Australian Government
Department of Health, Disability and Ageing

Upcoming Changes to Chronic Disease Management Framework – What Do the Changes Mean for Practice Nurses, Aboriginal and Torres Strait Islander Health Practitioners and Aboriginal Health Workers?

Last updated: 6 June 2025

- From 1 July 2025, GP management plans (GPMPs) and team care arrangements (TCAs) will be replaced with a single GP chronic condition management plan (GPCCMP).
- Practice nurses, Aboriginal and Torres Strait Islander Health Practitioners, and Aboriginal Health Workers will be able to assist the GP or prescribed medical practitioner to prepare or review a GPCCMP.
- Patients with a GPCCMP will be able to access services provided by a practice nurse or Aboriginal and Torres Strait Islander Health Practitioner on behalf of a medical practitioner using items 10997, 93201 and 93203.
    - Patients with a GPMP and/or TCA in place prior to 1 July 2025 can continue to access these services under those plans until 30 June 2027 (see separate factsheet on transition arrangements).
- Patients with a GPCCMP will be able to access an Aboriginal and Torres Strait Islander health service provided by an Aboriginal and Torres Strait Islander Health Practitioner or an Aboriginal Health Worker using MBS items 10950, 81300, 93000, 93013, 93048 and 93061.
    - Patients with a GPMP and/or TCA in place prior to 1 July 2025 can continue to access these services under those plans until 30 June 2027 (see separate factsheet on transition arrangements).
    - Requirements for the GP or prescribed medical practitioner to collaborate with other members of the team when preparing or reviewing a patient's plan have been removed. Patients will be referred directly to services.
    - Aboriginal and Torres Strait Islander Health Practitioner and Aboriginal Health Workers should be aware that referrals for service 10950, 81300, 93000, 93013, 93048 and 93061 written on or after 1 July 2025 must meet the new referral requirements (see separate factsheets on referrals and allied health services).
    - Referrals written prior to 1 July 2025 remain valid until all services under the referral have been provided (see separate factsheet on transition arrangements).

- To remain eligible for these services, patients (other than those covered by the transition arrangements) will have to have had their GPCCMP prepared or reviewed in the previous 18 months.

What are the changes?

- Overall, these changes are intended to modernise, streamline and simplify the MBS items for patients with a chronic condition.
- The ability for practice nurses, Aboriginal and Torres Strait Islander Health Practitioners and Aboriginal Health Workers to assist in the preparation of a GPCCMP has been specified in the regulatory arrangements for the new items.
- The nature of the services that can be provided using items 10997, 93201, 93202,10950, 81300, 93000, 93013, 93048 and 93061 are not changing as part of these reforms. However, there are changes to the item descriptors for these items because of the removal of GPMPs and TCAs, and commencement of GPCCMPs. These changes:
  - Allow patients that had a GPMP and/or TCA prior to 1 July 2025 to continue to access these services under those plans until 30 June 2027 (see separate factsheet on transition arrangements).
  - Allow patients that have had a GPCCMP prepared or reviewed in the previous 18 months to access these services.
- For services provided using MBS items 10950, 81300, 93000, 93013, 93048 and 93061, referrals written on or after 1 July 2025 will be in the form of a letter, not the form used previously. Referrals written before 1 July 2025 remain valid until all services under the referral have been provided (see separate factsheet on referral requirements).

Why are the changes being made?

These changes are a result of a review by the MBS Review Taskforce (the Taskforce), which was informed by the General Practice and Primary Care Clinical Committee (GPPCCC). More information about the Taskforce and associated Committees is available in Medicare Benefits Schedule Review in the consumer section of the Department of Health, Disability and Ageing (the department) website.

A full copy of the GPPCCC's final report can be found in the Publications section of the department website.

What does this mean for providers?

The changes recognise the importance of practice nurses, Aboriginal and Torres Strait Islander Health Practitioners, and Aboriginal Health Workers in the management of chronic conditions within primary care. Key changes include:

- Removal of multiple plans to enable access to follow up services.

- Formalised arrangements for support provided by practice nurses, Aboriginal and Torres Strait Islander Health Practitioners and Aboriginal Health Workers who assist with the preparation and review of GPCCMP.

How will these changes affect patients?

Patients will benefit from simplified arrangements. The revised framework will support patients by ensuring regular reviews of the management of their chronic conditions.

Who was consulted on the changes?

The GPPCCC was established in 2016 by the Taskforce, to provide broad clinician and consumer expertise. The MBS Review included a public consultation process on the proposed changes from December 2018 to March 2019. Feedback was received from a broad range of stakeholders and considered by the GPPCCC prior to making its final recommendations to the Taskforce.

Following the MBS Review, ongoing consultation occurred through an Implementation Liaison Group which included, amongst other stakeholders, the Australian Medical Association, the Royal Australian College of General Practitioners, the Rural Doctors Association, Allied Health Professionals Australia, the Australian Primary Health Care Nurses Association, and the National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners. A Communications Working Group was also established which included representatives of the affected health professions to support communications to health professionals.

How will the changes be monitored and reviewed?

Changes to MBS items are subject to post-implementation review. Post-implementation reviews typically occur around 2 years after implementation of the change.

Providers are responsible for ensuring Medicare services claimed using their provider number meet all legislative requirements. All Medicare claiming is subject to compliance checks and providers may be required to submit evidence about the services they bill. More information about the department's compliance program can be found on its website at Medicare compliance.

Where can I find more information?

The full item descriptor(s) and information on other changes to the MBS can be found on the MBS Online website. You can also subscribe to future MBS updates by visiting 'Subscribe to the MBS' on the MBS Online website.

Providers seeking advice on interpretation of MBS items, explanatory notes and associated legislation can use the department's email advice service by emailing askMBS@health.gov.au.

Private health insurance information on the product tier arrangements is available at www.privatehealth.gov.au. Detailed information on the MBS item listing within clinical categories is available on the department's website. Private health insurance minimum accommodation benefits information, including MBS item accommodation classification, is available in the latest version of the *Private Health Insurance (Benefit Requirements) Rules 2011* found on the Federal Register of Legislation. If you have a query in relation to private health insurance, you should email PHI@health.gov.au.

Subscribe to 'News for Health Professionals' on the Services Australia website to receive regular news highlights.

If you are seeking advice in relation to Medicare billing, claiming, payments, or obtaining a provider number, please go to the Health Professionals page on the Services Australia website or contact Services Australia on the Provider Enquiry Line – 13 21 50.

The data file for software vendors when available can be accessed via the Downloads page.

Please note that the information provided is a general guide only. It is ultimately the responsibility of treating practitioners to use their professional judgment to determine the most clinically appropriate services to provide, and then to ensure that any services billed to Medicare fully meet the eligibility requirements outlined in the legislation.

This factsheet is current as of the Last updated date shown above and does not account for MBS changes since that date.