

CDM Contribution items (Medicare items 729 and 731)

Important reminders

The Department of Health and Ageing would like to remind GPs about key requirements when contributing to the development or review of multidisciplinary care plans prepared by other providers. This list provides a brief summary only – practitioners should refer to the latest Medicare Benefits Schedule for full details of the items, and the department's web site (www.health.gov.au) for more information.

1. The recommended frequency for contribution items 729 and 731 is once every six months.
2. MBS item 729 is for patients with a chronic medical condition who are having a multidisciplinary care plan prepared or reviewed for them by another health or care provider (i.e. other than the usual GP).
3. This can include contribution to hospital discharge plans for both private and public inpatients being discharged from hospital. (Item 731 should be used for patients who are residents of aged care facilities on discharge from hospital).
4. MBS items 729 and 731 do not require an attendance with the patient - a GP can contribute on the basis of knowledge of the patient and the health and care needs. This can take place by telephone or in person at the invitation of the provider (e.g. discharge planner) developing the care plan.
5. MBS item 731 is available for GP to contribute to a multidisciplinary care plan for a resident of an aged care home.
6. MBS item 731 was introduced because it was recognised that Australian Government-funded aged care residents are already required to have a care plan prepared for them by the aged care home facility (usually on admission or soon after arriving at the facility), and that it would be appropriate for GP input to a resident's care to be made by way of contribution to the care plan required to be maintained by the aged care home.
7. For the GP to be able to contribute to the resident's care plan and claim item 731, the plan must be multidisciplinary, meaning that, consistent with the other CDM Medicare items, the resident has a chronic medical condition and complex needs requiring care from a multidisciplinary team. Not all care plans prepared for residents of aged care homes will necessarily be multidisciplinary, and it will depend on the needs of the resident.
8. It is expected that the GP's contribution to the resident's multidisciplinary care plan would be through direct collaboration with the aged care facility at the request of the facility. The contribution must be based on the GP's knowledge of the resident and the health and care needs and may include a personal attendance by the GP with the patient.
9. Once a GP has contributed to a resident's care plan and item 731 has been claimed on Medicare, the resident is eligible for Medicare rebates for up to five allied health visits each year. The need for allied health services must be identified in the resident's care plan. It is up to the GP to determine that the resident has a clinical need to for allied health services and to determine the type and number of services required by the resident.
10. It would not be appropriate for a third party to either request the GP's contribution on behalf of the aged care facility or to direct the GP on what the contribution should be. Consequently, it is not appropriate for allied health providers to provide part-completed referral forms to GPs for signature, particularly in a way that pre-empts the GP's decision about the services required by the patient.
11. All CDM items should be provided by the patient's usual GP. The term 'usual GP' would not generally apply to a practice that provides a one-off service to a patient. Any services designed to prevent or manage chronic illness are best provided by the GP or practice that will be responsible for the patient's long term care.