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# Medicare Benefits Schedule Review Taskforce

## Principles and Rules Committee Taskforce Findings

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This document outlines the Medicare Benefits Schedule (MBS) Taskforce’s recommendations relating to MBS principles and rules.

The Taskforce considered the recommendations from the Principles and Rules Committee and feedback from public consultation.

The Taskforce endorsed all of the recommendations from the Principles and Rules Committee and submitted these to the Minister for Health for Government consideration.

<b>Number of recommendations made</b>
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6
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The intent of these recommendations is to align MBS principles and rules with contemporary medical practice and to eliminate the inappropriate use of MBS items by medical practitioners.

### Taskforce recommendations

#### Issue 1 – Provider education in MBS rules and processes

The Taskforce noted that many providers of MBS services have limited awareness of the rules and procedures involved in MBS billing, and may adopt questionable practices on the advice of colleagues. The Department of Human Services 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.

- △ *The Taskforce recommended 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.*

#### Issue 2 – Initial vs subsequent attendances and determining a single course of treatment

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 Taskforce was concerned about the practice of a new initial attendance item being claimed even though the attendance may be part of ongoing care for that patient’s condition—part of a single course of treatment.

△ *The Taskforce recommended 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.*

### **Issue 3 – Removal of the differential fee structure for remaining ‘G&S’ items**

These are currently MBS items where a different item number and lower and higher fees apply depending on whether the service is provided by a general practitioner or a specialist—‘G&S’ items. There are currently 62 such items covering 31 services. These items are the remnants of a much higher number of items introduced in the 1970s.

The Taskforce noted that these arrangements are anomalous and unfair, that there had been a steady reduction in MBS items with differential fees, and that many MBS items comparable to these 31 services do not have differential fees.

△ *The Taskforce recommended removing the differential items and fees and introducing a single item for each of these services with a fee at the (higher) specialist rate.*

### **Issue 4 – Co-claiming attendances with procedures**

The Taskforce was concerned that some specialists claim a subsequent specialist attendance when it is provided on the same day as a procedure, even when the procedure has been scheduled in advance and there is no real need for an attendance.

The adverse consequences of this practice 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 increases costs to Medicare and patients, without increasing the care provided to patients.

The Taskforce’s view is that where an attendance is necessary for and intrinsic to a procedure, the attendance cannot be co-claimed as a separate service.

△ *The Taskforce recommended prohibiting the co-claiming of subsequent specialist consultations with procedures that have already been agreed to take place.*

### **Issue 5 – Aftercare**

It is a principle of the MBS that surgeons should provide ‘aftercare’ to their patients—that is, medical care related to a patient’s recovery from an operation—as part of the original service. For that reason, there is currently a prohibition on claiming Medicare benefits for ‘aftercare’ services.

However, this means that some providers, often GPs, are unable to access MBS items for aftercare services, despite having no relationship with the original surgeon and being unable to be

reimbursed by them for the aftercare service. This also means that patients miss out on Medicare benefits for aftercare services. The Taskforce noted that the current arrangements do not reflect common practice and prevent appropriate access to the MBS.

- △ *The Taskforce recommended lifting the current restriction to allow all practitioners other than the provider of the initial procedure to claim for services in the aftercare period.*
- △ *In particular, this change supports access to MBS services in rural areas or locations where it may be difficult to access ongoing specialist aftercare services.*

## **Issue 6 – Specialist-to-specialist referrals**

The GP is generally regarded as the primary source of referrals. A GP referral is valid for a period of 12 months, unless it 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. The comparatively short three-month 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.

Notwithstanding concerns from consumers and providers, the Taskforce recognised the primacy of the general practitioner as ‘gatekeeper’ to the broader health system and primary point of patient contact. The Taskforce considered that the clinical benefits for patients from continuity of GP involvement in their care supported the current arrangements.

- △ *The Taskforce recommended that the three-month limit of specialist-to-specialist referrals be maintained.*

Information and evidence supporting each of these recommendations is included in the Principles and Rules Committee report.