Enhanced Primary Care

MBS Item Numbers

Question & Answers Relating to

Care Planning Item Numbers

October 2001

Medicare Enquiry Line 132011

Enhanced Primary Care Item Numbers
Care Planning – Issues from the General Practitioner's perspective

These are items 720 to 728.

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2. Can I do another care plan if the patient already has one?
3. Who can have a care plan?
4. Is there any age restriction on who can have a care plan?
5. Can the patient ask for a care plan?
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22. If I am involved (or was involved) in a coordinated care trial, will this affect the way that I use the care planning items?

Group 2 – Care Planning – Issues from the General Practitioner's perspective
These are items 720 to 728.

1. What is a care plan?
A care plan is an action plan that sets out the health care needs of the patient and identifies the kind of services and supports that are needed to meet them. GPs can develop care plans for those patients who have no existing care plan, or can contribute to the care plans developed by other health and community care providers. Care plans have a number of mandatory components as outlined in the MBS book.

2. Can I do another care plan if the patient already has one?
Benefits are payable to the patient for preparation of a care plan only once in a six month period. In general, doctors should not duplicate existing plans.

3. Who can have a care plan?
A care plan can be developed for anyone (except nursing home residents) who has multidisciplinary care needs and one or more chronic conditions that:

- lasts or is likely to last for at least six months; or
- is a terminal illness.

The care planning team members should provide different kinds of services (for example, general practice services, physiotherapy, podiatry, or community care services like Home Help and Home Maintenance).

4. Is there any age restriction on who can have a care plan?
There is no age restriction on patients for this service.

5. Can the patient ask for a care plan?
Yes. Either a GP or a patient can initiate a care plan.

6. Does the patient have to agree to the preparation of the care plan?
Yes, the patient must consent to the preparation of the plan.

7. Can consent for a care plan be obtained retrospectively if a GP and patient are not in the same location at the same time?
No. Consent must be obtained prior to preparing a care plan.

8. Can a doctor proceed with a care plan without a patient's consent?
No. The patient's consent must be obtained before proceeding. Formal consent must be recorded by the GP on the patient's file and can take the form of a signed form developed by the GP or can be recorded as an annotation on the patient's file.

9. Who can give consent on behalf of a patient?
The person giving consent may be legally recognised as someone who is entitled to manage the patient's affairs. This may include a parent or other relative, or a carer.

10. Does the patient have to be present during the care planning?
No, the patient does not need to be present but the patient does need to provide consent to the care plan being undertaken and also agree to the goals of the plan. In some cases having the patient or carer present may facilitate the development of the care plan and their presence should be considered.

11. Do I really need two other health and community care providers for the care plan team?
Yes, the care plan is indicated when a patient has multi-disciplinary care needs that are complex. The patient is not eligible for a rebate unless the team comprises the general

practitioner and at least two other members. No more than one of the additional members of the team can be another medical practitioner (usually a specialist or consultant physician).

12. Why do I need to involve other health and community care providers?

The care planning items are specifically designed for patients with multidisciplinary care needs. The involvement of other health and community care providers will help to ensure that the care plan is coordinated and that all providers are informed of the needs of the patient; the goals of the plan; and their role in implementing it. The patient is not eligible for a rebate unless the team comprises the general practitioner and at least two other members, no more than one of whom may be another medical practitioner (usually a specialist or consultant physician).

13. Who can participate on a care plan team?

The care plan team must include at least two other health and community care providers. Only one of these can be another medical practitioner. Examples of other service providers that may be included in a team are:

- Aboriginal Health Care Workers
- Audiologists
- Dental Therapists
- Dentists
- Dieticians
- Occupational Therapists
- Optometrists
- Orthoptists
- Orthotists or Prosthetists
- Pharmacists
- Physiotherapists
- Podiatrists
- Psychologists
- Registered Nurses
- Social Workers
- Speech Pathologists

A team may also include home and community care service providers, or care organisers, such as:

- Education Providers
- Meals on Wheels
- Home Help
- Home Nursing
- Personal Care Workers
- Probation Officers

If the patient has a carer, he or she can be involved in preparing the care plan. However, a carer cannot be counted as a formal member of the care plan team.

14. Can a Teacher be considered a formal care provider in the development of a care plan?

Yes. There is provision for “Education Providers” to be included in multi-disciplinary care plan teams. This covers teachers, school counsellors and guidance officers.

15. What if one of the members of the care plan team doesn't agree with the finished plan?

A rebate is only payable for a care plan that can be implemented (ie. any services identified in the plan must be available and arrangements must have been made to ensure that the patient has access to those services). This presupposes that the other members have agreed to the care plan. If one or more of the other members of the team object to the plan, it would be unlikely that the plan could be implemented. In this case, the GP should ascertain the nature of the objection(s) and find a solution that would allow the plan to be implemented.

16. What happens if the patient doesn't agree with the results of a care plan?

A patient cannot be compelled to accept the outcomes of a care plan. However, as long as the requirements for the service set out in the Medicare Benefits Schedule are met, the GP can claim a fee for the service, and the patient can claim a Medicare rebate.

17. Can other members of the care plan team also charge a fee for participating?

There is no MBS rebate for services provided by the other care planning team members. Financial arrangements between the patient and the other (non-GP) health and community care providers must be managed separately. In some cases services may be provided through other community sources or State government provisions. Rebates for other services may be available through private health funds.

18. Can a patient's carer be counted as a member of a care plan team?

The patient's carer can be involved in the development of a care plan and can be an important source of information when undertaking the development of the plan. However, the carer cannot be counted as one of the two health and community care providers who, along with the GP, comprise the minimum members of a care planning team.

19. Do the other members of the care plan team have to be physically present or can they participate via teleconference?

Yes, other members can contribute by teleconference.

20. Do I have to send copies of the finished care plan to the patient and the other members of the care plan team?

Yes, it is a requirement of the care planning items that, for benefits to be paid, the patient and all other members of the team receive copies of the care plan. This helps to ensure that all participants are informed of their contribution to the care plan, and their role in its implementation.

21. What if the services identified in the care plan aren't available?

A care plan must be capable of being implemented, and therefore the availability of services must be confirmed before they are included in the plan. Services that are not available must not be included in a care plan. A rebate will only be paid for this item if the care plan documents the agreement of the other service providers specified in the plan to provide services to the patient.

22. If I am involved (or was involved) in a coordinated care trial, will this affect the way that I use the care planning items?

This should not affect how you use the items. You may use care planning documentation and guidelines developed for a coordinated care trial as a guide to help you make more effective use of the new care planning items. However, you must still meet the requirements of the items, as set out in the Medicare Benefits Schedule book.

23. If the patient has veteran's entitlements, will this affect their eligibility for the care planning items?

No, any veteran who fits the eligibility criteria for the care planning process operated by the Department of Veterans Affairs (DVA) can still claim for a DVA care plan. In this situation a copy of the care plan must be sent to DVA.

24. Should I continue to send veteran's care plans to the Commonwealth Department of Veterans Affairs?

If you are registered with the Department of Veterans Affairs (DVA) as a Local Medical Officer (LMO) you will receive the full Schedule fee if you send a copy of the completed care plan to DVA. If you are a GP who is not registered with DVA, you will receive 85% of the Schedule fee plus a loading if you send a copy of the completed care plan to DVA.

RECENTLY ASKED QUESTIONS
Community Sector EPC Item Numbers
August 2001

1. What involvement does a pharmacist need to have in a care plan to consider them a part of the "team"? For example, is just dispensing medications sufficient, is providing patients with Webster packs sufficient, etc?

For a pharmacist to qualify as a member of a multidisciplinary care team, he/she would need to provide professional advice or assistance to meet the needs of the patient beyond that which would normally be expected as part of the specific dispensing process. Examples of such services might be preparing dosette boxes and explaining their use to the patient, providing advice on inhaler use to asthmatics or advice on interaction between medications.

2. Should GPs be working only with the health and care providers listed in the RACGP Guidelines and MBS Explanatory Notes as members of multidisciplinary care teams?

The health and care providers listed in the RACGP Guidelines and pro-formas and in the MBS Explanatory Notes are examples only of persons who, for the purposes of care planning and case conferencing may be included in a multidisciplinary care team. These lists are not exclusive or prescriptive. It may be appropriate for health or care providers other than those listed to be members of a multidisciplinary care team, where they are providing a different kind of care or service to meet the health or care needs of the patient.

3. In organising a care plan what communication should the GP have with the other care providers?

There are three likely scenarios:

(a)the other care providers (or one of them) are/is already providing ongoing health or care services to the patient (for example, the patient is already seeing a specialist).

Assuming such a situation in which:

- when the care plan is being developed the care already being provided by another health/care provider is appropriate for the patient's relevant needs and doesn't need alteration;
- there is an existing relationship between the GP and the other care provider, (in this example, a medical specialist); and
- there is no other need to interact with the other care provider about the patient's care needs;

Then in this situation it would be sufficient for the GP to advise the other provider that the care plan has been prepared and provide a copy of the care plan (which should clearly identify what other providers are providing what care to the patient, and anything likely to be of significance to the other providers' treatment of the patient).

(b) the other care providers identified to provide care to the patient are not already providing care to the patient.

In this situation the GP must communicate with the other care providers and get their agreement to be members of the multidisciplinary team providing required services to the patient.

(c) the GP has identified that a change is required in the care being provided by one of the other care providers identified to be a member of the team

If the care currently being provided requires alteration then this change should be undertaken in consultation with the other provider.

4. The dietitian sees the patient in 6 months time and believes what the GP has wanted is no longer appropriate?

As per above, this would not affect claiming for organising the care plan, assuming the relevant care plan requirements have been met. (In practice, it would be expected that the dietician and the GP would communicate to identify why the original treatment is no longer appropriate, whether the patient's needs have changed, what treatment is now appropriate etc).

5. A GP has an existing relationship with the diabetes service and regularly organises care plans for their patients including these other services. The GP spends 45 minutes putting together a care plan (including the other services but not contacting them every time), asks the patient to make an appointment with the dietitian and diabetes educator and gives a copy of the completed care plan to the patient to take along to the first visit (which is likely to be in 6 months time). When can the GP claim the item number? A number of services (especially in rural areas) are very cross with GPs for increasing their workload and for being prescriptive about what they want the patient to have without really being aware of what the service can provide.

In this scenario, by not communicating with the other service providers about their involvement in the multidisciplinary care team, the GP has not met all of the requirements of the item:

- The plan must include the arrangements for giving the required treatment to the patient – these arrangements have not been made at the time the GP gives the care plan to the patient
- Preparation of the plan must include telling the patient who will be included in the multidisciplinary care team, and giving copies of relevant parts of the plan to the people who will provide the treatment set out in the plan – without communicating with the other providers it would be difficult to meet either of these requirements.

This scenario suggests a poor relationship between the GP and the other service providers, starting with inadequate communication. Successful multidisciplinary care depends on timely and effective communication between the different health and care providers and a clear mutual understanding of their respective roles and capacities

6. Can practitioners obtain consent to multidisciplinary case conferences and care plans during periods when patients with mental health problems are in remission/otherwise free from symptoms (even though those services will only be required when those symptoms manifest themselves some time in the future)?

The requirements for obtaining consent to any medical service apply also to the EPC MBS items.

Obtaining consent for an EPC multidisciplinary care planning or case conferencing service should be consistent with normal clinical practice. In meeting the requirements for obtaining consent, and using his or her clinical judgement of a patient's circumstances, a GP may consider it appropriate to discuss with the patient the future provision of medical services to meet the patient's needs, and to obtain the patient's agreement to the provision of such services.

While an EPC service is no different to any other medical service in terms of the requirement to, and processes of, obtaining consent, the consent which is so obtained, consistent with normal medical practice, for an EPC care planning or case conferencing service, must include the following EPC-specific matters.

The MBS Explanatory Notes set out what the patient, or the person providing consent on their behalf, must agree to before a care planning or case conferencing service is provided. Essentially, this requires that the patient, or the person providing consent on their behalf, understands the nature of the service to be provided and is aware of who will be included in the team. The patient, or the person providing consent on their behalf, should have an opportunity to specify what information they want provided to/withheld from members of the team, and agree to the service being provided. The patient should be made aware that the care planning or case conferencing service will attract a fee for which a Medicare benefit will be payable. The patient's agreement to the service must be recorded on the patient's file – this can be a signed form or recorded as an annotation on the patient's file.

7. What happens if a patient has a care plan, organised by their GP, and for some reason the patient requires another care plan from an agency looking after a different health care need, with the GP contributing?

As a general principle, if a patient currently has an active care plan the GP should not duplicate the plan. While a GP may contribute to a care plan for a patient which is being developed by other health and community care providers, the EPC items for care planning are

based on the premise that the patient should ideally have one care plan addressing their health and care needs and the actions required to meet them. The care planning items are not designed to enable a GP to provide the same input to more than one care plan for the same patient. There would not appear to any benefit to the patient from having multiple care plans each containing the same input from the patient's GP.

8. **If the circumstances of the patient are significantly different and another provider wants to do a CP and asks the GP to be involved then there are two basic options:**

The GP could agree to contribute to that care plan, or the GP could undertake a review of the current GP care plan to ensure that changes in care needs are now met. Deciding which of these options to take will depend on the nature and significance of the changes in the patient's circumstances. If the GP decides to contribute to the other agency's care plan it would not be appropriate to also continue with the GP's own care plan.

For instance, a GP does a care plan for a geriatric diabetes patient. The patient goes on to have a hip replacement and the Ambulatory Care Program wants to do a care plan for the patient to manage their recovery, with the GP contributing. How could they work this?

In the example given, if a patient is discharged from hospital following a hip replacement then it would be appropriate for the GP to contribute to a discharge care plan organised by the hospital and then subsequently modify the GP's care plan at an appropriate interval using the care plan review item. The GPs contribution to a discharge care plan in this case would not be a problem as the patient's condition is significantly altered. The focus of the discharge care plan and the community care plan coordinated by the GP are different but complementary.

9. **In another instance the same diabetes patient develops asthma, and an asthma team would like to do a care plan with the GP contributing, how does this affect the original Care Plan for Diabetes?**

There has been a significant change in the patient?s condition and a review of a care plan could be used in this case as well.

10. **In the case of the GP making a referral to a team (an aged care team or a rehabilitation team) the GP would not know the name of the actual provider until the patient had been seen and allocated to a provider. In this case it is impossible for the GP to have the agreement from the actual person providing the service at the time of drawing up the plan. Is it then reasonable for the GP to have 'in principle' agreement from the team?**

The GP has responsibility for insuring that the health services required by the patient are available and can be easily accessed. Therefore, if the GP has discussed this with the ?team? coordinator then it would be reasonable that this would be considered appropriate for the care plan.

11. **Can the Division negotiate an 'in principle' agreement on behalf of all the GP's in the Division if the team never refuses a referral? Can GP's have a written agreement with specialist that would cover all their referrals?"**

It is not appropriate for Divisions to negotiate in-principle agreements with any agency or, to have written agreements with a specialist covering all referrals.

A referral is a request to a specialist or a consultant physician for investigation, opinion, treatment and/or management of a condition or problem of a patient or for the performance of a specific examination(s) or test(s).

For a valid referral to take place:-

(i) the referring practitioner must have turned his or her mind to the patient/s need for referral and communicate relevant information about the patient to the specialist or consultant physician
(ii) the instrument of referral must be in writing by way of a letter or note to a specialist or to a consultant physician and must be signed and dated by the referring practitioner; and
(iii) the specialist or consultant physician to whom the patient is referred must have received the instrument or referral on or prior to the occasion if the professional service to which the referral relates.

Therefore, each referral must be an individual written assessment of the patients condition and medical requirements.