Medicare Benefits Schedule Review Taskforce

Final first report of the MBS Principles and Rules Committee

2016

Important note

The recommendations from the Principles and Rules Committee detailed in the body of this report, including the executive summary, were released for public consultation on 9 September 2016.

The Principles and Rules Committee considered feedback from the public consultation and agreed to defer further consideration of its recommendations regarding Issue 2: the 'complete medical service' and multiple operation rule which is detailed in the Addendum to this report. All other recommendations remain unchanged.

The final recommendations from the Principles and Rules Committee and feedback from the public consultation will be provided to the Medicare Benefits Schedule (MBS) Review Taskforce (the Taskforce) for consideration before the Taskforce makes its final recommendations to Government.

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1. Executive summary

The MBS Principles & Rules Committee (the Committee) was established to consider matters falling within the scope of the MBS Review which are not of a strictly clinical nature. This includes the examination, and updating where appropriate, of the legislative and regulatory framework underpinning the MBS, but also involves consideration of broader questions about the principles, objectives and boundaries shaping the MBS's conceptual approach and its impact in practice.

The Committee's membership comprises nine clinicians, a consumer representative, and a health policy expert, and includes two *ex officio* MBS Review Taskforce (the Taskforce) members. Each member is highly respected in their field and brings a wealth of experience and expertise to the Committee's deliberations.

The Committee will make recommendations to the Taskforce on measures, including legislative amendments, to give effect to the preferred approaches and practices the Committee identifies. Many of these will guide the future quality operation of the MBS. The Committee intends that the changes it recommends are enforceable where appropriate.

As with all Review bodies, the Committee's draft recommendations are released for stakeholder consultation prior to presentation to the Taskforce, and that is the purpose of this first report. The Committee will consider stakeholder feedback and revise its recommendations if appropriate. The Taskforce will then consider these draft recommendations, along with stakeholder feedback, before making its recommendations to the Minister for consideration by Government. The Committee is also charged with developing principles to guide the Review's Clinical Committees in developing their recommendations and designing new MBS items.

To date, the Committee has made findings, and drafted principles and recommendations, in the following areas:

1. The introduction of mandatory health provider education and assessment on MBS rules and procedures to assist providers with appropriate billing of MBS services.
2. Principles on the concept of a 'complete medical service' in the MBS context, and a proposal to introduce a three-item limit on the payment of MBS benefits for procedural services, with defined exceptions and in conjunction with the existing multiple operations rule.
3. Clarification on the appropriate claiming of initial and subsequent specialist and consultant physician attendance items.
4. Removing the differential fee structure for the 34 remaining MBS items with different Schedule fees depending on whether the service is performed by a general practitioner or specialist (the 'G&S' items) and setting a single MBS fee at the current specialist rate.
5. Clarification on the appropriate claiming of an attendance item with a procedural item.
6. Removing current restrictions on the claiming of aftercare services.
7. The maintenance of the existing three-month time limit on specialist-to-specialist referrals.

The Committee will put forward further draft principles and recommendations over the course of the Review.

2. About the Medicare Benefits Schedule (MBS) Review

2.1 Medicare and the MBS

What is Medicare?

Medicare is Australia's universal health scheme which enables all Australian residents (and some overseas visitors) to have access to a wide range of health services and medicines at little or no cost.

Introduced in 1984, Medicare has three components: free public hospital services for public patients; subsidised drugs covered by the Pharmaceutical Benefits Scheme; and subsidised health professional services listed on the Medicare Benefits Schedule.

What is the Medicare Benefits Schedule?

The Medicare Benefits Schedule (MBS) is a listing of the health professional services subsidised by the Australian Government. There are over 5,700 MBS items which provide patient benefits for a comprehensive range of services including consultations, diagnostic tests and operations.

2.2 What is the MBS Review Taskforce?

The Government established a Medicare Review Taskforce to review all of the over 5,700 MBS items to ensure they are aligned with contemporary clinical evidence and practice and improve health outcomes for patients. The Taskforce will also seek to identify any services that are unnecessary, outdated or potentially unsafe, and to develop a 'roadmap' for the operation of the MBS over coming years.

What are the goals of the Taskforce?

The Taskforce is committed to providing recommendations to the Minister that will allow the MBS to deliver on each of these four key goals:

- **Affordable and universal access**— the evidence demonstrates that the MBS supports very good access to primary care services for most Australians, particularly in urban Australia. However, despite increases in the specialist workforce over the last decade, access to many specialist services remains problematic with some rural patients being particularly under-serviced.
- **Best practice health services**— one of the core objectives of the Review is to modernise the MBS, ensuring that individual items and their descriptors are consistent with contemporary best practice and the evidence base where possible. Although the Medical Services Advisory Committee (MSAC) plays a crucial role in thoroughly evaluating new services, the vast majority of existing MBS items pre-dates this process and has never been reviewed.
- **Value for the individual patient**—another core objective of the Review is to have a MBS that supports the delivery of services that are appropriate to the patient's needs, provide real clinical value and do not expose the patient to unnecessary risk or expense.
- **Value for the health system**—achieving the above elements of the vision will go a long way to achieving improved value for the health system overall. Reducing the volume of services that

provide little or no clinical benefit will enable resources to be redirected to new and existing services that have proven benefit and are underused, particularly for patients who cannot readily access those services currently.

2.3 Methods: The Taskforce's approach

The Taskforce is reviewing existing MBS items, with a primary focus on ensuring that individual items and usage meet the definition of best practice. At the same time, a review of the principles and rules underpinning the MBS is being undertaken by the MBS Principles and Rules Committee.

Within the Taskforce's brief there is considerable scope to review and advise on all aspects which would contribute to a modern, transparent and responsive system. This includes not only making recommendations about new items or services being added to the MBS, but also about a MBS structure that could better accommodate changing health service models.

The Taskforce has made a conscious decision to be ambitious in its approach and seize this unique opportunity to recommend changes to modernise the MBS on all levels, from the clinical detail of individual items, to administrative rules and mechanisms, to structural, whole-of-MBS issues. The Taskforce will also develop a mechanism for the ongoing review of the MBS once the current Review is concluded.

The Taskforce is undertaking a program of work across the entire MBS to ensure it is contemporary, reflects up-to-date clinical practice and allows for the provision of health services that improve health outcomes.

The Taskforce has endorsed a clinician-led methodology whereby the clinical review of MBS items is undertaken by Clinical Committees and Working Groups. The Taskforce has asked Clinical Committees to undertake the following tasks:

1. Consider whether there are MBS items within each Committee's remit that are obsolete and should be removed from the MBS.
2. Consider priority reviews of selected MBS services nominated by the Taskforce.
3. Develop a programme of work to consider the clinical efficacy of the balance of MBS services within the Committee's remit.
4. Advise the Taskforce on general MBS issues identified by the Committee in the course of its deliberations.

Draft recommendations from the Clinical Committees are released for stakeholder consultation. The Clinical Committees will consider feedback from stakeholders and then provide recommendations to the Taskforce in a Review Report. The Taskforce will consider the Review Report from Clinical Committees and stakeholder feedback before making recommendations to the Minister for consideration by the Government.

3. About the MBS Principles and Rules Committee

The MBS Principles and Rules Committee (the Committee) was established to consider matters falling within the scope of the MBS Review which are not of a strictly clinical nature. It is one of the Review's Terms of Reference to:

> *Advise on a departmental program of work that aims to update the Health Insurance Act 1973 and regulations (MBS rules) that underpin MBS funding.*

Addressing this Term of Reference is one aspect of the Committee's work. This includes the examination, and updating where appropriate, of the legislative and regulatory framework underpinning the MBS, but also involves consideration of broader questions about the principles, objectives and boundaries shaping the MBS's conceptual approach and its impact in practice.

The Committee's membership comprises nine clinicians, a consumer representative, and a health policy expert, and includes two *ex officio* MBS Review Taskforce (the Taskforce) members. Each member is highly respected in their field and brings a wealth of experience and expertise to the Committee's deliberations. As with all the Review's activities, consumer engagement is key to the Committee's work. A *Summary for consumers* is provided at Appendix A, giving a consumer perspective on the issues and recommendations in this report, and discussing the potential impact of the recommendations on consumers.

The Committee will make recommendations to the Review Taskforce on measures, including legislative amendments, to give effect to the preferred approaches and practices the Committee identifies. Many of these will guide the future quality operation of the MBS. The Committee intends that the changes it recommends are enforceable, where appropriate.

As with all Review bodies, the Committee's draft recommendations are released for stakeholder consultation prior to presentation to the Taskforce, and that is the purpose of this first report. It presents the Committee's first tranche of findings and draft recommendations. The report does not represent the final position of the Principles and Rules Committee or the Taskforce on these issues. The Committee will consider stakeholder feedback and revise its recommendations if appropriate. The Taskforce will then consider these draft recommendations, along with stakeholder feedback, before making its recommendations to the Minister for consideration by Government.

The Committee is also charged with developing principles to guide the Review's Clinical Committees in developing their recommendations and designing new MBS items.

3.1 Committee members

Table 1: Principles and Rules Committee members

Name	Position/organisation	Declared conflict of interest*
Professor Michael Grigg (Chair)	Past President, Royal Australasian College of Surgeons; Past President, Australia and New Zealand Society of Vascular Surgery; Private practitioner, vascular surgery	Nil
Dr Penny Browne	General practitioner; Senior Medical Officer, Avant Mutual Group Ltd	Nil
Dr Eleanor Chew	General practitioner; Past Chair of Council, Royal Australian College of General Practitioners	Nil
Dr Michael Coglin	Chief Medical Officer, Healthscope Ltd	Nil
Professor Adam Elshaug (*ex officio* Taskforce member)	Professor of Health Policy; *HCF Research Foundation Professorial Research Fellow; Co-Director, Menzies Centre for Health Policy, School of Public Health*	Nil
Associate Professor Alex Hunyor	Associate Professor of Ophthalmology, University of Sydney; Director, Retina Associates; Chair, Medicare Advisory Committee, Royal Australian & New Zealand College of Ophthalmologists	Nil
Dr Gerard Ingham	Rural general practitioner; Member, Professional Services Review	Nil
Dr Michael Jones	Radiologist	Nil
Ms Debra Kay	Consumer representative	Nil
Dr Matthew McConnell (*ex officio* Taskforce member)	Public health physician; Clinical Planning Team, Country Health SA Local Health Network	Nil
Associate Professor Ken Sikaris	Chemical pathologist, Melbourne Pathology; Director of Clinical Support Systems, Sonic Healthcare; Associate Professor, Pathology, University of Melbourne	Nil

* Conflict of interest other than being a provider of MBS services

3.2 Conflicts of interest

All members of the Taskforce, Principles and Rules Committee, Clinical Committees and Working Groups are asked to declare any conflicts of interest at the start of their involvement and reminded to update their declarations periodically.

4. Draft principles and recommendations

4.1 Issue 1—Provider education in MBS rules and processes

Issue

Taskforce and Committee members have noted that many providers have limited awareness of the rules and procedures involved in billing for MBS services, and may adopt questionable practices on the advice of colleagues.

The Department of Human Services (DHS) provides a range of screen reader and interactive provider education modules on its website to educate providers in the use of the MBS, but there is currently no compulsion for providers to consult this resource and many are unaware of its existence.

Draft principle and recommendations

The Committee noted the range and quality of the DHS education resources and agreed on the value of such education in promoting efficient and appropriate practices and as a means of impressing providers with an appreciation of the responsibilities attached to access to public funding through the MBS. The Committee recommends that the satisfactory completion of an online assessment in MBS rules and processes should be a prerequisite for the granting of a MBS provider number by DHS.

The proposal, if implemented, would involve a modest additional impost on providers. However, there would be potential benefits in terms of more efficient practice administration, and a reduced risk of incurring penalties (for example, the repayment of improperly paid benefits) from breaching compliance with MBS billing requirements.

The Committee also recommends that professional colleges be encouraged to include ongoing education in MBS rules and processes as part of their continuing professional development programmes.

Issue 1—Provider education in MBS rules and processes

Draft principle and recommendations for public consultation

Principle

That a provider of MBS services, having the access to public funding their eligibility entails, has an obligation to acquire knowledge of MBS rules and billing requirements adequate to ensure their compliance with those rules and requirements as they apply to the provider's practice.

Recommendations

1. That access to a MBS provider number should be dependent on, in addition to existing application processes, the applicant's successful completion of an online assessment on MBS rules and billing requirements.
2. That professional colleges be encouraged to include ongoing education in MBS rules and processes as part of their continuing professional development programs.

4.2 Issue 2—The 'complete medical service' and the multiple operation rule

Issue

This issue concerns the claiming of multiple MBS items for a single episode of care and the extent to which that is appropriate. There is an obvious tension between the notions that all MBS items are a 'complete medical service', and that a number of separate items are to be considered as one service under the multiple operation rule.

The Committee's view is that clearer guidance is required in this area to address inappropriate claiming of items which has become embedded in practice over time. It is now commonplace, for example, for many surgical procedures to be billed using different multiple item numbers for the same surgery. This practice is not transparent, potentially unfair and appears to be a misuse of the intention behind the multiple operation rule—although it is partly a symptom of the out-of-date nature of many items and their descriptors. The consequences of this practice include:

- Patients receiving the same service receiving different levels of Medicare benefit
- Patients having increased out-of-pocket costs if providers choose to charge an out-of-pocket cost for each item listed on the patient invoice
- Increased MBS expenditure from higher numbers of items claimed, without proportionate increases in the care provided to patients.

The intent of the multiple operation rule is to allow for billing of multiple but quite *distinct* operations performed at the same time e.g. excising a skin lesion and performing a hernia repair. Instead, practice has evolved whereby multiple items are claimed when related surgical procedures are performed e.g. removal of glioma, cranioplasty and stereotactic localisation.

Discussion

The 'complete medical service'

The MBS explanatory notes (G.14.1) include a section headed *Principles of interpretation of the MBS*, which states:

> Each professional services listed in the MBS is a complete medical service. Where a listed service is also a component of a more comprehensive service covered by another item, the benefit for the latter service will cover the former.
>
> Where a service is rendered partly by one medical practitioner and partly by another, only the one amount of benefit is payable. For example, where a radiographic examination is started by one medical practitioner and finalised by another.

These principles, as with many elements of the MBS explanatory notes, date to the 1970s. However, the guidance they provide is ambiguous leading to significant variations in practice, with different practitioners claiming different sets of MBS items ostensibly to provide the same service.

Current advice for providers on billing complete medical services, developed by the Department of Health and available on the Department of Human Services website, is at Appendix B.

Multiple operation rule

The multiple operation rule (explanatory note T.8.2) applies to fees for services in MBS Group T8– Surgical operations, and governs the amount of Medicare benefit payable for multiple operations performed on a patient on the one occasion. In general, the fees for two or more operations are calculated as follows:

- 100% for the item with the greatest Schedule fee
- plus 50% for the item with the next greatest Schedule fee
- plus 25% for each other item.

Section 15 of the *Health Insurance Act 1973* legislates the multiple operation rule. Under subsection 15(1)(b), such multiple operations are deemed to constitute 'one professional service', rather than a collection of individual MBS services for which claims otherwise would be made separately.

The following tables show the relative proportions of multi-item claims for a single episode of care involving surgical services. Note that for the purposes of this analysis an episode of care is defined as items provided to the same patient, by the same provider on the same date of service.

Table 2: Number of services and benefits paid per episode of care for surgical procedures (Category 3 – Group T8)—2014–15

Number of items claimed within an episode of care	Sum of services	Sum of benefits	Benefits (proportion of total benefits)	Benefits (cumulative percentage)
1	6,584,215	$1,088,132,793	63.4%	63.4%
2	2,169,217	$400,388,308	23.3%	86.7%
3	586,195	$125,431,205	7.3%	94.0%
4	233,927	$54,777,320	3.2%	97.2%
5	120,044	$26,088,746	1.5%	98.8%
6	68,692	$12,343,323	0.7%	99.5%
7	35,557	$5,692,175	0.3%	99.8%
8	13,570	$1,984,666	0.1%	99.9%
9	5,412	$842,602	0.0%	100.0%
10	1,811	$303,225	0.0%	100.0%
11	568	$123,746	0.0%	100.0%
12	262	$38,266	0.0%	100.0%
13	133	$25,933	0.0%	100.0%
14	35	$9,269	0.0%	100.0%
16	17	$4,996	0.0%	100.0%
18	40	$3,512	0.0%	100.0%
Totals	**9,819,695**	**$1,716,190,086**	**100%**	**100%**

Source: Unpublished data, Department of Health (Date of service)

Of note is the high proportion of benefits paid for episodes where 1, 2 or 3 items were claimed (94 percent of total benefits paid), and the sharp decline in multi-item claims after this point—to virtually zero for eight or more services.

The following table shows the breakdown of 4-or-more item claims by specialty.

Table 3: Benefits paid by derived specialty for surgical procedures (Category 3 – Group T8)—2014–15

Derived specialty	Total benefits paid	Benefits paid (4 or more items within an episode)	Benefits (proportion of total benefits)
Specialist - Surgery - Cardio-thoracic surgery	$28,269,341	$10,963,948	39%
Specialist - Surgery - Neurosurgery	$41,663,966	$14,889,733	36%
Specialist - Urogynaecology	$1,541,454	$402,019	26%
Specialist - ENT	$100,295,924	$17,226,015	17%
Specialist - Surgery - Plastic and reconstructive surgery	$67,123,675	$8,988,067	13%
Specialist - Oral and maxillofacial surgery	$4,824,573	$611,650	13%
Specialist - Surgery - Urology	$67,139,382	$7,218,833	11%
Specialist - Obstetrics and gynaecology	$61,914,996	$5,065,879	8%
Specialist - Surgery - Orthopaedic surgery	$192,012,248	$15,026,459	8%
Specialist - Surgery - Vascular surgery	$13,852,290	$984,094	7%
Specialist - Surgery - General surgery	$208,343,151	$9,748,584	5%
Specialist - Internal medicine	$10,143,694	$452,891	4%
Specialist - Cardiology	$73,076,016	$2,948,211	4%
Specialist - Surgery - Paediatric surgery	$3,770,005	$91,066	2%
Specialist - College trainee - Physician	$67,328	$1,610	2%
Specialist - Ophthalmology	$281,538,378	$4,905,403	2%
Specialist - Psychiatry	$59,256	$985	2%
GP - VRGP - Procedural	$62,180,921	$955,679	2%
Specialist - Dermatology	$51,747,410	$778,002	2%
GP - NONVRGP - Procedural	$22,054,943	$293,873	1%
Specialist - Rehabilitation medicine	$360,958	$3,840	1%
All other specialty groups	*$424,208,975*	*$680,937*	*0%*

Source: Unpublished data, Department of Health (Date of service)

An argument used to support claiming a higher number of services than might seem appropriate is that patients benefit from the higher total of Medicare benefits they accrue. Firstly, the 'gaming' of the MBS for any purpose—even the ostensible benefit of patients—is inappropriate.

Secondly, this argument is not supported by the data. The following chart shows the average out-of-pocket cost for in-hospital surgical operations grouped by the number of MBS items claimed within a single episode of patient care. These data show that the average out-of-pocket cost for a surgical procedure increases as the number of items claimed increases. For example, patients who received one surgical item in an episode of care had an average gap payment of $500. This amount increases to $1,200 where three MBS items are claimed. The data show that increasing the number of items claimed in the one episode of care (co-claiming of MBS items) does not have the effect of reducing out-of-pocket costs for patients.

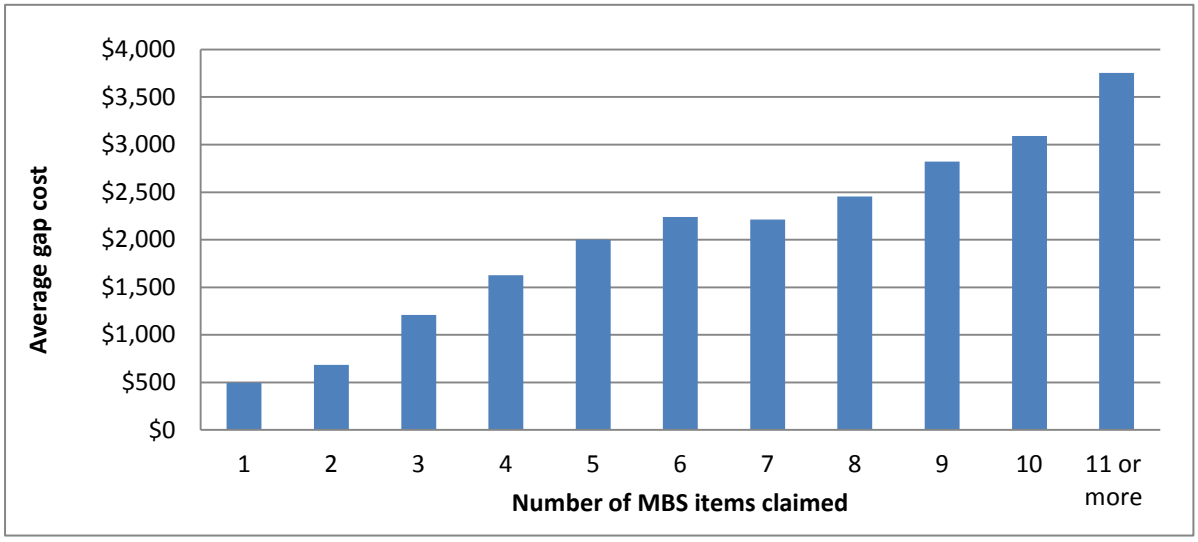

FIgure 1. Average out-of-pocket cost by number of items claimed during a single patient episode of care for in-hospital surgical operations in 2014-15

Notes: 1) Patient episode is defined as the number of MBS items provided to the same patient on the same day by the same provider. 2) Data presented is for MBS services within Group T8 (surgical operations) of the MBS. 3) Out-of-pocket (OOP) cost is calculated to be the difference between the provider fee charged and MBS benefits paid. 4) Benefits paid through private health insurance have not been included in the calculation of OOP cost. Source: unpublished data, Department of Health (Date of service, including claimed processed to May 2016).

Draft principles and recommendation

In drafting the following principles and recommendation, Committee members noted that there is variation in the number of MBS items claimed by different practitioners in relation to equivalent services and that, while the claiming of multiple MBS items is acceptable in some cases, anecdotal evidence suggests abuse in this area, particularly in relation to the claiming of additional procedures which should be considered intrinsic to the main procedure—for example, the billing of a suture for a surgical procedure. Members also noted the existence of online tools available to providers to assist them in maximising the number of MBS items claimed for a single service.

Issue 2—The 'complete medical service' and the multiple operation rule

Draft principles and recommendation for public consultation

Principles

1. There is an expectation that a single MBS item should be claimed in relation to the provision of a discrete medical service, unless there are sound clinical reasons for the claiming of multiple MBS items.
2. Where more than one MBS item is claimed in relation to the provision of a discrete medical service, the number and type of those MBS items should be consistent across all providers, resulting in the same level of Medicare benefit for all patients.

Recommendation

The Committee recommends that benefits be paid for a maximum of three MBS items in relation to a single procedure, and that the existing multiple operation rule be applied to these MBS items.

4.3 Issue 3—Initial vs subsequent attendances and determining a single course of treatment

Issue

This issue is concerned with the relationship between a referral from a general practitioner (GP) to a specialist or consultant physician and the status of the course of treatment covered by that referral.

Specialists and consultant physicians have access to 'initial' and 'subsequent' attendance items. Initial attendances, with a higher MBS fee, are to be claimed on the first occasion a provider sees a particular patient in relation to a specific medical condition i.e. at the commencement of a 'single course of treatment.' Subsequent attendance items are to be claimed for future attendances on that patient as part of that course of treatment.

The issue being addressed here arises where a new initial attendance item is claimed upon receipt of a new referral even though the attendance may be part of ongoing care for that patient's condition—part of a single course of treatment. The higher fee for initial items provides some incentive to claim them, resulting in higher costs to Medicare and patients than might be necessary.

Discussion

The referral mechanism is a key operational component of Australia's healthcare system, giving effect to the principle that general practice should be the gatekeeper to the broader system, and secondary medical care in particular.

Referrals from a GP are valid for 12 months, unless stated differently on the referral letter or note. For example, a referral could be valid for 3, 6 or 18 months, or be indefinite. While 12 month referrals are more common, a GP may write an indefinite referral for a patient who is in the continuing care and management of a specialist or consultant physician for a specific condition—for example, macular degeneration.

The Committee considered specialist/consultant physician referrals and noted the problem of providers claiming a higher-rebated initial attendance item—for a new course of treatment items in circumstances where a lower-rebated subsequent attendance item would be more appropriate.

It is the Committee's view that where the patient needs continuing care by a specialist or consultant physician as part of the same 'single course of treatment', a new referral issued because the period of a previous referral has expired should not trigger another initial attendance (i.e. item 104 for specialists or item 110 for consultant physicians).

The current MBS explanatory notes stipulate that a new referral may initiate a new course of treatment and therefore a new initial attendance item where the referring practitioner:

- deems it necessary for the patient's condition to be reviewed; and
- the patient is seen by the specialist or the consultant physician outside the currency of the last referral; and

- the patient was last seen by the specialist or the consultant physician more than 9 months earlier.

This note is a summary of rule 1.1.4 from the *Health Insurance (General Medical Services Table) Regulations* and some practitioners have interpreted this to mean that any attendance on the same patient, in relation to a continuing condition and occurring more than 9 months after the previous attendance, constitutes the commencement of a new course of treatment, allowing the claiming of an initial attendance item.

Background data

The following tables show that, for specialist services, 4.5 per cent of patients who had a new referred initial attendance (item 104) in 2013–14 had another item 104 billed by the same specialist within a 12 month period. If the data are expanded to 18 months, 10.7 per cent of patients claimed another item 104 with the same provider. For consultant physicians (item 110) these figures are slightly higher at 5.0 per cent for 12 months, and 10.7 per cent for 18 months.

The data also revealed that 0.04 per cent of patients who had a new referred initial attendance (item 104) had a second 104 item billed by the same provider on the following day. The same was found for item 110 where the percentage was also 0.04.

It is important to note that it is not possible to ascertain from the data whether or not these are genuine new courses of treatment for different conditions. In addition, the data disclose that most specialists and consultant physicians who see patients on an ongoing basis do not claim a new initial attendance item (item 104 or 110) after a defined period.

Table 4: Number of times item 104 (specialist initial attendance) billed in a 12-month period, same patient, same provider (Category 1 – Group A3—2013–14)

Number of times item 104 claimed	Number of patients
2	198,899
3	9,373
4	1,168
5	221
6	58
7+	11

Source: Unpublished data, Department of Health (Date of service)

Table 5: Number of times item 110 (consultant physician initial attendance) billed in a 12 month period, same patient, same provider (Category 1 – Group A4—2013–14)

Number of times item 110 claimed	Number of patients
2	101,965
3	6,097
4	852
5	192
6	31

Source: Unpublished data, Department of Health (Date of service)

Draft principle and recommendation

The Committee notes that there seems to be an excess of initial specialist and consultant physician attendances (items 104 and 110) being claimed. In part this may be due to confusion over whether initiation of a new referral is linked to the ability to claim an initial attendance. Options considered by the Committee to address this issue included:

- Amending rules and definitions around the concept of a 'single course of treatment' to improve clarity
- Introducing a time-tiered attendances structure for specialists and consultant physicians, as currently applies to GP attendances
- Abolishing the initial/subsequent attendance structure and replacing it with a new single specialist attendance item, supplemented by an extended specialist attendance item where the attendance lasts for longer than, say, 40 minutes. The fee for the 'new' specialist attendance item would be designed to be cost neutral overall.

The Committee notes that the Taskforce will establish a specific Specialist/Consultant Physician Attendances Clinical Committee which will consider the structure of attendance items, including the option of time-tiered items.

Issue 3— Initial vs subsequent attendances and determining a single course of treatment

Draft principle and recommendation for public consultation

Principle

The decision to commence a new course of treatment should be made on clinical grounds rather than simple reference to the patient's referral status. A new referral for an existing patient does not necessarily denote the commencement of a new course of treatment, allowing the claiming of an initial attendance MBS item.

Recommendation

That only one initial attendance item be claimed in relation to any single course of treatment for a particular patient, regardless of the duration of that course of treatment. All other attendances are to be considered subsequent attendances.

4.4 Issue 4—Removal of the differential fee structure for remaining 'G&S' items

Issue

These are currently 'differential' MBS items where a different item number and level of benefit are allocated to General Practitioners and Specialists for the same medical service—hence 'G&S' items. There are currently 64 such items in the MBS—that is, 32 services which have a different item number depending on whether they are provided by a GP or a specialist. These items are the remnants of a much higher number of items introduced in the 1970s. The Committee was asked to consider whether the retention of these items, and the approach they embody, is appropriate.

A list of all the current G&S items, and relevant information including the difference between the 'G' and 'S' benefits for each service, is at Appendix C.

Discussion

In 1970 the Gorton Government introduced a revised medical benefits scheme, partly in response to the findings of the Nimmo Committee of Enquiry into Health Insurance. Among other things, the Nimmo Committee had recommended the establishment of a list of 'Most Common Fees' being charged in each State for all the medical services and procedures provided by medical practitioners and that, where appropriate, fees charged by specialists in the practice of their speciality should be ascertained separately from the fees charged by GPs.

It also recommended that differential benefits should be provided where there were differences between the common fee charged by specialists and those charged by GPs for the same medical service.

The list of 'Most Common Fees', with a separate schedule of fees for each State, was prepared by the Australia Medical Association and adopted as the basis for the 1970 Medical Benefits Schedule. It included 340 differential benefits applied for the same service when rendered by a GP or specialist.

The remaining G&S items can be divided into two categories:

Items restricted to in-hospital services only

- Where the items are restricted to in-hospital only, it can be assumed that hospital accreditation processes play a role in ensuring that the practitioner performing the services has the appropriate qualifications to perform the service.
- Data shows only a small number of GPs providing the services. In some cases, all the GP services are provided in-hospital, indicating that the doctors have admitting rights.
- The data is based on MBS claiming statistics—GPs providing the service does not necessarily indicate that a person does not have appropriate training.

Items with both in- and out-of-hospital benefits

In many cases the items with in and out-of-hospital benefits are minor procedures, however, there are some items which it may be appropriate to consider whether it is safe to perform the service out-of-hospital. For example:

- **30110** and **30111**—Excision of large bursa or ganglion (around 24 percent of services are provided out-of-hospital)
- **35526** and **35527**—Excision of urethral carbuncle (less than 6 per cent of services provided out-of-hospital)
- **35617** and **35618**—Cone biopsy, amputation or repair of the cervix (around 15 per cent of services provided out-of-hospital).

Draft principle and recommendation

The Committee noted the origin of the G&S arrangements in the hospital 'honorary' system under which specialists were in effect only reimbursed for 40 per cent of their time and had to make up the shortfall through MBS revenue. As the honorary system is no longer in place, the differential fees introduced to address it should be eliminated.

The Committee noted the relatively low usage of the G&S MBS items, particularly by GPs, and suggested that there would be a modest and acceptable increase in expenditure if all G&S MBS items were set at the S level.

The Committee also noted that the current arrangements are anomalous and unfair, that there had been a steady reduction in MBS items with differential fees over a substantial period, and that many MBS items comparable to those in the 'G&S' category do not have differential fees.

Members noted that there is a negligible risk that the proposed changes would encourage GPs to perform procedures for which they are not qualified.

Issue 4—Removal of the differential fee structure for remaining 'G&S' items

Draft principle and recommendation for public consultation

Principle

That a MBS fee is paid for a service, regardless of who performs it.

Recommendation

That the current differential fee structure for 32 remaining 'G&S' MBS items, whereby a lower or higher fee is set depending on whether the service is performed by a GP or specialist respectively, be abolished and a single fee for these services be set at the current specialist rate.

4.5 Issue 5—Co-claiming attendances with procedures

Issue

In line with its focus on promoting appropriate MBS billing practices, the Committee addressed the practice of claiming attendance items with procedural items. The Committee noted that practice in this area is variable and that the relevant MBS rules are ambiguous. In many cases co-claiming seems to be driven by choices made by providers (often by a small number of providers), rather than by the nature of the procedure or patient factors.

In particular, the Committee was concerned to address the practice of 'routine' co-claiming of attendances even when there is no substantive 'attendance' component of the service. The MBS explanatory notes currently provide the following guidance in this area (using the term 'consultation' to refer to attendances):

> **G.14.3. Consultation and procedures rendered at the one attendance**
>
> Where, during a single attendance, a consultation (under Category 1 of the MBS) and another medical service (under any other Category of the Schedule) occur, benefits are payable subject to certain exceptions, for both the consultation and the other service. Benefits are not payable for the consultation in addition to an item rendered on the same occasion where the item is qualified by words such as "each attendance", "attendance at which", "including associated attendances/consultations", and all items in Group T6 and T9. In the case of radiotherapy treatment (Group T2 of Category 3) benefits are payable for both the radiotherapy and an initial referred consultation.
>
> Where the level of benefit for an attendance depends upon the consultation time (for example, in psychiatry), the time spent in carrying out a procedure which is covered by another item in the MBS, may not be included in the consultation time. A consultation fee may only be charged if a consultation occurs; that is, it is not expected that consultation fee will be charged on every occasion a procedure is performed.

The Committee noted that adverse consequences of co-claiming with procedures include patients having increased out-of-pocket costs, with no added clinical benefit, if providers choose to charge an out-of-pocket cost for each item listed on the patient invoice. Increasing rates of co-claiming also increase costs to Medicare and patients without increases in the care provided to patients.

The Committee's view was that the practice is not always reasonable, and that the variability of the practice between providers and between service types is itself sufficient reason to examine the issue.

The Committee noted that there are a number of different settings where procedures and attendances are claimed together. Some of these are reasonable and others are not. These various scenarios and the Committee's observation are as follows:

1. In primary care settings, simple office-based procedures are routinely claimed with attendances where the decision to perform the procedure is made during the attendance. The Committee suggests that this is appropriate care. The Committee noted that procedural-based general practice should be supported and care should be taken not to disincentivise appropriate primary care. However, in cases where the procedure has been pre-arranged (e.g. a planned skin excision) and no other service is provided in conjunction with the procedure, an attendance should not be claimed.
2. In specialist practice, office attendances can be accompanied by specific MBS rebates for examinations and minor procedures. These include some office-based endoscopic examinations. It is the Committee's view that where these services warrant a separate item and are an adjunct to the primary attendance services then it may be reasonable for them to claimed with the primary attendance service.
3. In specialist/consultant physician practice, initial attendance (items 104, 110 and similar) are co-claimed with same-day procedures, consistent with appropriate initial assessment and scheduling of same-day operative procedures for reasons of clinical urgency (e.g. appendectomy) or availability. The Committee's view is that this is reasonable practice when the attendance meets the requirements for an initial attendance.
4. In specialist/consultant physician practice, follow-up ('subsequent') attendances (items 105, 116 and similar) are co-claimed with same-day operative procedures, where the 'primary' service is the procedure not the attendance. The reasons for this may vary but arguably many of these attendances are for care that could be considered integral to the procedural service (e.g. marking up a patient preoperatively) or so minor as to not be a distinct service (e.g. greeting a patient before the procedure or informing a patient of the outcome of the procedure). Any attendance by the proceduralist immediately following the procedure is 'aftercare' and ordinarily covered under the procedural item.

The Committee noted that the practice of claiming attendances with procedures is highly variable. Even considering procedures where attendances are frequently claimed (for example, 79 per cent of eye injections for macular degeneration) a number of providers never or infrequently co-claim an attendance. For other high-volume procedures such as colonoscopy, claiming of attendances is common (17 per cent) but the majority of providers never or infrequently co-claim an attendance. This might suggest that the practice is driven by providers rather than patient or clinical factors.

The data also demonstrate that even some complex surgical procedures have relatively high rates of same day co-claiming of subsequent attendances. For example, 10–20% of craniotomies for tumours or aneurysms are claimed with an attendance.

The Committee's view is that, in the setting described in scenario 4 above, it is not reasonable to claim a follow-up attendance on the same day as a procedure and that a reasonable expectation is that the procedural item should cover this component of the service.

One argument that has been put forward in defence of this practice is that the subsequent attendance is being claimed when the Schedule fee for the service is low; however, the billing practice is not confined to items with low Schedule fees. For example, there are a number of occasions (more than 50) when a subsequent attendance has been claimed on the same day as a cardiac surgery procedure with a Schedule fee in excess of $2,000.

Examples of co-claiming of attendances with procedures with high Schedule fees include:

- **50612**—scoliosis treatment by segmental instrumentation with a Schedule fee of $4,874.50. More than 44 per cent of services are co-claimed with an attendance.
- **38565**—repair or replacement of the aortic arch an ascending aorta with a Schedule fee of $3,482.25. More than 17 per cent of services are claimed with an attendance.
- **49345**—total hip replacement with allograft of femur and acetabulum with a Schedule fee of $3,481.80. More than 33 per cent of services are claimed with an attendance.
- **30594**—pancreatectomy for pancreatitis following attempted drainage with a Schedule fee of $2,178.25. More than 62 per cent of services are claimed with an attendance.

In 2013–14, there were more than 1.2 million occasions where a subsequent attendance (including items 105, 116 or 133) was provided by the same practitioner on the same day as a therapeutic procedure with a Schedule fee of more than $100 (MBS Groups T1 and T8). This equates to around 20 per cent of procedures. Additional data on co-claiming practices are at Appendix D.

Procedures commonly claimed in association with subsequent attendances include:

- **42738**—injection into the eye for the treatment of macular degeneration. A subsequent attendance is also claimed 79 per cent of the time, by 92 per cent of providers.
- **38218**—coronary angiography. A subsequent attendance is claimed on the same day 60 per cent of the time by 84 per cent of providers.
- **42788**—laser capsulotomy. A subsequent attendance is claimed on the same day more than 50 per cent of the time, by 92 per cent of providers.
- **30473**—oesophagoscopy with or without biopsy. A subsequent attendance is claimed on the same day more than 18% of the time, by 27 per cent of providers.
- **32090**—colonoscopy with or without biopsy. A subsequent attendance is claimed on the same day more than 17 per cent of the time, by 30 per cent of providers.

Conclusions and possible administrative measures

The Committee noted that, in specialist/consultant physician practice, it is acceptable that an initial attendance be co-claimed with a procedure, in circumstances where the decision to perform the procedure is made during that attendance.

However, the Committee's view is that the practice of claiming subsequent attendances, in settings where the principal service is a procedure, is not reasonable for the reasons outlined above. Possible administrative measures considered by the Committee to address this practice include:

1. Prohibit the billing of specialist follow-up attendance items (items 105, 116, and similar) with all procedures. This would be a clear rule which is administratively straightforward (i.e. it could be introduced into the Medicare claiming system). However, it would be difficult to exclude services where the principal service was an attendance and would mean that overall rebates for some services would be very low.
2. Prohibit the billing of specialist follow-up attendance items (items 105, 116 and similar) for more complex procedures. It is suggested that the MBS fee/rebate for the procedure could be used as a proxy for complexity. This would better target those services where the primary service is the procedure, rather than the attendance, and could be applied broadly rather than on a case-by-case basis. This option is administratively straightforward and would create a consistent approach across the MBS.

   If the threshold were a MBS fee of, say, $200, then this would impact on over 1,500 items in Groups T.1 and T.8. In 2014–15, 80 per cent of these were never claimed with a subsequent specialist attendance (items 105, 116 and 133). Of the attendances which were co-claimed, 26 per cent were for an eye injection, usually provided out-of-hospital, which has a Schedule fee of $300.75. A further 12 per cent are for colonoscopy items with fees of $334.35 and $469.20. There are around 1,200 items with a MBS fee over $300 in Groups T.1 and T.8.

   This approach would also permit the co-claiming of GP attendances with procedures typically performed by GPs.

In general, it would seem desirable that there be greater consistency between practitioners and their billing practices. This could be achieved by amendments to regulations and prohibitions on co-claiming (whether at an item level or across a broad range of services).

It could also be encouraged through barriers on claiming—referred to by DHS as 'soft blocks'—where a claim for an attendance is accepted only where a provider has notated the invoice, explaining the rationale for the service (similar to the current 'not usual aftercare' arrangement). However, this increases the administrative burden on the practitioner and potentially delays the patient receiving their benefit. In any case, the current explicit explanations on appropriate claiming are clearly ineffective given the variability between providers.

Draft principles and recommendations

The Committee is of the view that the following draft principles and administrative measures, if implemented, should be enforceable through inclusion in regulations. The Committee was concerned to ensure that these principles do not exclude emergency scenarios from co-claiming eligibility.

The Committee also noted the need to address 'exceptions to the rule'—eye injections were suggested as a service where, although the decision to perform the procedure is often made during an attendance (consistent with principle 2), it is nonetheless inappropriate to co-claim the attendance. Guidance in such cases could be included in the item descriptor.

It was also noted that, while these principles are very high level for broad application, Clinical Committees might develop more detailed, discipline-specific rules on particular scenarios, consistent with these principles.

Issue 5—Co-claiming attendances with procedures

Draft principles and recommendations for public consultation

Principles

1. Where an attendance is necessary for and intrinsic to a procedure, the attendance cannot be co-claimed as a separate service.
2. Attendance items should only be eligible to be claimed for the attendance at which the decision to perform the procedure was made, or if an attendance regarding a matter unrelated to the procedure occurs at the same time as a procedure.
3. Changes to the MBS should not provide a disincentive for procedures by GPs.
4. Specialists and consultant physicians may not claim an attendance item when referred a patient where the referral is not for an opinion but a specific procedure.

Recommendations

1. That the MBS regulations and explanatory notes be amended to state:

a) Where the decision to perform a procedure is made during an attendance, that attendance and the consequent procedure can be co-claimed, whether the procedure is performed contiguously with the attendance or after some interval of time on the same day.

b) Where an attendance occurs in relation to a procedure that has already been agreed to take place, co-claiming of an attendance item cannot occur unless another unrelated medically significant issue is dealt with during the attendance. Pre-procedure attendances should not be charged for, as they constitute an integral part of the procedure.

c) An attendance to obtain consent immediately prior to a procedure or attendances immediately after a procedure regarding outcomes and post-procedure care cannot be claimed.

4.6 Issue 6—Aftercare

Issue

There is currently a prohibition on claiming Medicare benefits for 'aftercare' services, on the basis that the costs of any aftercare are covered by the MBS fee for the initial procedure. This means that some providers are unable to bill for aftercare services, despite having no direct relationship with the original proceduralist and being unable to be reimbursed by them for the aftercare service, as the current arrangements presume.

As with other elements of the MBS, this approach has remained essentially unchanged since the mid-70s and it is one of the main objectives of the Committee to update such arrangements where appropriate.

Background

'Aftercare' is not explicitly mentioned in legislation, but is defined in the MBS explanatory notes. Subsection 3(5) of the *Health Insurance Act 1973* refers to 'post-operative treatment':

> *Unless the Minister otherwise directs, a professional service, not being a service specified in an item in the general medical services table that is expressed to relate to a professional attendance by a medical practitioner (however described), a dental practitioner, a participating optometrist, a participating midwife or a participating nurse practitioner, shall be deemed to include all professional attendances necessary for the purposes of post-operative treatment of the person to whom the professional service is rendered.*

The MBS explanatory notes specify that: 'For the purposes of this book, post-operative treatment is generally referred to as "aftercare"', and define 'aftercare' as follows:

> *Aftercare is deemed to include all post-operative treatment rendered by medical practitioners, and includes all attendances until recovery from the operation, the final check or examination, regardless of whether the attendances are at the hospital, private rooms, or the patient's home. Aftercare need not necessarily be limited to treatment given by the surgeon or to treatment given by any one medical practitioner.*

Discussion

Complications arise from the application of this definition to preclude the payment of Medicare benefits for all attendances in the aftercare period, on the basis that these services have effectively been 'funded' by the benefit for the original operation. Further advice on aftercare from the MBS explanatory notes is at Appendix E. According to information from the Department of Human Services (DHS), the Schedule fee for 'most' surgical items in Category 3—Therapeutic Procedures of the MBS includes an amount for routine post-operative treatment.

Items in Category 3 also have aftercare periods of varying durations assigned to them, during which the aftercare prohibition applies. The MBS makes a special case of aftercare for fractures, and includes a list of 'reasonable' aftercare periods for the treatment of various fractures, ranging from a minimum of six weeks for a fracture of the terminal phalanx of a finger or thumb, to three months for both shafts of the forearm or humerus, to a maximum of six months for a spinal fracture.

Further complications arise from the notion that aftercare may be provided by practitioners other than the original surgeon, necessitating sharing of the Medicare benefit for the original operation.

> *If a surgeon delegates aftercare to a patient's medical practitioner, then a Medicare benefit may be apportioned on the basis of 75% for the operation and 25% for the aftercare. Where the benefit is apportioned between two or more medical practitioners, no more than 100% of the benefit for the procedure will be paid.*

The key question is whether it is reasonable to maintain that the costs of all aftercare attendances—both specialist and GP—should be deemed to be covered by the Medicare benefit for the original operation.

An associated question is whether it is reasonable to expect this benefit to be apportioned between the original provider and providers of aftercare, from both a financial and logistical point of view. The Committee is of the view that this arrangement is impracticable and reference to it should be removed from the MBS.

These issues are particularly relevant to GPs, who are routinely the providers of aftercare rather than specialists. In most cases the GP will have no formal relationship with the provider of the initial procedure, and will have no recourse in terms of recouping the costs of providing aftercare attendances.

It has also been suggested through previous public consultation that the current arrangements may have the unintended consequence of discouraging specialists from providing appropriate aftercare.

In its discussions the Committee noted the high level of annoyance among GPs in particular at the current prohibition on claiming services during the aftercare period for a service performed by another practitioner. The Committee considered two possible changes to the current aftercare arrangements:

1. Removing the prohibition on claims for attendances in the aftercare period while reducing the fees for relevant initial services to remove the aftercare component.
2. Allowing all practitioners other than the provider of the initial procedure to claim for services in the aftercare period.

The Committee noted that, even if the aftercare prohibition were removed, it would still be necessary to set a procedure's aftercare period to enable the distinction between an aftercare attendance and 'review' attendances. The Committee noted that the DHS payment system attaches

an aftercare period to each item in MBS Category 3, but that there is a high degree of variation in these periods and this information is not readily available to practitioners.

The Committee suggests that the current system be replaced with a simpler one whereby there are two aftercare periods of, say, one month and two months. Using the Schedule fee as a proxy for complexity, the shorter or longer aftercare period would apply depending on whether the Schedule fee is lower or higher than a figure to be determined—say, $300.

Draft principles and recommendations

The Committee is of the view that the following measures, if implemented, should be enforceable through inclusion in regulations. In general, these principles reflect the fundamental premise that practitioners should provide their own aftercare. However, where this is impracticable, a change to current arrangements is proposed which would enable the claiming of MBS benefits for aftercare services provided by any medical practitioner other than the initiating proceduralist. It is expected that, in most cases, this will be a GP.

Issue 6—Aftercare

Draft principles and recommendations for public consultation

Principles

1. Aftercare is deemed to include all post-procedure treatment rendered by the medical practitioner who performed the procedure and includes all attendances by that proceduralist until recovery from the procedure, regardless of whether the attendances are at the hospital, private rooms, or the patient's home.
2. If a patient is re-referred at any time in the future to a proceduralist for an opinion with respect to a procedure performed by that proceduralist, a review attendance only should be claimed irrespective of the time after the procedure.
3. Services which are not part of normal aftercare are billable and administrative arrangements that enable payment for these services should continue (for example noting 'not normal aftercare' on the account).

Recommendations

1. That the definition of 'aftercare' in the MBS explanatory notes be amended by the deletion of "Aftercare need not necessarily be limited to treatment given by the surgeon or to treatment given by any one medical practitioner" and its replacement with "for the purposes of Medicare claiming the aftercare claiming restriction applies only to the medical practitioner who performed the initial procedure and not to other practitioners who see the patient during the aftercare period." Providers other than the practitioner who performed the initial procedure should not be prohibited from claiming for aftercare services during the aftercare period.
2. That the current system of assigning aftercare periods to MBS items, with its high degree of variation, be replaced by a two-tiered system under which an aftercare period of one month or two months would apply depending on whether the Schedule fee for the service in question is lower than or equal to, or higher than, $300.
3. That the following reference to aftercare arrangements be removed from the MBS, on the basis that the practice it proposes is impracticable:

   If a surgeon delegates aftercare to a patient's medical practitioner, then a Medicare benefit may be apportioned on the basis of 75% for the operation and 25% for the aftercare. Where the benefit is apportioned between two or more medical practitioners, no more than 100% of the benefit for the procedure will be paid.

4.7 Issue 7—Specialist-to-specialist referrals

Issue

The comparatively short duration of specialist-to-specialist referrals has been the subject of numerous complaints from consumers and providers. Examples include cancer patients who are receiving multi-modality treatment where the radiation oncology treatment lasts longer than three months. It is also raised by radiation oncology practices which treat patients with adjunct therapy to surgery or chemotherapy.

A patient may either seek a new referral (from either the originating specialist/consultant physician or from their GP) or the patient may consult the specialist directly, without obtaining a new referral from another medical practitioner, but such attendances attract a Medicare rebate at the un-referred (lower) rate rather than the specialist rate. For example, item 105 has a Schedule fee of $43.00 whereas a standard unreferred attendance has a Schedule fee of $21.00.

Discussion

As noted above, the referral mechanism is a key operational component of Australia's healthcare system, giving effect to the principle that general practice should be the gatekeeper to the broader system, and secondary medical care in particular.

A 'referral' is a request to a specialist or a consultant physician for investigation, opinion, treatment and/or management of a condition or problem of a patient or for the performance of a specific examination(s) or test(s). For a valid referral to take place:

- the referring practitioner must have undertaken a professional attendance with the patient and turned his or her mind to the patient's need for referral and have communicated relevant information about the patient to the specialist or consultant physician (this need not mean an attendance on the occasion of the referral);
- the instrument of referral must be in writing as a letter or note to a specialist or to a consultant physician and must be signed and dated by the referring practitioner; and
- the specialist or consultant physician to whom the patient is referred must have received the instrument of referral on or prior to the occasion of the professional service to which the referral relates.

The GP is generally regarded as the primary source of referrals. Cross-referrals between specialists and/or consultant physicians should usually occur in consultation with the patient's GP.

A referral is valid for the period specified in the referral, which is taken to commence on the date of the specialist's or consultant physician's first service covered by that referral. Where the referral originates from an eligible practitioner other than a specialist or consultant physician, the referral is valid for a period of 12 months, unless the referring practitioner specifies a period more or less than 12 months, including indefinite validity.

Where a referral originates from a specialist or consultant physician, it is valid for 3 months, except where the referred patient is an admitted hospital patient. For admitted patients, the referral is valid for 3 months or the duration of the admission whichever is the longer. This limitation is set in the regulations, and reflects the Government's commitment to reinforce the role of the GP as the entry point to the health care system, and to enhance their role in co-ordinating patient care. These arrangements have the support of both the Australian Medical Association and the Royal Australian College of General Practitioners.

As it is expected that the patient's GP will be kept informed of the patient's progress, a referral from a specialist or a consultant physician must include the name of the patient's GP/s and/or practice. Where a patient is unable or unwilling to nominate a GP or practice this must be stated in the referral.

Draft principle and recommendation

Notwithstanding concerns from consumers and providers, the Committee agreed to maintain the three-month limit on specialist-to-specialist referrals. The Committee noted the key role of the general practitioner as 'gatekeeper' to the broader health system and primary point of patient contact, and that the three-month limit facilitated regular ongoing contact between patient and GP. This was seen to be especially important when the patient's condition changes or they develop new conditions, and these can be better and more efficiently managed by the GP.

Overall, the Committee considered that the clinical benefits for patients from continuity of GP involvement in their care supported the current arrangements.

Issue 7—Specialist-to-specialist referrals

Draft principle and recommendation for public consultation

Principle

That, in general, referral arrangements should reflect to primacy of the general practitioner as the gatekeeper to the broader health system.

Recommendation

That the existing three-month limit on specialist-to-specialist referrals be maintained.

Appendix A - Summary for consumers—MBS Principles and Rules Committee recommendations

The MBS Principles and Rules Committee looks at whether the Medicare laws and rules are working as they should for the Australian public. The Committee drafts reports for the Taskforce, who decide when and how to seek community feedback. This report contains the Committee's first group of recommendations to support consumers' health and safety, and the best use of Medicare (see Table A1).

Table A1: Summary of issues and impacts for consumers, and recommendations of the Principles and Rules Committee

Issue and current impact on consumers	**Recommendations**	**Future impact for consumers if the recommendations are adopted**
1. Issue The Medicare billing rules are not always understood or followed by clinicians. ***Impact*** Consumers fund Medicare through their taxes – they want it to be used properly and fairly. If this doesn't happen this can cost them more as an individual and/or as a taxpayer.	1. Any clinician who uses Medicare is trained to use it properly using the Department of Human Service's online training resources (www.humanservices.gov.au/health-professionals/subjects/medicare-benefits-schedule-education-health-professionals) 2. Clinicians complete this training before they get a Medicare provider number. 3. Health professional colleges and associations support ongoing education about Medicare rules and principles.	Δ Consumers can be more confident that clinicians know how to use Medicare properly. Δ Over-claiming and wastage are minimised so that Medicare funding is available for more people and services.
2. Issue Different clinicians bill Medicare differently for the same service. ***Impact*** Consumers cannot compare clinician services and costs for the same procedure. The more items claimed for a procedure, the more it	4. Clinicians claim the same item(s) for the same service. 5. All clinicians use one MBS item per service *for example* if someone has surgery, the stitches should be claimed as part of the surgery, not as an extra cost. 6. If the rule says a clinician can claim for more than one item, the maximum items claimed should be three.	Δ Consumers can compare billing and costs for the same procedure. Δ Consumers get the same rebate for the same service. Δ Consumers can easily see and compare the nature of gap fees.

Issue and current impact on consumers	Recommendations	Future impact for consumers if the recommendations are adopted
costs Medicare/the taxpayer. In some cases, consumers are charged multiple gap fees, adding to consumers' out of pocket costs.	7. If the rule says a clinician can claim for more than one item, the items claimed should be the same for the same situation with every clinician (and every consumer). 8. Different services provided at the same time can be claimed separately where they are obviously different, for example surgery on both ears in the one episode of care.	Δ Medicare (and the consumer) are billed for reasonable costs.
3. Issue Different specialists bill Medicare differently for follow-up visits, especially when an existing patient gets a new referral. ***Impact*** Consumers cannot predict and compare rebates for ongoing specialist visits.	9. Specialists claim for planning a new course of treatment when they first see you. 10. Specialists claim for planning a new course of treatment if a referral identifies a new condition/issue. 11. Specialists do not claim for planning a new course of treatment just because you have a new referral.	Δ Consumers and Medicare are only billed for planning a new course of treatment as required – not for routine follow-up. Δ Consumers can have a referral that lasts for as long as there is no change in their specialist care needs (for example 3, 6, 12, 18 months – or an indefinite referral).
4. Issue Thirty-two Medicare items have a different fee for the same service, depending on whether the service is provided by a GP or specialist. ***Impact*** Consumers can pay more – or less – for same	12. Make the fee the same for the 34 items and set it at the higher specialist rate. In all cases the provider will be competent to provide the service.	Δ Consumers are Medicare are billed based on the service provided/received.

Issue and current impact on consumers	Recommendations	Future impact for consumers if the recommendations are adopted
procedure just because of the role of the person doing it (not because it is a more specialist procedure).		
5. ***Issue*** Some clinicians claim for a consultation as well as a procedure in the same episode of care – even though the consultation is a necessary part of the procedure. ***Impact*** Consumers and Medicare are charged twice (for the procedure and the consultation) by some clinicians.	13. Clinicians cannot charge for a consultation when it's part of providing a planned procedure. This includes pre-procedure visits, since these are all part of the same service. It also includes when the patient's referral is for a specific procedure. 14. If an unexpected procedure is identified in a consultation and is extra to what was expected, it can be billed.	Δ Consumers and Medicare are not billed extra for a consultation when it is just part of a planned procedure. Δ The cost of a procedure and informed financial consent are addressed at the time of the person deciding to (not) have a procedure. Δ Consumers are charged the same for the same procedure, delivered in the same circumstances.
6. ***Issue*** Sometimes 'aftercare' (i.e. follow-up from a procedure) is included in the original bill but where it's provided by a different doctor it can't be billed and the patient misses out on a benefit for the service. ***Impact*** Consumers have different experiences of billing for	15. Every follow-up to a procedure, until recovery, is billed as part of the aftercare package, regardless of whether the attendances are at the hospital, private rooms, or the patient's home. 16. If an unexpected issue arises, it is charged as a review, not a new service. 17. If you are referred back to someone regarding a procedure they delivered, this is billed as a review, not a new service.	Δ Consumers will experience consistency in billing for aftercare.

Issue and current impact on consumers	Recommendations	Future impact for consumers if the recommendations are adopted
aftercare.	18. Aftercare is described in two tiers only, for example one or two months 19. Services that are not aftercare should be marked 'not normal aftercare' on the bill.	
7. Issue Feedback has been received that the three month period for a specialist referral to another specialist is too short. *Impact* GPs are the gate-keepers to specialist services. A referral from one specialist to another can only last for three months: a referral from a GP to a specialist can be for any time including an indefinite referral.	20. Medicare should work so that the GP is the key person in your care, coordinating referrals and making sure all your health care information is in one place 21. If a referral from a specialist runs out (after 3 months), you can go back to the specialist – or your GP, to get another as needed	Δ No change Δ Consumers will still only be able to get a 3 month referral from one specialist to another; they can get longer referrals through their GP.

Appendix B - DHS guidance—Correct Medicare billing for a complete medical service

What is a complete medical service?

A long standing general principle in the Medicare Benefits Schedule (MBS) is that each professional service listed is a complete medical service in itself. To bill an item you must be confident you have fulfilled the service requirements as specified in the item descriptor. The full description of the service is important as it ensures correct identification of the service and thereby avoids the possibility of error in the processing and claiming of Medicare benefits.

Where a service is covered by more than one item it is important to understand the requirements of each item. Some comprehensive items will specify that other services should be provided in conjunction with that item and other items will describe only the specific service provided. In such cases the item representing the comprehensive or 'complete' service is the item that should be claimed, not the items representing the individual services.

Where a comprehensive item is used, separate items should not be claimed for any of the individual services included in the comprehensive service. For example, benefit is not payable for item 49809 (a foot tenotomy – cutting of the tendon) or item 50112 (correction of contracted joint) when claimed in association with item 49848 (correction of claw or hammer toe) since the cutting of the tendon and correction of contracted joint is an integral part of the operation for correcting claw or hammer toe.

Does this mean practitioners can only bill one item?

Where only one service is rendered, only one item should be billed. Where more than one service is rendered on one occasion of service, the appropriate item for each discrete service may be billed, provided that each service fully meets the item descriptor. Where an operation comprises a combination of procedures which are commonly performed together and for which there is an MBS item that specifically describes the combination of procedures then only that item should be billed.

The incorrect use of MBS items can result in penalties, including the health care provider being asked to repay monies that have been incorrectly received. Therefore, it is extremely important to understand the full requirements of each medical service, and the complete medical service principle, prior to billing a MBS item.

Will compliance be a focus of increased Medicare audits by Medicare Australia?

Medicare Australia's current risk assessment processes will continue to apply to all items claimed under Medicare. Practitioners are identified using a combination of the following techniques:

- artificial intelligence (predictive computer programs)
- claiming data analyses
- intelligence analysis (analysis of information specific to a case or person)
- top providers data analysis
- tip-offs from the public and referrals

Practitioners should claim the most appropriate Medicare item for the service they provide to the patient. When billing for a service the practitioner should ask two questions:

1. Does the service rendered comply with the time and content requirements of the MBS item descriptor? and
2. Would the majority of my peers accept that the treatment provided during the service is clinically appropriate for this patient?

A practitioner who can confidently answer yes to both questions and who has adequately documented the service should be able to address any concerns raised in the event of an audit by Medicare Australia or an investigation by the Professional Services Review.

Appendix C - Utilisation data on 'G&S' items

Table C1: G&S items with both in- and out-of-hospital benefits 2014–15

Item number	Short item descriptor	Schedule fee	Benefits paid	Services	Patients	Providers	% services provided out-of-hospital	Bulk-billing rate for out-of-hospital services
30041	G - Repair of wound of the skin or subcutaneous tissue	$144.00	$710,400	5,869	5,783	3,419	99.0%	87.0%
30042	S - Repair of wound of the skin or subcutaneous tissue	$185.60	$21,758	169	147	115	18.3%	74.2%
30048	G - Repair of wound of the skin or subcutaneous tissue, involving deeper tissue	$149.75	$118,737	931	945	719	98.1%	85.4%
30049	S - Repair of wound of the skin or subcutaneous tissue, involving deeper tissue	$185.60	$5,255	40	39	35	27.5%	45.5%
30067	G - Removal of Foreign body in the muscle, tendon or other deep tissue	$223.60	$610,680	3,188	3,138	1,827	95.5%	89.9%
30068	S - Removal of foreign body in the muscle, tendon or other deep tissue	$276.80	$513,786	2,561	2,451	980	30.0%	78.8%
30074	G - Diagnostic biopsy of the lymph gland, muscle or other deep tissue or organ	$117.55	$252,208	2,575	2,433	459	95.4%	89.3%
30075	S - Diagnostic biopsy of the lymph gland, muscle or other deep tissue or organ	$149.75	$2,474,209	19,796	18,321	1,768	91.6%	63.9%
30102	G - Excision of sinus involving deep tissue	$149.75	$3,894	41	36	28	48.8%	100.0%
30103	S - Excision of sinus involving deep tissue	$183.90	$24,272	207	193	137	26.1%	81.5%
30106	G - Excision of small bursa or ganglion	$155.40	$68,726	530	505	357	96.6%	86.7%
30107	S - Excision of small bursa or ganglion	$219.95	$103,551	674	644	362	20.8%	59.3%
30110	G - Excision of large bursa or ganglion	$284.35	$33,156	198	194	94	23.2%	89.1%

Item number	Short item descriptor	Schedule fee	Benefits paid	Services	Patients	Providers	% services provided out-of-hospital	Bulk-billing rate for out-of-hospital services
30111	S - Excision of large bursa or ganglion	$371.50	$1,176,561	8,097	7,753	791	0.5%	73.7%
30265	G - Removal of calculus from salivary gland	$117.55	$5,805	66	65	58	72.7%	85.4%
30266	S - Removal of calculus from salivary gland	$149.75	$41,480	384	371	215	35.2%	38.5%
30282	G - Removal of ranula or mucous cyst of the mouth	$155.40	$14,713	116	106	81	85.3%	74.7%
30283	S - Removal of ranula or mucous cyst of the mouth	$204.70	$80,368	507	487	226	49.3%	39.6%
30659	G - Circumcision of a male aged 10 year or over	$149.75	$197,804	723	840	70	95.3%	24.2%
30660	S - Circumcision of a male aged 10 year or over	$185.60	$398,192	2,956	2,953	581	4.9%	19.9%
30675	G - Excision of pilonidal cyst or sinus, or sacral sinus or cyst	$299.45	$36,468	155	141	101	78.1%	86.0%
30676	S - Excision of pilonidal cyst or sinus, or sacral sinus or cyst	$379.05	$544,756	2,229	2,085	656	8.9%	83.9%
35512	G - Excision of Bartholin's cyst	$179.40	$3,745	28	28	24	39.3%	90.9%
35513	S - Excision of Bartholin's cyst	$221.70	$38,293	239	235	159	9.6%	34.8%
35516	G - Marsupialisation of Bartholin's cyst or gland	$116.35	$6,643	77	77	70	40.3%	71.0%
35517	S - Marsupialisation of Bartholin's cyst or gland	$146.00	$83,491	810	777	447	7.3%	22.0%
35526	G - Excision of urethral carbuncle	$116.35	$391	10	10	9	0.0%	0.0%
35527	S - Excision of urethral carbuncle	$146.00	$8,575	128	126	98	5.5%	71.4%
35617	G - Cone biopsy, amputation or repair of the cervix	$173.70	$3,274	35	35	34	11.4%	25.0%
35618	S - Cone biopsy, amputation or repair of the cervix	$218.00	$157,133	1,018	1,000	337	3.8%	28.2%
37622	G - Vasotomy or vasectomy	$193.20	$2,294,929	12,207	12,251	286	89.7%	10.1%
37623	S - Vasotomy or vasectomy	$229.85	$1,706,176	9,509	9,509	720	25.6%	8.8%

Source: Unpublished data, Department of Health (Date of processing)

Table C2: G&S items restricted to in-hospital services only 2014–15

Item number	Short item descriptor	Schedule fee	Benefits paid	Services	Patients	Providers
30009	G - Dressing of localised burns, under general anaesthetic	$60.75	–	–	–	–
30010	S - Dressing of localised burns, under general anaesthetic	$73.90	$527	10	7	np
30013	G - Dressing of extensive burns, under general anaesthetic	$130.90	np	np	np	np
30014	S - Dressing of extensive burns, under general anaesthetic	$155.40	$1,515	16	13	9
30620	G - Repair umbilical, epigastric or linea alba hernia (age 10 yrs<)	$299.45	$20,066	124	121	78
30621	S - Repair umbilical, epigastric or linea alba hernia (age 10 yrs<)	$407.50	$1,553,041	7,312	7,180	1,081
30634	G - Correction of varicocele	$235.05	$1,167	7	6	np
30635	S - Correction of varicocele	$291.80	$43,836	227	218	139
30638	G - Orchidectomy	$299.45	$1,695	8	8	8
30641	S - Orchidectomy	$407.50	$81,292	346	288	190
35639	G - Curettage, with or without dilation, of the uterus	$134.90	$104,683	1,101	1,087	152
35640	S - Curettage, with or without dilation, of the uterus	$183.00	$1,190,914	14,248	14,059	827
35683	G - Suspension of fixation of the uterus	$351.30	np	np	np	np
35684	S - Suspension of fixation of the uterus	$471.15	$1,284	np	np	np
35687	G - Sterilisation or transection or resection of the fallopian tubes	$325.20	$12,906	66	66	39

Item number	Short item descriptor	Schedule fee	Benefits paid	Services	Patients	Providers
35688	S - Sterilisation or transection or resection of the fallopian tubes	$397.25	$351,742	1,469	1,472	504
35712	35712: G - Laparotomy involving…(1 such procedure)	$362.15	$23,753	107	108	63
35713	35715: S - Laparotomy involving…(1 such procedure)	$452.85	$288,171	998	996	450
35716	G - Laparotomy involving…(2 or more such procedures)	$434.35	$10,670	37	37	21
35717	S - Laparotomy involving…(2 or more such procedures)	$545.30	$306,973	917	913	357
41665	G - Removal of nasal polyp or polypi (requiring admission to hospital)	$172.50	$1,536	26	22	14
41668	S - Removal of nasal polyp or polypi (requiring admission to hospital)	$219.95	$49,090	734	579	163

Source: Unpublished data, Department of Health (Date of processing), np: data not available for publication

Items in Table C3 fall within the remit of the Obstetrics and Ear, Nose and Throat Surgery Clinical Committees, and those Committees independently recommended that the differential fee structure for their respective items should be abolished and replaced with a single fee at the specialist rate.

Table C3: G&S items under remit of Obstetrics and Ear, Nose and Throat Surgery Clinical Committees, and restricted to in-hospital services only 2014–15

Item number	Short item descriptor	Schedule fee	Benefits paid	Services	Patients	Providers
35676	G - Removal of an ectopic pregnancy	$425.00	np	np	np	np
35677	S - Removal of an ectopic pregnancy	$536.00	$7,847	20	21	20
41788	G - Removal of tonsil and/or adenoids (less than 12 years)	$219.95	$16,333	118	118	9
41789	S - Removal of tonsil and/or adenoids (less than 12 years)	$295.70	$4,273,410	19,888	19,892	410
41792	G - Removal of tonsil and/or adenoids (less than 12 years or over)	$276.80	$23,859	128	125	37
41793	S - Removal of tonsil and/or adenoids (less than 12 years or over)	$371.50	$2,909,682	11,016	11,020	433
41796	G - Arrest of haemorrhage, following removal of tonsils and/or adenoids	$113.70	$725	10	10	10
41797	S - Arrest of haemorrhage, following removal of tonsils and/or adenoids	$144.00	$20,722	207	202	125
41800	G - Removal of adenoids	$117.55	$2,289	60	60	8
41801	S - Removal of adenoids	$162.95	$656,711	10,548	10,450	408

Appendix D - MBS data and explanatory notes on co-claiming practices

Table D1: Top 20 procedural services– by proportion of services claimed on the same day as an initial or subsequent attendance 2014-15

Item number	Specialty group	Item descriptor	Schedule fee	Services	Providers	% of services claimed same day as subsequent attendance	% of providers co-claiming subsequent attendance	% of services claimed same day as initial attendance	% of providers co-claiming initial attendance
42741	Ophthalmology	Posterior juxtascleral depot for macular degeneration	$300.75	260	14	89%	57%	7%	29%
43021	Ophthalmology	Photodynamic therapy, one eye	$455.05	191	43	85%	77%	4%	16%
38273	Cardiac	Transcatheter closure of patent ductus arteriosus	$912.30	13	np	85%	60%	0%	-
42668	Ophthalmology	Removal of, corneal sutures	$75.30	4,187	431	85%	86%	9%	40%
14227	Rehabilitation medicine	Implanted infusion pump, refilling of reservoir, with baclofen for the management of severe chronic spasticity	$97.95	576	33	81%	45%	6%	18%
42738	Ophthalmology	Injection into the eye	$300.75	286,631	676	79%	92%	4%	74%
40862	Neurology	Deep brain stimulation (unilateral) for the treatment of: Parkinson's disease	$189.70	5,933	45	78%	78%	2%	38%
42782	Ophthalmology	Laser trabeculoplasty, for the treatment of glaucoma	$451.10	25,153	607	76%	89%	9%	43%
37444	Urology	Ureterolithotomy	$999.65	np	np	75%	20%	25%	20%
36605	Urology	Insertion of ureteric stent, with removal of calculus	$690.70	np	np	75%	75%	0%	25%
43816	Paediatrics	Laparotomy for Ileal atresia, colonic atresia or meconium ileus	$1,204.60	np	np	75%	75%	0%	-
42824	Ophthalmology	Retrobulbar injection of alcohol or other drug, as an independent procedure	$69.90	710	129	74%	85%	14%	35%
50658	Orthopaedics	Examination and manipulation of the hip for hip dysplasia	$197.75	48	8	73%	50%	2%	13%
38213	Cardiac	Cardiac electrophysiological study implanted defibrillator	$408.70	79	41	72%	59%	5%	10%
41509	ENT	Surgical removal of keratosis obturans from, external	$162.95	3,476	149	72%	72%	21%	67%

Item number	Specialty group	Item descriptor	Schedule fee	Services	Providers	% of services claimed same day as subsequent attendance	% of providers co-claiming subsequent attendance	% of services claimed same day as initial attendance	% of providers co-claiming initial attendance
		auditory meatus							
42792	Ophthalmology	Laser vitreolysis or corticolysis of lens material	$353.35	20	np	72%	75%	0%	-
42786	Ophthalmology	Laser iridotomy	$353.35	13	6	71%	50%	29%	33%
32517	Vascular	Ligation of the long and short saphenous vein	$1,193.40	451	74	71%	36%	5%	28%
41569	ENT	Decompression of facial nerve in its mastoid portion	$1,194.25	75	17	70%	29%	0%	-
42811	Ophthalmology	Transpupillary thermotherapy	$451.10	56	np	70%	60%	9%	100%

Source: Unpublished data, Department of Health (Date of service), np: data not available for publication

In comparison, Table D2 shows there are a number of procedural items where co-claiming of attendance services is infrequent, or non-existent.

Table D2: Procedures where co-claiming of attendance items is not common

Item number	Item descriptor	Schedule Fee	Services	Providers	% of services claimed same day as subsequent attendance	% of providers co-claiming subsequent attendance
40600	Cranioplasty, reconstructive	$955.00	2,450	187	0.1%	0.5%
32500	Varicose Multiple injections of sclerosant for varicose veins	$109.80	50,984	556	0.2%	7.2%
39131	Management of patient and adjustment or reprogramming of neurostimulator for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris	$127.80	4,247	66	0.1%	6.1%
42758	Goniotomy	$699.45	932	57	0.2%	3.5%
35691	Sterilisation by interruption of fallopian tubes	$158.70	1,036	351	0.4%	0.9%
40312	Partial or total laminectomy for intradural lesion	$1,466.30	257	113	0.4%	0.9%
39112	Intracranial decompression of Cranial nerve using microsurgical techniques	$1,541.50	434	82	0.3%	1.2%

Source: Unpublished data, Department of Health (Date of service)

Table D3: Top 20 (T8) procedural items by service volumes with co-claimed attendance (excludes excision of skin lesion items)

Item number	Description	Schedule fee	Services	Number of services claimed with attendance	% of services claimed with attendance	Number of services claimed with subsequent attendance	% of services claimed with subsequent attendance	% of practitioners co-claiming subsequent attendance
30473	Oesophagoscopy	177.10	367,117	140,467	38%	69,278	19%	57%
32090	Fibreoptic colonoscopy	334.35	330,466	125,598	38%	59,882	18%	56%
13918	Cytotoxic chemotherapy, administration of, by intravenous infusion 1-6 hrs	97.95	293,089	140,847	48%	139,563	48%	79%
41764	Nasendoscopy or sinoscopy or fibreoptic examination of nasopharynx and larynx	122.85	291,668	248,424	85%	89,891	31%	72%
42738	Eye injection	300.75	286,631	237,769	83%	226,689	79%	92%
32093	Fibreoptic colonoscopy for the removal of 1 or more polyps	469.20	252,018	90,596	36%	42,215	17%	51%
13945	Accessing long-term implanted drug delivery device for cytotoxic chemotherapy,	52.50	193,804	100,753	52%	99,674	51%	71%
41647	Ear toilet	109.90	186,454	169,164	91%	90,102	48%	42%
42702	Cataract surgery	760.65	164,570	6,055	4%	5,483	3%	19%
13706	Transfusion of blood or bone marrow already collected	83.35	139,917	69,075	49%	66,534	48%	40%
14206	Hormone or living tissue implantation by cannula	35.60	124,947	88,904	71%	13,745	11%	5%
14221	Accessing of long-term implanted device for delivery of therapeutic agents	52.50	121,621	79,140	65%	76,345	63%	62%
13915	Cytotoxic chemotherapy, administration of, either by intravenous push technique or by intravenous infusion of not more than 1 hours duration	65.05	112,803	43,932	39%	43,117	38%	75%

Item number	Description	Schedule fee	Services	Number of services claimed with attendance	% of services claimed with attendance	Number of services claimed with subsequent attendance	% of services claimed with subsequent attendance	% of practitioners co-claiming subsequent attendance
30219	incision with drainage of haematoma, furuncle, small abscess or similar lesion not requiring admission to a hospital	27.35	105,767	82,954	78%	1,578	1%	2%
13757	Therapeutic venesection for the management of haemochromatosis, polycythemia vera or porphyria cutanea tarda	72.95	102,230	43,494	43%	15,525	15%	5%
35614	Examination of lower genital tract by a Hinselmanntype colposcope	63.90	82,327	77,036	94%	34,081	41%	83%
36812	Cystoscopy with urethroscopy, with or without urethral dilatationurinary tract except a service to which item 37327 applies (Anaes.)	166.70	76,265	32,730	43%	26,786	35%	40%
13924	Cytotoxic chemotherapy, administration of more than 6 hrs	65.25	68,800	9,771	14%	9,736	14%	71%
42788	Laser capsulotomy	353.35	66,349	58,489	88%	33,553	51%	92%
30094	Diagnostic percutaneous aspiration biopsy of deep organ	189.40	56,541	14,968	26%	3,169	6%	9%

Source: Unpublished data, Department of Health (Date of service)

Extracts from the current MBS explanatory notes relevant to co-claiming issues

G.14.1. Principles of interpretation of the MBS

Each professional service listed in the MBS is a complete medical service. Where a listed service is also a component of a more comprehensive service covered by another item, the benefit for the latter service will cover the former.

Where a service is rendered partly by one medical practitioner and partly by another, only the one amount of benefit is payable. For example, where a radiographic examination is started by one medical practitioner and finalised by another.

G.14.3. Consultation and procedures rendered at the one attendance

Where, during a single attendance, a consultation (under Category 1 of the MBS) and another medical service (under any other Category of the Schedule) occur, benefits are payable subject to certain exceptions, for both the consultation and the other service. Benefits are not payable for the consultation in addition to an item rendered on the same occasion where the item is qualified by words such as "each attendance", "attendance at which", “including associated attendances/consultations", and all items in Group T6 and T9. In the case of radiotherapy treatment (Group T2 of Category 3) benefits are payable for both the radiotherapy and an initial referred consultation.

Where the level of benefit for an attendance depends upon the consultation time (for example, in psychiatry), the time spent in carrying out a procedure which is covered by another item in the MBS, may not be included in the consultation time.

A consultation fee may only be charged if a consultation occurs; that is, it is not expected that consultation fee will be charged on every occasion a procedure is performed.

A.5. Attendances by general practitioners (Items 3 to 51, 193, 195, 197, 199, 597, 599, 2497-2559 and 5000-5067)

Other services at the time of attendance

Where, during the course of a single attendance by a general practitioner, both a consultation and another medical service are rendered, Medicare benefits are generally payable for both the consultation and the other service. Exceptions are in respect of medical services which form part of the normal consultative process, or services which include a component for the associated consultation (see the General Explanatory Notes for further information on the interpretation of the Schedule).

Appendix E - MBS explanatory notes on aftercare services

T.8.4.—Aftercare (post-operative treatment)

Definition

Section 3(5) of the *Health Insurance Act 1973* states that services included in the Schedule (other than attendances) include all professional attendances necessary for the purposes of post-operative treatment of the patient. For the purposes of this book, post-operative treatment is generally referred to as 'aftercare'.

Aftercare is deemed to include all post-operative treatment rendered by medical practitioners, and includes all attendances until recovery from the operation, the final check or examination, regardless of whether the attendances are at the hospital, private rooms, or the patient's home. Aftercare need not necessarily be limited to treatment given by the surgeon or to treatment given by any one medical practitioner.

The medical practitioner determines each individual aftercare period depending on the needs of the patient as the amount and duration of aftercare following an operation may vary between patients for the same operation, as well as between different operations.

Private patients

Medicare will not normally pay for any consultations during an aftercare period as the Schedule fee for most operations, procedures, fractures and dislocations listed in the MBS item includes a component of aftercare. There are some instances where the aftercare component has been excluded from the MBS item and this is clearly indicated in the item description.

There are also some minor operations that are merely stages in the treatment of a particular condition. As such, attendances subsequent to these services should not be regarded as aftercare but rather as a continuation of the treatment of the original condition and attract benefits. Likewise, there are a number of services which may be performed during the aftercare period for pain relief which would also attract benefits. This includes all items in Groups T6 and T7, and items 39013, 39100, 39115, 39118, 39121, 39127, 39130, 39133, 39136, 39324 and 39327.

Where there may be doubt as to whether an item actually does include the aftercare, the item description includes the words 'including aftercare'. If a service is provided during the aftercare phase for a condition not related to the operation, then this can be claimed, provided the account identifies the service as 'Not normal aftercare', with a brief explanation of the reason for the additional services.

If a patient was admitted as a private patient in a public hospital, then unless the MBS item does not include aftercare, no Medicare benefits are payable for aftercare. If, however, a surgeon delegates aftercare to a patient's medical practitioner, then a Medicare benefit may be apportioned on the

basis of 75% for the operation and 25% for the aftercare. Where the benefit is apportioned between two or more medical practitioners, no more than 100% of the benefit for the procedure will be paid.

Medicare benefits are not payable for surgical procedures performed primarily for cosmetic reasons. However, benefits are payable for certain procedures when performed for specific medical reasons, such as breast reconstruction following mastectomy. Surgical procedures not listed on the MBS do not attract a Medicare benefit.

Where an initial or subsequent consultation relates to the assessment and discussion of options for treatment and, a cosmetic or other non-rebatable service are discussed, this would be considered a rebatable service under Medicare. Where a consultation relates entirely to a cosmetic or other non-Medicare rebatable service (either before or after that service has taken place), then that consultation is not rebatable under Medicare. Any aftercare associated with a cosmetic or non-Medicare rebatable service is also not rebatable under Medicare.

Public patients

All care directly related to a public in-patient's care should be provided free of charge. Where a patient has received in-patient treatment in a hospital as a public patient (as defined in Section 3(1) of the *Health Insurance Act 1973*), routine and non-routine aftercare directly related to that episode of admitted care will be provided free of charge as part of the public hospital service, regardless of where it is provided, on behalf of the state or territory as required by the National Healthcare Agreement. In this case no Medicare benefit is payable.

Notwithstanding this, where a public patient independently chooses to consult a private medical practitioner for aftercare, then the clinically relevant service provided during this professional attendance will attract Medicare benefits.

Where a public patient independently chooses to consult a private medical practitioner for aftercare following treatment from a public hospital emergency department, then the clinically relevant service provided during this professional attendance will attract Medicare benefits.

Addendum to the Report from the Principles and Rule Committee

A.1 MBS Reviews Taskforce review of public consultation submissions

The Principles and Rules report was released for public consultation on 9 September 2016 for four weeks.

The Principles and Rules Committee reviewed the public consultation feedback and decided to defer further consideration of the recommendation for Issue 2: The 'complete medical service' and the multiple operation rule until more MBS Review clinical committees have developed recommendations in the context of the ‘complete medical service’. All other recommendations remain unchanged.