Diabetes Cycle of Care

Accessing the MBS item number for the PIP incentive

Set up a register of all known patients with diabetes attending the practice. Minimum information should include patient’s name, identifier (eg practice file number) and contact details. When you have a register and an active recall/reminder system, sign up the practice to the PIP Diabetes scheme.

Identify from the register patients who need specific diabetes care and initiate a “Cycle of Care”, including recalls when necessary.*

(* If the practice can verify that a demonstrable recall system was already in place, and that the minimum requirements for an annual program of care were already in train for a particular patient then the GP can claim the SIP under 12 months from sign-on.)

Optional Associated Activities

GP Management Plan (GPMP)
MBS Item No. 721
For patient with a chronic condition lasting 6 months or terminal: GP must document assessment, management goals as agreed with patient, and identification of treatment and ongoing service.

Team Care Arrangements (TCA)
MBS Item No. 723
For patients with chronic condition and complex needs (eg. co-morbidities or a range of complications impairing function). GP must collaborate with, and document a plan for, a team including self and at least two other service providers, each of whom provides a different kind of ongoing care or treatment to meet the specific needs of the patient.

Service Incentive Payment (SIP): A SIP of $40.00 is paid quarterly to GPs for each annual cycle of care completed for a patient with established diabetes mellitus. The SIP is paid when a diabetes specific MBS item number (Items 2517-2526 and 2620-2635) is claimed and the minimum requirements of the diabetes cycle of care have been met.

The MBS item numbers are from Group A18 or A19, for more information see explanatory notes at MBS Online.

Outcomes Payment: An outcomes payment of $20.00 per diabetic SWPE per year is received by practices where at least 2% of practice patients are diagnosed with diabetes mellitus and a diabetes cycle of care has been completed on at least 50% of these patients.

The number of patients in a practice with established diabetes mellitus is based on the number of patients (based on SWPE) who have had an HbA1c test in the last two years.

Patient Management

- An annual “cycle of care” must be completed for each patient, based on RACGP and Diabetes Australia guidelines. Where appropriate, use practice nurse and refer to podiatrist, ophthalmologist, dietician, etc. As long as Cycle of Care activities are completed it does not matter which health professional provides the service.
- Use a checklist such as that available on software.
- Use normal attendance items for consultations and reviews, except the last visit in the cycle.

Diabetes Cycle of Care – activities which must be completed

Every 6 months:
- measure BMI
- measure BP
- examine feet

Every 12 months:
- measure HbA1c
- test for micro-albuminuria
- check kidney health - eGFR * from Oct 2013
- TG, total & HDL cholesterol
- provide self-care education
- review medication
- check “SNAP”, i.e. smoking, nutrition, alcohol & physical activity.

Every 24 months:
- Full eye check.

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