MBS Item 10997 service and a GPMP, TCA or MCP service being ‘in place’.

Once a GPMP, TCA or MCP is in place, it could immediately be followed by a clinically relevant Item 10997 service on the same day, or an Item 10997 service could be rendered on a subsequent day.



What do the terms in the Medicare Benefits Schedule mean?

Chronic Disease - a chronic medical condition is one that has been or is likely to be present for at least six months including, but not limited to, asthma, cancer, cardiovascular illness, diabetes mellitus, mental disorders, arthritis and musculoskeletal conditions. A patient is considered to have complex care needs if they require ongoing care from a multidisciplinary team consisting of their GP and at least two other health professionals.

Enhanced Primary Care (EPC) Planning Team - the allied health professional providing the service may be part of the EPC planning team convened by the GP to manage a patient's chronic and complex care needs. However, the service may also be provided by an allied health professional that is not part of the EPC planning team, provided that the service has been identified as necessary by the patient's GP.

GP Management Plan - this item is for patients with a chronic or terminal medical condition who will benefit from a structured approach to management of their care needs. A rebate can be claimed once the patient's usual GP (or another GP in the same practice) has prepared a GPMP by completing the steps and meeting the requirements specified in the MBS Explanatory Notes. The GP may be assisted by their practice nurse, Aboriginal health worker or other health professional in the GP's medical practice or health service. The service must include a personal attendance by the GP with the patient, as part of Item 721.

The steps in preparing a GPMP must include:

- assessing the patient to identify and/or confirm all of the patient's health care needs, problems and relevant conditions
- agreeing management goals with the patient for the changes to be achieved by the treatment and services identified in the plan
- identifying any actions to be taken by the patient
- identifying treatment and services that the patient is likely to need, and making arrangements for provision of these services and ongoing management
- documenting the patient needs, goals, patient actions, treatment/services and a review date, i.e. completing the GPMP document.

Team Care Arrangement (TCA) - this item is for patients with a chronic or terminal medical condition and who require ongoing care from a multidisciplinary team of their GP and at least two other health or care providers. A rebate can be claimed once the patient's usual GP (or a GP in the same practice) has coordinated the development of TCA. The GP may be assisted by their practice nurse, Aboriginal health worker or other health professional in the GP's medical practice or health service. The service must include a personal attendance by the GP with the patient as part of item 723.

The steps in coordinating TCA must include:

- discussing with the patient which treatment/service providers should be asked to collaborate with the GP in completing TCA
- gaining the patient's agreement to share relevant information about their medical history, diagnoses, GPMP etc (with or without restrictions) with the proposed providers
- contacting the proposed providers and obtaining their agreement to participate, realising that they may wish to see the patient before they provide input but that they may decide to proceed after considering relevant documentation, including any current GPMP



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- collaborating with the participating providers to discuss potential treatment/services they will provide to achieve management goals for the patient
- documenting the goals, the collaborating providers, the treatment/services they have agreed to provide, any actions to be taken by the patient and a review date, i.e. completing the TCA document
- providing the relevant parts of the TCA to the collaborating providers and to any other persons who, under the TCA, will give the patient the treatment/services mentioned in the TCA.

What do the Medicare Explanatory Notes Say? (As at 1 February 2009)

Explanatory note M2.1 advises that practitioners can use item 10997 to provide monitoring and support on occasions between EPC plans.

“Item 10997 will assist patients who require access to ongoing care, routine treatment and ongoing monitoring and support between the more structured reviews of the care plan by the patient's usual GP.”

This explanatory note gives no advice as to whether the item can be billed on the same day as an EPC item.

“Item 10997 may be used to provide:

- checks on clinical progress;
- monitoring medication compliance;
- self management advice, and;
- collection of information to support GP reviews of Care Plans.”

The fourth dot point above may suggest that Item 10997 may be used in association with MBS review items 725, 727 and 731.

“Where the GP and practice nurse/Aboriginal Health Worker are at the same location, the GP is not required to be present while the chronic disease monitoring and support is undertaken. It is up to the GP to decide whether they need to see the patient. Where the GP has a consultation with the patient, then the GP is entitled to claim a Medicare item for the time and complexity of their personal attendance on the patient. The time the patient spends receiving a service from the practice nurse or Aboriginal health worker is itemised separately under Item 10997 and should not be counted as part of the Medicare item claimed for time spent with the GP. Where the practice nurse or Aboriginal Health Worker provides another service (eg immunisation) on the same day, the GP is able to claim for both practice nurse/Aboriginal Health Worker items.”

This suggests that Item 10997 and any of the items 721, 723, 725, 727, 729 or 731 might be billed on the same day, as they are different services and thus both claimable.

What does the legislation say? (As at 1 January 2009)

The *Health Insurance (General Medical Services Table) Regulations 2008* provides the following:

“Service provided by a practice nurse or registered Aboriginal health worker to a person with a chronic disease, if:



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- (a) the service is provided on behalf of and under the supervision of a medical practitioner; and
 - (b) the person is not an admitted patient of a hospital; and
 - (c) the person has a GP management plan, team care arrangements or multidisciplinary care plan in place and the service is consistent with the plan or arrangements;
- to a maximum of 5 services per patient in a calendar year”

The Rules of Interpretation in the *Health Insurance (General Medical Services Table) Regulations 2008* provides the following:

Rule 3 General

“Practice nurse means a registered or an enrolled nurse who is employed by, or whose services are otherwise retained by, a general practice.

Registered Aboriginal health worker means a person registered as an Aboriginal health worker under the Health Practitioners Act (NT) who is employed by, or whose services are otherwise retained by, a general practice or health service in the Northern Territory in relation to which the Minister has made a direction under subsection 19 (2) of the Act.”

Rule 71 Meaning of expressions used in item 10997

“In item 10997:

- GP management plan means a plan under item 721 or 725.
- Multidisciplinary care plan means a plan under items 729 or 731.
- Person with a chronic disease means a person who has a care plan under items 721, 723, 725, 725, 729 or 731.
- Team care arrangement means a plan under item 723 or 727.”

What is likely to happen in practice?

Patients typically present to their usual general practitioner to have a care plan performed. However, it is accepted that practice nurses and Aboriginal health workers can assist the GP in the preparation of the plan.

For example, it could be clinically relevant to bill MBS Item 10997 on the same day as an MBS Item 721. The practice nurse may be well qualified in lifestyle counselling. The patient sees the GP for GPMP about diabetes. Part of the plan is to see the nurse for lifestyle counselling and this could reasonably happen on the same day after the GP has finished the GPMP for the patient. This could be particularly the case for rural or remote patients, where transport and access to the GP can be a major barrier to access to health care.

Application of this APS

As from the date of effect, Medicare Australia will assess all claims in relation to MBS item 10997 in accordance with the Administrative Position Statement FPM03/08.