MBS Items for Palliative Care

Medicare Australia supports proactive, person centred care planning for any person with a chronic or terminal illness through remunerated care planning item numbers.

We suggest that GPs may consider adding 'Palliative Care' as a diagnosis within their medical software program (as clinically appropriate) so that practices can set up effective recall reminders systems to support the use of such MBS item numbers.

What is available through Medicare to support Palliative Care patients and their families?

Community patients

- GP Management Plan (GPMP)
- Team Care Arrangement (TCA) and linkage to the Enhanced Primary Care Program
- Case Conferencing
- General Consults (level A – D) – Advance Care Planning could be completed with a Level D consult
- Mental Health Care Plans and linkage to Psychology supports (as clinically relevant)
  NB: Carers may benefit from this also
- Home Medicine Review
- GPMP and TCA reviews
- Practice RN Chronic Care Reviews

Resident's of Aged Care Facilities

- Comprehensive Medical Assessment
- Residential Medication Management Review
- Contribution to a care plan
- Case Conferencing
- General Consults (level A – D)

Prognostic Indicators

For many people suffering from a chronic illness a point is reached where it is clear that the person will die from their condition. Despite this, for many conditions it may be difficult, if not impossible and potentially unhelpful, to estimate prognosis accurately. The Prognostic Indicator Guidance developed as part of the Gold Standards Framework (GSF) provides useful prompts or triggers to a healthcare professional that discussions about the end of life should be initiated, if this has not already happened". (Prognostic Indicator Guidance Paper © National Gold Standards Framework Centre England 2005 Date: Sept 2008)

This Prognostic Indicator guidance has been circulated within resources posted out for the 'Doctor's Bag'

See following Business Cases - developed by Claudia Giugni, Clinical Nurse Consultant, representative for the Palliative Care Nurses Association on the RPCP Management Advisory Group.

NSW Central West Division of General Practice Ltd

An example of planned Palliative Care within a General Practice setting

Betty is a 65 year old lady with COPD diagnosed 3 years ago. She sees her GP regularly and has been generally stable. However, over the past 6 months she describes difficulty in managing at home due to breathlessness and has been admitted to the local hospital twice throughout this time. She lives with her husband Tom who is very concerned about Betty.
Today, Betty has come for a routine GP visit and describes breathlessness that now limits most of her normal activities of daily living. On assessment Betty is found to have a FEV1 of 25%, O2 saturations of 88% and describes breathlessness on mild activity.
Betty's GP diagnoses progressive COPD.

Suggested Options:

- Manage any outstanding medical issues (infection, hypoxia etc)
- Code Betty with a 'Palliative Care' diagnosis in her patient record
- Book Betty in for a planned GP Management Plan +/- Team Care Arrangement (as today she is only booked in for a routine (10 minute) consult) to look at her full supportive / palliative care needs (consider using supplied Chronic Care / Palliative Care Template) **NB: This can be assisted / commenced by the practice nurse**
- Alert practice staff to enable them to set up recall / reminder systems for care planning, including case conferences and advance care planning.

(For the sake of this example, we will call the time when Betty has her GPMP – 0 months) NB: This is all at the clinical discretion of the GP and the treating GP should also be confident that their peers would deem the provision of any service to be medically necessary and clinically relevant.

Timeframe	MBS Item	Medicare Remuneration
0 months	**GP management Plan (721)** (General Practice Nurse can support this)	**$133.65**
	Team Care Arrangement - TCA (723) (General Practice Nurse can support this)	**$105.90**
	(NB: Likely to need support from other practitioners – if >2 people required in addition to the GP, a Team Care Arrangement can be completed. This enables linkage to the Enhanced Primary Care Program)	
2 months	**Case Conference organised by GP - (739)** (or practice staff) 30 mins (This offers the opportunity for family/carers/patients to continue to participate in Betty's care)	**$112.10**
	Referral for a Domiciliary Medication Management Review (900) (This medication review is timely after a full GPMP is completed to ensure optimal medication management)	**$143.40**
4 months	**Level D consult to complete Advance Care Planning (44)** (This work will have been flagged at earlier consults- this session is to focus further on this ongoing process. Advance Care Planning is not completed in a single conversation)	**$97.80**
6 months	**GP Management Plan Review (732)** (General Practice Nurse can support this)	**$66.80**
	Or Coordinate a TCA Review (732) (if > 2 professional + GP involved in Care)	
8 months	**Case Conference organised by GP (735)** (or practice staff) at least 20 minutes	**$ 65.40**
12 months	**Repeat GP Management Plan** as above- if clinical change noted	

In addition to the above, Practice Nurses can assist planning and independent reviews (10997 - $11.35) and GPs can always utilize their general consults as required to address unplanned care needs. Using the planned care option as above over a 12 month period, the practice can ensure longer appointments are scheduled and remuneration can be at least $725.05 per patient, per year- enhancing efficiency and best practice within Palliative care for all.

An example of planned Palliative Care within a RACF

Barry is 74 with dementia, osteoarthritis and peripheral vascular disease. He has recently been admitted to a Residential Aged Care Facility and is assessed according to their funding requirements as 'high care'. Over the past year Barry has continued to deteriorate functionally, has lost 15% of his body mass and records a serum albumin of 20g/l. He has had chronic arthritic pain and peripheral vascular pain managed with analgesics over several years. The RACF states Barry is not eating well and they are having difficulties in communicating effectively with him.

Barry is a widower with 4 children, 2 of whom live locally.

Suggested Options:

- Manage any outstanding medical issues
- Code Barry with a 'Palliative Care' diagnosis in his patient record
- Book Barry in for a planned Comprehensive Medical Assessment (CMA) and referral for a Residential Medication Management Review (RMMR)
- Alert practice staff to enable them to set up recall / reminder systems for care planning, including case conferences, advance care planning and support via the Enhanced Primary Care Program.

For the sake of this example, we will call the time when Barry has his CMA – 0 months
NB: This is all at the clinical discretion of the GP and the treating GP should also be confident that their peers would deem the provision of any service to be medically necessary and clinically relevant.

Timeframe	MBS Item	Medicare Remuneration
0 months	**Comprehensive Medical Assessment (707)** (Practice Nurses can support this) It will be important to identify at this stage who is appointed to assist with healthcare decisions for Barry, if he is found not to have 'capacity' for such discussions given his progressive dementia	**$ 249.10**
	Referral for a Residential Medication Management Review (903)	**$ 98.20**
	(This medication review is timely after a full CMA is completed to ensure optimal medication management)	
1 months	**Contribute to the Resident's care plan at the facility (731)** (This allows linkage for Barry into the Enhanced Primary Care Program)	**$65.20**
2 months	**Case Conference organised by GP (or practice staff) (739)** (This offers the opportunity for staff / family / carers / patients to continue to participate in Barry's care) 30 mins	**$112.10**
4 months	**Level D consult to complete Advance Care Planning (51)** (This work will have been flagged at earlier consults- this session is to focus further on this ongoing process. The fee for item 44, plus $43.25 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 44 plus $3.10 per patient.	**$97.80**
6 months	**Review of Barry's Care Plan (731)** (Practice Nurses can support this)	**$65.20**
8 months	**Case Conference organised by GP (or practice staff) (739)** 30 mins	**$112.10**
12 months	**Repeat Comprehensive Medical Assessment** as above- if clinical change noted	

In addition to the above, Practice Nurses can assist planning and GPs can always utilize their general consults as required to address unplanned care needs. Using the planned care option as above over a 12 month period, the practice can plan for Facility appointments and remuneration can be at least $799.70 per patient, per year- enhancing efficiency and best practice within Palliative care for all.