Care Planning in General Practice

An overview of the Medicare initiatives available to GPs when preparing a GP Management Plan and/or Team Care Arrangement for patients with chronic disease.

This guide will also assist services that wish to collaborate with GPs on care planning – whether publicly funded services or Medicare registered allied health providers.

Key to abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AHP</td>
<td>Allied Health Professional</td>
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<tr>
<td>AHS</td>
<td>Allied Health Service</td>
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<td>CDM</td>
<td>Chronic Disease Management</td>
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<tr>
<td>EPC</td>
<td>Enhanced Primary Care</td>
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<tr>
<td>GPMP</td>
<td>GP Management Plan</td>
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<tr>
<td>MBS</td>
<td>Medical Benefits Scheme</td>
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<tr>
<td>SIP</td>
<td>Service Incentive Payment</td>
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<tr>
<td>TCA</td>
<td>Team Care Arrangements</td>
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Chronic Disease Management

Many GP visits occur because a patient has an acute problem, when neither the patient nor doctor can effectively address long-term management of the chronic condition causing the problem.

Evidence shows that chronic disease management (CDM) strategies lead to improved health outcomes for people with chronic conditions. CDM includes planned visits, care coordination, quality links with allied health service, and patient involvement in self-management. A written care plan is a primary tool in this kind of management.

What is a chronic condition?

The criteria for GPs is a condition “...that has been or is likely to be present for at least six months, or is terminal, including but not limited to asthma, cancer, cardiovascular illness, diabetes mellitus, mental health conditions (including dementia), arthritis and musculoskeletal conditions and stroke.” MBS explanatory notes

What is a CDM care plan?

In general practice a care plan is “a process for setting and achieving goals”. This involves:

- assessment of the patient’s condition/s in relation to overall health and functionality
- outlining the practitioner’s goals for the patient
- addressing the patient/carer’s needs and goals
- planning treatments and actions which will meet the goals, and
- planning review steps.

If the GP involves other health and care professionals, the plan will also include:

- collaboration between team members to prepare the plan
- recording of each party’s goals and the treatment/care planned to meet those goals, and
- regular review of the team arrangements.

MBS item numbers

GPs are paid through the Medical Benefits Scheme for the preparation of care plans, under a Department of Health & Ageing program called Primary Care Items ‘Chronic Disease Management’.

When preparing plans and claiming for these services, GPs must comply with Medicare rules and guidelines. GPs claim by submitting the ‘item’ number to Medicare which relates to the specific service under the MBS.

Since July 2005 there have been two kinds of CDM care-planning services available in general practice: the GP Management Plan (GPMP) and the Team Care Arrangement (TCA). GPs can prepare one or the other or both. Together these two types of plan equate to the previous ‘EPC’ multidisciplinary care plan.

For Department of Health & Ageing information go to: www.health.gov.au/mbsprimarycareitems

For Medicare items and explanatory notes go to: www.mbsonline.gov.au

For a summary of care planning items see the back page of this Guide.
**GP Management Plan**

This is a plan prepared by the GP, for a patient of any age with one or more chronic conditions, outlining the goals, care and service which the doctor and patient agree on together.

A GPMP need not involve any other parties. However, most practices combine it with a TCA and provide a single “combo” plan to all parties.

Remember to note on the plan the patient’s own goals and the actions which they identify and agree to undertake. It is helpful for all members of the team to be aware of this patient perspective.

**Team Care Arrangement**

This is a plan prepared by a GP in collaboration with other services, for a patient of any age who has one or more chronic conditions and who would benefit from multidisciplinary care. For instance, where routine management is compounded by unstable or deteriorating condition, increasing frailty or dependence, development of complications, comorbidities or a change in social circumstance.

The TCA outlines the goals, care and services which the multidisciplinary team agree on together, with the consent of the client. It includes the client’s contribution, as above.

The team must comprise at least 3 health or care providers (including the preparing GP) and:

- the services must be available within a reasonable time (GP/nurse is responsible for checking this)
- each service must provide different & ongoing care
- each team member should make a brief written or verbal contribution to the TCA (or give their ok to the contribution which the GP or nurse has written on their behalf)
- each TCA should be tailored to the individual patient.

Teams can be made up of a variety of care types, for example:
- a GP, a teacher and a specialist
- a GP, a community diabetes educator and a community dietician
- a GP, a private Medicare-registered physiotherapist and the local council HACC service.

**Both GPMP & TCA:**

- should be prepared by the patient’s usual GP
- are for patients in the community (not in a residential aged care facility or in hospital).

Recommended frequency is every 2 years; GPs may not claim for preparation of a GPMP/TCA within 12 months of a previous claim, unless exceptional circumstances* apply.

Care plans do not have an ‘expiry date’; the GPMP & TCA remain valid as long as the patient’s condition warrants and as long they are reviewed periodically. (This means that after the minimum or recommended time the GP can prepare a new plan if warranted or s/he can review the original plan on an ongoing basis. Either way, the patient will be entitled to five Medicare allied health services per year – see page 5.)

**Reviews**

The GPMP and the TCA should be reviewed regularly by the preparing GP or a GP in the same practice.

Review of a TCA is done in consultation with all services involved, with their contribution noted.

The minimum time between MBS review claims is 3 months, although the recommended frequency between reviews is 6 months. But a review can be done inside the minimum time in exceptional circumstances*.

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* Exceptional circumstances – where there has been a significant change in the patient’s clinical condition, or care arrangements, or ability to function. Examples: hospitalisation; development of co-morbidities; death of a career; onset of depression.
General Practice / Allied Health liaison

Where plans are initiated by general practice...

GPs may have assistance from a Practice Nurse, or other health professional, to gather information and prepare care plan documents. This is done on behalf of the GP who must consult the patient as part of the service and must review the finished plan.

Allied health may be contacted by a practice manager or practice nurse to:

- invite them to participate in a TCA
- exchange confidentiality agreements
- obtain allied health input to the plan, ie
  - arrange a mutually convenient time to speak to the GP, or
  - submit a draft of the TCA for the allied health provider’s approval, or
  - offer background information on the patient and request the AHP’s input verbally or by exchange of faxes / emails (a paragraph outlining his/her goals for the client and the care or service they will provide to meet those goals).

Once the client has seen and approved the finished TCA, the practice must provide all team members with a copy. The TCA should include review dates; reviews will be a similar process to the initial liaison.

In addition to formal feedback on client progress, team members may want to contact each other to discuss a problem. Allied health – please send a fax, including your name, organisation and discipline, and the client’s name. State that you are a member of the TCA for this client, outline the issue that you would like to discuss with the GP and request a return call.

Consider whether an incident (deterioration in condition or change of care circumstances) may warrant an unscheduled review or a new plan or a case conference.

Where plans are initiated by allied health...

Publicly-funded or private allied health providers can invite GPs to contribute to their own plan.

However, a request for contribution is not ideal. It is preferable to invite the GP to ‘prepare’ a care plan, for which s/he can claim the full MBS fee. This is partly because these claims often fund the employment costs of a practice nurse who plays a significant role for the client. It is also because Medicare rules prohibit the GP from preparing a GPMP/TCA for 3 months after a ‘contribution’ item claim.

Note, a TCA can exist alongside another organisation’s plan. The GP-prepared TCA may be based on information given by that organisation. The ideal end result is a plan containing elements from both parties.

It is in the client’s interests to have a GP-prepared plan (a GPMP and TCA), because this entitles them to access allied health Medicare services in combination with community or council services. See page 5.

Residents in Aged Care Facilities

GPs can be invited to contribute to the care plan of a residential aged care facility (RACF). The client can then access private Medicare registered allied health services. GPs cannot prepare a GPMP or TCA for a resident of a facility because this would duplicate the facility’s plan.

GPs can contribute to discharge care plans prepared by a hospital for residents being discharged back to the RACF.

A GP can coordinate a TCA for a private in-patient being discharged from hospital back to the facility – but only where the GP is providing the in-patient care.
MBS Item Descriptors & Explanatory notes

When preparing care plans (GPMP and TCA), doctors and practice nurses must follow the rules and eligibility criteria outlined in the current MBS. See www.health.gov.au/mbsonline

Private services which register for the Allied Health Medicare Initiative receive a supplementary MBS booklet from Medicare with details of the item related to their discipline.

Allied Health Medicare Initiative (‘EPC’)

Patients with a chronic condition can access rebates for certain private Medicare-registered allied health services. See Appendix 1 ‘Care Planning Team Members’ for a list of eligible disciplines.

Before providing a referral to a Medicare-registered allied health service, the GP must first complete both a GP Management Plan (GPMP) and Team Care arrangement (TCA), or contribute to an aged care facility’s plan for a resident with a chronic condition.

- Rebates are only available where the requirement for the service has been noted on the TCA (or aged care facility plan) and where a signed referral has been supplied by the GP on the form available from the DH&A website. Go to www.health.gov.au/mbspri marycareitems and from the “in this section” box select Individual Allied Health Services; or phone 132 011.

- Rebates are limited to 5 allied health visits per year in total (not 5 per service type/discipline).

- The GP may write a referral for up to 5 further Medicare-rebated visits each calendar year if the GPMP + TCA remains active*.

- The initiative is confusing for clients. It helps if both private and community allied health providers and client understand the scheme. Give clients an information sheet: see www.health.gov.au/mbspri marycareitems

- Allied health providers can suggest that the client talk to their usual GP about eligibility and ask the GP to check whether a GPMP/TCA already exists. AHPs should offer a rebate until this has been done. AHPs may not fill in a referral form and send it to the GP to sign.

- Note that a gap fee may apply to some private services – GP, nurse or the client should check in each case.

- The rebate can assist clients where a publicly funded service is not immediately available. For instance, the GP could put the client on the community waiting list and refer to a private provider for the first month or two. It is recommended the GP/nurse develop a strategy for communication between providers.

- Some community health services offer ‘MBS clinics’ alongside their community funded services. These clinics are usually run by contracted private providers. The client can usually move from MBS to community services within the one organisation and with the advantage of in-house referral to the CDM program.

- A Team Care Arrangement can include any number of services above the minimum three. New or further services should be added to everyone’s copy of the TCA as they are put in place. Reviews should be used to keep the TCA current.

Dental Health Initiative

Medicare rebates on dental costs are available for patients who are managed under a GPMP and TCA, where the oral health is impacting on the patient’s general health. For an information sheet and referral form, go to www.health.gov.au/dental or ask your local Division of General Practice / GP Network for advice.
**Practice team roles in the preparation of a GPMP / TCA**

Refer to MBS item descriptors and explanatory notes: “A practice nurse, Aboriginal health worker or other health professional may assist a GP with items 721, 723, and 732 (e.g. in patient assessment, identification of patient needs and making arrangements for services). However, the GP must review and confirm all assessments and arrangements, and see the patient.”

<table>
<thead>
<tr>
<th>Suggested tasks:</th>
</tr>
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<tbody>
<tr>
<td>Establishment of a database of local allied health services, on clinical software and/or paper.</td>
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<tr>
<td>Initial patient recruitment, eg. database search for eligible patients. Phone or letter contact (an alternative to opportunistic recruitment during GP consults).</td>
</tr>
<tr>
<td>Explanation to patient (phone or in person prior to GP consultation) of the purpose of GPMP / TCA, steps, costs, etc as per checklist.</td>
</tr>
<tr>
<td>Review of history and current assessments, identification of patient needs and personal goals, discussion of actions to be taken by the patient</td>
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<tr>
<td>Discussion with patient about AH services which could be invited to participate in a TCA (ie. services currently being used by the patient or which the patient will be referred to).</td>
</tr>
<tr>
<td>Providing basic lifestyle advice, applying ‘health coaching’ or ‘motivational interviewing’ techniques, using Lifescripts or similar. (Where the client requires ongoing self management support, they should be referred to a professional with this expertise.)</td>
</tr>
<tr>
<td>Follow-up of outstanding test results and similar information for GP.</td>
</tr>
<tr>
<td>Contacting allied health to invite them to participate in a particular TCA; discussing their collaboration on required services/treatments. Arranging face-to-face or phone or fax exchange with the GP is necessary.</td>
</tr>
<tr>
<td>Typing / copying / filing of GPMP / TCA proforma.</td>
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<tr>
<td>Making consult appointment with patient, for GP to discuss the draft care plan with patient and obtain patient agreement.</td>
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<tr>
<td>Sending final copy of plan to all parties.</td>
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<tr>
<td>Ensuring admin claims correct item number.</td>
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</table>

Note, these tasks are undertaken on behalf of the GP. They do not entitle the nurse to be one of the minimum 3 providers on a Team Care Arrangement.

MBS item 10997 for ongoing monitoring of the care plan by a practice nurse can be claimed up to 5 times per year once the GPMP/TCA is in place.

**Obtaining Consent to prepare a GPMP or TCA**

The GP must discuss the purpose of the GPMP and/or TCA with the patient. The explanation must include:

- informing the patient that he or she will incur a charge for the service provided by the practitioner for which a Medicare rebate will be payable;
- informing the patient of any additional costs he or she will incur; and
- explaining to the patient the nature of a GPMP and/or TCA and asking the patient whether he or she agrees to it taking place.

In the case of a TCA the explanation must include:

- informing the patient that his or her medical history, diagnosis and care preferences may be discussed with other care providers;
- providing an opportunity for the patient to specify what medical and personal information s/he wants to be conveyed to, or withheld from, the other members of the multidisciplinary care team.

Note the consent on each proforma. The patient may sign the practice’s copy of the document, or the GP may sign on their behalf by annotating the electronic record.

Patients will often be unsure whether they have an active GPMP or TCA in place, or how many Medicare claims they have made in the current calendar year. They can obtain this information from Medicare on 132 011. The provider may enquire with Medicare on their behalf with client authority.

Further information on CDM care planning

GPs and Practice Nurses may request a visit from their Division of General Practice / GP Network for assistance with CDM. Information sheets, allied health service referral forms, and phone advice are available from divisions or from the following sources.

AHPs working with a GP new to care planning can refer them to their local Division of General Practice / GP Network for assistance and/or to the sites below.

Medicare Australia

- Medicare items and explanatory notes: www.mbsonline.gov.au
- Medicare provider enquiry line 132 150.
- Clients can phone Medicare direct on the **public line 132 011** to find out if they have an existing care plan, GPMP or TCA, and the date at which it commenced.
- Clients can also phone Medicare direct on the **public line 132 011** to find out how many allied health or dental rebates they have received in the current calendar year.

Department of Health and Ageing (DH&A)

- DoHA 1800 020 103, ask for Primary Care section or Allied Health Section
- Email questions to: medicare.prov@medicareaustralia.gov.au
- For information on Medicare rebated services, and a referral form, go to www.health.gov.au/mbsprimarycareitems and from the "in this section" box select Individual Allied Health Services; or phone 132 011.

Appendices attached:

1. Care Planning potential team members
2. “Invitation to Participate” sample letter
3. Sample blank GPMP-TCA proforma
4. MBS items cheat sheet.

An electronic copy of this booklet is available from admin@impetus.org.au
Care Planning Team Members

MBS requirement: To develop Team Care Arrangements for a patient, at least two health or care providers / organisations who will be providing ongoing treatment to the patient must collaborate with the GP in the development of the TCA.

Each of the health or care providers must provide a different kind of ongoing care to the patient.

Each person can be counted only once as a team member, even where they offer more than one different service.

One of the minimum team of three is the GP.

*Health providers can include, among others:*
- aboriginal health workers
- asthma educators
- audiologists
- consultant physician
- dental therapists
- dentists
- diabetes educators
- dietitians
- drug & alcohol workers
- exercise physiologists
- mental health workers
- occupational therapists
- optometrists
- orthoptists, orthotists or prosthetists
- pharmacists
- physiotherapists
- podiatrists
- psychologists
- registered nurses*
- social workers
- specialist / consultant physician
- speech therapist
- pathologists.

*Community service providers can include:*
- alcohol & drug support workers
- chaplains
- community care coordinators
- community aged care package coordinators
- disability services coordinators
- education providers (teachers)
- home nursing
- personal care workers (paid)
- probation officers
- HACC service providers, incl meals on wheels & home help.

Health and care providers can be sourced through local community health centres, mental health services, aboriginal health services, shire offices & hospitals. To find a provider, try:

www.connectingcare.com
www.humanservicesdirectory.vic.gov.au
www.cdm.ahpa.com.au

*Allied Health Services eligible to register for Medicare rebate scheme:*
- Aboriginal Health Worker
- Diabetes Educator
- Audiologist
- Exercise Physiologist
- Dietitian
- Mental Health Worker (eg. psychologist, mental health nurse, some social workers)
- Occupational Therapist
- Physiotherapist
- Podiatrist or Chiropodist
- Chiropractor
- Osteopath
- Psychologist
- Speech Therapist

- A practice nurse can assist in the preparation of a plan and in patient education on behalf of the GP, but is not one of the TCA members in her/his own right.
- A practice nurse can be a team member when they provide specific ongoing care in their own right, eg. where the nurse is a trained diabetes or asthma educator.

- Interpreters & TCA organisers (ie. admin) cannot be counted as team members.

- The patient’s informal or family carer may be included on the TCA (contributing a goal and/or action) but does not count as one of the minimum three team members. A paid professional carer may be a team member.
Appendix 3: “Invitation to Participate” sample letter

[Practice Letterhead]

Date

Provider’s Organisation
Address line 1
Address line 2

Dear (allied health professional’s name) ………………………………………………………

Re: Team Care Arrangement for ………………………………………… DOB: …./…./…..

The Medicare Primary Care initiative aims to improve coordinated care of patients with chronic conditions and complex care needs. The initiative provides GPs with an opportunity to develop a multidisciplinary Team Care Arrangement (TCA) for such patients.

I am currently developing a TCA for the above patient who has given consent to include you as a member of the team.

Attached is a copy of the draft TCA (care plan).

I would be grateful if you could advise me:

a) whether you are available to provide ongoing care to the patient and are willing to be involved in the TCA?

b) whether you are satisfied with the TCA (care plan) or have any suggestions for changes?

I would appreciate your response either by phone or by completing the details below and faxing this page back to me.

When the TCA (care plan) is completed and you have seen the patient we will ask you to provide the usual feedback and to participate in TCA Reviews (every 6 months unless circumstances require more frequently).

Yours sincerely

GP Name

_______________________________
Communication re Team Care Arrangement

I, …………………………………………., have read the TCA (care plan) for the above patient and (please tick boxes as appropriate)

☐ am willing to be involved in the TCA / care plan, and I am satisfied with the plan as it is.

☐ am willing to be involved in the TCA / care plan, and I would like to make some changes to the plan (if so, please attach your suggested changes).

Signature: …………………………………………………………… Date: …./…./…..

CONFIDENTIAL
File this health information securely in the client’s record, or destroy if not participating in TCA.

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With acknowledgement to Department of Health & Ageing
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I have explained the purpose of a GPMP & costs involved. 
The patient has agreed to proceed with the preparation of the GPMP.

GP MANAGEMENT PLAN

<table>
<thead>
<tr>
<th>Patient problems / needs / relevant conditions</th>
<th>Goals - changes to be achieved, including patient/carer’s goals</th>
<th>Required treatments and services including patient actions.</th>
<th>Arrangements for treatments/services (when, who, contact details).</th>
</tr>
</thead>
</table>

Copy of GPMP provided to patient/carer/other relevant providers? YES / NO  GPMP added to the patient’s records? YES / NO

Date service was completed: .................................................................  Review Date: ..............................................................................................................

I have discussed the finished GP Management Plan with the patient, who has accepted it: ..............................................................................................................................................................................

(GP Signature & Date)
Patient’s Name: 

I have explained the purpose of a Team Care Arrangement (TCA) & costs involved. The patient agrees to the involvement of other providers and to share her/his clinical information without / with restrictions (identify if the latter). The patient has agreed to proceed with the preparation of the TCA.

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**TEAM CARE ARRANGEMENT**

<table>
<thead>
<tr>
<th>Goals - changes to be achieved, including patient/carer goals.</th>
<th>Required treatments and services including patient actions.</th>
<th>Planned treatments/services (when, who, contact details).</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

Copy of TCA supplied to patient/carer, team members and other relevant persons (with patient permission as above)? YES / NO  
TCA added to the patient’s records? YES / NO  
Date service was completed: .............................................................. Review Date: 
I have discussed the finished TCA with the patient, who has accepted it: .................................................................................................................. (GP Signature & Date)  
*Referral forms for Medicare allied health and dental care services completed, if eligible private service required? YES / NA*
<table>
<thead>
<tr>
<th>MBS No</th>
<th>Description</th>
<th>MBS Fee as at Nov10</th>
<th>Patient Eligibility</th>
<th>Recommended frequency</th>
<th>Minimum claiming period</th>
<th>Task summary.</th>
</tr>
</thead>
</table>
| 721    | Preparation of GP Management Plan (GPMP) | $138.75 usual GP* | Patient in the community with a chronic or terminal condition. Or, where the preparing GP is providing in-hospital care, a private in-patient with chronic condition being discharged from hospital, including private patients being discharged back into an aged care facility (this is an in-hospital service @ 75%). | Once every 2 years supported by regular review services (see 732) | 12 mths** | ▪ Explain purpose of plan to patient and record patient’s consent and agreement to prepare.  
▪ Assess patient re health care needs, problems and function  
▪ Agree on management goals with patient  
▪ Identify any actions to be taken by patient  
▪ Identify required GP treatment  
▪ Identify services (unless doing this on a TCA)  
▪ Document needs, goals, patient actions, treatment/services and a review date on the plan proforma  
▪ Discuss finished plan and provide a copy to patient (and carer ). |
| 723*   | Coordination of Team Care Arrangements (TCA) | $109.95 usual GP* | Patient in community with a chronic or terminal condition who also requires ongoing care from a multidisciplinary team of at least 3 health or care providers including the GP. Or a private in-patient as above requiring multidisciplinary care. | Once every 2 years supported by regular review services (see 732) | 12 mths** | ▪ Explain purpose of team care to patient and record consent agreement to prepare  
▪ Discuss which services are needed (or in place) and gain patient’s agreement to share relevant information  
▪ Contact proposed providers and request their participation  
▪ Collaborate with participating providers re goals & treatments  
▪ Document goals, collaborating providers, treatment/services, patient actions and a review date on the TCA proforma  
▪ Discuss finished plan with patient and provide a copy to all parties. |
| 732    | Review of GPMP and/or Coordination of Review of TCA | $69.35 GP* | Patient who has a current GPMP (721) or TCA (723) and requires a review | Once every 6 months | 3 mths** | ▪ Review GPMP (repeat above process) and document any changes  
▪ Consult team providers on progress against treatment / services.  
▪ Document any changes to patient’s TCA.  
▪ Set next review date |
| 729    | Contribution by GP to a multidisciplinary care plan being prepared or reviewed by another service | $67.70 Other provider | Patient having a multidisciplinary care plan prepared or reviewed by another care provider, eg. CHS. | Once every 6 months | 3 mths** | ▪ Collaborate with the provider preparing or reviewing the plan  
▪ Forward a copy of your contribution for their records  
▪ Include your contribution to the care plan in patient’s records. |
| 731*   | Contribution by GP to multidisciplinary care plan prepared for a resident by an aged care facility or by a hospital for resident. | $67.70 RACF | Patient of residential aged care facility (RACF) having a multidisciplinary care plan prepared or reviewed by the RACF or discharging hospital. | Once every 6 months | 3 mths** | ▪ As for Item 729  
▪ contribute at the invitation of the facility  
▪ discuss with facility if Medicare private allied health services would benefit patient and provide EPC referral. |

* Plans and reviews are to be done by the patient's usual GP, or another GP in the same practice. In preparing a GPMP or TCA, or review, a GP may be assisted by their practice nurse or other health professional in the practice; the GP must authorise the final document. Note, all above services must include a personal attendance by the GP with the patient, who must review the final plan. Review may be done by a new practice where the patient has changed practices. A new plan may be done by a new practice where the patient has changed practices, if warranted by significantly changed services or treatments – annotate the claim to explain to Medicare.  
** These services can also be provided more frequently in exceptional circumstances – where there has been a significant change in the patient’s clinical condition or care circumstances – annotate the claim to explain to Medicare.  
+ Patients who have both a GPMP (721) and a TCA (723) in place, or where the GP has claimed item 731 for an aged care resident, can access allied health Medicare rebated services to a maximum of 5 services per year (not 5 per type).