

## MBS Summary Guide

### Medicare Items relating to Chronic Disease Prevention & Management

#### Item 721 - GP Management Plan

##### Description

- Management of patients with chronic/complex medical conditions
- Goal setting between GP & Patient
- Length of Plan = 2 years
- Rebate \$124.95

##### Eligibility

- Chronic medical condition present for 6 month or more
- Excludes risk factors; raised cholesterol, hypertension, etc.
- Further information; GP Information Kit – New Medicare CDM Management Items

##### Review

- Item 725
- Every 6 months

##### Practice Nurse

- Assist GP with; patient assessment, establish patient needs, goals, actions, treatment/services and review date

##### Resources

- GP Information Kit; Booklet and template
- Lifescripts Assessment and Prescription resources

#### Item 723 - Team Care Arrangement

##### Description

- Extension of GP Management Plan
- Management of patients requiring multidisciplinary care
- Provides patient with access to 5 allied health rebates per calendar year
- Length of Plan = 2 years
- Rebate \$98.95

##### Eligibility

- Recommended that patient has GP Management Plan (721) in place
- Patients requiring care from multidisciplinary team - minimum 3 health care providers (GP/PN+2 others)

##### Review

- Item 727
- 6 months

##### Practice Nurse

- Assist GP with; collaborate with team members, establish and document patient goals, services, actions and review date

##### Resources

- GP Information Kit; Booklet, template and sample letter to allied health team members
- Medicare Allied Health Referral Form
- Lifescripts Assessment and Prescription resources

#### Item 717 - 45 Year Old Health Check

##### Description

- For the prevention of patients at risk of developing a chronic medical condition
- Detection and prevention chronic disease and enable early intervention strategies
- Rebate \$100
- Once only for eligible patients

##### Eligibility

- Aged between 45-49 inclusive
- At risk of developing a chronic disease
- Must display at least one risk factor

##### Practice Nurse

- Assist GP with; identifying eligible patients, information collection, patient assessment, arranging interventions (as required) and providing advice and information to patient.

##### Resources

- GP Information Kit; Booklet, template local services directory
- Lifescripts assessment and prescription resource

*This material is only a summary and must be read in conjunction with the Medicare Benefits Schedule Book or the information provided within the Sutherland Division of General Practice information kits.*

**For further information contact Shona Dutton Ph: 9525 4011  
or visit the Division website [www.shiregps.org.au](http://www.shiregps.org.au)**

## CLAIMING SERVICE INCENTIVE PAYMENTS (SIP - DIABETES)

To be eligible for a SIP of \$40 per patient per year it is necessary to complete an annual program of care for a patient with diabetes. Over 12 months the patient must receive the **minimum** requirements of care\* listed below. **Additional** levels of care will be needed by insulin-dependent patients and those with abnormal review findings, complications and/or co-morbidities.

Blood Pressure	Every 6 months
Ht / Wt / waist (BMI)	Every 6 months
Feet Exam	Every 6 months
Glycaemic control (HbA1c)	Once per year
Blood lipids	Once per year
Microalbuminuria	Once per year
Eye Exam	At least every 2 years
Smoking	Review once per year
Healthy eating plan	Review once per year
Physical activity	Review once per year
Self care education	Review once per year
Medications	Review once per year

\*Based on RACGP Diabetes general practice guidelines, 2006/07.

\*Lifescrpts resources may be used to assist with risk factor management reviews

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