Australian Government
Department of Health, Disability and Ageing

Upcoming Changes to Chronic Disease Management Framework – MBS Items for GP Chronic Condition Management Plans

Last updated: 22 May 2025

- From 1 July 2025, GP management plans (GPMPs) and team care arrangements (TCAs) will be replaced with a single GP chronic condition management plan (GPCCMP).
- The existing MBS items for developing and reviewing GPMPs and TCAs will cease and new MBS items for the GPCCMP will be introduced.
- This factsheet details the requirements of the new MBS items. For an overview of the changes, changes to referral requirements for allied health services, impact on other health care providers and transition arrangements for patients with an existing GPMP and/or TCA please see the separate factsheets.
- GPCCMPs can be prepared and reviewed by general practitioners (GPs) and prescribed medical practitioners (PMPs) either face to face, or via video. A practice nurse, Aboriginal and Torres Strait Islander Health Practitioner or Aboriginal Health Worker may assist with the development or review of a plan.
- Patients registered with MyMedicare must access GPCCMP items through the practice where they are enrolled; patients that are not registered may access the services through their usual GP.
- The requirements for a GPCCMP have been streamlined compared to GPMPs and TCAs. Consultation with at least two collaborating providers is no longer required. GPs and PMPs can refer patients with a GPCCMP directly to relevant services. There is no requirement for allied health providers to confirm acceptance of the referral or otherwise provide input into the preparation of the GPCCMP. However, the requirements for allied health providers to provide a written report back to the GP after the provision of certain services (e.g. the first service under a referral) are unchanged.
- Consistent with current arrangements, items for the preparation or review of a GPCCMP cannot be co-claimed on the same day as general attendance items.
- Items for preparing a GPCCMP can be claimed every 12 months if clinically relevant; GPCCMP reviews are available every 3 months if clinically relevant. Plans may be prepared or reviewed earlier if exceptional circumstances apply.
- While GPCCMPs do not expire, patients must have had a GPCCMP prepared or reviewed in the previous 18 months to continue to access allied health and other services under the plan.
- GPCCMP items may be claimed with single bulk billing incentives when eligible patients are bulk billed and will be included in the Bulk Billing Practice Incentive Program from 1 November 2025.

What are the changes?

- From 1 July 2025 the following MBS items will cease:
  - GP management plans – 229, 721, 92024, 92055
  - Team care arrangements – 230, 723, 92025, 92056
  - Reviews – 233, 732, 92028, 92059.
- The ceased items will be replaced with new items for GPs and PMPs to prepare and review GPCCMPs (see Table 1).
- Practice nurses, Aboriginal and Torres Strait Islander Health Practitioners and Aboriginal Health Workers will be able to assist the GP or prescribed medical practitioner to prepare or review a GPCCMP.
- Patients can access the following MBS-supported services where they are consistent with their GPCCMP:
  - Up to 5 individual allied health services per calendar year (10 services for patients of Aboriginal or Torres Strait Islander descent).
  - Up to 5 services provided on behalf of a medical practitioner by a practice nurse or Aboriginal and Torres Strait Islander Health Practitioner.
  - For patients with type 2 diabetes, an assessment of their suitability for group dietetics, diabetes education or exercise physiology services and, if they are suitable, up to 8 group services for the management of diabetes per calendar year.

Table 1: GP Chronic Condition Management Items commencing 1 July 2025*

Name of Item	GP item number	Prescribed medical practitioner item number
Prepare a GP chronic condition management plan – face to face	965	392
Prepare a GP chronic condition management plan - video	92029	92060
Review a GP chronic condition management plan – face to face	967	393
Review a GP chronic condition management plan – video	92030	92061

ELIGIBLE PATIENTS

- GPCCMPs are for patients with one or more chronic medical conditions who would benefit from a structured approach to their care.
  - A chronic medical condition that has been (or is likely to be) present for at least 6 months or is terminal.
- There is no list of eligible conditions. It is up to the GP or PMP's clinical judgment to determine whether an individual patient with a chronic condition would benefit from a GPCCMP.
- Patients registered with MyMedicare must access GPCCMP items through the practice where they are enrolled. Patients who are not registered must access GPCCMP items through their usual GP. These requirements are the same for face to face and telehealth items.
- GPCCMPs are not available to patients who are care recipients in a residential aged care facility. Allied health services are available to these patients through a multidisciplinary care plan (see standalone factsheet).

PREPARING A GPCCMP

- The MBS fee to prepare a GPCCMP is **$156.55** for GPs and **$125.30** for PMPs.
- Unless exceptional circumstances apply, a GPCCMP can be prepared once every 12 months if it is clinically relevant to do so. It is not required that a new plan be prepared each year, existing plans can continue to be reviewed.
- A GPCCMP is intended to set out the patient's treatment and management goals, actions to be taken and, where multidisciplinary care is required and the services to which the patient will be referred.
- The plan is intended to be a patient-centred plan. While there are a range of MBS-supported services available for patients with a GPCCMP, services that are supported through other funding mechanisms can also be identified in the plan.
- Subject to the patient's consent, GPs and PMPs are encouraged to upload the GPCCMP to My Health Record.
- Preparing a GPCCMP will be defined as preparing a written plan which describes:
  - the patient's chronic condition(s) and associated health care needs
  - health and lifestyle goals developed by the patient and medical practitioner using a shared decision making approach
  - actions to be taken by the patient
  - treatment and services the patient is likely to need
  - if the patient would benefit from multidisciplinary care to manage the chronic condition(s) the services that the medical practitioner will refer the patient to (including the purposes of those treatments or services)
  - arrangements to review the plan, including the proposed timeframe for review.
- If the patient is to be referred to a member of a multidisciplinary team, the GP or PMP must:

- obtain the patient's consent to sharing relevant information, including relevant parts of the plan, with the multidisciplinary team
- if the patient consents, the GP must provide relevant parts of the plan to the members of the multidisciplinary team, in addition to the referral (see separate factsheet for referral requirements)
    - there is no requirement for allied health providers to confirm acceptance of the referral or otherwise provide input into the preparation of the GPCCMP. However, the requirements for allied health providers to provide a written report back to the GP after the provision of certain services (e.g. the first service under a referral) are unchanged

- The process of developing and finalising a GPCCMP must include:
    - Recording the patient's consent and agreement to the preparation of the plan
    - Offering a copy of the plan to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees)
    - Adding a copy of the plan to the patient's medical records.

REVIEWING A GPCCMP

- A key objective of the changes to the arrangements for chronic condition management is to encourage regular reviews of GPCCMPs. An existing GPCCMP can be reviewed and amended on an ongoing basis.
    - The new MBS items to review a GPCCMP should only be used to review an existing GPCCMP. If a patient requires a review of a GPMP or TCA that was put in place prior to 1 July 2025 they should be transitioned to the new arrangements through the preparation of a GPCCMP.
- Unless exceptional circumstances apply, a GPCCMP can be reviewed every 3 months, if it is clinically relevant to do so.
- Reviewing a GPCCMP means that:
    - The GP or PMP must discuss and document:
        - the patient's progress in relation to the goals mentioned in the GPCCMP
        - whether any updates should be made to the GPCCMP.
    - Taking into account:
        - whether the goals remain appropriate and the degree of progress towards the goals
        - information provided by members of the multidisciplinary team (if any) in relation to their treatment of the patient and the extent to which the services provided by the members of the multidisciplinary team are supporting the patient to meet the patient's goals.
    - The arrangements to review the plan are updated, including the proposed timeframe for review, and any other required updates to the plan are made in consultation with the patient.

- If the patient is to be referred to a member of the multidisciplinary team for management of the patient's chronic condition, the GP or PMP must:

- Obtain the patient's consent to sharing relevant information, including relevant parts of the plan, with members of the multidisciplinary team
- Provide relevant updated parts of the plan to the members of the multidisciplinary team if the patient consents.

- The process of reviewing a GPCCMP must include:
  - Recording the patient's consent and agreement to the updates
  - Offering a copy of the updated plan to the patient and the patient's carer (if any) if the practitioner considers it appropriate and the patient agrees
  - Adding a copy of the updated plan to the patient's medical records.

MULTIDISCIPLINARY TEAM

- For the purposes of GPCCMPs, a member of the multidisciplinary team is a person other than the GP or PMP who:
  - Provides treatment or service to the patient, and
  - Provides a different kind of treatment or services to the patients than each other member of the multidisciplinary team, and
  - Is not an unpaid carer of the patient.
- Members of the multidisciplinary team do not need to provide services through the MBS to be a member of a patient's multidisciplinary team

Why are the changes being made?

These changes are a result of a review by the MBS Review Taskforce, which was informed by the General Practice and Primary Care Clinical Committee. More information about the Taskforce and associated Committees is available in Medicare Benefits Schedule Review in the consumer section of the Department of Health, Disability and Ageing website.

A full copy of the General Practice and Primary Care Clinical Committee's final report can be found in the Publications section of the Department of Health, Disability and Ageing website.

What does this mean for providers?

The changes aim to simplify, streamline, and modernise the arrangements for health professionals. Key changes include:

- Removal of multiple plans
- Collaboration with members of the patient's multidisciplinary team will no longer be required in the development of the plan
- Better supporting continuity of care through strengthened usual medical practitioner requirements
- Patients registered through MyMedicare will be required to access the plan and review items through the practice where they are registered, with other patients continuing to access the items through their usual GP.

How will these changes affect patients?

Patients will benefit from simplified arrangements. The revised framework will support patients through improved continuity of care and improved arrangements for the transfer of information between members of their care team.

Who was consulted on the changes?

The General Practice and Primary Care Clinical Committee (GPPCCC) was established in 2016 by the MBS Review Taskforce (the 'Taskforce'), to provide broad clinician and consumer expertise. The MBS Review included a public consultation process on the proposed changes from December 2018 to March 2019. Feedback was received from a broad range of stakeholders and considered by the GPPCCC prior to making its final recommendations to the Taskforce.

Following the MBS Review (during implementation), ongoing consultation occurred through an Implementation Liaison Group which included, amongst other stakeholders, the Australian Medical Association, the Royal Australian College of General Practitioners, the Rural Doctors Association, Allied Health Professionals Australia, the Australian Primary Health Care Nurses Association, and the National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners. A Communications Working Group was also established which included representatives of the affected health professions to support communications to health professionals.

How will the changes be monitored and reviewed?

Changes to MBS items are subject to post-implementation review. Post-implementation reviews typically occur around 2 years after implementation of the change.

Providers are responsible for ensuring Medicare services claimed using their provider number meet all legislative requirements. All Medicare claiming is subject to compliance checks and providers may be required to submit evidence about the services they bill. More information about the Department of Health, Disability and Ageing's (the department's) compliance program can be found on its website at Medicare compliance.

Where can I find more information?

The full item descriptor(s) and information on other changes to the MBS can be found on the MBS Online website. You can also subscribe to future MBS updates by visiting 'Subscribe to the MBS' on the MBS Online website.

Providers seeking advice on interpretation of MBS items, explanatory notes and associated legislation can use the department's email advice service by emailing askMBS@health.gov.au.

Private health insurance information on the product tier arrangements is available at www.privatehealth.gov.au. Detailed information on the MBS item listing within clinical categories is available on the department's website. Private health insurance minimum

accommodation benefits information, including MBS item accommodation classification, is available in the latest version of the *Private Health Insurance (Benefit Requirements) Rules 2011* found on the Federal Register of Legislation. If you have a query in relation to private health insurance, you should email PHI@health.gov.au.

Subscribe to 'News for Health Professionals' on the Services Australia website to receive regular news highlights.

If you are seeking advice in relation to Medicare billing, claiming, payments, or obtaining a provider number, please go to the Health Professionals page on the Services Australia website or contact Services Australia on the Provider Enquiry Line – 13 21 50.

The data file for software vendors when available can be accessed via the Downloads page.

Please note that the information provided is a general guide only. It is ultimately the responsibility of treating practitioners to use their professional judgment to determine the most clinically appropriate services to provide, and then to ensure that any services billed to Medicare fully meet the eligibility requirements outlined in the legislation.

This factsheet is current as of the Last updated date shown above and does not account for MBS changes since that date.