Upcoming Changes to Chronic Disease Management Framework – Overview

Last updated: 22 May 2025

- From 1 July 2025, there will be a new framework for chronic disease management.
- The changes simplify, streamline, and modernise the arrangements for health care professionals and patients.
- These changes primarily affect medical practitioners, however, allied health professionals providing MBS services should be aware of the changes to plan and referral requirements.
- Transition arrangements will be in place for 2 years to ensure current patients do not lose access to services.

What are the changes?

From 1 July 2025:

- 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 a new streamlined GP chronic condition management plan (see table below for item numbers)
  - The updated framework will be known as chronic condition management.
  - The GP chronic condition management plan will be available to patients with at least one medical condition that has been (or is likely to be) present for at least 6 months, or is terminal.
  - To support continuity of care, patients registered through MyMedicare will be required to access the GP chronic condition management plan and review items through the practice where they are registered. Other patients will be able to access the items through their usual GP.
  - The plans are intended to support patients that would benefit from a structured approach to their care.
  - Patients will be eligible for the plan if their condition is managed by their GP or prescribed medical practitioner, whether or not multidisciplinary care is required.
  - Where multidisciplinary care is required, patients will be able to access the same range of services currently available through GP management plans and team care arrangements.
  - GPs and prescribed medical practitioners will refer patients with a GP chronic condition management plan to allied health services directly. The requirement to consult with at least two collaborating providers, as described under the current team care arrangements will be removed.

    - 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 GP chronic condition management plan.
- To encourage reviews and ongoing care, the MBS fees for planning and review items will be equalised. The fee for the preparation or review of a plan will be **$156.55** for GPs and **$125.30** for prescribed medical practitioners. Patients will also need to have their GP chronic condition management plan prepared or reviewed in the previous 18 months to continue to access allied health services
    - Consistent with current arrangements, unless exceptional circumstances apply, a GP chronic condition management plan can be prepared once every 12 months (if necessary) and reviews can be conducted once every 3 months. It is not required that a new plan be prepared each year, existing plans can continue to be reviewed.
- The current referral form for allied health services will no longer be required. Referrals will be in the form of referral letters, consistent with the arrangements for referrals to medical specialists.
- **Patients that had a GP management plan and/or team care arrangement in place prior to 1 July 2025 will be able to continue to access services consistent with those plans for two years. From 1 July 2027, a GP chronic condition management plan will be required for ongoing access to allied health services.**
- From 1 July 2027, a GP chronic condition management plan will be required to access domiciliary medication management reviews (items 245 and 900).
- These changes do not affect multidisciplinary care plan items (231, 232, 729, 731, 92026, 92027, 92057, 92058).

Table 1: 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

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 Report from the General Practice and Primary Care Clinical Committee – Phase 2 | Australian Government Department of Health, Disability and Ageing 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
- Use of referral letters will support the provision of relevant clinical information to allied health professionals
- 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, and Allied Health Professionals Australia. A Communications Working Group

was also established which included, amongst others, representatives of the affected allied health professions to support communications to allied 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 two 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.