

Chronic Disease Support & Medicare Item 10997

Wed 05 April 12:30pm AEST



PRESENTED BY:



Kim Poyner Founder & Director, MediCoach



Magali De Castro Leadership & Development Coach, HotDoc



Riwka HagenPrincipal Consultant,
Medical Business Services

In the spirit of reconciliation, HotDoc acknowledges the Traditional Custodians of country throughout Australia and their connections to land, sea and community.

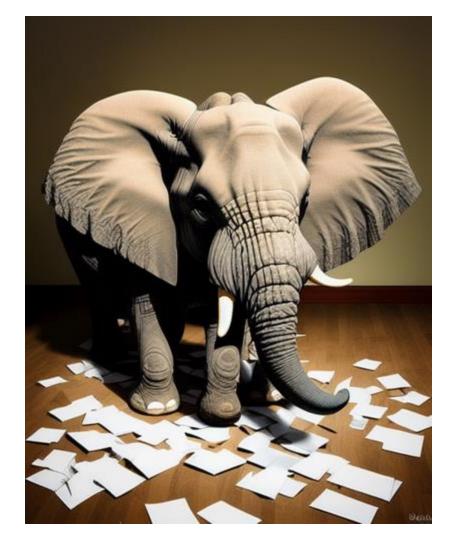
We pay our respect to their elders past and present and extend that respect to all Aboriginal and Torres Strait Islander peoples today.

Today we'll cover

Chronic Disease Support & Medicare item 10997

- Discuss the implications & impact of the recent Medicare compliance letters sent to 600 GPs in relation to item 10997
- Overview of Medicare requirements & eligibility criteria for item 10997
- When and how to use this item well
- Documentation requirements when using this item
- Q&A with the panel

Why talk about 10997 now?



Item 10997:

Provision of *monitoring and support* for a person with a chronic disease by a practice nurse or Aboriginal and Torres Strait Islander health practitioner



Other formats for item 10997:

10997 (face-to-face) 93201 (telehealth) 93203 (phone) Chronic disease monitoring and support service These services are available to patients with a GP Management Plan, Team Care Arrangements or Multidisciplinary Care Plan. Claim these items up to 5 times per patient per calendar year.

Medicare descriptor for item 10997

Taken from mbsonline.gov.au

Service provided to a person with a chronic disease by a practice nurse or an Aboriginal and Torres Strait Islander health practitioner if:

- (a) the service is **provided on behalf of and under the supervision of a medical practitioner**; and
- (b) the person is **not an admitted patient of a hospital**; and
- (c) the person has a GP Management Plan, Team Care Arrangements or Multidisciplinary Care Plan in place; and
- (d) the service is consistent with the GP Management Plan, Team Care Arrangements or Multidisciplinary Care Plan to a maximum of 5 services per patient in a calendar year



Explanatory notes for item 10997 (Note MN.12.4)

Additional information worth noting:

Item 10997 will assist patients who require access to ongoing care, routine treatment and ongoing monitoring and support between the more structured reviews of the care plan by the patient's usual GP.

Item 10997 may be used to provide:

- checks on clinical progress;
- monitoring medication compliance;
- **self management advice**, and;
- collection of information to support GP/medical practitioner reviews of Care Plans.

The services provided (...) should be consistent with the scope of the GP Management Plan, Team Care Arrangements, or Multidisciplinary Care Plan



Explanatory notes for item 10997 (Note MN.12.4)

Additional information worth noting:

- Patients whose condition is unstable/deteriorating should be referred to their GP
- General practices (...) should also have a written clinical risk management strategy covering issues like clinical roles, patient follow up and patient consent.
- The claiming GP or medical practitioner does not have to be physically present at the time the service is provided. However, the GP/medical practitioner should be able to be contacted if required.
- Where the GP/medical practitioner has a consultation with the patient, then they are entitled to claim a Medicare item for the time and complexity of their personal attendance on the patient.
- Item 10990 or 10991 (bulk billing incentives) can be claimed in conjunction with item 10997 (where patient meets 10990/10991 requirements



AskMBS Advisory

General Practice #1 (Released 24/10/22)

Added in relation to 10997:

"This item should <u>not</u> be claimed in relation to assistance provided to the GP to <u>prepare</u> a GP Management Plan or Team Care Arrangements.

It would not be expected that item 10997 would be routinely claimed on the same day as items 721 or 723."

WHEN IS IT APPROPRIATE TO USE ITEM 10997?

Item 10997 is for the provision of monitoring and support for a person with a chronic disease by a practice nurse or Aboriginal and Torres Strait Islander health practitioner on behalf of a medical practitioner. Item 10997 can only be claimed where a GP Management plan, Team Care Arrangements or Multidisciplinary Care Plan is in place and can be claimed for a maximum of 5 services per patient in a calendar year. It may be used to provide:

- checks on clinical progress;
- · monitoring of medication compliance;
- · self-management advice, and
- the collection of information to support GP/medical practitioner reviews of care plans.

The services provided by the practice nurse or Aboriginal and Torres Strait Islander health practitioner should be consistent with the scope of the patient's GP Management Plan, Team Care Arrangements, or Multidisciplinary Care Plan.

Item 10997 is intended to be used for monitoring or support services for a person with a chronic condition between the more structured reviews of the care plan by the patient's usual GP. This item should not be claimed in relation to assistance provided to the GP to prepare a GP Management Plan or Team Care Arrangements. It would not be expected that item 10997 would be routinely claimed on the same day as items 721 or 723.



When & how to use item 10997

Medicare's suggestions

Item 10997 may be used to provide:

- checks on clinical progress;
- monitoring medication compliance;
- self management advice, and;
- collection of information to support GP/medical practitioner reviews of Care Plans.

But in more practical terms...

- What activities would qualify for the 10997 item?
- What documentation is required?
- What needs to be written in the patient's care plan?

Where to from here?

Listen to the discussion with Karen Booth from APNA

Episode 10 The critical role of nursing in primary care. Karen Booth, APNA



Published on: 17th March, 2023

medicubes.captivate.fm



Thanks for watching!

To find out more about HotDoc, visit practices.hotdoc.com.au