

ITEM 731

CONTRIBUTION TO &/OR REVIEW OF A CARE PLAN

What is it?

A multidisciplinary care plan initiated by the RACF and involves at least 2 other contributing members^a, each providing a different kind of care (one of whom may be a GP).

Attendance by a medical practitioner to **CONTRIBUTE/REVIEW:**

- a) a multidisciplinary care plan for a resident in a RACF, prepared by that facility; or
- b) a multidisciplinary care plan prepared for a resident by another provider before the resident is **discharged** from a hospital or an approved day-hospital facility, or to a review of such a plan by another provider.

The resident need not be present while documentation is prepared and members of the team are contacted for input. All members of the team do not have to be communicating at the one time.

Eligibility

- RACFs are funded to provide a care plan for each permanent resident, with the focus primarily being on the nursing care needs of the resident.
- Resident with a chronic condition^b and complex care needs.

Frequency

Once every 6 months, however it can be claimed at a maximum of 3 monthly intervals where there has been a significant change in the resident's clinical condition or care circumstances. The resident's invoice or Medicare voucher should be annotated to briefly indicate the reason why the service involved was required earlier than the minimum time interval for this item.

A rebate will not be paid

- Within 3 months of a previous claim for the same item;

The Process

1. RACF staff must invite GP to contribute/review the resident's care plan.
2. RACF to obtain consent from resident/person responsible so the GP can contribute and or review the care plan and share relevant information with the other providers.
3. RACF to send the relevant section of the nursing care plan to the GP, or hand the care plan to GP at a visit. The GP can then contribute and/or review the care plan (ensuring this contribution is added to the resident's file). Communication between GP and co-ordinating provider must be based on two way communication, that is, face to face, telephone, fax, email or written correspondence. GP must then sign, discuss and/or fax their contribution back to the RACF.
4. Set care plan review date by adding a recall to the resident's file. Recommendation: 6 monthly.
5. GP to claim Item 731.

Where a resident's GP has contributed to a care plan prepared by the RACF or discharging hospital, the resident is eligible to access Medicare rebates under the allied health items.

a May include Aboriginal health care workers, audiologists, dental therapists, dietitians, occupational therapists, optometrists, orthoptists or prosthetists, pharmacists, physiotherapists, podiatrists, psychologists, registered nurses, social workers, speech pathologists. The resident/person responsible is not included in the minimum of 3. *b* Chronic medical condition is one that has been or is likely to be present for at least 6 months." Medicare Benefits Schedule A28.43, November 2006.