Australian Government
Department of Health, Disability and Ageing

Guideline for substantiating coordination of the development of Team Care Arrangements (for a medical practitioner)

What you need to know

This guideline outlines what you can do to substantiate the coordination of the development of Team Care Arrangements rendered by eligible medical practitioners for Medicare Benefits Schedule (MBS) item 723.

The guideline is not exhaustive, and you can respond to a Medicare compliance audit or review using any documents you think substantiate the concern raised.

However, we may determine more information is needed and request additional documentation to substantiate services you have claimed.

Read the health professional guidelines about substantiating claims for Medicare compliance purposes before proceeding.

Documents you may use to substantiate a claim

Any document you give us should have been created during or as soon as practicable after the treatment occurred. It should include the patient's name and the date the treatment was provided.

To substantiate that the coordination of Team Care Arrangements has occurred, you may provide:

- **a copy or excerpt of a document describing the Team Care Arrangements** - clearly showing the patient's name and information that meets all the requirements outlined in the MBS descriptor

Note: for patients to be eligible for referral services, for example items 10950 to 10970 a valid GP Management Plan must also exist for the patient (item 721).

Rule 2.17.4 of the *Health Insurance (General Medical Services Table) Regulation 2016*, as reflected in MBS explanatory note A37, outlines all required components to coordinate the development of team care arrangements.

Additional supporting evidence may include:

- **an excerpt/s from the patient's clinical file** - clearly showing the patient's name, the date of service and the date/s that valid Team Care Arrangements were coordinated and agreed to by the patient. There should be a minimum of two collaborating providers details listed as part of the Team Care Arrangements. It should also collectively contain enough information showing all the elements of the Team Care Arrangements
- **a copy or excerpt of a document showing that a review or amendment of the Team Care Arrangements has occurred** - clearly showing the patient's name and

the date of the review of the Team Care Arrangements. This copy or excerpt should include all elements to meet the requirements in the MBS descriptor for Item 732

Note: rule 2.17.5 of the Health Insurance (General Medical Services Table) Regulation 2016, as reflected in MBS explanatory note A37, outlines all required components to coordinate a review of team care arrangements.

In most cases, a patient's clinical information will be the only way to confirm that a specific service was provided, and substantiate you received the correct Medicare benefit.

If you need to use a patient's clinical information you can censor any details that aren't relevant. You can also choose to provide the information to one of our medical advisers.

Resources

- Health Insurance (General Medical Services Table) Regulation 2016
- MBS Online
- Administrative Record Keeping Guidelines for Health Professionals
- Health Professional Compliance