GP Chronic Conditions Management (GPCCM) MBS User Guide

National MyMedicare PHN Implementation Program

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The purpose of this resource is to support general practices to effectively use GPCCM MBS items to deliver comprehensive, proactive care for patients with chronic conditions (a medical condition likely to be present for ≥6 months, or terminal); including regular review of management plans.

The new framework for CCM from 1 July 2025 both simplifies and streamlines the arrangements for health care professionals and patients. To enhance continuity of care, **patients registered with MyMedicare must access GPCCMP items through the practice where they are registered for MyMedicare.** Patients that are not MyMedicare registered may access CCM services through their usual GP. There is no list of eligible chronic conditions; it is up to GP clinical judgment to determine if an individual patient's chronic condition is likely to last for more than 6 months and would benefit from a GPCCMP.

Previous Chronic Disease Management MBS items for GP management plans (229, 721, 92024, 92055), team care arrangements (230, 723, 92025, 92056) and reviews (233, 732, 92028, 92059) will cease and be replaced with the new CCM MBS items. Transition arrangements will be in place for 2 years to ensure current patients don't lose access to services under CDM plans prepared prior to 1 July 2025.

Chronic Condition Management items from 1 July 2025

Name of Item	GP item number	Prescribed Medical Practitioner item number	Frequency of Claiming	Fee
Prepare a GP chronic condition management plan – face to face	965	392	Initial plan development. New plan only if clinically necessary.	GPs - $156.55 PMPs - $125.30
Prepare a GP chronic condition management plan - video	92029	92060	Initial plan development. New plan only if clinically necessary.	GPs - $156.55 PMPs - $125.30
Review a GP chronic condition management plan – face to face	967	393	Up to every 3 months if clinically relevant	GPs - $156.55 PMPs - $125.30
Review a GP chronic condition management plan – video	92030	92061	Up to every 3 months if clinically relevant	GPs - $156.55 PMPs - $125.30

Disclaimer: *This resource provides examples of how GPCCM MBS Items can be used by general practices and should be used as a guide only. General practices or Aboriginal Community Controlled Health Organisations (ACCHO) should consider their model of care, clinical judgement and team structure to inform their application of GP Chronic Condition Management MBS items. All MBS billings must be for clinically relevant services. GPs should use their clinical judgement in relation to what individual patients require.* Please refer to MBS online for the most current and detailed information on all MBS items. https://www.mbsonline.gov.au/

MBS Quick Guide

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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

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

CARE MANAGEMENT AND HEALTH ASSESSMENT SERVICES	Face to Face	Telehealth
GP chronic condition management plan** (Initial plan, then only if clinically neccesary)	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 GPCCMP (5 PER YEAR)	10997	Phone 93203 Video 93201
Practice Nurse/Aboriginal Health Practitioner follow-up services for Aboriginal and Torres Strait Islander patients (only available to patients with a 715-health assessment) (10 PER YEAR)	10987	Phone 93202 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	

**Patients with a General Practitioner Chronic Disease Management Plan/Review can access the following MBS services:

† MyMedicare registered patients can only access these services at their MyMedicare general practice

*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. (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.)

- Allied Health Services: Up to 5 individual sessions per year (10 for Aboriginal or Torres Strait Islander patients).
- Nurse or Health Practitioner Services: Up to 5 services annually, provided on behalf of a doctor.
- Type 2 Diabetes Group Services: Initial assessment to determine suitability, and up to 8 yearly group sessions for dietetics, education, or exercise.

GP CASE CONFERENCING ITEMS			
Case Conference GP organises	735	739	743
Case Conference GP participating	747	750	758

Chronic Condition Management Plans and Reviews

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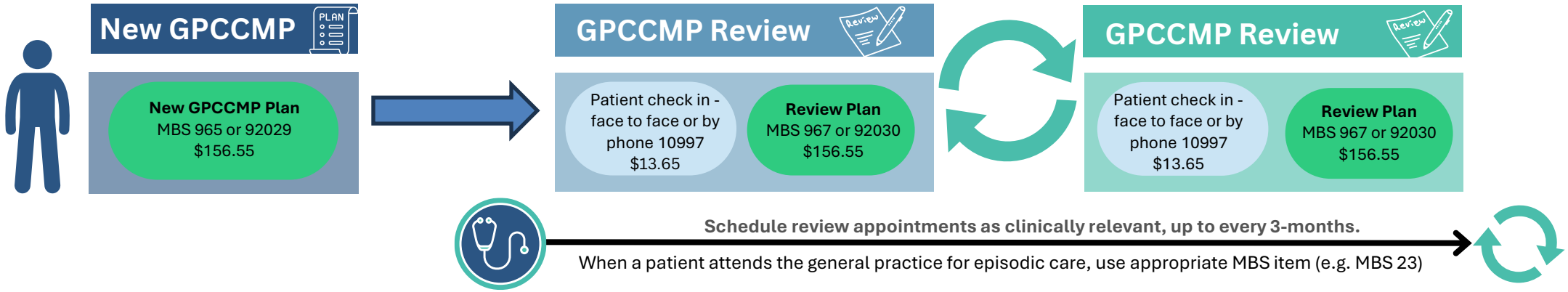

New GPCCMP

1.Patient Eligibility

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

2. Develop Management Plan: Practice Nurse, Aboriginal Health Workers or Practitioners may contribute to preparing the plan - GP must see patient

☐ Explain the management plan process, gain informed consent, and collaboratively identify patient, 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 Reviews

☐ Review GPCCMPs up to every 3 months if clinically appropriate
☐ Use MBS item 967 (face-to-face) or 92030 (video)
☐ Assess patient progress, update goals and services, record consent
☐ Review letters from other providers and note updates in patient file
☐ Provide an updated copy to the patient and carer
☐ Share updates with other providers (if applicable)
☐ Encourage upload to My Health Record (with consent)
☐ Consider future review appointments

Allied Health Referrals and other GPCCMP Considerations

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Allied Health Referrals

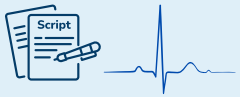
Consider any allied health care your patient may require have when writing the management plan with them.

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

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. **Visit HealthPathways Melbourne here**.