

Changes to Chronic Disease Management (CDM) Framework – FAQs

Updated 2 July 2025

1. What are the key changes to the Chronic Disease Management (CDM) framework?

From 1 July 2025, existing Medicare Benefits Schedule (MBS) items for General Practitioner Management Plans (GPMPs) and Team Care Arrangements (TCAs) will be replaced with a new streamlined GP Chronic Condition Management Plan (GPCCMP). This includes an equalising of MBS rebates for the preparation and review of plans.

2. Which MBS items will cease, and what will replace them?

Effective 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

These will **be replaced with** the new GPCCMP, which consolidates the previous items into a more streamlined approach.

- Prepare a GPCCMP: 965, 392 (face to face); 92029, 92060 (video)
- Review a GPCCMP: 967, 393 (face to face); 92030, 92061 (video)

3. Will patient eligibility change at all?

No, eligibility will remain consistent with previous arrangements. The GPCCMP will be available to patients with at least one medical condition that has been (or is likely to be) present for at least six months or is terminal. **There is no list of eligible conditions.** It is up to the GP or prescribed medical practitioner's (PMP) clinical judgment to determine whether an individual patient with a chronic condition would benefit from a GPCCMP.

4. Why are these changes taking place?

The changes to the CDM framework are the result of a review by the [MBS Review Taskforce](#). The intent of the changes is to simplify, streamline, and modernise the arrangements for healthcare professionals and patients.

5. Should I be concerned about the viability of my general practice with these new changes?

The impact of the changes on annual funding for CDM will depend on your billing approach for each individual patient.

The new Medicare rebate will be the same for the preparation and the review of a plan – \$156.55 for GPs and \$125.30 for prescribed medical practitioners. Previously, the rebate for preparation of a GPMP (MBS items 721 and 92024) was \$164.35, preparation of TCAs (MBS items 723 and 92025) was \$130.25 and a review (MBS items 732 and 92028) was \$82.10.

6. Are there changes to the frequency of plan reviews?

Unless exceptional circumstances apply, a GPCCMP can be prepared once every 12 months (if necessary) and reviews can be conducted once every three months. It is not required that a new plan be prepared each year – existing plans can continue to be reviewed.

Patients will need to have their GPCCMP prepared or reviewed in the previous 18 months to continue to access allied health services.

7. How do I manage the process for a patient who has an existing GPMP and/or TCA in place before 1 July 2025?

Patients with a GPMP and/or TCA in place prior to 1 July 2025 can continue to access services related to those plans as follows:

- Through MBS item 10997 (and its telehealth equivalents 93201 and 93203) under existing GPMPs and TCAs until 30 June 2027.
- Individual and group allied health services can be accessed under existing GPMPs and TCAs until 30 June 2027. Medical practitioners can continue to write referrals under these plans.
- Referrals for allied health services written prior to 1 July 2025 will remain valid until all services under the referral have been provided.

MBS items for reviewing GPMPs and TCAs will cease on 1 July 2025. If a patient requires a review of their GPMP and/or TCA after 1 July 2025 a new GPCCMP should be prepared using the items for preparation of a GPCCMP.

From 1 July 2027 only patients with a GPCCMP will be eligible to access domiciliary medication management reviews through the MBS (items 245 and 900).

8. Can I still use a GPMP and/or TCA from 1 July 2025?

From 1 July 2025, any new plans put in place will need to meet the requirements of a GPCCMP and be billed using the new items.

Any new referrals for allied health services should meet the new referral requirements that come into effect on 1 July 2025, regardless of whether the referral is made under a GPMP, TCA or GPCCMP.

9. What are the new Medicare item numbers?

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

10. Are there any transition arrangements for existing patients?

Yes. Transition arrangements will be in place to ensure continuity of care for patients currently under the existing CDM items. These arrangements will facilitate the smooth implementation of the new framework without disrupting ongoing patient care.

Patients with a GPMP and/or TCA in place prior to 1 July 2025 can continue to access services related to those plans as follows:

- Through MBS item 10997 (and its telehealth equivalents 93201 and 93203) under existing GPMPs and TCAs until 30 June 2027.
- Individual and group allied health services can be accessed under existing GPMPs and TCAs until 30 June 2027. Medical practitioners can continue to write referrals under these plans.
- Referrals for allied health services written prior to 1 July 2025 will remain valid until all services under the referral have been provided.

From 1 July 2027:

- a GPCCMP will be required for ongoing access to allied health services (including item 10997 and telehealth equivalents)
- a GPCCMP will be required to access domiciliary medication management reviews (items 245 and 900).

11. Will the types of multidisciplinary care/services available under the framework change?

Where multidisciplinary care is required, patients will be able to access the same range of services currently available through GPMPs and TCAs. Practice nurses, Aboriginal and Torres Strait Islander Health Practitioners and Aboriginal Health Workers will be able to assist the GP or PMP to prepare or review a GPCCMP.

12. As a GP, what is the new process to refer patients to allied health services?

GPs and PMPs will refer patients with a GPCCMP to allied health services directly. The requirement to consult with at least two collaborating providers, as described under the current TCA requirements, will be removed. The current referral form for allied health services will no longer be required. **Referrals will be in the form of referral letters, consistent with referrals to other medical specialists.** Patients that had a GPMP and/or TCA in place prior to 1 July 2025 will be able to continue to access services consistent with those plans for two years.

One of the objectives of the changes is to provide patients with greater choice and flexibility. The minimum requirements can be found [here](#) (page 2).

Referrals do not need to:

- specify the name of the allied health provider to provide the services. For example, a patient can take a referral to physiotherapy services under their GPCCMP to a physiotherapist of their choice
 - Acceptance of a referral is at the discretion of the individual allied health professional, subject to anti-discrimination legislation.
- specify the number of services to be provided under the referral. However, nothing prevents the referring medical practitioner from specifying the number of services if they choose to do so. **Referrals can be signed and transmitted electronically.** Where the intended allied health provider is known, referring practitioners are encouraged to send referrals electronically where possible to minimise the risk of lost referrals.

13. Can I access MBS bulk billing incentives with the new CDM items?

The new 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.

14. Will the new Medicare items be indexed?

It is expected the items will be indexed annually along with other GP MBS items. Indexation for 1 July 2025 has already been factored into the rebates for the new items as stated above – no additional increase will be applied.

15. Will 'other health professionals' be permitted to assist the GP in preparing a GP chronic condition management plan under the new arrangements?

Under the new arrangements, only practice nurses, Aboriginal and Torres Strait Islander health practitioners, and Aboriginal health workers will be authorised to assist a GP or prescribed medical practitioner in preparing or reviewing a chronic condition management plan.

The ability for 'other health professionals' to assist, which was referenced in the [explanatory note for current MBS Item 721](#), is not included in the new regulatory provisions.

There will be consideration for further regulatory changes in the post-implementation review of the changes 12-24 months post commencement.

16. Where can I find more detailed information and resources?

Comprehensive details, including updated item descriptors and implementation guides, are available on the MBS Online website:

For more information, all MBS fact sheets are available [here](#). This includes:

- [Overview Fact Sheet](#)
- [MBS Explanatory note \(AN.15.3\)](#)
- [Transition Arrangements for Existing Patients](#)
- [Referral Arrangements for Allied Health Services](#)
- [MBS Items for GP Chronic Condition Management Plans](#)
- [Upcoming Changes to Chronic Disease Management Framework - Allied Health Providers](#)
- [Upcoming Changes to Chronic Disease Management Framework - Practice Nurse, Aboriginal Health Workers and Aboriginal and Torres Strait Islander Health Practitioners](#)

These resources provide more information to assist in understanding and implementing the upcoming changes.

17. Do allied health providers need to confirm they have received the referral prior to claiming items for GPCCMP?

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.

18. Do patients need to be registered with MyMedicare to access GPCCMP items?

Patients already 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. These requirements are the same for face-to-face and telehealth items.

19. Do I need to prepare a new GPCCMP plan for a patient each year?

It is not required that a new plan be prepared each year. Existing plans can continue to be reviewed.

20. How will this change impact my patients and their health outcomes?

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.

21. What is the RACGP doing to support its members and has any advocacy to government taken place?

A summary of the changes [have been uploaded to the RACGP website](#). Further materials will be made available to members as they are developed.

The RACGP advocated strongly for a delay to the original implementation date, November 2024, to ensure practices had sufficient time to prepare for the changes. The RACGP has been clear with government that GPs need time to plan for their patients and that sufficient funding is needed for GPs to provide this critical care to patients with chronic disease.

22. If no team care is required, is a GPCCMP still valid if no allied health referrals are made?

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 PMP, 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 GPMPs and TCAs.

23. What are the impacts of these changes on Aboriginal and Torres Strait Islander patients and ACCHOs?

An Aboriginal and Torres Strait Islander Health Practitioner or Aboriginal Health Worker may assist with the development or review of a plan.

Patients who identify as being of Aboriginal and Torres Strait Islander descent can still access 10 individual allied health services per calendar year (rather than the standard 5 allied health services for other patients).

24. If a patient has an existing GPMP prior to 1 July 2025, do we need to complete a GPCCMP plan and/or review?

MBS items for reviewing GPMPs and TCAs will cease on 1 July 2025. If a patient requires a review of their GPMP and/or TCA after 1 July 2025 a new GPCCMP should be prepared.

25. How many allied health services are available per year for patients with 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 Aboriginal or Torres Strait Islander patients).
- 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.

If a patient is referred to a member of a multidisciplinary team, you must obtain the patient's consent to share information, including relevant parts of the plan, with the multidisciplinary team.

Members of the multidisciplinary team do not need to provide services through the MBS to be a member of the team.

26. Are obesity and hypertension included in the definition of a chronic disease and therefore eligible for a GPCCMP?

There is no list of eligible conditions. The guidance released by the Department of Health, Disability and Ageing states that 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.

Whether a patient meets the eligibility requirement of having a chronic or terminal condition is a clinical judgement for their GP.

27. How often can we claim items for preparing or reviewing a GPCCMP?

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.

Disclaimer

The information set out in this publication is current at the date of first publication and is intended for use as a guide of a general nature only and may or may not be relevant to particular patients or circumstances. Nor is this publication exhaustive of the subject matter. Persons implementing any recommendations contained in this publication must exercise their own independent skill or judgement or seek appropriate professional advice relevant to their own particular circumstances when so doing. Compliance with any recommendations cannot of itself guarantee discharge of the duty of care owed to patients and others coming into contact with the health professional and the premises from which the health professional operates.

As per the [RACGP Statement on Medicare interpretation and compliance](#):

As with all specialist medical colleges, the RACGP has no legal authority to interpret MBS rules and regulations. There is no guarantee that Medicare will consider the use of an MBS item number appropriate, even if the RACGP does. It is the responsibility of the treating practitioner to ensure that any service billed to Medicare meets the item descriptor in the MBS and any eligibility requirements in full. You should maintain appropriate patient notes to demonstrate how you meet the descriptor of any Medicare service billed. Any further enquiries relating exclusively to interpretation of the MBS can be emailed to askMBS@health.gov.au