Practice Assist
Strengthening general practice in WA

Fact Sheet
V4 / July 2024

MBS items to support planned palliative care in general practice and residential aged care

Planned palliative care will benefit patients with a progressive chronic disease, who have recent or persistent decline in their health and a positive response to the prognostic indicator outlined below:

Prognostic indicator

As a prompt to start planned palliative care, use the following "surprise" question:

Would you be surprised if this patient dies in the next year?

Note: It is unhelpful to try to predict a date in discussion with the patient and family.

Using a planned palliative approach for patients in general practice and residential aged care does not mean a shift away from active medical care. The aim is to focus on symptomatic management and support quality of life for the patient until death.

Patients in general practice

When providing planned palliative care to patients in general practice, the services and care arrangements are at the discretion of the treating GP.

As a guide, the practice team can refer to the general practice 12-month suggested time frame for palliative care with Medicare initiatives and MBS items (page 2).

It can also be helpful for the practice team to:

- ask the practice nurse to assist the GP with planning palliative care services
- set up reminders for care planning, case conferences and advance care planning (ACP)
- schedule longer appointments for planned services
- include an ACP discussion in health assessments and care plans
- use general consultations to address unplanned care needs.

Patients in residential aged care

When providing planned palliative care to patients in residential aged care, the services and care arrangements are at the discretion of the treating GP.

As a guide, the practice team can refer to the residential aged care 12-month suggested time frame for palliative care with Medicare initiatives and MBS items (page 3).

It can also be helpful for the practice team to:

- ensure decisions for a palliative approach are discussed with facility staff
- ask the practice nurse to assist the GP with planning palliative care services
- set up reminders for care planning, case conferences and ACP
- schedule longer appointments for planned services
- include an ACP discussion in health assessments and care plans
- use general consultations to address unplanned care needs.

General Practice in Aged Care Incentive

The MyMedicare General Practice in Aged Care Incentive aims to support more regular, planned care to be delivered in aged care homes. It replaces the PIP GP Aged Care Access Incentive which ceased on 31 July 2024.

Providers may benefit from rural loadings and rebates from longer and more complex MBS items included in the incentive servicing requirements. Providers may also be eligible to receive the triple bulk billing incentive introduced in November 2023. The triple bulk billing incentive is available for each bulk-billed visit to an aged care resident.

Practices can register for the General Practice in Aged Care Incentive through MyMedicare from 1 July 2024. Eligible providers and practices registered with MyMedicare will be able to receive quarterly incentive payments for meeting the General Practice in Aged Care Incentive eligibility and servicing requirements. For further information, visit the Services Australia website.

Further information

- HealthPathways Palliative Care
- General practice 12-month suggested time frame for palliative care
- Residential aged care 12-month suggested time frame for palliative care
- MBS Online
- Palliative Care Australia

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Patients in general practice
12-month suggested time frame for palliative care

Time frame	Medicare initiative	Activities	MBS item
1st week	Over 75 Year Health Assessment	Select relevant item based on complexity and practice nurse's and GP's time. Introduce a discussion about advance care planning (ACP) or palliative care.	701 - 707
	Health Assessment for Aboriginal and Torres Strait Islander people	Health assessment for a patient of Aboriginal or Torres Strait Islander descent, provided by a GP (not more than once in a 9-month period). Introduce a discussion about ACP or palliative care.	715
2nd week	GP Management Plan (GPMP)	For patients with chronic disease, include a discussion about ACP or a palliative care approach.	721
	Team Care Arrangement (TCA)	Requires at least 3 providers, including the GP, to collaborate on care. Entitles the patient to Medicare allied health services, 5 per calendar year.	723
3rd week	GP Mental Health Treatment Plan	Select the relevant item depending on time and the GP's training, as per Diagnostic and Statistical Manual of Mental Disorders (DSM-5) criteria.	2700 - 2717
1st month	Case Conference	Opportunity for holistic informed approach to ongoing care for providers, carers and family. Organised by the GP, time dependent, requires the GP and at least 2 other providers (e.g. palliative care specialist) in real time.	739, 743
2nd month	Domiciliary Medication Management Review (DMMR)/Home Medicines Review (HMR)	Referral to an eligible pharmacist to ensure optimal management of a patient with 5 or more medications and/or complexity.	900
4th month	Long consultation	To complete ACP documentation, after earlier discussions. Level D or E.	44, 123
5th month	Review GP Mental Health Treatment Plan	4 weeks to 6 months after the preparation of the plan, review the referral feedback and progress against goals.	2712
6th month	GPMP review	Discuss the progress against the goals and actions.	732
	TCA review	Discuss the progress with team members. MBS item 732 can be claimed twice in the same day if services are separate, and the times noted.	732, 739
8th month	Case Conference	Organised by the GP, time dependent, for the GP and 2 other providers in real time.	735, 739, 743
During the 12 months	Practice nurse care plan monitoring or Aboriginal and Torres Strait Islander health practitioner	5 services per patient in a calendar year, where a GPMP is in place.	10997
	Professional attendance by a nurse practitioner	Relevant item based on complexity and nurse practitioner's time.	82205 - 82215
	Follow-up service	Provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner for an Indigenous person who has had a health assessment.	10987
After 12 months	Repeat the health assessment, care plan and reviews, where clinically required, and review ACP conversation/documentation.		As above

For eligibility, service components and remuneration details of the MBS items, refer to MBS Online.
Further information about changes to bulk billing is available via November 2023 Bulk Billing Incentive Items and GP tables and Bulk Billing in General Practice from 1 November 2023.

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Patients in residential aged care
12-month suggested time frame for palliative care

Time frame	Medicare initiative	Activities	MBS item
1st week	Comprehensive Medical Assessment (CMA)	On admission, then annually, identify who is appointed to assist with health care decisions for patients who do not have capacity for palliative care discussions. Select the relevant item based on complexity and the practice nurse's and GP's time. Assess advance care planning (ACP) documentation.	701 - 707
	Residential Medication Management Review (RMMR)	Referral to an eligible pharmacist to ensure optimal management of a patient with 5 or more medications and/or complexity.	903
2nd week	GP Mental Health Treatment Plan	Select the relevant item depending on time and the GP's training, as per Diagnostic and Statistical Manual of Mental Disorders (DSM-5) criteria.	2700 - 2717
1st month	Care Plan Contribution	For patients with chronic disease, the GP contributes to the facility's plan. The GP's contribution entitles the patient to Medicare allied health services, 5 per calendar year.	731
2nd month	Case Conference	Opportunity for holistic informed approach to ongoing care for providers, carers, and family. Organised by the GP, time dependent, requires the GP and at least 2 other providers (e.g. palliative care specialist) in real time.	739, 743
4th month	Long consultation	To complete an Advance Health Directive (WA document) after earlier discussions. Level D or E. MBS item 90001 provides a call-out fee for the initial attendance by the GP at one residential aged care facility (RACF), on one occasion, applicable only to the first patient seen on the RACF visit.	90051, 90054 90001
5th month	Review GP Mental Health Treatment Plan	4 weeks to 6 months after the preparation of the plan, review the referral feedback and progress against goals.	2712
6th month	Care Plan Contribution	Review of the facility's multidisciplinary plan and the GP's contribution.	731
8th month	Case Conference	Organised by the GP, time dependent, for the GP and 2 other providers in real time.	739, 743
After 12 months	Repeat the CMA, case conferences and care plan contributions, where clinically required, and review ACP documentation.		As above

For eligibility, service components and remuneration details of the MBS items, refer to MBS Online.
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This resource has been adapted from information developed by North Western Melbourne Primary Health Network (NWMPHN).

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