RACGP

Changes to Chronic Disease Management (CDM) Framework – FAQs

Updated 16 December 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) were 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 were **ceased**:

- GP Management Plans: 229, 721, 92024, 92055
- Team Care Arrangements: 230, 723, 92025, 92056
- Reviews: 233, 732, 92028, 92059

These were **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 ceased 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 came 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 and item 10997 (and telehealth equivalents)
- a GPCCMP will be required to access domiciliary medication management reviews (items 245 and 900).

For more information on transition arrangements see MBC Online AN.15.5.

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 previously 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.

For more information on the services available see MBS Online AN.15.4.

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 previous referral form for allied health services is no longer 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.

For more information on referral requirements see MBS Online AN.15.6.

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.

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

More detailed information on the specific requirements is available in the MBS Online explanatory notes, including:

- AN.15.3 – Overview of MBS items to support the management of chronic conditions in general practice
- AN.15.4 – Allied health and Aboriginal and Torres strait Islander health and wellbeing services for chronic condition management – an overview for general practice
- AN.15.5 – GP chronic condition management plans – transition arrangements for existing patients with a GP management plan and/or team care arrangement
- AN.15.6 – Referral requirements for allied health and other primary health care services

- AN.0.47 – GP chronic condition management plans (MBS items 392, 393, 965, 967, 92029, 92030, 92060, 92061)
- MN.12.4 – Services for a person with a chronic condition by a practice nurse or Aboriginal and Torres Strait Islander health practitioner (MBS items 93201, 93023, 10997)

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 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.

19. 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.

20. 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.

21. 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 previously available through GPMPs and TCAs. For further information see MBS Online AN.15.4.

22. 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).

23. 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 ceased 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.

24. 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.

25. 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.

MBS Online AN.0.47 provides further guidance on when a GPCCMP may be used.

26. 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.

27. Do electronic referrals need to be signed by hand?

Electronic referrals do not require a handwritten signature. The signature method must:

- identify the person signing
- Show they intended to approve the referral

Examples of acceptable electronic signatures include, but are not limited to:

- inserting a digital copy of the referrer's signature in the document
- sending the referral from an email account owned by the referrer
- using an online or digital platform that securely links the referrer's identity to the referral or securely transmits it

28. Is there minimal consultation time for a GPCCMP as per Medicare billing?

No, there is no minimal consultation time for a GPCCMP. However, the GP is required to see the patient and all requirements of the items must be met

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

No. If a patient is not registered with MyMedicare they can access CCM through their **usual medical practitioner**, defined as:

- a general practitioner or prescribed medical practitioner:
  - who has provided the majority of services to the person in the past 12 months; or
  - who is likely to provide the majority of services to the person in the following 12 months; or
  - located at a medical practice that:
    - has provided the majority of services to the person in the past 12 months; or
    - is likely to provide the majority of services to the person in the next 12 months.

However, patients already registered with MyMedicare must access GPCCMP items through the practice where they are enrolled.

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

30. When a patient's GP works at multiple locations, can they perform CDM plans and reviews across multiple sites for their patient registered with MyMedicare?

From 1 July 2025, if a patient is registered in MyMedicare:

- They can only access GP chronic condition management plan preparation and review services from the practice location where they are registered with MyMedicare. These services can be delivered by any eligible provider at this practice location, not just their preferred GP.
- They cannot access GP chronic condition management plan preparation and review services from another practice or practice location, even if they see their preferred GP at that location.

31. When a patient's GP works at a multi-site practice, can they perform CDM plans and reviews across multiple locations under the same practice when a patient is registered with MyMedicare?

If a MyMedicare registered patient's preferred GP works from multiple locations for the same practice (which is not a hub and spoke arrangement) and the patient visits this GP at more than one location.

- The patient, provider and practice should ensure that any GP chronic condition management plan preparation and review services are delivered at the practice location where the patient is registered for MyMedicare. This includes ensuring that any telehealth appointments for these services are linked to the patient's MyMedicare registered practice.
- The patient can visit the preferred GP at other locations for other services that are not linked to MyMedicare, such as when requiring a medical certificate, script or referral for blood tests.

32. Can a GPCCMP prepared at another practice be reviewed at a new practice?

Yes, if requested to do so by the patient and:

- The patient is registered with MyMedicare and the new practice, or
- The GP at the new practice meets the "usual medical practitioner" requirements and the patient is not registered with MyMedicare at a different practice.

A GPCCMP can be reviewed by an "associated medical practitioner ", which is defined as a "medical practitioner who, if not engaged in the same general practice as the general practitioner or prescribed medical practitioner mentioned in the item, performs the service described in the item at the request of the patient (or the patient's guardian)."

This means if a patient changes practices they do not necessarily require a new plan. Importantly the new practice must have access to the original plan (for example if the patient's medical records are transferred) so that it can be reviewed. The intent of the GPCCMP is to encourage continuity of care, and this should be done at the patient's regular practice.

33. How do you check if a patient is registered with MyMedicare at another practice?

Currently, there is no comprehensive way to check MyMedicare status. The most direct way is to ask the patient if they are registered in the program, or to check via MyHealthRecord.

34. If a patient has multiple chronic diseases, do I need to do a different GPCCMP for each disease, and how do I decide which conditions should be included?

No, the GPCCMP is intended to be a comprehensive plan for the patient. There should be a summary of the patient's condition at the time of writing the plan, containing the most clinically relevant conditions. There is a requirement to include goals, and there may be common goals and intersections across the conditions that address the most pressing issues.

35. Is it possible to co-bill a 967 and 10997?

Services under item 10997 should not be billed with a CDM plan or review item, or any other consultation item, unless the service provided by a practice nurse or Aboriginal Torres Strait Islander health practitioner is a separate and clinically relevant service that would not be considered a component of the consultation. Any services provided using item 10997 must be consistent with the patient's GPCCMP.

See this fact sheet and MBS Online explanatory note MN.12.4 for more information on billing MBS item 10997.

36. Can a bulk billing incentive item number be co-billed with MBS items 965, 967 or 707?

GPCCMP items may be claimed with single bulk billing incentives when eligible patients are bulk billed.

Fact sheet for reference can be found here. Quick claiming guides for bulk billing incentives for each Modified Monash area are available on MBS Online MN1.3 – MN.1.8.

37. Could you co-claim any GPCCMP items with other MBS items

You cannot co-claim general attendance items with GPCCMP items. Other items may be co-claimed with a GPCCMP in accordance with the standard MBS co-claiming requirements ie. they must be distinct services that are clinically relevant and all requirements of the item must be met. The list of items included in the co-claiming restrictions can be found in MBS Explanatory Note AN.0.47.

Fact sheet for reference can be found here.

38. Can a patient be withdrawn from MyMedicare on the day of service if they go to a new practice and claim GPCCMP the same day at the new practice?

Yes. If a patient is withdrawn from MyMedicare on the day of service, they must register for MyMedicare at the new practice on the same day for a GPCCMP item to be paid.

If the patient is withdrawn from MyMedicare 2 days prior to the date of service, they do not need to register for MyMedicare at the new clinic.

39. Could you co-claim any GPCCMP items with a mental health care plan?

There are no changes to the way that the preparation of mental health treatment plans (MHTP) interact with chronic condition management plans. GPs may provide both types of plan to a patient if they determine that the patient is eligible for both plans, and they are both clinically relevant to treat the patient. To co-claim the preparation of a MHTP item and a GPCCMP item, both services must be clinically relevant and distinct services. A practitioner will need to ensure they meet all requirements of the distinct services separately. In addition, it is important to note that a MHTP does not expire and that a new MHTP should not be created unless exceptional circumstances exist.

40. Can a practice nurse prepare the plan? And if so how can the billing be done?

Under the new arrangements, practice nurses, Aboriginal and Torres Strait Islander health practitioners, and Aboriginal health workers can assist a GP or prescribed medical practitioner in preparing or reviewing a chronic condition management plan. The GPCCMP item numbers should be billed as usual when this occurs as the GPCCMP items are a complete medical service. It is a requirement that the GP/prescribed medical practitioner sees the patient as part of the service, and they are responsible for the service.

41. Do UCC (Urgent Care Centers) qualify to sign patients up under MyMedicare and provide CCMPs?

No, Urgent Care Clinics are not eligible to register for MyMedicare**.** To participate in the MyMedicare program, healthcare providers must deliver patient-centred, continuous, comprehensive, and coordinated primary care services to individuals, families, and communities.

Eligible practice types are outlined in section 2.2 Practice Type of the MyMedicare Program Guidelines.

42. Is there a way the practice can see how many visits have been used in the 12 months if the patient goes from one clinic to a new clinic?

To check a patient's eligibility providers can check for the number of services available using the MBS items online checker in Health Professional Online Services (HPOS) Check MBS Item numbers Health professionals - Services Australia or the care plan history in HPOS Patient details in HPOS - Health professionals - Services Australia.

Disclaimer