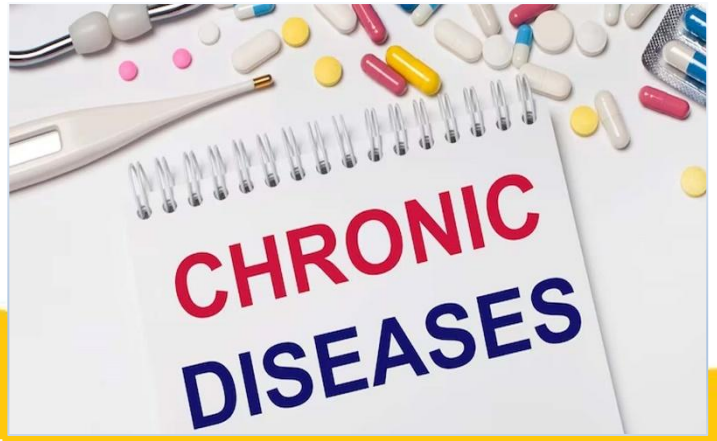
Larter.

Changes to MBS Chronic Condition Management



A stronger primary health system.

Learning Objectives

At the end of this workshop, the participants should be able to:

- Describe in detail the changes to Chronic Disease Management made on July 1st, 2025
- Recall the new item numbers, rebates and claiming requirements along with changes to the current referral process.
- Explore how these changes may influence the Practice Nurse's role and highlight the wide range of additional services nurses can deliver to strengthen their contribution within general practice.

Chronic Condition Management Changes 01/07/2025

Chronic Condition Management

- From 1 July 2025, there is a new framework for chronic disease management.
- The changes simplify, streamline, and modernise the arrangements for health care professionals and patients.
- Allied health professionals providing MBS services should be aware of the changes to plan and referral requirements.
- Transition arrangements will be in place for 2 years

Chronic Condition Management

From 1 July 2025:

- Items for:
- GP management plans (229, 721, 92024, 92055)
- Team care arrangements (230, 723, 92025, 92056) Reviews (233, 732, 92028, 92059)

  will cease.

- The updated framework will be known as Chronic Condition Management.

Chronic Condition Management

MBS Taskforce Recommendations:

- Agreed that GPMP and TCA should be combined
  - 30% of TCA's billed during the reviewed period did not access allied health services
- Item 731 to remain- (forms part of GPACI services)
- Copy of the plan to be uploaded to My Health Record
- Allied health services will be linked to the new item

https://www.health.gov.au/resources/publications/medicare-benefits-schedule-review-taskforce-final-report

Chronic Condition Management

Focus of change is on the importance of **reviewing** and updating patients plan in the optimisation of patient outcomes.

- 55% of previous 721/723 did not receive a review
- Reviews will be strengthened with the aim that it is conducted by a GP at the practice where the patient is enrolled with MyMedicare.

Chronic Condition Management

- Claiming item 965 will ensure eligibility for subsidised Allied Health consultations through Medicare.

- Removal of “red tape” associated with the previous process:

  - Seeking and receiving consent to participate
  - Minimum providers (previously 3)

- Rebalancing of 965 and 967 into equal value

New item numbers 1.7.25

Name of Item	GP item number	Prescribed medical practitioner item number
Develop a GP chronic condition management plan – face to face	965-**$156.55**	392-**$125.30**
Develop a GP chronic condition management plan - telehealth	92029-**$156.55**	92060-**$125.30**
Review a GP chronic condition management plan – face to face	967-**$156.55**	393-**$125.30**
Review a GP chronic condition management plan – telehealth	92030-**$156.55**	92061-**$125.30**

Preparing a GPCCMP

Preparing a GPCCMP

Preparing a GPCCMP will be defined as preparing a written plan which describes:

- The patient's chronic condition(s) and associated health care needs and;
- Develop health and lifestyle goals **as set by the patient and medical practitioner** using a shared decision-making approach and;
- Actions to be taken by the patient and treating practitioners and;
- Treatment and services the patient is likely to need.

Preparing a GPCCMP

If the patient would benefit from multidisciplinary care to manage the chronic condition(s)

- the services that the medical practitioner will refer the patient to
- including the purposes of those treatments or service and;

- Arrangements to review the plan, including the proposed timeframe for review.

- Consent to upload to MyHealth Record.

Preparing a GPCCMP

If the patient is to be referred to a member of a multidisciplinary team, the GP must:

- obtain the patient's consent to sharing relevant information.
- **Note**: there is no requirement for allied health providers to confirm acceptance of the referral or otherwise provide input into the preparation of the GPCCMP, as was previously the case.

- Allied health providers requirement to provide a written report after the provision of certain services (e.g. the first service under a referral) are unchanged.

Preparing a GPCCMP

The process of developing and finalising a GPCCMP must include:

- Recording the patient's consent and agreement to the preparation of the plan
- Offering a copy of the plan to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees)
- Adding a copy of the plan to the patient's medical records
- Uploading a copy to the patients MyHealth record (where consent is obtained)

GP CHRONIC CONDITION MANAGEMENT PLAN

ITEM: GP Chronic Condition Management Plan- MBS Item 965

PATIENT DETAILS:	GP DETAILS:

DATE CARE PLAN PREPARED: Insert date

PATIENT CONSENT OBTAINED: Insert consent obtained

PROBLEM LIST: (Health summary of current conditions)

ALLERGIES: Allergies recorded

CURRENT MEDICATIONS: Populate current medications

Smoking smoking status

Biometrics: Insert Weight, Height, BMI, BP (sitting and standing) O2 sats, Pulse, Temp etc

SERVICE PROVIDERS: WHAT OTHER CARE PROVIDERS ARE INVOLVED

NAME	SPECIALITY	CARE PROVIDED
Dr. Frederick Foote	Podiatrist	Foot care
Mrs. Fiona Glass	Ophthalmologist	Monitor Glaucoma
Dr. Timothy	Diabetes Educator	Education and support
Miss Fran Pushup	Exercise Physiologist	Implement/supervise exercise
Dr. Ian Hormone	Endocrinologist	Manage Diabetes

PROBLEMS/ NEEDS, GOALS AND PLANNED ACTIONS

Current Health Needs/ Problems	Goal	Planned Actions/ Tasks	Service Provider Responsible
[Main condition]	Increase patient's understanding of Chronic condition.	Patient education.	GP
Self-management	introduce self-management where appropriate	Counselling, support, education.	GP, Allied Health, Specialist
General health monitoring.	Monitoring of general health	Review patient's status. • Measure weight, height, BMI, blood pressure. • Tests specific to this chronic condition	GP How often? • once every 6-12 months.
Medications.	Correct use of medication, with minimal side-effects.	Education about medications. Home medicine review if needed.	Pharmacist
Future complications. Reduce risk of hospitalisation.	• To prevent/minimise the long-term effects of Chronic Pain on body and everyday life. • To manage medication.	• Annual complication assessment & review. • Adjustment of medication.	Consultant physician
Smoking	complete cessation	support, educate, counsel	GP
Need for healthy diet.	To maintain a healthy weight & healthy, adequate nutrition.	Increase understanding of healthy eating. Review diet.	Dietitian / Health Educator & GP
Need for physical activity.	To exercise for at least 30 minutes, most days of the week.	• To establish a regular exercise routine. • Reinforce activity.	• An exercise program of patient's choice. • Reinforced by GP.
Alcohol	low risk alcohol consumption is ZERO	assess medications for potential alcohol interactions - advise patient. Encourage patients to abstain from alcohol at all or limit intake to 2 or less standard drinks a day.	GP.
Weight	Waist measurement: Male< 94 cm Female < 80 cm BMI <25 kg/m2	assess and monitor BMI and WC, set goals, review, educate	GP
Psychosocial burden of chronic condition, impact on social life.	prevent adverse effects of chronic condition on everyday life	assessment, education, support, referral.	GP

PATIENT AGREEMENT TO THE GOALS OF THE CARE PLAN: AGREED

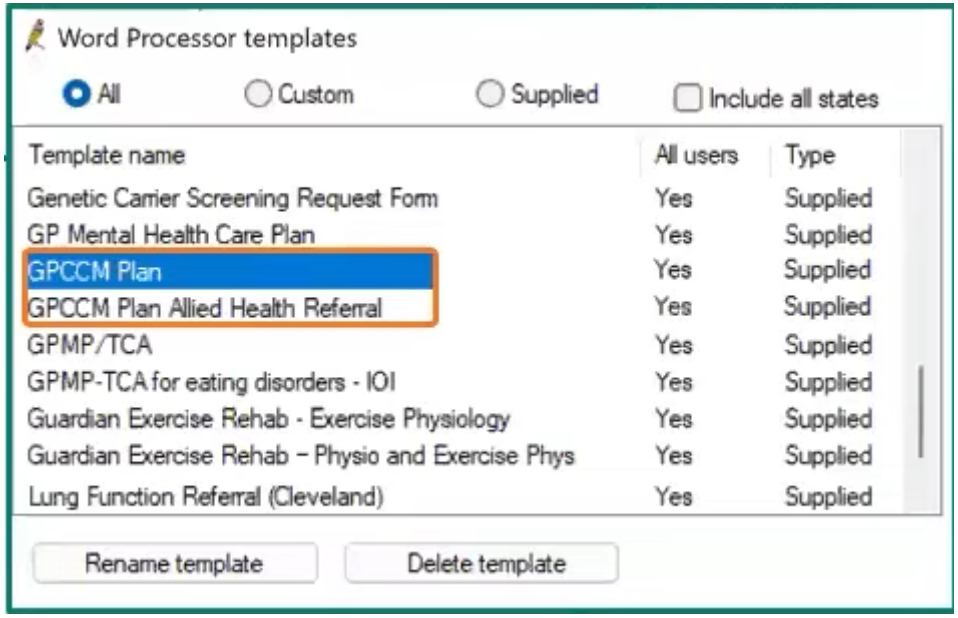
I understand the above Care Plan recommendations and agree to the outlined goals.

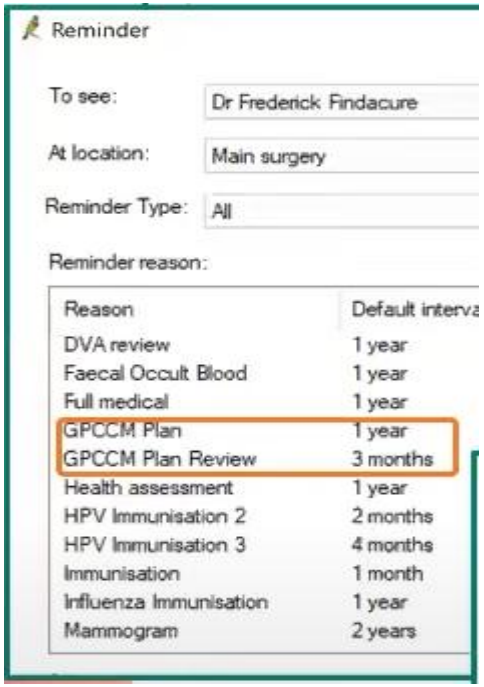
Copy of Care Plan given to patient: **Yes**

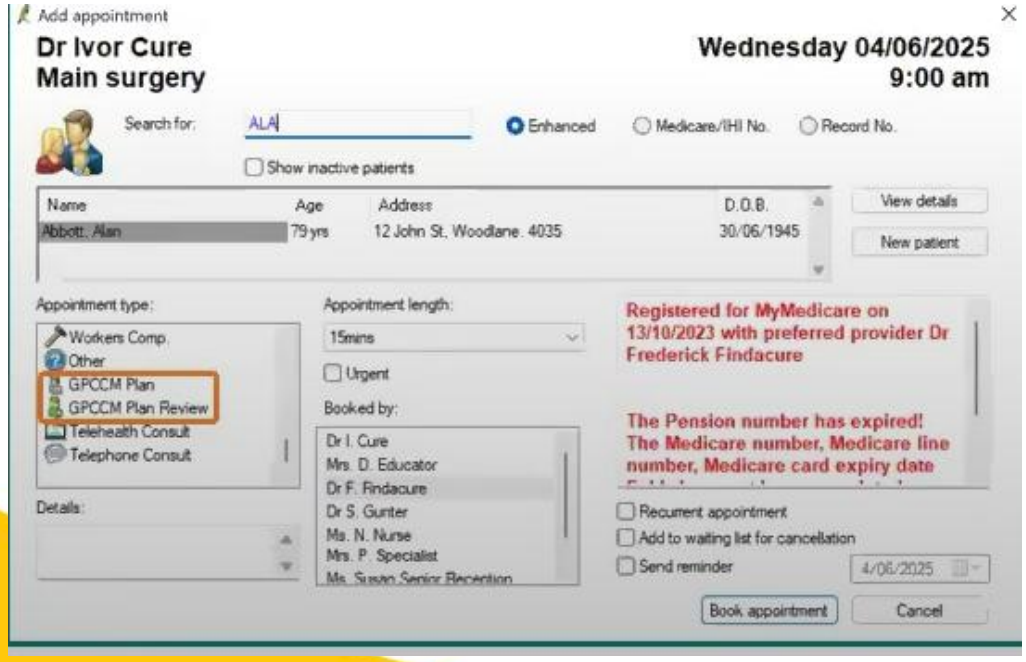
Recommended review date: **3 OR 6 MONTHS**

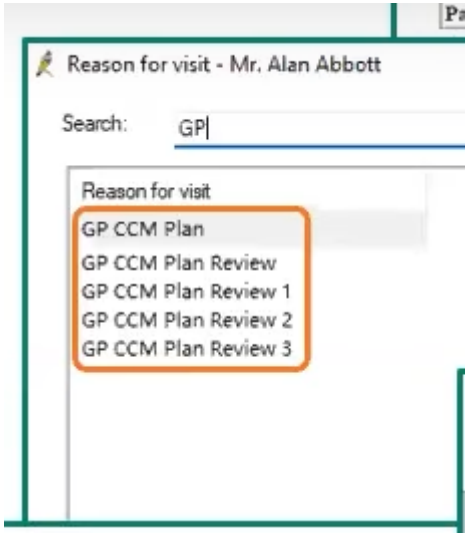
Reminder added: **Yes**

Consent to upload to MyHealth Record: Yes/No **Uploaded: Yes/No**


Word Processor templates
All
Custom
Supplied
Include all states
Template name
All users
Type
Genetic Carrier Screening Request Form Yes Supplied
GP Mental Health Care Plan Yes Supplied
GPCCM Plan Yes Supplied
GPCCM Plan Allied Health Referral Yes Supplied
GPMP/TCA Yes Supplied
GPMP-TCA for eating disorders - IOI Yes Supplied
Guardian Exercise Rehab - Exercise Physiology Yes Supplied
Guardian Exercise Rehab – Physio and Exercise Phys Yes Supplied
Lung Function Referral (Cleveland) Yes Supplied
Rename template
Delete template


Reminder
To see: Dr Frederick Findacure
At location: Main surgery
Reminder Type: All
Reminder reason:
Reason
Default interva
DVA review 1 year
Faecal Occult Blood 1 year
Full medical 1 year
GPCCM Plan 1 year
GPCCM Plan Review 3 months
Health assessment 1 year
HPV Immunisation 2 2 months
HPV Immunisation 3 4 months
Immunisation 1 month
Influenza Immunisation 1 year
Mammogram 2 years


Add appointment
Dr Ivor Cure
Main surgery
Wednesday 04/06/2025
9:00 am
Search for: ALA
Enhanced
Medicare/IHI No.
Record No.
Show inactive patients
Name
Age
Address
D.O.B.
Abbott, Alan
79 yrs
12 John St, Woodlane, 4035
30/06/1945
View details
New patient
Appointment type:
Workers Comp.
Other
GPCCM Plan
GPCCM Plan Review
Telehealth Consult
Telephone Consult
Appointment length:
15mins
Urgent
Booked by:
Dr I. Cure
Mrs. D. Educator
Dr F. Findacure
Dr S. Gunter
Ms. N. Nurse
Mrs. P. Specialist
Details:
Registered for MyMedicare on 13/10/2023 with preferred provider Dr Frederick Findacure
The Pension number has expired! The Medicare number, Medicare line number, Medicare card expiry date
Recurrent appointment
Add to waiting list for cancellation
Send reminder
4/06/2025
Book appointment
Cancel


Reason for visit - Mr. Alan Abbott
Search: GP
Reason for visit
GP CCM Plan
GP CCM Plan Review
GP CCM Plan Review 1
GP CCM Plan Review 2
GP CCM Plan Review 3

Reviewing a GPCCMP

Reviewing a GPCCMP

- A key objective of the changes is to encourage regular reviews of GPCCMPs.
- An existing GPCCMP can be reviewed and amended on an ongoing basis
- The new MBS items to review a GPCCMP (967)should only be used to review an existing GPCCMP (965)
- If a patient requires a review of a GPMP or TCA that was put in place **prior to 1 July 2025** they should be transitioned to the new arrangements through the preparation of a GPCCMP.

Reviewing A GPCCMP

- Unless exceptional circumstances apply, a GPCCMP can be reviewed every 3 months, if it is clinically relevant to do so.

Reviewing a GPCCMP means that:

- The GP must discuss and document:
  - the patient's progress in relation to the goals mentioned in the GPCCMP
  - whether any updates should be made to the GPCCMP.

Reviewing A GPCCMP

Taking into account:

- Whether the goals remain appropriate and the degree of progress towards the goals
- information provided by members of the multidisciplinary team (if any) in relation to their treatment of the patient and
- the extent to which the services provided by the members are supporting the patient to meet the patient's goals.

Reviewing A GPCCMP

The process of reviewing a GPCCMP must include:

- Recording the patient's consent and agreement to the updates
- Offering a copy of the updated plan to the patient and the patient's carer (if any) if the practitioner considers it appropriate and the patient agrees
- Adding a copy of the updated plan to the patient's medical records.
- Uploading a copy to the patients MyHealth Record

Transition Arrangements

Transition arrangements

- Patients that had a GP management plan and/or team care arrangement in place prior to 1 July 2025 will be able to continue to access services consistent with those plans for two years.

- From 1 July 2027, a GP chronic condition management plan will be required for ongoing access to allied health services.

- Patients can continue to access services provided through MBS item 10997 (and its telehealth equivalents 93201 and 93203) under existing GPMPs and TCAs until 30 June 2027

Transition arrangements

- If a patient requires a review of a GPMP or TCA that was put in place prior to 1 July 2025 they should be transitioned to the new arrangements through the preparation of a GPCCMP

- From 1 July 2027 only patients with a GP chronic condition management plan (GPCCMP) will be eligible to access domiciliary medication management reviews through the MBS.

Changes to the Referral Process

Referral Requirements

- Referral requirements for most MBS-supported allied health services written on or after 1 July 2025, will change.
- These changes will ensure that the requirements are more consistent with the arrangements for referrals to medical specialists.

- Any 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 2025, current allied health referral forms will no longer be used.

Referral Requirements

There is no requirement for allied health providers:

- to confirm acceptance of the referral
- provide input into the preparation of the GP chronic condition management plan (GPCCMP).

- Unless otherwise specified by the referring medical practitioner, referrals to allied health services for patients with a chronic condition will be valid for 18 months.

Referral Requirements

The referral must include

- The name of the referring practitioner
- The address of the practice
- Referring Practitioner's provider number
- The date the referral was written
- be in writing
- be signed by the referring practitioner (which may be by electronic signature)
- explain the reasons for referring the patient, and any information the GP feels is relevant.

Referral Requirements

One of the objectives of the changes is to provide patients with greater choice and flexibility.

- 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 GP chronic condition management plan to a physiotherapist of their choice.
    - NB Acceptance of a referral is at the discretion of the individual practitioner, subject to anti-discrimination legislation.

Referral Requirements

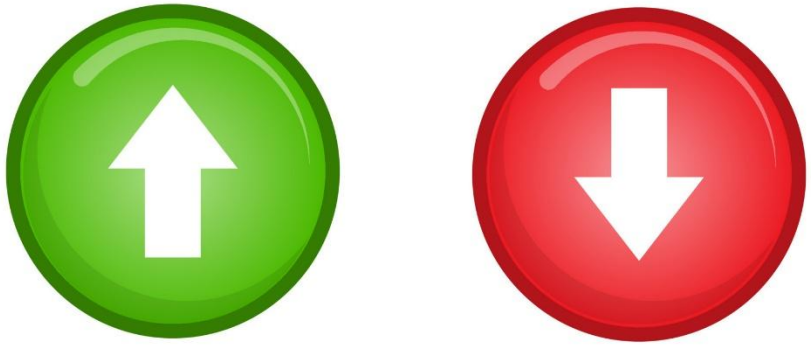
Specify the number of services to be provided.

- However, the referring medical practitioner can specify the number of services to be provided under the referral, 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.

What the changes may look like in your practice.



Chronic Condition Management

- The previous Medicare rebates for Chronic Disease Management Items:

- New GPMP (Item Number 721): $164.35 (once a year)
- New TCA (Item Number 723): $130.25 (once a year)

- Maximum Medicare rebate for GPMP/TCA items per patient per year amounts to $294.60.

- For a GP practice managing 2,000 patients on GPMP/TCA, this translates to total fees of **$589,200.00**

Chronic Condition Management

- The previous Medicare rebates for Chronic Disease Management Items:
- New GPMP (Item Number 721): $164.35 (once a year)
- New TCA (Item Number 723): $130.25 (once a year)
- Review GPMP (Item Number 732): $82.10 (three times a year)
- Review TCA (Item Number 732): $82.10 (three times a year)
- Maximum Medicare rebate for GPMP/TCA items per patient per year amounts to $787.20.
- For a GP practice managing 2,000 patients on GPMP/TCA, this translates to total fees of **$1,574,400.00**

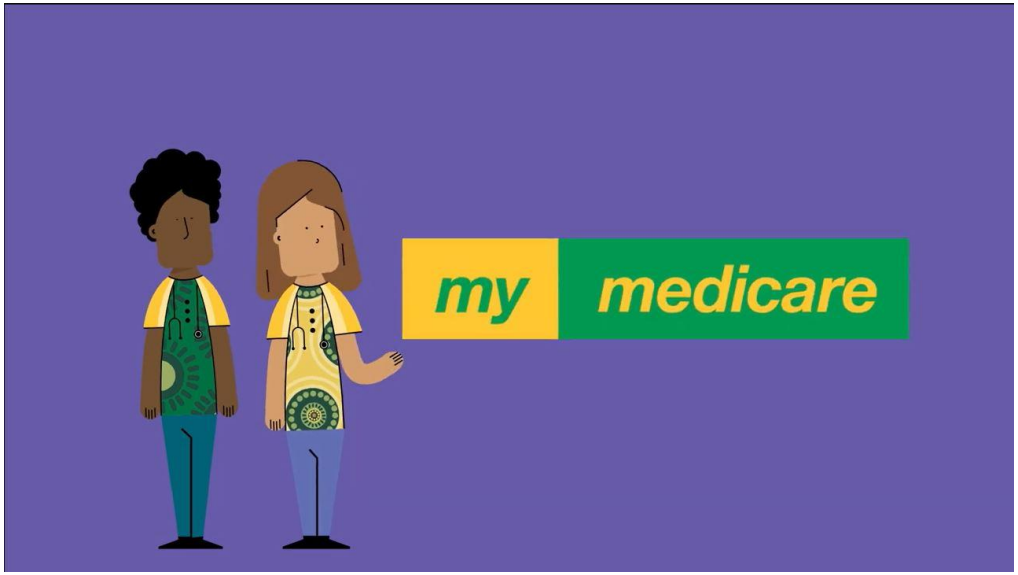
Chronic Condition Management

- Under the new system:

- New GPCCP (Item Number 965): $156.55 (once a year min)
- Review GPCCP (Item Number 967): $156.55 (three times a year)
- In this example, the new Medicare rebate per patient per year could be $626.20 per patient.

- For a practice managing 2,000 patients on GPCCP, this will result in total fees of **$1,252,400.00**

MyMedicare
Roles in engaging patients



Responsibilities

1. General Practitioners (GPs)

- **Discuss MyMedicare** with patients during consultations, explaining benefits (e.g., continuity of care, improved access to programs).
- **Confirm clinical eligibility** (e.g., patient relationship with the practice, usual GP).
- **Answer medical-related questions** about how registration supports chronic disease management, case conferencing, and other care pathways.
- **Encourage sign-up** by reinforcing benefits for long-term patient care.

Responsibilities

2. Practice Nurses

- **Support patient education** – explain MyMedicare in simple terms, answer general questions.
- **Assist with registration** by guiding patients through the online or paper form process.
- **Check patient details** (Medicare number, practice affiliation).
- **Follow up** with eligible patients (e.g., chronic/complex needs, frequent attenders) to encourage registration.

Responsibilities

3. Practice Manager

- **Oversee implementation** of MyMedicare registration processes within the practice.
- **Coordinate staff roles** and ensure training, policies, and workflows are clear.
- **Manage reporting requirements** and monitor registration uptake.
- **Communicate with PHNs and Services Australia** for compliance and troubleshooting.
- **Promote awareness** through practice newsletters, posters, and digital communications.

Responsibilities

4. Reception/Administrative Staff

- **First point of contact** – provide patients with information brochures or direct them to the nurse/GP.
- **Assist with registration logistics** – confirm patient eligibility, print forms, help with MyGov or PRODA (if required).
- **Update practice software** to reflect registered patients.
- **Track and record registrations** for practice reporting.

Why register with My Medicare?

Here at **(enter clinic name)** we pride ourselves in our ongoing commitment to our patients.

We invite you to register with us as your preferred general practice, to formalise our ongoing relationship.

Benefits to you:

- Longer MBS funded telephone and telehealth consultations to allow you access to a more comprehensive consult with your preferred GP.
- Eligibility for future funding opportunities as part of the Strengthening Medicare Taskforce review.
- Continuity of care through the knowledge that **(enter clinic name)** will value our relationship and continue to provide you with the best possible care.

Registration with our clinic will also provide the practice with future funding opportunities, allowing us to increase the services we have available for you to access.

How do I register:

Simply complete the attached registration form and return to our friendly reception team who will process the registration on your behalf.

If you have any questions or concerns, please speak to either your GP during your consultation, or to the team at reception.

We look forward to you registering with our practice and continuing our valuable patient-practice relationship.

The role of the Practice Nurse

The role of the Practice Nurse

The changes to Chronic disease management has seen, an impact on Practice Nurse roles within some practices leading to reduced nursing roles/hours.

- This should be the opposite. Changes in minimum 3 providers has expanded patient eligibility and has created potential for many more care plans to be performed.
- Understanding the numerous roles the PN undertakes is vital to advocating on your behalf within your practice
- Let's now look at the many different roles the PN undertakes

The role of the Practice Nurse

From Supportive Role to Integral Team Member

- **Earlier role:** Primarily administrative support, immunisations, wound care, and assisting the GP with procedures.

- **Now:** Seen as a core member of the care team, working independently within scope to deliver structured chronic disease management, preventive health, and patient education.

The role of the Practice Nurse

Expansion in Chronic Disease Management

- Nurses now lead much of the assessment, monitoring, and care planning for patients with diabetes, asthma, COPD, and cardiovascular disease.
- Proactive recall, care coordination, and patient engagement are increasingly nurse-led.
- Nurses are central to MyMedicare and chronic disease registers.

The role of the Practice Nurse

Preventive Health & Screening

- Responsible for health assessments (45–49-year-olds, 75+, Aboriginal & Torres Strait Islander assessments).

- Leading screening activities such as lung cancer screening eligibility checks, bowel cancer test follow-up, and cervical screening.

- Focus on risk factor management – obesity, smoking, alcohol, physical inactivity.

The role of the Practice Nurse

Patient Education & Self-Management

- Shift towards empowering patients with self-care tools and skills (e.g., home BP monitoring, asthma action plans)
- Increasing role in digital health literacy – helping patients use My Health Record, apps, and remote monitoring tools.

Care Coordination & Navigation.

- Strong role in transitions of care (hospital discharge follow-up, ensuring continuity).
- Advocating for patients and linking them to community services and social supports.

The role of the Practice Nurse

Data, Quality & Funding

- Integral in quality improvement (QI) activities
- Identifying gaps in care and helping practices maximise appropriate MBS billings.
- Using data to drive population health management rather than only individual patient care.

Expanded Scope & Specialization

- Many practices now employ nurses with special interests (e.g., diabetes education, wound care, mental health, women's health).
- Some undertake nurse practitioner training, expanding capacity for prescribing and advanced clinical roles.
- Increasing involvement in urgent care centres and primary care reform models.

Nurse Item Numbers

Chronic Condition Management

MBS Item 10997, Role of Practice Nurses:

This item can be claimed when a practice nurse or AHP provides monitoring and support services for a patient with a CDM plan, on behalf of the medical practitioner

- 5 per calendar year
- Service provided must be directly related to the patient's chronic disease

- MBS rebate $14.00

Chronic Condition Management

MBS Item 93201 (video) and 93203 (phone)

- Phone attendance by a Practice Nurse, AHW or AHP to a person with Chronic Disease.
- The person has in place:
  - a GPCCMP
  - Until 30/6/27 a current 721/723 prepared prior to July 1,2025
  - The service is consistent with the plan or arrangements

MBS Rebate- $14.10

Chronic Condition Management

MBS Item 10987/93202

- Follow up face to face OR **phone** attendance by Practice Nurse/AHP, on behalf of GP, for an Indigenous person who has received a health check if:
  - The service is provided on behalf of a GP
  - The service is consistent with the needs identified in the health assessment
  - 10 services per year

MBS rebate $27.95

Chronic Condition Management

MBS Item 10983, Role of Practice Nurses:

- Attendance by a Practice Nurse, AHW or AHP on behalf of the GP to provide clinical Support to a patient who:
    - Is participating in video conferencing with a specialist, consultant physician or Psychiatrist
    - Is not an admitted patient

MBS rebate: $37.85 (plus BB incentive)

Chronic Condition Management

Other services Nurses provided on behalf of a GP that generate income

- ABI- 11610/11611- $63.20
- ECG- 11707 $18.25
- Spirometry-115052/11506-$40.85 / $20.40
- Ear syringing- assist GP
- Dressings- assist GP
- Immunisations- assist GP
- Blood pressure monitors- 11607-$96.10
- Iron infusions- assist GP
- Cervical Screening
- Case conferencing- organise and participate

Australian Government
Department of Health and Aged Care

Correct billing of Medicare Benefits Schedule item 10997

Last updated 7 March 2024

Medicare Benefits Schedule (MBS) item 10997 may be claimed by medical practitioners and is intended for patients with chronic or terminal medical conditions who require access to ongoing care, routine treatment, ongoing monitoring and support in between more structured reviews by a General Practitioner or prescribed medical practitioner.

When to claim item 10997

Medical practitioners can claim item 10997 when:

- a patient has a Chronic Disease Management (CDM) plan in place, and
- the service is provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner on behalf of and under the supervision of a medical practitioner, and
- the patient is not an admitted patient of a hospital, and
- the service is consistent with the CDM plan.

Item 10997 may be claimed up to a maximum of 5 times per patient per calendar year

Examples of eligible services under item 10997

- Checks on clinical progress such as evaluating the efficacy of a prescribed or recommended therapy or patient goal, taking blood pressure, weight, or BMI.
- Monitoring medication compliance including assessing side effects, tolerability, efficacy and referral to the patient's medical practitioner for follow up where required.
- Self-management advice – advising the patient on modifiable lifestyle factors, how best to manage their chronic disease or condition, and providing other necessary support in line with the patient's CDM plan.

Services under item 10997 can provide valuable information which may be used when the medical practitioner reviews a CDM plan, or may facilitate a review.

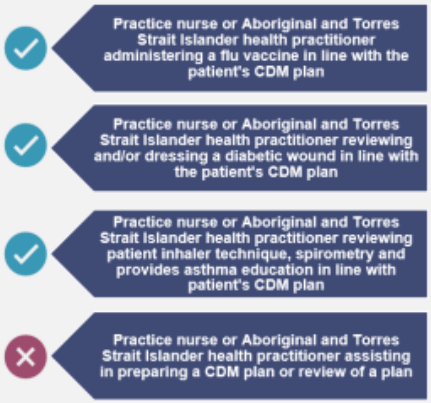
Services under item 10997 should not be billed with a CDM plan or review item, or any other consultation item, unless the service provided by a practice nurse or Aboriginal Torres Strait Islander health practitioner is a separate and clinically relevant service that would not be considered a component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

Reminders

- CDM plans are intended for patients with a chronic or terminal condition, that is, a condition that has been, or is likely to be present, for at least 6 months.
- The CDM plan and review items are for complete services; that is, the schedule fee for these services includes any assistance provided by practice nurses or Aboriginal and Torres Strait Islander health practitioners.
- CDM plans do not expire and can be reviewed when clinically necessary to ensure the goals of the plan are being met.
- CDM plans should not be co-claimed with other attendance items. Go to www.mbsonline.gov.au and search AN.0.47 for more information about CDM items

Claiming item 10997 at the same time as a CDM plan or review service

You can claim item 10997 where the service provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner is a separate and clinically relevant service that would not be considered a component of developing or reviewing a CDM plan. Item 10997 should not be claimed in relation to the assistance provided to medical practitioners to prepare or review a patient's CDM plan as this would be considered a duplication of services. It is expected that item 10997 would not be routinely claimed at the same time with a CDM plan or review item.



Further Information

- The Department of Health and Aged Care (the department) provides an email advice service for providers seeking advice on interpretation of MBS items and rules, and the *Health Insurance Act 1973* and associated regulations. If you have a query relating exclusively to interpretation of the Schedule, you should contact AskMBS on askmbs@health.gov.au.
- AskMBS also publishes advisories relating to commonly asked questions. These can be found on the department's website at http://www.health.gov.au by following the links Home > Resources > Collections > AskMBS advisories
- While the department provides these services and examples as guidance, it is the practitioner's responsibility to ensure all aspects of the MBS item descriptor are met and to correctly bill the appropriate MBS item.
- Full item descriptor(s) and information on MBS requirements can be found on MBS Online at www.mbsonline.gov.au

In summary:

- The practice nurse has evolved from being a supportive assistant to the GP into a specialist in chronic disease, preventive health, and care coordination.
- Changes to Chronic Disease management rely on the Practice nurses continuing role as the drivers of this program.
- The role will continue to expand with healthcare reform, digital health, and increasing demands on primary care.

- Advocating for the tremendous value the PN brings and the diverse role you play will secure the role in the future of General Practice

links to useful resources

- https://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-Upcoming+changes+to+the+MBS+Chronic+Disease+Management+Framework
- https://www.health.gov.au/our-work/upcoming-changes-to-mbs-chronic-disease-management-arrangements
- https://www1.racgp.org.au/newsgp/professional/full-details-of-incoming-cdm-changes-revealed
- https://cesphn.org.au/news/upcoming-changes-to-chronic-disease
- https://cesphn.org.au/news/mymedicare-chronic-conditions-management
- https://www.health.gov.au/resources/publications/strengthening-medicare-taskforce-report?language=en
- https://hpe.servicesaustralia.gov.au/INFO/MYMED/MYMEDINFO8.pdf
- https://www.health.gov.au/sites/default/files/2025-05/mymedicare-program-guidelines.pdf


QUESTIONS