Australian Government
Department of Health and Aged Care

Private Health Insurance Clinical Categories Review Advisory Committee Report

Contents

Executive Summary

The Clinical Categories Review 2021 (the review) sought feedback on a significant Australian Government reform for private health insurance (PHI) products, the introduction of standardised definitions of services offered in hospital insurance products. Conducted by an independent committee of experts, the Clinical Categories Review Advisory Committee (the committee) collected a range of views from insurers, private health service providers and consumers on the implementation of the clinical categories and its effectiveness to simplify and improve the transparency of hospital insurance products.

The committee noted the clinical categories have assisted consumers to better understand the services covered in their policy and to compare products more easily across the market. The committee also identified where the categories could be further simplified and improved.

This report sets out 24 recommendations for the Department of Health and Aged Care (the department) to better clarify the coverage requirements of the categories and the regulations in the *Private Health Insurance (Complying Product) Rules 2015* (the Complying Product Rules), better communicate amendments to the categories and to establish a new PHI disputes resolution framework. Whilst the recommendations incorporate feedback and proposals from stakeholders, the committee anticipates further consultations and in-depth analysis on potential impacts on premiums and customer communication will be conducted.

The review of the clinical categories considered:

- the range of services covered by the categories
- the assignment of Medicare Benefits Schedule (MBS) items to a category and the potential for additional procedural and diagnostic classifications codes to be included
- the regulatory framework for the categories
- the process to update and manage the clinical categories so that they reflect the most up-to-date range of hospital services in the MBS
- pathways to resolve complaints and disputes between stakeholders.

An in-depth analysis of the categories found that all hospital services covered under Medicare were sufficiently reflected in the current range of clinical categories and there was no need to expand the list of categories. The committee identified circumstances where categories could be simplified by amending the scope of covers to improve the readability and the utility of a category.

The committee did not believe there was a need for additional diagnostic or procedural classification codes, as it would introduce new complexities to the current arrangements. Instead, guiding principles have been proposed to clarify how to interpret the scope of cover of a category and the MBS items listed within it. In addition, the committee has suggested amendments to the Complying Product Rules to better reflect the intent of the regulations and improve transparency of coverage of hospital insurance products.

The ongoing management of the clinical categories was considered to be robust as the process to amend the categories engages a range of stakeholder views. Longer timeframes from when MBS and PHI changes are finalised to when changes commence were seen as one area for improvement. It was also suggested that combining PHI and MBS information into a single data file (.xml file) would be useful for stakeholders.

The committee envisions this report will address many of the concerns raised by stakeholders during the implementation of the clinical categories and thanks all those who assisted in the review.

Recommendations

Recommendations	Descriptions
Recommendation 1.	Health to review the current set of examples of medical conditions and procedures listed in the scope of cover of the categories to ensure they are representative of services covered and familiar to most consumers. The review should include consultations with stakeholders.
Recommendation 2.	Categories should clearly indicate if they cover the surgical removal of a tumour and more clearly direct non-surgical cancer treatments to the Chemotherapy, radiotherapy and immunotherapy for cancer category.
Recommendation 3.	The eye category should be renamed 'Eyes (other than cataracts)' to reduce consumer confusion over products that also cover the Cataracts category.
Recommendation 4.	Amend the scope of cover of Ear, nose and throat and Tonsils, adenoids and grommets to note tonsils, adenoids and grommets are included in Ear, nose and throat in Gold, Silver and Bronze products. Tonsils, adenoids and grommets are listed as a separate category in Basic Plus products.
Recommendation 5.	The Government's Private Health website could offer consumers the option to view the Hospital Product Tiers table with the clinical categories arranged by regions of the body/body systems. Categories that are subsets of another category could be displayed immediately after the more comprehensive category. For example, the table could list Cataracts immediately after Eye (not cataracts), and Joint replacements immediately after Bone, joint and muscle and Joint reconstructions.
Recommendation 6.	The Sleep studies category should be a minimum requirement for the Bronze tier, facilitating access to diagnostic sleep study services for Bronze and Silver products.
Recommendation 7.	Amend the scope of cover of Digestive system and Hernia and appendix to note hernias and appendectomies are included in Digestive system under Gold, Silver and Bronze products. Hernia and appendix is listed as a separate category in Basic Plus products. For Basic Plus products, the Hernia and appendix category should also identify which types of hernias are not covered by the category and are instead covered by the Digestive system category.
Recommendation 8.	Some hernia MBS items in Digestive system should be moved to the Hernia and appendix category, such as item 30621 for the repair of umbilical, epigastric or linea alba hernias.
Recommendation 9.	Categories where there are no MBS items listed or where the majority of covered services are not in the MBS (such as the dental and podiatric surgery categories), should note in the scope of cover that the category may provide limited benefits.
Recommendation 10.	Amend the scope of cover of Gynaecology and Miscarriage and termination of pregnancy to note miscarriage and termination of a pregnancy services are included in Gynaecology under Gold, Silver and Bronze products. Miscarriage and termination of pregnancy services are listed separately in Basic Plus products.

Recommendations	Descriptions
Recommendation 11.	MBS items 14203 and 14206 for hormone or living tissue implantation should be moved to either the Common treatments list or the Support treatments list.
Recommendation 12.	The name of the Breast surgery (medically necessary) and the Plastic and reconstructive surgery (medically necessary) categories could replace the reference to 'medically necessary' with 'Medicare payable services'.
Recommendation 13.	The skin flap MBS items 45201 and 45206 should be moved to the Skin category. The volume of services provided following the amendment should be monitored to ensure the items are not being over-serviced.
Recommendation 14.	Rename Weight loss surgery to 'Weight loss procedures' so that the category better reflects that it covers all weight loss related hospital procedures.
Recommendation 15.	Move spinal cord procedures to the Back, neck and spine category. Amend the scope of cover of the Brain and nervous system category to only cover the brain and peripheral nervous system.
Recommendation 16.	Additional classification systems such as ICD-10, ACHI and DRGs do not relate well to the clinical categories. These should not be added to Schedule 5 of the Complying Product Rules or be used for eligibility checking purposes.
Recommendation 17.	Coverage of medical admissions should be determined with respect to the scope of cover requirements in subrule 11F(2) of the Complying Product Rules and following the principles in Recommendation 19(ii). Coding systems such as ICD-10 and DRGs may be used in benefit payment determinations if their mapping complies with the requirements in 11F(2).
Recommendation 18.	The Complying Product Rules should be amended to clarify that the scope of cover has primacy over the MBS items. Proposed changes could include: • clarifying 11F(5)(a) to note hospital treatments involving the provision of an MBS item listed against a particular category in Schedule 5 are only covered if they are used to treat a condition described in column 2 of the table; and • amending the header of column 3 of the table in Schedule 5 to 'The following MBS items are included in the scope of cover if provided as part of treatment described in column 2 of this clinical category'.
Recommendation 19.	The following principles should be applied by stakeholders when determining coverage of a hospital admission: i. Coverage of an admission goes to the superordinate description of the scope of cover. The MBS items are subordinate to the descriptive scope of cover. ii. Cover should be determined by the diagnosis and intended therapeutic intervention, in good faith, at the point of admission. iii. A single admission may be covered by multiple clinical categories and benefits are payable for all categories included in the policyholder's policy.
Recommendation 20.	Health should publish case studies demonstrating how to interpret the regulations for complex admissions such as those in Appendix 5.

Recommendations	Descriptions
Recommendation 21.	Amend Rule 11G of the Comply Product Rules to only allow Rehabilitation, Hospital psychiatric services and Palliative care categories to offer restricted benefits in Basic Plus products. All other categories in Basic Plus products must be covered on a non-restricted basis.
Recommendation 22.	Amend Subrule 11H(3) to require all relevant hospital insurance products carry the 'Plus' branding. That is, if the product offers cover for clinical categories above the minimum requirements for that product tier, it is advertised as a 'Plus' product.
Recommendation 23.	The MBS data file released by MBS Online should include PHI classification information for a more streamlined process to communicate MBS and PHI changes. Health insurers and private hospitals should be consulted in the development of the new data file.
Recommendation 24.	Complaints regarding PHI matters which cannot be resolved using current mediation processes should be referred to an independent body with the powers to: • receive and arbitrate on disputes relating to PHI business • develop a code of conduct for insurers and service providers • publish precedents and clarifications on the legislation and regulations • publish regular reports on disputes • refer advice to Health where legislative amendments may be required to clarify the regulations • refer repeat offenders to APRA, AHPRA , ACSQHC and equivalent bodies. The disputes resolution framework and establishment of a complaints authority will require further consultation with the broader private health industry.

Introduction

A 2015 Government survey on PHI indicated consumers found health insurance confusing and complex. The lack of transparency was a potential barrier for consumers to confidently compare and select a policy that adequately met their individual needs. It also contributed to consumer perception that PHI was not economical for the average household.

In response, the 2017-18 Mid-Year Economic Fiscal Outlook included a package of reforms to make PHI simpler and more affordable for Australians1. The reforms included the development of standardised definitions of hospital services for insurance products. The Clinical Definitions Working Group was established by the Private Health Ministerial Advisory Committee (PHMAC) to review common insurance terms and advise on a new list of definitions. The resulting clinical categories (Appendix 3) reflected hospital services eligible for private insurance benefits and form the minimum coverage requirements for the then new hospital product tiers of Gold, Silver, Bronze and Basic (Appendix 4).

Each category defined which services were included and excluded, examples of common medical conditions or procedures covered by the category, and a list of indicative MBS items to assist in the consistent coverage of services. Where an MBS item could be covered by more than one category the item was either mapped to the most relevant category, a category in the lowest product tier or on one of the ancillary lists - the *Support treatments list or Common treatments list*. The *Support treatments* list includes items unlikely to be the main reason for an admission and supports the primary hospital procedure, such as pathology services. The Common treatments list includes items that could not easily be mapped to one category and could be the primary reason for admission such as a medical specialist consultation service.

Prior to implementation, the categories were consumer tested to ensure they were fit-for-purpose and several consultations were held with the broader industry to assist a smooth transition to the new arrangements. The clinical categories and product tiers commenced 1 April 2019 and insurers were granted a 12 month transition period to implement the new arrangements. Post implementation reviews were proposed to address any industry concerns and ensure the categories remained useful to consumers.

Review Approach

The Terms of Reference (ToR) (Appendix 1) of the committee were to advise Health on the:

- Effectiveness of the scope of cover of a clinical category to clearly define included and excluded services for all stakeholders
- The utility of MBS items to indicate included services and the value of mapping other procedural and diagnostic classification codes
- A framework to review, consult and communicate amendments to the clinical categories
- Stakeholder feedback on implementation issues

Eleven members were appointed to the committee bringing together expertise in private health insurance, private hospital administration, clinical practise and consumer representation (Appendix 2).

The committee was established from 15 February to 31 December 2021 and met four times over the course of the year, at which time the following topics were discussed:

[1] Mid-Year Economic and Fiscal Outlook 2017-18, p.160-161

- scope of cover – an evaluation of the definitions of covered services, the mapping of MBS items to the categories and a review of stakeholder feedback on implementation issues.
- additional classification codes – the assessment for the need for additional classification systems to support consistent coverage of services and address gaps in service coverage where there are no applicable MBS items.
- review of the regulations in the Complying Product Rules.
- the procedure for amending the clinical categories – a framework to review, consult and communicate amendments to the clinical categories, either due to MBS changes or feedback from stakeholders.
- a pathway for stakeholders to resolve disputes over the interpretation of the regulations.

Submissions for the review were received from January to February 2021 with an additional consultation on the committee's work plan conducted in March 2021. Submissions from insurers, service providers, medical colleges and consumer groups supported the proposed ToR and provided case studies for the committee to consider. Some submissions proposed the ToR be extended to include the product tiers; however, it was deemed that a review of the tiers would best be conducted separately given its complexity and the need for additional data.

Committee Considerations

Evaluation of the clinical categories

Stakeholder responses indicated different elements of the scope of cover of a category helped to clarify the intended coverage requirements of the category. Consumers often referred to the name of the category and the examples of common medical conditions whilst insurers often found the definition of a category to be too broad and preferred to use the MBS items to determine coverage. In light of the feedback, the committee noted the scope of cover of most categories could be better clarified with a particular focus on more consumer-friendly examples of medical conditions and procedures.

Recommendation 1

Health to review the current set of examples of medical conditions and procedures listed in the scope of cover of the categories to ensure they are representative of services covered and familiar to most consumers. The review should include consultations with stakeholders.

Individual evaluations of categories are set out below in the following related groups:

Individual Evaluation categories	Related groups
Haematology and oncology categories	(Blood; Chemotherapy, radiotherapy, immunotherapy for cancer)
Cardiovascular categories	(Heart and vascular system; Lung and chest)
Ophthalmology and otolaryngology related categories	(Eye; Cataracts; Ear, nose and throat; Implantation of hearing devices; Tonsils, adenoids and grommets; Sleep studies)
Digestive system related and dental categories	(Insulin pumps; Diabetes management; Kidney and bladder; Dialysis for chronic kidney failure; Gastrointestinal endoscopy; Hernia and appendix; Digestive system; Dental surgery)
Reproductive categories	(Miscarriages and termination of pregnancy; Gynaecology, Male reproductive system; Assisted reproductive system; Pregnancy and birth)
Reconstructive related categories	(Breast surgery; Plastic and reconstructive surgery; Skin; Weight loss surgery)
Neurological related clinical categories	(Pain management; Pain management with device; Brain and nervous system)
Orthopaedic categories	(Back, neck and spine, Bone Joint and muscle; Joint reconstructions; Joint replacements; Podiatric surgery)
Basic tier categories and the Support and Common treatments lists	(Palliative care; Rehabilitation; Hospital psychiatric services; Support treatments; Common treatments list)

Haematology and oncology clinical categories

Blood

The Blood clinical category covers a range of haematology conditions most of which are symptoms of conditions covered by other categories, such as anaemia caused by chronic renal failure. Despite this, there was support for the category to remain as a stand-alone category and no amendments were recommended.

Chemotherapy, radiotherapy and immunotherapy for cancer

Stakeholder feedback suggested the Chemotherapy, radiotherapy and immunotherapy for cancer category could be expanded to include tumour removal surgery. The committee noted the complex nature of cancer surgery and the potential requirement to repair surrounding tissues and organs made it difficult to tease out and properly describe surgical interventions for oncology without causing unintended consequences. There is also no uniform definition of cancer making it difficult to expand the scope of the category in a way that would be both medically accurate and consumer friendly.

The committee agreed not to include the surgical removal of cancer in the *Chemotherapy, radiotherapy and immunotherapy for cancer* category and instead amend the scope of cover of other categories to note if they include tumour removal surgery. The scope of cover should also clearly indicate where non-surgical cancer treatments are covered by the *Chemotherapy, radiotherapy and immunotherapy for cancer* category.

Recommendation 2

Categories should clearly indicate if they cover the surgical removal of a tumour and more clearly direct non-surgical cancer treatments to the *Chemotherapy, radiotherapy and immunotherapy for cancer* category.

Cardiovascular clinical categories

Heart and vascular system / Lung and Chest

The cardiovascular categories of Heart and vascular system and Lung and Chest were not found to be contentious. However, the scope of cover of Heart and vascular system could be improved to better reflect the range of services covered (see Recommendation 1). No other amendments were recommended.

Ophthalmology and otolaryngology related clinical categories

Eye / Cataracts

The committee agreed separating cataract services from general ophthalmology services was warranted given the cost on premiums for cataract procedures. However, the name of the *Eye (not cataracts)* category has caused confusion for consumers when their policy also included the Cataracts category. As such a name change is supported.

Recommendation 3

The eye category should be renamed ‘Eyes (other than cataracts)’ to reduce consumer confusion over products that also cover the Cataracts category.

Ear, nose and throat (ENT) / Tonsils, adenoids and grommets (TAG)

The separation of the ENT and TAG services was considered confusing to some consumers as complications arising from TAG surgeries are often interpreted by insurers as not within scope of the category and are instead seen within the scope of ENT. As a result, consumers have been left frustrated when advised they are not covered for treatment they expected to be included in their policy and incur unexpected out of pocket costs.

Prior to the implementation of the clinical categories, some insurers offered cover for tonsils, adenoids, and grommet surgery as a stand-alone service. With the introduction of the clinical categories, insurers were required to cover all services within a category and partial cover was not permitted. The separation of TAG and ENT allowed insurers to continue to offer relatively inexpensive services in Basic Plus products.

The committee considered if combining TAG with ENT would help simplify the clinical categories. Data from the Private Health Insurance Ombudsman (PHIO) indicated over half of Basic Plus products offered cover for both categories (Figure 1). The remaining 40 percent of Basic Plus products that only covered TAG could face increased pressure on premiums or may instead opt to reduced coverage of services if the two categories were combined.

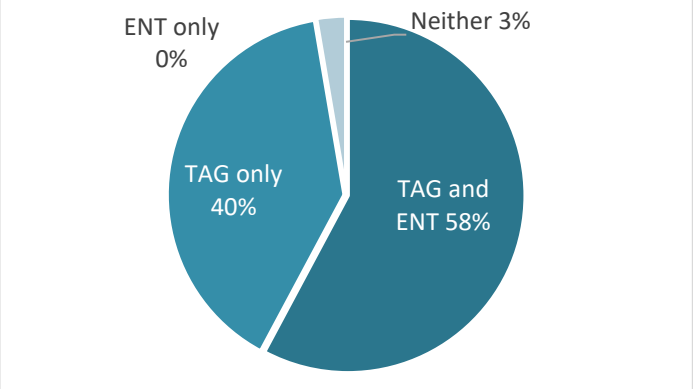

Figure 1. Coverage of Tonsils, adenoids and grommets (TAG) and Ear, nose and throat (ENT) categories for Basic Plus products (open and closed). Source: PrivateHealth.gov.au April 2021 Data

Some members supported combining the two categories, but the majority of members noted there was a desire from consumers for niche categories such as TAG to be kept as stand-alone services. Allowing these specialised categories to be covered in Basic Plus products caters for consumers who may not wish to have cover for all services relating to a region of the body/a body system, whilst still supporting them to hold cover for services important to them.

Basic and Basic Plus products can cater for consumers who may be looking to avoid the Lifetime Health Cover loading or the Medicare Surcharge levy but who are not wishing to hold comprehensive health insurance. Whilst not providing cover for a wider range of services, these products can play an important role in facilitating an early connection to PHI and significantly contributing to the risk equalisation pool. This in turn helps to reduce the cost of premiums for all policyholders. Minimising the appeal of PHI to this cohort by reducing the flexibility of services able to be covered in Basic Plus products could place upward pressure on premiums and reduce access to private hospital services.

The committee suggested clearer wording in the scope of cover for both TAG and ENT to note the two categories are closely related, and to highlight Basic Plus products may only cover a subset of services. This principle could be applied to other closely related categories such as Digestive system and Hernia and appendix.

The committee believed an alternative arrangement of clinical categories in the Hospital Product Tiers Table (Appendix 4) may also assist consumers to better understand which products offer cover for an entire body system and which products offer cover for only a subset of services. The alternate arrangement of the table could be made available on Government websites along with the current version of the table which arranges categories by the Gold, Silver, Bronze and Basic tiers.

Recommendation 4

Amend the scope of cover of Ear, nose and throat and Tonsils, adenoids and grommets to note tonsils, adenoids and grommets are included in Ear, nose and throat in Gold, Silver and Bronze products. Tonsils, adenoids and grommets are listed as a separate category in Basic Plus Products.

Recommendation 5

The Government's Private Health website could offer consumers the option to view the Hospital Product Tiers table with the clinical categories arranged by regions of the body/body systems. Categories that are subsets of another category could be displayed immediately after the more comprehensive category. For example, the table could list *Cataracts* immediately after *Eye (not cataracts)*, and *Joint replacements* immediately after *Bone, joint and muscle* and *Joint reconstructions*.

Implantation of hearing devices

The committee did not consider Implantation of hearing devices to be a contentious category and no amendments were recommended.

Sleep studies

The *Sleep studies* category was noted as being unusual as it offers cover for a diagnostic tool which can be used for heart, respiratory and central nervous system conditions. These conditions are covered by other clinical categories and the scope of these categories often include investigative procedures making it unclear which category should cover sleep studies.

Sleep studies is a minimum requirement for Gold products but PHIO data indicates the category is relatively inexpensive and commonly offered in 'Plus' products (Figure 2). Almost half of Basic Plus products offered cover either on a restricted or covered basis and most Bronze Plus and Silver Plus products offered coverage on a non-restricted basis.

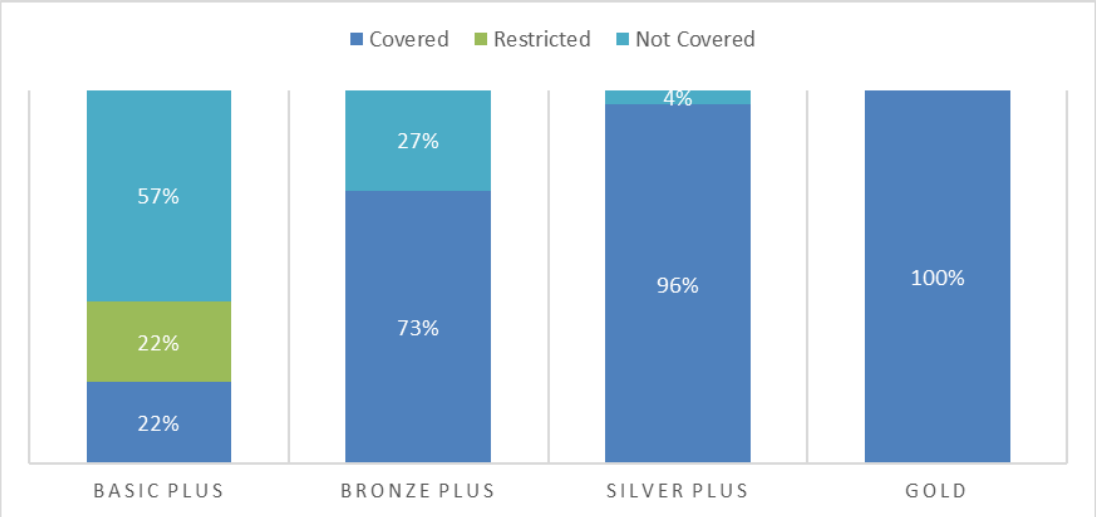

Figure 2. Coverage of Sleep studies across product tiers. Source: PrivateHealth.gov.au April 2021 Data

Given its broad inclusion in hospital insurance products and its use as a diagnostic tool, the committee agreed the regulations should support easier access to the category.

Recommendation 6

The *Sleep studies* category should be a minimum requirement for the Bronze tier, facilitating access to diagnostic sleep study services by Bronze and Silver products.

Digestive system related and dental categories

Insulin pumps / Diabetes management

The committee noted the provision of insulin pumps and diabetes management services are largely provided as out-patient procedures and do not require a hospital admission. Coverage for services in these categories are primarily for patients who may be in hospital for other non-related reasons but require diabetes support treatment.

There is consumer support for the retention of these categories, especially from those who require diabetes support. They find it reassuring to have categories that specifically relate to their health needs and it is unclear which category would cover these services if *Insulin pumps* and *Diabetes management (excluding insulin pumps)* were removed.

No amendments were recommended.

Kidney and bladder / Dialysis for chronic kidney failure

The *Kidney and bladder and Dialysis for chronic kidney failure* categories were not considered to be contentious and no amendments were recommended.

Hernia and appendix / Digestive system

The Hernia and appendix and Digestive system categories are both minimum requirements for Bronze products, however, the separation of hernias and appendectomies from other digestive procedures allows insurers to offer cost-effective services in Basic Plus products.

The original intent of *Hernia and appendix* was to offer cover for inguinal hernias which are relatively simple conditions to treat. More complex hernia services, such as treatment for ventral hernias were mapped to the Digestive system. From a consumer perspective, the distinction between complex and simple hernias is confusing and has led to coverage disputes with insurers.

The committee considered if the two categories should be combined. PHIO data indicates over half of Basic Plus products offer cover for *Hernia and appendix and Digestive system* (Figure 3). Some members supported this proposal, but the majority of members noted there was a desire from consumers for niche categories as *Hernia and appendix*.

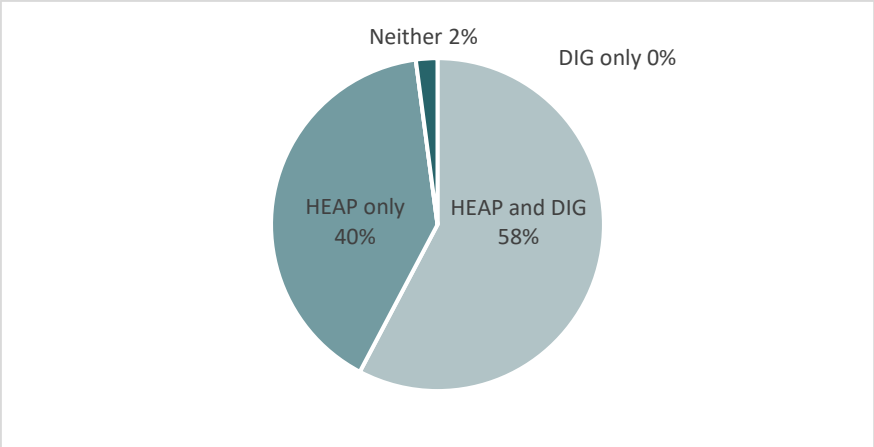

Figure 3. Coverage of Hernia and appendix (HEAP) and Digestive system (DIG) categories for Basic Plus products (open and closed). Source: PrivateHealth.gov.au April 2021 Data

Instead, it is proposed that both the *Digestive system and Hernia and appendix* scope of covers be amended to help consumers to more easily understand which services are not covered in the *Digestive system* category.

Recommendation 7

Amend the scope of cover of *Digestive system and Hernia and appendix* to note hernias and appendectomies are included in Digestive system in Gold, Silver and Bronze products. Hernia and appendix is listed as a separately category in Basic Plus products.

For Basic Plus products, the *Hernia and appendix category* should also identify which types of hernias are not covered by the category and are instead covered by the Digestive system category.

Recommendation 8

Some hernia MBS items in Digestive system should be moved to the *Hernia and appendix category*, such as item 30621 for the repair of umbilical, epigastric or linea alba hernias.

Gastrointestinal endoscopy

The Gastrointestinal endoscopy category provides cover for a class of medical procedures. Prior to the introduction of the clinical categories, these procedures were commonly covered as stand-alone services. The committee did not express any concerns in retaining the category despite it being closely related to the *Digestive system* category as it did not cause confusion for consumers. The committee did note, the name of the category may not be very consumer-friendly, but the public has got used to the name and there is no need for a change.

Dental surgery

The *Dental surgery* category provides benefits for surgical dental treatment provided in hospital. However, many of the services within the scope of the category are not included in the MBS such as wisdom tooth removal. The MBS items that are listed in the category relate to cleft lip and cleft palate (CLCP) services which are largely reconstructive and also fall within scope of the *Plastic and reconstructive surgery* category. Despite this, the committee did not find a need to move CLCP items out of *Dental surgery*.

Where there are no MBS items claimable for a hospital service, subsection 72-1(2) of the *Private Health Insurance Act 2007* (PHI Act) requires only hospital accommodation benefits to be payable if they meet the requirement of the *Private Health Insurance (Benefit Requirement) Rules* (the Benefit Requirement Rules). Benefits for the dentist's fee may be covered under general treatment if the policyholder has a combined product that includes dental surgery services. The committee proposes this information should be more clearly noted in both the *Dental surgery* and *Podiatric Surgery* categories.

Recommendation 9

Categories where there are no MBS items listed or where the majority of covered services are not in the MBS (such as the dental and podiatric surgery categories), should note in the scope of cover that the category may provide limited benefits.

Reproductive categories

Male reproductive system

The committee discussed if the clinical categories could be simplified by combining *Male reproductive system* with gynaecological services under a collective 'Reproductive system' category. The concern was the potential perception by consumers that the reproductive system category would primarily relate to female services. As such, there was agreement to retain *Male reproductive system* as a separate category and no amendments were recommended.

Miscarriage and termination of pregnancy / Gynaecology

Some members supported amalgamating *Miscarriage and termination of pregnancy with Gynaecology* as both categories are a minimum requirement for Bronze products and are closely related. Data from the PHIO indicated many Basic Plus products covered both categories. Only three percent of products covered *Miscarriage and termination of pregnancy* by itself and 19 percent covered only Gynaecology (Figure 4).

However, for consistency with Recommendations 4 and 7, it is proposed that *Miscarriage and termination of pregnancy* should be retained as a stand-alone category and the scope of cover amended.

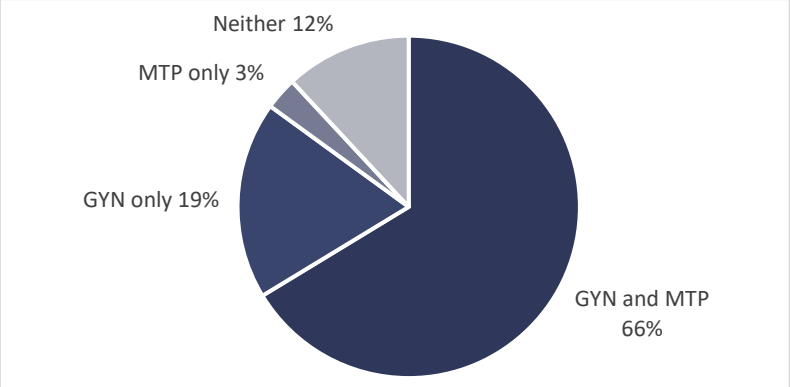

Figure 4. Coverage of Gynaecology (GYN) and Miscarriage and termination of pregnancy (MTP) categories for Basic Plus products (open and closed). Source: PrivateHealth.gov.au April 2021 Data

Recommendation 10

Amend the scope of cover of *Gynaecology and Miscarriage and termination of pregnancy* to note miscarriages and termination of a pregnancy are included in *Gynaecology* under Gold, Silver and Bronze products. Miscarriage and termination of pregnancy services are listed separate in Basic Plus products.

Assisted Reproductive Services

It was noted MBS items 14203 and 14206[2] for hormone or living tissue implantation are listed in the Assisted Reproductive Services category, which is a minimum requirement for Gold tier products. The items are also relevant to categories covered in lower tier products. To reduce complications during the eligibility checking process, the committee proposed moving the items to one of the ancillary lists.

Recommendation 11

MBS items 14203 and 14206[2] for hormone or living tissue implantation should be moved to either the *Common treatments list* or the *Support treatments list*.

Pregnancy and birth-related services

This category was not considered to be contentious and no amendments were recommended.

Reconstructive related categories

Breast surgery (medically necessary)

Some stakeholders indicated the name of the *Breast surgery (medically necessary)* and the *Plastic and reconstructive surgery (medically necessary)* categories did not clearly indicate that they provide cover for non-cosmetic procedures. This view was not widely held by all stakeholders, and it was noted that 'medically necessary' also included the psychological need for plastic surgery, such as reconstruction after breast cancer procedures.

Both the Breast surgery and the Plastic and reconstructive surgery categories provide cover for procedures that are eligible for Medicare benefits. As such, the title of the categories could refer to the Medicare benefit eligibility to better clarify which services are included.

Recommendation 12

The name of the *Breast surgery (medically necessary)* and the *Plastic and reconstructive surgery (medically necessary)* categories could replace the reference to 'medically necessary' with 'Medicare payable services'.

Plastic and reconstructive surgery (medically necessary) / Skin

Stakeholder feedback noted the assignment of MBS items between *Plastic and reconstructive surgery (medically necessary)* and *Skin* was confusing with many procedures normally used in skin cancer surgery listed in the plastic and reconstructive surgery category.

[2] MBS item 14203: Hormone or living tissue implantation, by direct implantation involving incision and suture (Anaes.)
MBS item 14206: Hormone and living tissue implantation by cannula

The committee reviewed the MBS items listed in both categories and recommended minor changes.

Recommendation 13

The skin flap MBS items 45201 and 45206[3] should be moved to the Skin category. The volume of services provided following the amendment should be monitored to ensure the items are not being over-serviced.

Weight loss surgery

The Weight loss surgery category covers both surgical procedures to lose weight as well subsequent treatment to remove excess skin. Feedback from policyholders indicated confusion around the coverage of procedures to remove excess skin following non-surgical weight loss. The committee agreed to retain excess skin removal procedures in the *Weight loss surgery* category and to amend the name of the category to reflect that it includes all weight loss related procedures.

Recommendation 14

Rename *Weight loss surgery* to 'Weight loss procedures' so that the category better reflects that it covers all weight loss related hospital procedures.

Neurological related clinical categories

Pain management / Pain management with device

The committee noted consumer groups were confused which category provided cover for non-implanted pain management devices. The *Pain management* category provides coverage for non-surgical hospital treatments for pain, such as nerve-block injections or radiofrequency probes. These services are relatively low-cost services and are covered in Bronze tier products and above.

Pain management with device provides benefits for the surgical implantation or management of a device. Related costs for a device can be comparatively more expensive than non-invasive procedures which is why the category is a minimum requirement for Gold products.

The PHI Act requires benefits be paid for a prosthesis if the device is on the Prostheses List and a Medicare benefit (i.e. an MBS item) is payable. Where the device is not listed on the Prostheses List or the MBS item is not payable, insurers are not required to pay benefits for the device.

The committee suggested further engagement with consumer groups to better understand the problem before any changes to the regulations are proposed.

[3] MBS item 45201: *Muscle, myocutaneous or skin flap, where clinically indicated to repair one surgical excision made in the removal of a malignant or non-malignant skin lesion (only in association with items 31000, 31001, 31002, 31003, 31004, 31005, 31358, 31359, 31360, 31363, 31364, 31369, 31370, 31371, 31373 or 31376)-may be claimed only once per defect (Anaes.)*
MBS item 4520620
MBS item 45206: *Single stage local flap if indicated to repair one defect, on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals and excluding H-flap or double advancement flap not in association with any of items 31356 to 31376*

Brain and nervous system / Back, neck and spine

The overlap between the two categories is largely due to spinal cord procedures. The spinal cord is part of the central nervous system and is presently covered in the *Brain and nervous system* category. However, many spinal cord procedures such as a spinal decompression includes orthopaedic MBS items. This has caused eligibility checking problems if only one of the categories was included in the patient's policy.

To simplify the Brain and nervous system category, the committee proposed that spinal cord and related services be moved to Back, neck and spine.

Recommendation 15

Move spinal cord procedures to the *Back, neck and spine* category. Amend the scope of cover of the *Brain and nervous system* category to only cover the brain and peripheral nervous system.

Orthopaedic clinical categories

Joint reconstructions / Bone, joint and muscle

There are four categories that primarily relate to orthopaedic services: *Joint reconstructions, Bone joint and muscle, Back neck and spine,* and *Joint replacements*. These categories are covered across Bronze, Silver and Gold tiers with many Basic Plus products also including low cost orthopaedic services. Consumers found it difficult to understand the differences between the orthopaedic categories and the committee noted clearer statements within the categories would assist consumers to distinguish coverage differences.

To simplify the range of orthopaedic categories the committee considered combining *Joint reconstructions with Bone, joint and muscle* as both are minimum requirements for Bronze tier products. The PHIO data indicates over half of Basic Plus products include both categories (Figure 5). Given the large volume of orthopaedic services provided to policyholders, it was anticipated that combining these two categories would have significant financial impacts on premiums. The committee did not wish to recommend merging these two categories without actuarial data to quantify the outcomes.

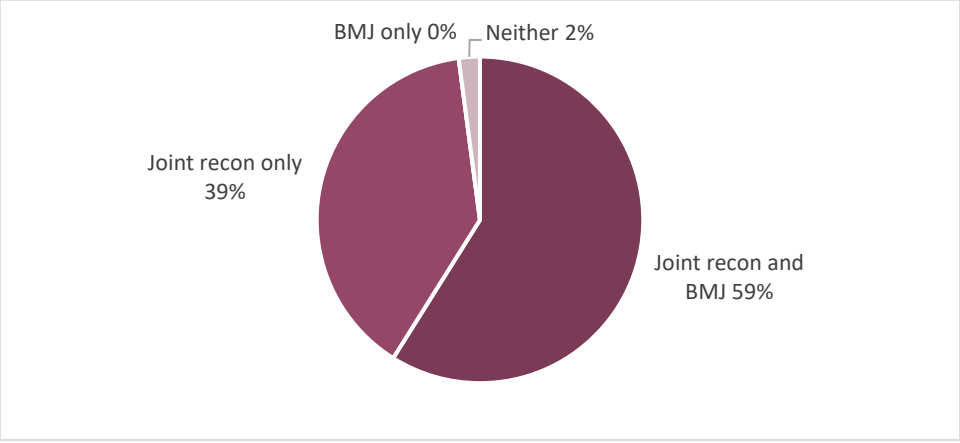

Figure 5. Coverage of Joint reconstructions (Joint recon) and Bone, joint and muscle (BJM) categories in Basic Plus products (open and closed). Source: PrivateHealth.gov.au April 2021 Data

Joint replacements

Stakeholder advice noted some insurers used additional classification codes such as Diagnosis Related Groups (DRGs) to determine coverage of service which had led to some joint reconstructions being classified as joint replacements. Joint reconstructions are

relatively low cost orthopaedic services commonly offered in Basic Plus products and above. Joint replacements are more complex procedures that are covered in Silver Plus products and above. The committee considered if redefining the scope of *Joint replacements* to procedures that require a prosthesis on the Prostheses List would assist to distinguish services between the two categories.

The Prostheses List includes a range of products that attract a private health insurance rebate. Prostheses range from whole or partial joints to consumable products used in joint reconstructions and other general orthopaedic procedures. By limiting the *Joint replacements* category to procedures involving a prosthesis, relatively simple orthopaedic procedures currently covered in *Joint reconstructions* and *Bone, joint and* muscle could be moved to the Joint replacements category. The committee did not believe this was the intent of the category and as a result agreed to retain the present definition of *Joint replacements*.

Podiatric Surgery

The committee noted in 2017 the Clinical Definitions Working Group was advised the Medical Services Advisory Committee (MSAC) was assessing an application to include new in-hospital MBS items for podiatric surgeons. Podiatric surgeons are considered allied health professionals under Medicare and limited to claiming only out-of-hospital services. The MSAC application requested new items for accredited podiatric surgeons to claim a limited range of in-hospital foot and ankle surgical items.

To date, there are no surgical items for podiatrists and the *Podiatric Surgery (provided by a registered podiatric surgeon)* category only requires insurers to provide hospital accommodation benefits for relevant services. Insurers can provide cover for services provided by a podiatrist under general treatment cover, similar to *Dental surgery*. The committee did not deem the scope of cover for podiatric surgery contentious and did not recommend any amendments.

Basic product categories

Prior to the implementation of the clinical categories *Palliative care, Rehabilitation and Hospital psychiatric services* were minimum requirements for all hospital insurance products. During the development of the clinical categories and product tiers, insurers expressed the need for a tier that allowed for low cost policies for consumers who were primarily looking to avoid the Medicare Surcharge Levy and the Lifetime Health Cover loading. The Basic tier was developed around the previous minimum requirements for hospital insurance products.

The committee noted the flexibility allowed for insurers to offer Basic Plus products that targets specific cohorts of the population has resulted in many ‘junk products’ but changes to the Basic tier were noted as being outside the scope of this Review.

Rehabilitation

Many services covered by the Rehabilitation category do not attract a Medicare benefit and benefit rates for services and accommodation are negotiated in agreements between healthcare providers and insurers. Benefits for rehabilitation can also be covered on a restricted or unrestricted basis in Basic, Bronze and Silver products in accordance with Rule 11G. The Complying Product Rules allow restricted categories to cover some services within the category on an unrestricted basis, though this is not noted in the policy’s Private Health Information Statement (PHIS). Healthcare providers have expressed frustration that it was unclear which services within these categories attract restricted benefits until claims are lodged. In keeping with the intent of improving transparency of hospital insurance policies it was felt that insurers should make it clear which services attract restricted benefits within a category (see also Recommendation 21).

Hospital psychiatric services

There were concerns that some insurers had a very broad interpretation of services that fall within the scope of Hospital psychiatric services. For example, hospital admissions where a procedure/s might be covered by an alternative clinical category were being coded to the Hospital psychiatric services category due to an underlying mental health diagnosis. The committee agreed these types of admissions were not intended to be covered by the *Hospital psychiatric services* category and would be best addressed in a robust disputes resolution framework than amending the scope of the category.

Palliative care

This category was not considered to be contentious and no amendments were recommended.

Support treatments list / Common treatments list

MBS items in the *Support treatments list* usually support the investigation or treatment of a medical condition described in a clinical category. Regulations requires items on the *Support treatments list* and *Common treatments list* be covered if they fall within the scope of cover of a category listed as an inclusion in a policy.

To reduce the burden of manually processing claims for individual support items, a 2018 'Frequently Asked Questions' web page on the reforms suggested insurers could cover all items on the *Support treatments list* for Bronze products and above. This advice was only intended as guidance and insurers were able to develop their own systems to manage claims for items on the list. A product may instead choose to cover only those items related to categories included in the policy. For example, if a policy does not cover *Pregnancy and birth-related services*, related support items do not need to be covered.

The *Common treatments li*st includes items that relate to multiple categories. It was noted the list should be reviewed whenever there are significant changes to the clinical categories, such as amendments to the scope of a category, to ensure items are not unnecessarily retained on the list when they could instead be listed in a category.

Utility of MBS items and Other Interventional Classification Systems

During the development of the clinical categories in 2017, the PHI Clinical Definitions Working Group recommended the clinical categories be accompanied by MBS items to ensure consistent coverage of services across insurers. MBS items were chosen as the preferred classification code as they were widely used by insurers which meant an easier adoption of the new definitions, and the items were familiar to consumers.

MBS items work well for surgical procedures but have been found to be insufficient for medical admissions which has caused claiming issues for private hospitals. The committee considered if additional classifications systems of disease and interventions such as those listed in Table 1 could compliment MBS items.

Table 1: Description of common interventional classification systems

Classification system	Abbreviation	Features
International Statistical Classification of Disease and Related Health Problems 10th revision modified to the Australian context	ICD-10-AM	Alphanumeric classification that contains codes for diseases and health conditions, including: • signs and symptoms

Classification system	Abbreviation	Features
		• abnormal findings • social factors • external causes of mortality, morbidity, and/or injury
Australian Classification of Health Interventions	ACHI	Numeric classification system that is structured by: • body system and site • intervention type, related to MBS Item number, dental, allied health intervention and cosmetic surgery
Australian Refined Diagnosis Related Groups	AR-DRG	Utilises a combination of ACHI codes, ICD-10-AM codes, patient demographics, and hospital resource information to classify admitted patient episodes

Many of the codes in Table 1are not known at the time of admission and are determined following discharge. From this perspective these additional codes would be of little benefit for consumers. From an industry perspective, the codes could offer a more simplified system of determining coverage. However, MBS items can have multiple links to different classification systems potentially resulting in codes being applicable to more than one clinical category. This is already a problem with the MBS items where an item may be within scope of multiple categories making eligibility checking processes complicated and resource intensive. Including additional classification systems in the Complying Product Rules could potentially further complicate this problem.

The committee agreed DRGs, ICD and ACHI codes do not relate well to the clinical categories and are not appropriate mechanisms to determine coverage of services in the private hospital sector. Where insurers undertake their own mapping, it is encouraged these are made available to service providers, but this information should not influence billing and claiming practices.

Recommendation 16

Additional classification systems such as ICD-10, ACHI and DRGs do not relate well to the clinical categories. These should not be added to Schedule 5 of the Complying Product Rules and should not be used for eligibility checking purposes.

Recommendation 17

Coverage of medical admissions should be determined with respect to the scope of cover requirements in subrule 11F(2) of the Complying Product Rules and following the principles in Recommendation 19 (ii). Coding systems such as ICD-10 and DRGs may be used to assist in benefit payment determinations if their mapping complies with the requirements in 11F(2).

Evaluation of the Regulatory Framework for the Clinical Categories

The regulatory framework for the clinical categories is primarily set out in Rules 11F, 11G and Schedules 5-7 of the Complying Product Rules as shown in Table 2. The regulations are not well understood by all stakeholders which has led to disputes over the interpretation over several aspects of the regulations. The committee noted the intent of the regulations could be better communicated. Stakeholders also have a responsibility to familiarise themselves with the regulatory requirements in the Rules.

Table 2. Clinical categories provisions in the Private Health Insurance (Complying Product) Rules 2015

Reference in the Rules	Description of provisions
Rule 11F	• Coverage requirements for a complying health insurance policy under 63-10 of the Private Health Insurance Act 2007
Rule 11G	• Provision for restricted cover
Schedule 5	Table of clinical categories
Schedule 6	Common Treatments list
Schedule 7	Support Treatments list

Rule 11F – Coverage requirements of a clinical category

Rule 11F sets out the coverage requirements for a hospital insurance policy with Subrule 11F(2) specifically defining the scope of cover of a clinical category. The scope is intended to be inclusive and not limited by the list of MBS items in Schedule 5. However, the practical implementation of the clinical categories has led to many insurers primarily using the MBS items to determine coverage. Interpretations of Subrule 11F(5) has also promoted a view that MBS items are of equivalent importance and the items can be used to determine coverage without regard to the scope of cover.

Of concern is where an MBS item is relevant to more than one category. Present limitations in insurer claiming software does not support MBS items being placed in more than one clinical category. Items have instead been listed in the category most likely to cover the service or to the category that is a minimum category for lowest applicable product tier. Where an MBS item is within scope but not specifically listed within a category, consumers, private hospitals and clinicians have raised concerns that incorrect eligibility advice is being provided.

The committee proposed clarifying Subrule 11F(5) to remove ambiguity over the supremacy of the scope of cover over the MBS items. The table of clinical categories in Schedule 5 could also be amended to indicate the MBS listed within a category are to be covered only when they are provided to treat conditions within the scope of the category.

The committee developed guiding principles to support the interpretation of the Rules and compiled case studies to demonstrate how the principles should be applied (Appendix 5).

The committee noted patients should be informed their policy might not cover the entire admission during Informed Financial Consent discussions, especially for admissions where the presenting diagnosis is unclear.

Recommendation 18

The Complying Product Rules should be amended to clarify that the scope of cover has primacy over the MBS items. Proposed changes could include:

- clarifying 11F(5)(a) to note hospital treatment involving the provision of an MBS item listed against a particular category in Schedule 5 is only covered if it is used to treat a condition described in column 2 of the table; and

- amending the header of column 3 of the table in Schedule 5 to 'The following MBS items are included in the scope of cover if provided as part of treatment described in column 2 of this clinical category'.

Recommendation 19

The following principles should be applied by stakeholders when determining coverage of a hospital admission:

i. Coverage of an admission goes to the superordinate description of the scope of cover. The MBS items are subordinate to the scope of cover.

ii. Cover should be determined by the diagnosis and intended therapeutic intervention, in good faith, at the point of admission.

iii. A single admission may be covered by multiple clinical categories and benefits are payable for all categories included in the policyholder's policy.

Recommendation 20

Health should publish case studies demonstrating how to interpret the regulations for complex admissions such as those in Appendix 5.

Rule 11G – Restricted Cover

Rule 11G sets out which clinical categories can be covered on a restricted basis under the product tier arrangements (Appendix 4). If a category is included in a policy, all services within a category must be covered. Rule 11G allows minimum benefits to be provided for services, as set out in the table in 72-1(2) of the *PHI Act*. That is:

- minimum benefits towards the cost of accommodation as set out in the Benefit Requirement Rules
- 25 percent of the MBS Schedule Fee
- minimum benefits for a prosthesis on the Prostheses List, where an MBS item is payable for the service.

Restricted categories may incur out of pocket costs for theatre fees, additional hospital fees, accommodation and medical costs.

For Gold products, no category can be restricted. For Silver and Bronze products (and related 'Plus' products), *Rehabilitation, Hospital psychiatric services* and *Palliative care* can be restricted. All categories in Basic and Basic Plus products can provide restricted benefits.

Rule 11G does not prevent some services within a restricted category from attracting unrestricted benefits, as described in the Explanatory Statement for the *Private Health Insurance (Reform Amendment) Rules 2018*[4]:

'For basic policies, Rule 11G does not prevent the policy from providing restricted cover for a selection of hospital treatments within a clinical category and unrestricted cover for other hospital treatments within the same clinical category. However, if a basic policy provides both restricted and unrestricted cover within a single clinical category, the product's private health information statement must indicate that the relevant clinical category is covered on a restricted basis.'

This provision also applies to Rehabilitation, Hospital psychiatric services and Palliative care in Silver and Bronze products.

The committee did not support differing benefit levels being applied to services within a category and recommend limiting which categories can offer restricted benefits. Across Gold, Silver, Bronze and Basic categories, only the Rehabilitation, Hospital psychiatric services and Palliative care categories should be allowed to offer restricted categories to reduce the out of pocket costs for Basic Plus policyholders.

Recommendation 21

Amend Rule 11G of the Comply Product Rules to limit only the Rehabilitation, Hospital psychiatric services and Palliative care categories be able to offer restricted benefits. All other categories in the Basic Plus products must be covered on a non-restricted basis.

Rule 11H – Naming conventions of 'plus' products

Rule 11H pertains to the naming conventions of hospital insurance products using the Gold, Silver, Bronze and Basic product tiers. The committee noted Subrule 11H(3) allows products to be branded as a 'Plus' product when it offers cover for categories above the minimum requirements for the Basic, Bronze or Silver tiers. This provision is optional and not all eligible products carry the 'Plus' branding.

Consumer surveys indicate policyholders may not realise their policy offers cover for services above the minimum requirements unless branded as a 'Plus' product. This may cause problems if the consumer switches insurers and the new insurer is also not aware of the coverage of additional categories. This could result in additional waiting periods being imposed that have already been served. In line with improving transparency of hospital insurance products and supporting consumers to make informed choices when comparing products, the committee agreed provisions in 11H(3) should be amended to require consistent naming of 'Plus' products.

[4] www.legislation.gov.au/Details/F2018L01414/Explanatory%20Statement/Text

Recommendation 22

Amend Subrule 11H(3) to require all relevant hospital insurance products carry the ‘Plus’ branding. That is, if the product offers cover for clinical categories above the minimum requirements for that product tier, it is advertised as a ‘Plus’ product.

Ongoing Management of the Clinical Categories

Amendments to the clinical categories largely stem from changes to the MBS or from stakeholder feedback. The process to update the clinical categories is outlined in Figure 6.

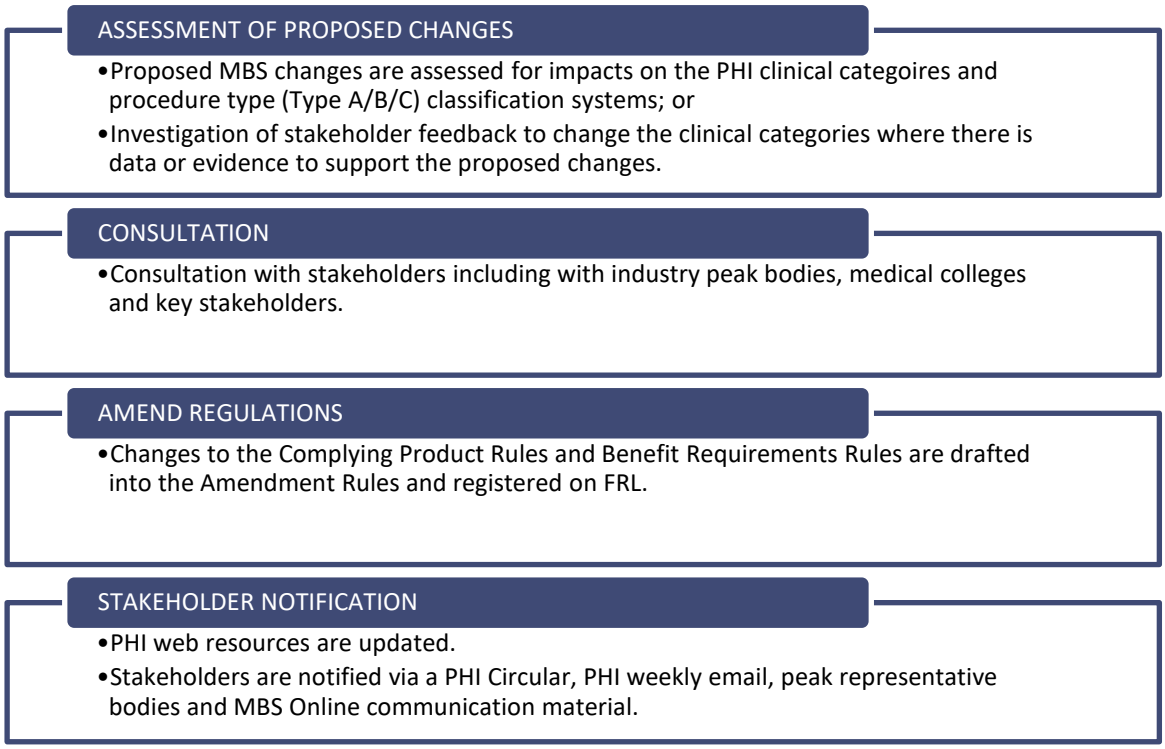

Figure 6. Overview of the clinical categories amendment process

Assessment of proposed changes

Proposed changes to the MBS, such as recommendations made by the MSAC or as part of the MBS Taskforce Reviews, are considered by Health in terms of impacts to the PHI regulations in the Complying Product Rules and the Benefit Requirement Rules.

Alternatively, feedback from stakeholders on potential issues with existing PHI classifications may initiate a review where there is sufficient supporting evidence.

Assessments of MBS changes consider (but not limited to):

- if the service has the potential to be delivered as 'Hospital Treatment' under the PHI Act, the Complying Product Rules and/or Benefit Requirement Rules for policies with hospital cover
- all relevant clinical indications for use, likely length of stay, theatre time and sedation requirements (for procedure type classifications)
- current classification of similar services, both for consistency and to determine if they may require updating
- policy intent as provided by MBS policy teams, MBS Review Taskforce or MSAC recommendations
- existing feedback and submissions from stakeholders
- MBS claiming data, Hospital Casemix Protocol data and/or PHIO data on coverage of categories in Plus products

- practical matters including administration by industry, potential for confusion during eligibility checks, ease of understanding for consumers, compliance.

Consultation process

Where possible, external consultations are undertaken on the proposed PHI changes through:

- direct communications with representative bodies and key stakeholders
- Weekly PHI email including the PHI Regulatory Amendments and Consultations Calendar
- MBS communication processes such as Implementation Liaison Groups (ILGs), the AMA co-design process[5], MBS webinars and factsheets available on MBS Online[6]

The committee noted early notification and consultation on potential changes to the clinical categories allows the industry to properly assess impacts and provide Health with considered advice supported by evidence. The industry would prefer three months notification prior to the implementation of changes but it is understood this is not always possible. Possible avenues to communicate changes earlier is to include PHI information in the MBS factsheets and MBS data file (.xml file)[7] released by MBS Online. Implementation dates should also consider the time required by stakeholders to update their systems, including updates to Services Australia's Electronic Claim Lodgement and Information Processing Service Environment (ECLIPSE).

Recommendation 23

The MBS data file released by MBS Online should include PHI classification information for a more streamlined process to communicate MBS and PHI changes. Health insurers and private hospitals should be consulted in the development of the new data file.

Regulatory changes and stakeholder notification

The finalised PHI classification changes are drafted into PHI Amendment Rules and registered on the Federal Register of Legislation[8] (FRL) to give legal effect prior to commencement. The amendments are later compiled into a new version of the Complying Product Rules and Benefits Requirements Rules. Notification of the registration of the Amendment Rules, and the release of updated PHI web resources are sent via a PHI Circular[9] and the weekly PHI email respectively.

Industry's National Procedure Banding Schedule

The National Procedure Banding Schedule is an industry led and managed classification process that assigns MBS items to one of 15 bands representing the relative total costs of service delivery in the private hospital system. The bands consider the costs not included in the MBS professional service fee such as theatre fees, hospital staffing costs, and consumables. The National Procedures Banding Committee (NPBC) and the banding schedule are separate from Government, the Benefit Requirements Rules and the procedure-type classifications for accommodation benefits.

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[5] www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/ama-and-australian-government-agree-to-strengthening-the-mbs-review-process-and-informed-financial-consent
[6] www.mbsonline.gov.au
[7] www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/downloads
[8] www.legislation.gov.au/
[9] www.health.gov.au/news/phi-circulars

Following the release of PHI classification information, the NPBC recommends procedure bands for MBS items which may then inform Hospital Purchaser Provider Agreements negotiated between hospitals and insurers. In the context of the MBS Review and PHI Reforms, the Clinical Categories Review Advisory Committee noted the utility of the current national banding process and the potential for it to be updated.

Additional PHI reforms announced in the 2021/22 Budget includes funding for an independent study to assess the effectiveness of the hospital default benefit arrangements under 'Supporting our Hospitals - Affordable and Sustainable Private Health Insurance Reform'[10]. The objective of the study is to optimise the regulatory settings for system efficiency and sustainability. With procedural costs contributing to the overall hospital funding of $11.2 billion (70 percent) of the $15.9 billion in private health insurance hospital treatment benefits paid for in 2020/21[11], the procedure banding process could also be considered as part of the review of default benefit arrangements for hospitals.

Disputes Resolution Pathway

As an extension to the considerations of how the clinical categories are managed, the committee considered the current pathways to resolve conflicts between stakeholders. At present, matters may be referred to different government agencies who have differing powers to investigate and recommend an outcome. For example, disagreements regarding eligibility for benefits under the clinical categories are commonly referred to the PHIO, which has the powers to investigate and mediate conflicts under Part IID of the *Ombudsman Act 1976*[12]; Health provides advice on the interpretation of the legislation; false and misleading behaviour can be raised with the Australian Competition and Consumer Commission (ACCC); and concerns regarding professional conduct or clinical governance may be referred to the Professional Service Review, Australian Health Practitioner Regulation Agency (AHPRA) or the Australian Commission on Safety and Quality in Health Care (ACSQHC).

The committee acknowledged the PHIO has the confidence of the industry, but its powers are limited to mediating complaints. The committee proposed that a disputes resolution framework should include an independent decision-making body with powers to collect evidence, make binding recommendations and publish precedents. The Australian Financial Complaints Authority[13] has similar powers and investigates insurance complaints but does not consider PHI issues as these are currently investigated by the PHIO.

A PHI complaints authority could also provide legislative amendment recommendations to Health. For serious or repeated offences, the authority could refer parties to other regulatory bodies such as the Australian Prudential Regulation Authority (APRA), AHPRA or ACSQHC. Where appropriate, the proposed dispute resolution framework should align with processes being developed to address Type C certification issues.

If a new body was to be established it would require considerable resourcing, which in part could be funded by the industry, similar to the PHIO. If an existing body were given additional responsibilities, it would require expanded legislative powers and appropriate resourcing. It was noted Health was not an appropriate complaints authority as it is the legislation interpretation body and the two processes should be separate.

[10] www.health.gov.au/resources/collections/supporting-our-hospitals
[11] Australian Prudential Regulation Authority, Quarterly Private Health Insurance Statistics June 2021
[12] https://www.legislation.gov.au/Series/C2004A01611
[13] https://www.afca.org.au/make-a-complaint/insurance

Recommendation 24

Complaints regarding the categories and interpretation of the legislation, which cannot be resolved using current mediation processes, should be referred to an independent body with the powers to:

- receive and arbitrate on disputes relating to PHI business
- develop a code of conduct for insurers and service providers
- publish precedents and clarifications on the legislation and regulations
- publish regular reports on disputes
- refer advice to Health where legislative amendments may be required to clarify the regulations
- refer repeat offenders to APRA, AHPRA , ACSQHC and equivalent bodies.

The disputes resolution framework and establishment of a complaints authority will require further consultation with the broader private health industry.

Appendix 1: Terms of reference

Private Health Insurance Clinical Categories Review Advisory Committee Terms of Reference

Background

The private health insurance clinical categories for hospital treatment were introduced as part of the package of reforms announced by the Government on 13 October 2017, to make private health insurance simpler for consumers. The clinical categories improve the transparency of services covered in a product and form the minimum requirements for the Gold, Silver, Bronze and Basic private health insurance hospital product tiers.

The clinical categories commenced 1 April 2019 and insurers had until 1 April 2020 to fully transition all their hospital products to the new arrangements. As part of the implementation process, a review of the clinical categories will be conducted by an independent committee.

Scope

The Private Health Insurance Clinical Categories Review Advisory Committee (the committee) will advise the department on the:

- effectiveness and clarity of the 'scope of cover' of the clinical categories, as set out in Column 2, Schedule 5 of the *Private Health Insurance (Complying Product) Rules 2015* (the Rules);
- effectiveness of the list of procedures for the clinical categories, as set out in Column 3 of Schedule 5, Schedules 6 and Schedule 7 of the Rules, and the effectiveness and practicality of introducing additional procedure and diagnostic codes;
- establishment of a framework to review, consult and communicate amendments to the clinical categories; and
- stakeholder feedback on implementation issues.

Consideration on the arrangement of the clinical categories within the private health insurance hospital product tiers will not be a focus of the Review.

Membership

The committee will bring together key stakeholders with expertise in private health insurance, clinical practice and health service management. Members will be appointed by the department for their relevant knowledge and experience.

Appendix 2: Committee membership

Name	Expertise
Dr David Rankin (Chair)	Health service management and private health insurance operations
Dean Breckenridge	Health service management
Rebecca Lush	Private health insurance operations
Will Mitchell	Private health insurance operations
A/Prof Julian Rati OAM	Clinical practice
Jo Root	Consumer representation
Cathy Ryan	Health service management
A/Prof Andrew Singer	Government policy and clinical practise
Dr Jui Tham	Private health insurance operations
A/Prof Philip Truskett AM	Health service management
Dora Vlamis	Private health insurance operations

Appendix 3: Clinical categories

Clinical categories as at 1 November 2021

Notes:

1. Sets out what must be covered by an insurance policy that covers hospital treatment for the relevant clinical category.
2. A policy must cover any hospital treatments that are in the scope of cover of a clinical category included in the policy. Without limiting the scope of cover, for each clinical category this includes hospital treatments involving:
    - any MBS item number listed in the third column below; and
    - any MBS item mentioned in the separate Common and Support treatments tables of MBS items (except for the clinical category "Podiatric surgery (provided by a registered podiatric surgeon"), for which there are no MBS items and the scope of cover states the minimum cover).
    - The description details for MBS items can be found at MBS Online
3. 3. Where an MBS item is mentioned for a clinical category in the third column in the table below, the treatment including that MBS item is most likely to be provided under that clinical category, or a clinical category in the same or a higher product tier. However, the mention of an MBS item against a particular category does not mean it is only ever covered under that clinical category. A doctor may also appropriately provide the MBS item as hospital treatment for another clinical category, which would be covered. Some clinical categories have no MBS items. If there are MBS items relevant to the clinical category they may be included in the Common or Support treatments lists. These lists are for MBS items likely to be relevant to multiple categories or that are likely to support the provision of a treatment under a clinical category (e.g., pathology or anaesthetics).

Clinical category	Scope of cover[1]	Treatments that must be covered (MBS Items)[1, 2, 3]
Rehabilitation	Hospital treatment for physical rehabilitation for a patient related to surgery or illness. For example: inpatient and admitted day patient rehabilitation, stroke recovery, cardiac rehabilitation.	(No items listed)
Hospital psychiatric services	Hospital treatment for the treatment and care of patients with psychiatric, mental, addiction or behavioural disorders. For example: psychoses such as schizophrenia, mood disorders such as	Treatments involving the provision of the following MBS item: 170, 171, 172, 289, 297, 320, 322, 324, 326, 328, 342, 344, 346, 348, 350, 352, 364, 366, 367, 369, 370, 855, 857, 858, 861, 864, 866, 2700, 2701, 2712, 2713, 2715, 2717, 2721, 2723, 2725, 2727, 6018, 6019, 6023, 6024, 6025, 6026, 6028, 6029, 6031, 6032, 6034, 6035, 6037, 6038, 6042, 14216, 14217, 14219, 14220, 14224, 80005, 80015, 80020, 80101, 80105, 80115, 80120, 80130, 80140, 80145, 80155, 80165,

Clinical category	Scope of cover[1]	Treatments that must be covered (MBS Items)[1, 2, 3]
	depression, eating disorders and addiction therapy.	80170, 90250, 90251, 90252, 90253, 90254, 90255, 90256, 90257, 90264, 90265, 90272, 90274, 90276, 90278, 91285, 91287, 91723, 91727, 93300, 93303, 93306, 93309
Palliative care	Hospital treatment for care where the intent is primarily providing quality of life for a patient with a terminal illness, including treatment to alleviate and manage pain.	Treatments involving the provision of the following MBS items: 3005, 3010, 3014, 3015, 3018, 3023, 3028, 3032, 3040, 3044, 3051, 3055, 3062, 3069, 3074, 3078, 3083, 3088, 3093
Assisted reproductive services	Hospital treatment for fertility treatments or procedures. For example: retrieval of eggs or sperm, In vitro Fertilisation (IVF), and Gamete Intra-fallopian Transfer (GIFT). Treatment of the female reproductive system is listed separately under Gynaecology. Pregnancy and birth-related services are listed separately under Pregnancy and birth.	Treatments involving the provision of the following MBS items: 13200, 13201, 13202, 13203, 13206, 13209, 13212, 13215, 13218, 13221, 13251, 13260, 13290, 13292, 14203, 14206, 37605, 37606
Back, neck and spine	Hospital treatment for the investigation and treatment of the back, neck and spinal column, including spinal fusion. For example: sciatica, prolapsed or herniated disc, spinal disc replacement and spine curvature disorders such as scoliosis, kyphosis and lordosis.	Treatments involving the provision of the following MBS items: 30672, 35401, 44133, 50600, 50604, 50608, 50612, 50616, 50620, 50624, 50628, 50632, 50636, 50640, 50644, 51020, 51021, 51022, 51023, 51024, 51025, 51026, 51031, 51032, 51033, 51034, 51035, 51036, 51041, 51042, 51043, 51044, 51045, 51051, 51052, 51053, 51054, 51055, 51056, 51057, 51058, 51059, 51061, 51062, 51063, 51064, 51065, 51066, 51071, 51072, 51073, 51102, 51103, 51110,

Clinical category	Scope of cover[1]	Treatments that must be covered (MBS Items)[1, 2, 3]
	Joint replacements are listed separately under Joint replacements. Joint fusions are listed separately under Bone, joint and muscle. Spinal cord conditions are listed separately under Brain and nervous system. Management of back pain is listed separately under Pain management. Pain management that requires a device is listed separately under Pain management with device. Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.	51111, 51112, 51113, 51114, 51115, 51120, 51130, 51131, 51140, 51141, 51145, 51150, 51160, 51165, 51170, 51171
Blood	Hospital treatment for the investigation and treatment of blood and blood-related conditions. For example: blood clotting disorders and bone marrow transplants. Treatment for cancers of the blood is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.	Treatments involving the provision of the following MBS item: 13700
Bone, joint and muscle	Hospital treatment for the investigation and treatment of diseases, disorders and injuries of the musculoskeletal system. For example: carpal tunnel, fractures, hand surgery, joint fusion, bone spurs, osteomyelitis and bone cancer. Chest surgery is listed separately under Lung and chest.	Treatments involving the provision of the following MBS items:, 18350, 18351, 18353, 18354, 18360, 18361, 18365, 30103, 30107, 30226, 30229, 30232, 30235, 30238, 30241, 30244, 32036, 39331, 39332, 39336, 39339, 39342, 39345, 43521, 43527, 43530, 43533, 43876, 43879, 44325, 44328, 44331, 44334, 44338, 44342, 44346, 44350, 44354, 44358, 44359, 44361, 44364, 44367, 44370, 44373, 44376, 45605, 45788, 45851, 45855, 45857, 45859, 45861, 45863, 45867, 45869, 45871, 45873, 45875, 45945, 45978, 45981, 45987, 45993, 45996, 46300, 46303, 46308, 46330, 46333, 46335, 46336, 46339, 46340, 46341, 46342, 46348, 46351, 46354, 46357, 46360, 46363,

Clinical category	Scope of cover[1]	Treatments that must be covered (MBS Items)[1, 2, 3]
	Spinal cord conditions are listed separately under Brain and nervous system. Spinal column conditions are listed separately under Back, neck and spine. Joint reconstructions are listed separately under Joint reconstructions. Joint replacements are listed separately under Joint replacements. Podiatric surgery performed by a registered podiatric surgeon is listed separately under Podiatric surgery (provided by a registered podiatric surgeon). Management of back pain is listed separately under Pain management. Pain management that requires a device is listed separately under Pain management with device. Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.	46365, 46367, 46370, 46372, 46375, 46378, 46379, 46380, 46381, 46384, 46387, 46390, 46393, 46394, 46395, 46399, 46401, 46464, 46465, 46468, 46471, 46474, 46477, 46480, 46483, 46493, 47000, 47003, 47007, 47009, 47012, 47015, 47018, 47021, 47024, 47027, 47030, 47033, 47042, 47045, 47047, 47049, 47052, 47053, 47054, 47057, 47060, 47063, 47066, 47069, 47301, 47304, 47307, 47310, 47313, 47316, 47319, 47348, 47351, 47354, 47357, 47361, 47362, 47364, 47367, 47370, 47373, 47381, 47384, 47385, 47386, 47387, 47390, 47393, 47396, 47399, 47402, 47405, 47408, 47411, 47414, 47417, 47420, 47423, 47426, 47429, 47432, 47435, 47438, 47441, 47444, 47447, 47450, 47451, 47453, 47456, 47459, 47462, 47465, 47466, 47467, 47468, 47471, 47474, 47477, 47480, 47483, 47486, 47489, 47491, 47495, 47498, 47501, 47511, 47514, 47516, 47519, 47528, 47531, 47534, 47537, 47540, 47543, 47546, 47549, 47552, 47555, 47558, 47559, 47561, 47565, 47566, 47568, 47570, 47573, 47579, 47582, 47585, 47588, 47591, 47595, 47597, 47600, 47603, 47612, 47615, 47618, 47621, 47624, 47630, 47637, 47639, 47648, 47657, 47663, 47666, 47672, 47678, 47753, 47756, 47762, 47765, 47768, 47771, 47774, 47777, 47780, 47783, 47786, 47789, 47900, 47903, 47921, 47924, 47927, 47929, 47953, 47954, 47955, 47956, 47960, 47964, 47967, 47975, 47978, 47981, 47982, 47983, 47984, 48245, 48248, 48251, 48254, 48257, 48400, 48403, 48406, 48409, 48412, 48415, 48419, 48420, 48421, 48422, 48423, 48424, 48426, 48427, 48430, 48433, 48435, 48507, 48509, 48512, 48942, 48945, 48954, 48972, 48980, 48983, 48986, 49100, 49106, 49109, 49118, 49124, 49200, 49203, 49206, 49212, 49213, 49218, 49219, 49220, 49239, 49300, 49303, 49306, 49309, 49360, 49363, 49366, 49500, 49509, 49512, 49569, 49590, 49712, 49718, 49724, 49727, 49728, 49730, 49732, 49734, 49736, 49738, 49740, 49742, 49744, 49760, 49761, 49762, 49763, 49764, 49765, 49766, 49767, 49768, 49769, 49770, 49771, 49772, 49773, 49774, 49775, 49776, 49777, 49778, 49779, 49780, 49781, 49783, 49784, 49785, 49786, 49787, 49788, 49789, 49790, 49791, 49792, 49793, 49794, 49795, 49796, 49797, 49798, 49800, 49803, 49806, 49809, 49812, 49814, 49815, 49818, 49821, 49824, 49827, 49830, 49833, 49836, 49837, 49838, 49845,

Clinical category	Scope of cover[1]	Treatments that must be covered (MBS Items)[1, 2, 3]
		49851, 49854, 49860, 49866, 49878, 49881, 49884, 49887, 49890, 50107, 50112, 50115, 50118, 50130, 50200, 50201, 50203, 50206, 50209, 50212, 50215, 50218, 50221, 50224, 50233, 50236, 50239, 50242, 50245, 50300, 50303, 50306, 50309, 50310, 50312, 50321, 50324, 50330, 50335, 50336, 50339, 50345, 50348, 50351, 50352, 50354, 50357, 50360, 50369, 50372, 50375, 50378, 50381, 50384, 50390, 50393, 50394, 50395, 50396, 50399, 50426, 50428, 50450, 50451, 50455, 50456, 50460, 50461, 50465, 50466, 50470, 50471, 50475, 50476, 50508, 50512, 50524, 50528, 50532, 50536, 50540, 50544, 50548, 50552, 50556, 50560, 50564, 50568, 50572, 50576, 50580, 50584, 50588, 50592, 50596, 50654, 52056, 52057, 52058, 52059, 52060, 52061, 52062, 52063, 52064, 52066, 52069, 52072, 52073, 52075, 52078, 52081, 52084, 52087, 52090, 52092, 52094, 52095, 52096, 52097, 52098, 52099, 52102, 52105, 52114, 52126, 52129, 52130, 52131, 52180, 52182, 52184, 52186, 53200, 53203, 53206, 53209, 53212, 53215, 53218, 53220, 53221, 53224, 53225, 53226, 53227, 53230, 53233, 53236, 53239, 53400, 53403, 53406, 53409, 53410, 53411, 53412, 53413, 53414, 53415, 53416, 53418, 53419, 53422, 53423, 53424, 53425, 53427, 53429, 53439,
Brain and nervous system	Hospital treatment for the investigation and treatment of the brain, brain-related conditions, spinal cord and peripheral nervous system. For example: stroke, brain or spinal cord tumours, head injuries, epilepsy and Parkinson's disease. Treatment of spinal column (back bone) conditions is listed separately under Back, neck and spine. Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.	Treatments involving the provision of the following MBS items: 6007, 6009, 6011, 6013, 6015, 14227, 14234, 14237, 18377, 35000, 35003, 35006, 35009, 35012, 35412, 35414, 39007, 39013, 39015, 39018, 39113, 39300, 39303, 39306, 39307, 39309, 39312, 39315, 39318, 39319, 39321, 39324, 39327, 39328, 39329, 39330, 39333, 39503, 39604, 39610, 39612, 39615, 39638, 39639, 39641, 39651, 39654, 39656, 39700, 39703, 39710, 39712, 39715, 39718, 39720, 39801, 39803, 39815, 39818, 39821, 39900, 39903, 39906, 40004, 40012, 40018, 40104, 40106, 40109, 40112, 40119, 40600, 40700, 40701, 40702, 40703, 40704, 40705, 40706, 40707, 40708, 40709, 40712, 40801, 40803, 40850, 40851, 40852, 40854, 40856, 40858, 40860, 40862, 40905, 43987, 46364, 51011, 51012, 51013, 51014, 51015, 52800, 52803, 52806, 52809, 52812, 52815, 52818, 52821, 52824, 52826, 52828, 52830, 52832

Clinical category	Scope of cover[1]	Treatments that must be covered (MBS Items)[1, 2, 3]
Breast surgery (medically necessary)	Hospital treatment for the investigation and treatment of breast disorders and associated lymph nodes, and reconstruction and/or reduction following breast surgery or a preventative mastectomy. For example: breast lesions, breast tumours, asymmetry due to breast cancer surgery, and gynecomastia. This clinical category does not require benefits to be paid for cosmetic breast surgery that is not medically necessary.	Treatments involving the provision of the following MBS items: 30299, 30300, 30302, 30303, 31500, 31503, 31506, 31509, 31512, 31515, 31516, 31519, 31524, 31525, 31530, 31533, 31536, 31548, 31551, 31554, 31557, 31560, 31563, 31566, 45060, 45061, 45062, 45520, 45522, 45523, 45524, 45527, 45528, 45530, 45533, 45534, 45535, 45536, 45539, 45542, 45545, 45546, 45548, 45551, 45553, 45554, 45556, 45558
Cataracts	Hospital treatment for surgery to remove a cataract and replace with an artificial lens.	Treatments involving the provision of the following MBS items: 42698, 42701, 42702, 42703, 42704, 42705, 42707, 42710, 42713, 42716
Chemotherapy, radiotherapy and immunotherapy for cancer	Hospital treatment for chemotherapy, radiotherapy and immunotherapy for the treatment of cancer or benign tumours. Surgical treatment of cancer is listed separately under each body system.	Treatments involving the provision of the following MBS items: 13760, 13950, 14221, 14245, 14247, 14249, 15000, 15003, 15006, 15009, 15012, 15100, 15103, 15106, 15109, 15112, 15115, 15211, 15214, 15215, 15218, 15221, 15224, 15227, 15230, 15233, 15236, 15239, 15242, 15245, 15248, 15251, 15254, 15257, 15260, 15263, 15266, 15269, 15272, 15275, 15303, 15304, 15307, 15308, 15311, 15312, 15315, 15316, 15319, 15320, 15323, 15324, 15327, 15328, 15331, 15332, 15335, 15336, 15338, 15339, 15342, 15345, 15348, 15351, 15354, 15357, 15500, 15503, 15506, 15509, 15512, 15513, 15515, 15518, 15521, 15524, 15527, 15530, 15533, 15536, 15539, 15550, 15553, 15555, 15556, 15559, 15562, 15565, 15600, 15700, 15705, 15710, 15715, 15800, 15850, 15900, 16003, 16006, 16009, 16012, 16015, 16018, 30400, 34521, 34524, 34527, 34528, 34529, 34530, 34533, 34534, 34539, 34540, 35404, 35406, 35408, 50950, 50952

Clinical category	Scope of cover[1]	Treatments that must be covered (MBS Items)[1, 2, 3]
Dental surgery	Hospital treatment for surgery to the teeth and gums. For example: surgery to remove wisdom teeth, and dental implant surgery.	Treatments involving the provision of the following MBS items: 75006, 75030, 75033, 75034, 75036, 75037, 75039, 75042, 75045, 75048, 75049, 75050, 75051, 75156, 75200, 75203, 75206, 75400, 75403, 75406, 75409, 75412, 75415, 75600, 75603, 75606, 75609, 75612, 75615, 75618, 75621, 75800, 75803, 75806, 75809, 75812, 75815, 75818, 75821, 75824, 75827, 75830, 75833, 75836, 75839, 75842, 75845, 75848, 75851, 75854
Diabetes management (excluding insulin pumps)	Hospital treatment for the investigation and management of diabetes. For example: stabilisation of hypo- or hyper- glycaemia, contour problems due to insulin injections. Treatment for diabetes-related conditions is listed separately under each body system affected. For example, treatment for diabetes-related eye conditions are listed separately under Eye. Treatment for ulcers is listed separately under Skin. Provision and replacement of insulin pumps is listed separately under Insulin pumps.	Treatments involving the provision of the following MBS items: 31346
Dialysis for chronic kidney failure	Hospital treatment for dialysis treatment for chronic kidney failure. For example: peritoneal dialysis and haemodialysis.	Treatments involving the provision of the following MBS items: 13100, 13103, 13104, 13106, 13109, 13110

Clinical category	Scope of cover[1]	Treatments that must be covered (MBS Items)[1, 2, 3]
Digestive system	Hospital treatment for the investigation and treatment of the digestive system, including the oesophagus, stomach, gall bladder, pancreas, spleen, liver and bowel. For example: oesophageal cancer, irritable bowel syndrome, gall stones and haemorrhoids. Endoscopy is listed separately under Gastrointestinal endoscopy. Hernia and appendicectomy procedures are listed separately under Hernia and appendix. Bariatric surgery is listed separately under Weight loss surgery. Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.	Treatments involving the provision of the following MBS items: 11800, 11801, 11810, 13506, 14212, 30382, 30384, 30385, 30387, 30388, 30390, 30392, 30396, 30397, 30399, 30406, 30408, 30409, 30411, 30412, 30414, 30415, 30416, 30417, 30418, 30419, 30421, 30422, 30425, 30427, 30428, 30430, 30431, 30433, 30439, 30440, 30441, 30442, 30443, 30445, 30448, 30449, 30450, 30451, 30452, 30454, 30455, 30457, 30458, 30460, 30461, 30463, 30464, 30469, 30472, 30481, 30482, 30483, 30492, 30495, 30515, 30517, 30518, 30520, 30521, 30526, 30529, 30530, 30532, 30533, 30559, 30560, 30562, 30563, 30565, 30577, 30583, 30584, 30589, 30590, 30593, 30594, 30596, 30599, 30600, 30601, 30606, 30608, 30619, 30621, 30622, 30623, 30626, 30627, 30636, 30637, 30639, 30655, 30657, 30721, 30722, 30723, 30724, 30725, 30730, 30750, 30751, 30752, 30753, 30754, 30755, 30756, 30760, 30761, 30762, 30763, 30770, 30771, 30780, 30790, 30791, 30792, 30800, 30810, 31454, 31456, 31458, 31460, 31462, 31466, 31468, 31472, 32000, 32003, 32004, 32005, 32006, 32009, 32012, 32015, 32018, 32021, 32024, 32025, 32026, 32028, 32029, 32030, 32033, 32039, 32042, 32045, 32046, 32047, 32051, 32054, 32057, 32060, 32063, 32066, 32069, 32096, 32099, 32102, 32103, 32104, 32105, 32106, 32108, 32111, 32112, 32114, 32115, 32117, 32120, 32123, 32126, 32129, 32131, 32132, 32135, 32138, 32139, 32142, 32145, 32147, 32150, 32153, 32156, 32159, 32162, 32165, 32166, 32168, 32171, 32174, 32175, 32177, 32180, 32183, 32186, 32200, 32203, 32206, 32209, 32210, 32212, 32213, 32214, 32215, 32216, 32217, 32218, 32220, 32221, 41816, 41822, 41825, 41828, 41831, 41832, 43801, 43804, 43807, 43810, 43813, 43816, 43819, 43822, 43825, 43828, 43831, 43834, 43840, 43843, 43846, 43849, 43852, 43855, 43858, 43864, 43867, 43870, 43873, 43900, 43903, 43906, 43930, 43933, 43936, 43942, 43945, 43948, 43951, 43954, 43957, 43960, 43963, 43966, 43969, 43972, 43975, 43978, 43990, 43993, 43996, 43999, 44101, 44102, 44104, 44105

Clinical category	Scope of cover[1]	Treatments that must be covered (MBS Items)[1, 2, 3]
Ear, nose and throat	Hospital treatment for the investigation and treatment of the ear, nose, throat, middle ear, thyroid, parathyroid, larynx, lymph nodes and related areas of the head and neck. For example: damaged ear drum, sinus surgery, removal of foreign bodies, stapedectomy and throat cancer. Tonsils, adenoids and grommets are listed separately under Tonsils, adenoids and grommets. The implantation of a hearing device is listed separately under Implantation of hearing devices. Orthopaedic neck conditions are listed separately under Back, neck and spine. Sleep studies are listed separately under Sleep studies. Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.	Treatments involving the provision of the following MBS items: 11300, 18368, 30104, 30105, 30246, 30247, 30250, 30251, 30253, 30255, 30256, 30259, 30262, 30266, 30269, 30272, 30275, 30278, 30281, 30283, 30286, 30287, 30289, 30293, 30294, 30296, 30297, 30306, 30310, 30314, 30315, 30317, 30318, 30320, 30326, 30618, 30820, 31400, 31403, 31406, 31409, 31412, 31423, 31426, 31429, 31432, 31435, 31438, 38419, 38420, 38422, 38423, 38425, 38426, 38428, 41500, 41501, 41503, 41506, 41509, 41512, 41515, 41518, 41521, 41524, 41527, 41530, 41533, 41536, 41539, 41542, 41545, 41548, 41551, 41554, 41557, 41560, 41563, 41564, 41566, 41569, 41572, 41575, 41576, 41578, 41579, 41581, 41584, 41587, 41590, 41593, 41596, 41599, 41608, 41611, 41614, 41615, 41620, 41623, 41626, 41629, 41635, 41638, 41641, 41644, 41647, 41650, 41653, 41656, 41659, 41662, 41668, 41671, 41672, 41674, 41677, 41683, 41686, 41689, 41692, 41698, 41701, 41704, 41707, 41710, 41713, 41716, 41719, 41722, 41725, 41728, 41729, 41731, 41734, 41737, 41740, 41743, 41746, 41749, 41752, 41755, 41764, 41767, 41770, 41773, 41776, 41779, 41782, 41785, 41786, 41787, 41804, 41807, 41810, 41813, 41834, 41837, 41840, 41843, 41855, 41858, 41861, 41864, 41867, 41868, 41870, 41873, 41876, 41879, 41880, 41881, 41884, 41885, 41886, 41907, 41910, 43832, 45645, 45646, 47735, 47738, 47741, 51900, 51902, 52021, 52024, 52025, 52027, 52030, 52033, 52034, 52035, 52055, 52132, 52133, 52135, 52138, 52141, 52147, 52148, 52158, 53000, 53003, 53004, 53006, 53009, 53012, 53015, 53016, 53017, 53019, 53052, 53054, 53056, 53058, 53060, 53062, 53064, 53068, 53070, 53458, 53459, 53460
Eye (not cataracts)	Hospital treatment for the investigation and treatment of the eye and the contents of the eye socket. For example: retinal detachment, tear duct conditions, eye infections and medically managed trauma to the eye.	Treatments involving the provision of the following MBS items: 18366, 18369, 18370, 18372, 18374, 42503, 42504, 42505, 42506, 42509, 42510, 42512, 42515, 42518, 42521, 42524, 42527, 42530, 42533, 42536, 42539, 42542, 42543, 42545, 42548, 42551, 42554, 42557, 42563, 42569, 42572, 42573, 42574, 42575, 42576, 42581, 42584, 42587, 42588, 42590, 42593, 42596, 42599, 42602, 42605, 42608, 42610, 42611, 42614, 42615, 42617, 42620, 42622, 42623,

Clinical category	Scope of cover[1]	Treatments that must be covered (MBS Items)[1, 2, 3]
	Cataract procedures are listed separately under Cataracts. Eyelid procedures are listed separately under Plastic and reconstructive surgery. Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.	42626, 42629, 42632, 42635, 42638, 42641, 42644, 42647, 42650, 42651, 42652, 42653, 42656, 42662, 42665, 42667, 42668, 42672, 42673, 42676, 42677, 42680, 42683, 42686, 42689, 42692, 42695, 42719, 42725, 42731, 42734, 42738, 42739, 42740, 42741, 42743, 42744, 42746, 42749, 42752, 42755, 42758, 42761, 42764, 42767, 42770, 42773, 42776, 42779, 42782, 42785, 42788, 42791, 42794, 42801, 42802, 42805, 42806, 42807, 42808, 42809, 42810, 42811, 42812, 42815, 42818, 42821, 42824, 42833, 42836, 42839, 42842, 42845, 42848, 42851, 42854, 42857, 42869, 43021, 43022, 43023
Gastrointestinal endoscopy	Hospital treatment for the diagnosis, investigation and treatment of the internal parts of the gastrointestinal system using an endoscope. For example: colonoscopy, gastroscopy, endoscopic retrograde cholangiopancreatography (ERCP). Non-endoscopic procedures for the digestive system are listed separately under Digestive system.	Treatments involving the provision of the following MBS items: 11820, 11823, 30473, 30475, 30478, 30479, 30484, 30485, 30488, 30490, 30491, 30494, 30680, 30682, 30684, 30686, 30687, 30688, 30690, 30692, 30694, 30731, 32023, 32072, 32075, 32084, 32087, 32094, 32095, 32222, 32223, 32224, 32225, 32226, 32227, 32228, 32229, 32230
Gynaecology	Hospital treatment for the investigation and treatment of the female reproductive system. For example: endometriosis, polycystic ovaries, female sterilisation and cervical cancer. Fertility treatments are listed separately under Assisted reproductive services. Pregnancy and birth-related conditions are listed separately under Pregnancy and birth.	Treatments involving the provision of the following MBS items: 30062, 35410, 35500, 35502, 35503, 35506, 35507, 35508, 35509, 35513, 35517, 35518, 35520, 35523, 35527, 35530, 35533, 35534, 35536, 35539, 35542, 35545, 35548, 35554, 35557, 35560, 35561, 35562, 35564, 35565, 35566, 35568, 35569, 35570, 35571, 35572, 35573, 35577, 35578, 35581, 35582, 35585, 35595, 35596, 35597, 35599, 35602, 35605, 35608, 35611, 35612, 35613, 35614, 35615, 35616, 35618, 35620, 35622, 35623, 35626, 35627, 35630, 35633, 35634, 35635, 35636, 35637, 35638, 35641, 35644, 35645, 35646, 35647, 35648, 35649, 35653, 35657, 35658, 35661, 35664, 35667, 35670, 35673, 35680, 35684, 35688, 35691, 35694, 35697, 35700,

Clinical category	Scope of cover[1]	Treatments that must be covered (MBS Items)[1, 2, 3]
	Miscarriage or termination of pregnancy is listed separately under Miscarriage and termination of pregnancy. Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.	35703, 35706, 35709, 35710, 35713, 35717, 35720, 35723, 35726, 35729, 35730, 35750, 35753, 35754, 35756, 35759
Heart and vascular system	Hospital treatment for the investigation and treatment of the heart, heart-related conditions and vascular system. For example: heart failure and heart attack, monitoring of heart conditions, varicose veins and removal of plaque from arterial walls. Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.	Treatments involving the provision of the following MBS items: 6080, 6081, 6082, 6084, 90300, 11607, 13400, 32500, 32504, 32507, 32508, 32511, 32514, 32517, 32520, 32522, 32523, 32526, 32528, 32529, 32700, 32703, 32708, 32710, 32711, 32712, 32715, 32718, 32721, 32724, 32730, 32733, 32736, 32739, 32742, 32745, 32748, 32751, 32754, 32757, 32760, 32763, 32766, 32769, 33050, 33055, 33070, 33075, 33080, 33100, 33103, 33109, 33112, 33115, 33116, 33118, 33119, 33121, 33124, 33127, 33130, 33133, 33136, 33139, 33142, 33145, 33148, 33151, 33154, 33157, 33160, 33163, 33166, 33169, 33172, 33175, 33178, 33181, 33500, 33506, 33509, 33512, 33515, 33518, 33521, 33524, 33527, 33530, 33533, 33536, 33539, 33542, 33545, 33548, 33551, 33554, 33800, 33803, 33806, 33810, 33811, 33812, 33815, 33818, 33821, 33824, 33827, 33830, 33833, 33836, 33839, 33842, 33845, 33848, 34100, 34103, 34106, 34109, 34112, 34115, 34118, 34121, 34124, 34127, 34130, 34142, 34145, 34148, 34151, 34154, 34157, 34160, 34163, 34166, 34169, 34172, 34175, 34500, 34503, 34506, 34509, 34512, 34515, 34518, 34800, 34803, 34806, 34809, 34812, 34815, 34818, 34821, 34824, 34827, 34830, 34833, 35100, 35103, 35200, 35202, 35300, 35303, 35306, 35307, 35309, 35312, 35315, 35317, 35319, 35320, 35321, 35324, 35327, 35330, 35331, 35360, 35361, 35362, 35363, 38200, 38203, 38206, 38209, 38212, 38213, 38241, 38244, 38247, 38248, 38249, 38251, 38252, 38254, 38256, 38270, 38272, 38273, 38274, 38275, 38276, 38285, 38286, 38287, 38288, 38290, 38293, 38307, 38308, 38309, 38310, 38311, 38313, 38314, 38316, 38317, 38319, 38320, 38322, 38323, 38350, 38353, 38356, 38358, 38359, 38362, 38365, 38368, 38447, 38449, 38450, 38452, 38461, 38463, 38467, 38471,

Clinical category	Scope of cover[1]	Treatments that must be covered (MBS Items)[1, 2, 3]
		38472, 38474, 38477, 38484, 38485, 38487, 38490, 38493, 38495, 38499, 38502, 38508, 38509, 38510, 38511, 38512, 38513, 38515, 38516, 38517, 38518, 38519, 38550, 38553, 38554, 38555, 38556, 38557, 38558, 38568, 38571, 38572, 38600, 38603, 38609, 38612, 38615, 38618, 38621, 38624, 38627, 38637, 38653, 38670, 38673, 38677, 38680, 38700, 38703, 38706, 38709, 38715, 38718, 38721, 38724, 38727, 38730, 38733, 38736, 38739, 38742, 38745, 38748, 38751, 38754, 38757, 38760, 38764, 38766
Hernia and appendix	Hospital treatment for the investigation and treatment of a hernia or appendicitis. Digestive conditions are listed separately under Digestive system.	Treatments involving the provision of the following MBS items: 30574, 30615, 30640, 30645, 30646, 30648, 30720, 43805, 43835, 43837, 43838, 43841, 43939, 44108, 44111, 44114
Implantation of hearing devices	Hospital treatment to correct hearing loss, including implantation of a prosthetic hearing device. Stapedectomy is listed separately under Ear, nose and throat.	Treatments involving the provision of the following MBS items: 41603, 41604, 41617, 41618
Insulin pumps	Hospital treatment for the provision and replacement of insulin pumps for treatment of diabetes.	(No items listed)
Joint reconstructions	Hospital treatment for surgery for joint reconstructions. For example: torn tendons, rotator cuff tears and damaged ligaments. Joint replacements are listed separately under Joint replacements.	Treatments involving the provision of the following MBS items: 46324, 46325, 46345, 46408, 46411, 46414, 46417, 46420, 46423, 46426, 46432, 46434, 46438, 46441, 46442, 46444, 46450, 46453, 46456, 46492, 46495, 46498, 46500, 46501, 46502, 46503, 46504, 46507, 46510, 46522, 47592, 47593, 48900, 48903, 48906, 48909, 48939, 48948, 48951, 48958, 48960, 49104, 49105, 49121, 49215, 49221, 49224, 49227, 49230, 49233, 49236, 49503, 49506, 49536, 49542, 49544, 49548, 49551, 49564, 49565, 49570, 49572, 49574,

Clinical category	Scope of cover[1]	Treatments that must be covered (MBS Items)[1, 2, 3]
	Bone fractures are listed separately under Bone, joint and muscle. Procedures to the spinal column are listed separately under Back, neck and spine. Podiatric surgery performed by a registered podiatric surgeon is listed separately under Podiatric surgery (provided by a registered podiatric surgeon).	49576, 49578, 49580, 49582, 49584, 49586, 49703, 49706, 49709, 50333
Joint replacements	Hospital treatment for surgery for joint replacements, including revisions, resurfacing, partial replacements and removal of prostheses. For example: replacement of shoulder, wrist, finger, hip, knee, ankle, or toe joint. Joint fusions are listed separately under Bone, joint and muscle. Spinal fusions are listed separately under Back, neck and spine. Joint reconstructions are listed separately under Joint reconstructions. Podiatric surgery performed by a registered podiatric surgeon is listed separately under Podiatric surgery (provided by a registered podiatric surgeon).	Treatments involving the provision of the following MBS items: 46309, 46312, 46315, 46318, 46321, 46322, 48915, 48918, 48921, 48924, 48927, 49112, 49115, 49116, 49117, 49209, 49210, 49315, 49318, 49319, 49321, 49372, 49374, 49376, 49378, 49380, 49382, 49384, 49386, 49388, 49390, 49392, 49394, 49396, 49398, 49515, 49516, 49517, 49518, 49519, 49521, 49524, 49525, 49527, 49530, 49533, 49534, 49554, 49715, 49716, 49717, 49782, 49839, 49857
Kidney and bladder	Hospital treatment for the investigation and treatment of the kidney, adrenal gland and bladder.	Treatments involving the provision of the following MBS items: 11900, 11903, 11906, 11909, 11912, 11915, 11917, 11919, 11921, 12524, 12527, 18375, 18379, 30324, 36503, 36504, 36505, 36506, 36507, 36508, 36509, 36516, 36519, 36522, 36525, 36528, 36529,

Clinical category	Scope of cover[1]	Treatments that must be covered (MBS Items)[1, 2, 3]
	For example: kidney stones, adrenal gland tumour and incontinence. Dialysis is listed separately under Dialysis for chronic kidney failure. Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.	36531, 36532, 36533, 36537, 36543, 36546, 36549, 36552, 36558, 36561, 36564, 36567, 36570, 36573, 36576, 36579, 36585, 36588, 36591, 36594, 36597, 36600, 36603, 36604, 36606, 36607, 36608, 36609, 36610, 36611, 36612, 36615, 36618, 36621, 36624, 36627, 36633, 36636, 36639, 36645, 36649, 36650, 36652, 36654, 36656, 36663, 36664, 36665, 36666, 36667, 36668, 36671, 36672, 36673, 36800, 36803, 36806, 36809, 36811, 36812, 36815, 36818, 36821, 36822, 36823, 36824, 36827, 36830, 36833, 36836, 36840, 36842, 36845, 36848, 36851, 36854, 36860, 36863, 37000, 37004, 37008, 37011, 37014, 37015, 37016, 37018, 37019, 37020, 37021, 37023, 37026, 37029, 37038, 37039, 37040, 37041, 37042, 37043, 37044, 37045, 37046, 37047, 37048, 37050, 37053, 37300, 37303, 37306, 37309, 37318, 37321, 37324, 37327, 37330, 37333, 37336, 37338, 37339, 37340, 37341, 37342, 37343, 37344, 37345, 37348, 37351, 37354, 37369, 37372, 37375, 37381, 37384, 37387, 37388, 37390, 37800, 37801, 37842, 37845, 37848, 37851, 37854, 43981, 43984
Lung and chest	Hospital treatment for the investigation and treatment of the lungs, lung-related conditions, mediastinum and chest. For example: lung cancer, respiratory disorders such as asthma, pneumonia, and treatment of trauma to the chest. Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.	Treatments involving the provision of the following MBS items: 30090, 34133, 34136, 34139, 38415, 38416, 38417, 38418, 38421, 38424, 38427, 38430, 38436, 38438, 38440, 38441, 38446, 38448, 38453, 38455, 38460, 38462, 38464, 38466, 38468, 38469, 38643, 38656, 38800, 38803, 38806, 38809, 38812, 43861, 43909, 43912

Clinical category	Scope of cover[1]	Treatments that must be covered (MBS Items)[1, 2, 3]
Male reproductive system	Hospital treatment for the investigation and treatment of the male reproductive system including the prostate. For example: male sterilisation, circumcision and prostate cancer. Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.	Treatments involving the provision of the following MBS items: 30628, 30629, 30630, 30631, 30635, 30641, 30642, 30643, 30644, 30649, 30654, 30658, 30663, 30666, 37200, 37201, 37202, 37203, 37206, 37207, 37208, 37209, 37210, 37211, 37213, 37214, 37215, 37216, 37217, 37218, 37219, 37220, 37221, 37223, 37224, 37226, 37227, 37230, 37233, 37245, 37393, 37396, 37402, 37405, 37408, 37411, 37415, 37417, 37418, 37423, 37426, 37429, 37432, 37435, 37438, 37601, 37604, 37607, 37610, 37613, 37616, 37619, 37623, 37803, 37804, 37806, 37807, 37809, 37810, 37812, 37813, 37815, 37816, 37818, 37819, 37821, 37822, 37824, 37825, 37827, 37828, 37830, 37831, 37833, 37834, 37836, 37839
Miscarriage and termination of pregnancy	Hospital treatment for the investigation and treatment of a miscarriage or for termination of pregnancy.	Treatments involving the provision of the following MBS items: 16530, 16531, 35640, 35643, 35674, 35677, 35678
Pain management	Hospital treatment for pain management that does not require the insertion or surgical management of a device. For example: treatment of nerve pain and chest pain due to cancer by injection of a nerve block. Pain management using a device (for example an infusion pump or neurostimulator) is listed separately under Pain management with device.	Treatments involving the provision of the following MBS items: 39100, 39109, 39115, 39118, 39121, 39124, 39140, 39323, 45939

Clinical category	Scope of cover[1]	Treatments that must be covered (MBS Items)[1, 2, 3]
Pain management with device	Hospital treatment for the implantation, replacement or other surgical management of a device required for the treatment of pain. For example: treatment of nerve pain, back pain, and pain caused by coronary heart disease with a device (for example an infusion pump or neurostimulator). Treatment of pain that does not require a device is listed separately under Pain management.	Treatments involving the provision of the following MBS items: 14218, 39125, 39126, 39127, 39128, 39130, 39131, 39133, 39134, 39135, 39136, 39137, 39138, 39139
Plastic and reconstructive surgery (medically necessary) Plastic and reconstructive surgery (medically necessary) (cont.)	Hospital treatment which is medically necessary for the investigation and treatment of any physical deformity, whether acquired as a result of illness or accident, or congenital. For example: burns requiring a graft, cleft palate, club foot and angioma. Plastic surgery that is medically necessary relating to the treatment of a skin-related condition is listed separately under Skin. Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.	Treatments involving the provision of the following MBS items: 30003, 30006, 30010, 30014, 30017, 30020, 30176, 38457, 38458, 42860, 42863, 42866, 42872, 43882, 45000, 45003, 45006, 45009, 45012, 45015, 45018, 45019, 45021, 45024, 45025, 45026, 45027, 45030, 45033, 45035, 45036, 45039, 45042, 45045, 45048, 45051, 45054, 45200, 45201, 45202, 45203, 45206, 45207, 45209, 45212, 45215, 45218, 45221, 45224, 45227, 45230, 45233, 45236, 45239, 45240, 45400, 45403, 45406, 45409, 45412, 45415, 45418, 45439, 45442, 45445, 45448, 45451, 45460, 45461, 45462, 45464, 45465, 45466, 45468, 45469, 45471, 45472, 45474, 45475, 45477, 45478, 45480, 45481, 45483, 45484, 45485, 45486, 45487, 45488, 45489, 45490, 45491, 45492, 45493, 45494, 45496, 45497, 45498, 45499, 45500, 45501, 45502, 45503, 45504, 45505, 45506, 45512, 45515, 45518, 45519, 45560, 45561, 45562, 45563, 45564, 45565, 45566, 45568, 45569, 45570, 45572, 45575, 45578, 45581, 45584, 45585, 45587, 45588, 45589, 45590, 45593, 45596, 45597, 45599, 45602, 45608, 45611, 45614, 45617, 45620, 45623, 45624, 45625, 45626, 45627, 45629, 45632, 45635, 45641, 45644, 45647, 45650, 45652, 45653, 45656, 45658, 45659, 45660, 45661, 45662, 45665, 45668, 45669, 45671, 45674, 45675, 45676, 45677, 45680, 45683, 45686, 45689, 45692, 45695, 45698, 45701, 45704, 45707, 45710, 45713, 45714, 45716, 45720, 45723, 45726, 45729, 45731, 45732, 45735,

Clinical category	Scope of cover[1]	Treatments that must be covered (MBS Items)[1, 2, 3]
		45738, 45741, 45744, 45747, 45752, 45753, 45754, 45755, 45758, 45761, 45767, 45770, 45773, 45776, 45779, 45782, 45785, 45791, 45794, 45797, 45799, 45801, 45803, 45805, 45807, 45809, 45811, 45813, 45815, 45817, 45819, 45821, 45823, 45825, 45827, 45829, 45831, 45833, 45835, 45837, 45839, 45841, 45843, 45845, 45847, 45849, 45853, 45865, 45877, 45879, 45882, 45885, 45888, 45891, 45894, 45897, 45900, 45975, 45984, 45990, 50411, 50414, 50417, 50420, 50423, 51904, 51906, 52010, 52036, 52045, 52048, 52106, 52108, 52111, 52117, 52120, 52122, 52123, 52300, 52303, 52306, 52309, 52312, 52315, 52318, 52319, 52321, 52324, 52327, 52330, 52333, 52336, 52337, 52339, 52342, 52345, 52348, 52351, 52354, 52357, 52360, 52363, 52366, 52369, 52372, 52375, 52378, 52379, 52380, 52382, 52420, 52424, 52430, 52440, 52442, 52444, 52446, 52450, 52452, 52456, 52458, 52460, 52480, 52482, 52484, 52600, 52603, 52606, 52609, 52612, 52615, 52618, 52621, 52624, 52626, 52627, 52630, 52633, 52636, 53242, 53453, 53455, 75024, 75027
Podiatric surgery (provided by a registered podiatric surgeon)	Hospital treatment for the investigation and treatment of conditions affecting the foot and/or ankle, provided by a registered podiatric surgeon, but limited to cover for: • accommodation; and • the cost of a prosthesis as listed in the prostheses list set out in the Private Health Insurance (Prostheses) Rules, as in force from time to time. Note: Insurers are not required to pay for any other benefits for hospital treatment for this clinical category but may choose to do so.	(No items listed)

Clinical category	Scope of cover[1]	Treatments that must be covered (MBS Items)[1, 2, 3]
Pregnancy and birth	Hospital treatment for investigation and treatment of conditions associated with pregnancy and childbirth. Treatment for the baby is covered under the clinical category relevant to their condition. For example, respiratory conditions are covered under Lung and chest. Female reproductive conditions are listed separately under Gynaecology. Fertility treatments are listed separately under Assisted reproductive services. Miscarriage and termination of pregnancy is listed separately under Miscarriage and termination of pregnancy.	Treatments involving the provision of the following MBS items: 16400, 16401, 16404, 16406, 16407, 16408, 16500, 16501, 16502, 16505, 16508, 16509, 16511, 16512, 16514, 16515, 16518, 16519, 16520, 16522, 16527, 16528, 16533, 16534, 16564, 16567, 16570, 16571, 16573, 16590, 16591, 16600, 16603, 16606, 16609, 16612, 16615, 16618, 16621, 16624, 16627, 82100, 82105, 82110, 82115, 82120, 82125
Skin	Hospital treatment for the investigation and treatment of skin, skin-related conditions and nails. The removal of foreign bodies is also included. Plastic surgery that is medically necessary and relating to the treatment of a skin-related condition is also included. For example: melanoma, minor wound repair and abscesses. Removal of excess skin due to weight loss is listed separately under Weight loss surgery. Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.	Treatments involving the provision of the following MBS items: 12012, 12017, 12021, 12022, 12024, 14050, 14100, 14106, 14115, 14118, 14124, 18362, 30023, 30024, 30026, 30029, 30032, 30035, 30038, 30042, 30045, 30049, 30052, 30055, 30064, 30071, 30099, 30180, 30183, 30187, 30189, 30190, 30191, 30192, 30196, 30202, 30207, 30210, 30216, 30219, 30223, 30311, 30676, 30679, 31000, 31001, 31002, 31003, 31004, 31005, 31206, 31211, 31216, 31220, 31221, 31225, 31245, 31250, 31340, 31345, 31356, 31357, 31358, 31359, 31360, 31361, 31362, 31363, 31364, 31365, 31366, 31367, 31368, 31369, 31370, 31371, 31372, 31373, 31374, 31375, 31376, 44136, 46486, 46489, 46513, 46528, 46531, 46534, 47904, 47906, 47915, 47916, 47918, 52000, 52003, 52006, 52009, 52039, 52042, 52051, 52054

Clinical category	Scope of cover[1]	Treatments that must be covered (MBS Items)[1, 2, 3]
Sleep studies	Hospital treatment for the investigation of sleep patterns and anomalies. For example: sleep apnoea and snoring.	Treatments involving the provision of the following MBS items: 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217, 12250, 12254, 12258, 12261, 12265, 12268, 12272
Tonsils, adenoids and grommets	Hospital treatment of the tonsils, adenoids and insertion or removal of grommets.	Treatments involving the provision of the following MBS items: 41632, 41789, 41793, 41797, 41801
Weight loss surgery	Hospital treatment for surgery that is designed to reduce a person's weight, remove excess skin due to weight loss and reversal of a bariatric procedure. For example: gastric banding, gastric bypass, sleeve gastrectomy.	Treatments involving the provision of the following MBS items: 30165, 30168, 30171, 30172, 30177, 30179, 31569, 31572, 31575, 31578, 31581, 31584, 31585, 31587, 31590

Appendix 4: Private health insurance hospital product tiers

HOSPITAL TREATMENTS BY CLINICAL CATEGORY	BASIC	BRONZE	SILVER	GOLD
Rehabilitation	✓(R)	✓(R)	✓(R)	✓
Hospital psychiatric services	✓(R)	✓(R)	✓(R)	✓
Palliative care	✓(R)	✓(R)	✓(R)	✓
Brain and nervous system	O (R)	✓	✓	✓
Eye (not cataracts)	O (R)	✓	✓	✓
Ear, nose and throat	O (R)	✓	✓	✓
Tonsils, adenoids and grommets	O (R)	✓	✓	✓
Bone, joint and muscle	O (R)	✓	✓	✓
Joint reconstructions	O (R)	✓	✓	✓
Kidney and bladder	O (R)	✓	✓	✓
Male reproductive system	O (R)	✓	✓	✓
Digestive system	O (R)	✓	✓	✓
Hernia and appendix	O (R)	✓	✓	✓
Gastrointestinal endoscopy	O (R)	✓	✓	✓
Gynaecology	O (R)	✓	✓	✓
Miscarriage and termination of pregnancy	O (R)	✓	✓	✓
Chemotherapy, radiotherapy & immunotherapy for cancer	O (R)	✓	✓	✓
Pain management	O (R)	✓	✓	✓
Skin	O (R)	✓	✓	✓
Breast surgery (medically necessary)	O (R)	✓	✓	✓
Diabetes management (excluding insulin pumps)	O (R)	✓	✓	✓
Heart and vascular system	O (R)	O	✓	✓
Lung and chest	O (R)	O	✓	✓
Blood	O (R)	O	✓	✓
Back, neck and spine	O (R)	O	✓	✓
Plastic and reconstructive surgery (medically necessary)	O (R)	O	✓	✓
Dental surgery	O (R)	O	✓	✓
Podiatric surgery (provided by a registered podiatric surgeon)	O (R)	O	✓	✓
Implantation of hearing devices	O (R)	O	✓	✓
Cataracts	O (R)	O	O	✓
Joint replacements	O (R)	O	O	✓
Dialysis for chronic kidney failure	O (R)	O	O	✓
Pregnancy and birth	O (R)	O	O	✓
Assisted reproductive services	O (R)	O	O	✓
Weight loss surgery	O (R)	O	O	✓
Insulin pumps	O (R)	O	O	✓
Pain management with device	O (R)	O	O	✓
Sleep studies	O (R)	O	O	✓

✓ Minimum requirement of the product tier

(R) Insurers are allowed to offer cover for this clinical category on a restricted basis/with limited benefits

O Optional for insurer to include – not a minimum requirement of the product tier

Appendix 5: Case studies of complex admissions

The table below indicates which categories would provide benefits for the admission using principles set out in Recommendation 19.

Scenario	Reason for admission	Procedures	Clinical categories providing coverage for the admission
Patient with mechanical sleep apnea requiring surgical intervention and treatment of teeth grinding	Treatment for sleep apnea	• Tonsil surgery to remove tonsils • Dental surgery to treat grinding	Tonsils, adenoids and grommets
Skin cancer patient	Removal of skin lesions	• Removal of skin lesion • Plastic surgery to repair wound	Skin
Perforated ear drum	Repair of ear drum	• Repair of ear drum • Skin graft	Ear, nose and throat
Patient with fractured ankle following fall as a result of substance abuse (alcohol)	Treatment of fractured ankle	• Reconstruction of ankle • Medical management of pancreatitis • Cognitive behavioural therapy for addiction	Joint reconstruction
Patient with unmanaged diabetes admitted for commencement of renal dialysis. Also has a long-standing hernia.	Commencement of kidney dialysis	• Dialysis for chronic renal failure • Hernia repair	Dialysis for chronic renal failure
Patient with chronic kidney failure admitted for acute hernia repair	Repair of hernia	• Hernia repair • Dialysis for chronic renal failure	Hernia and appendix
Tummy tuck and breast lift following significant weight loss	Medically necessary reconstructive surgery	• Lipectomy • Breast reconstruction	Weight loss surgery
Revision of bariatric surgery and division of adhesions	Correction of weight loss surgery	• Revision of gastroenterostomy • Laparotomy including the division of abdominal adhesions	Weight loss surgery

Definitions and acronyms

Term	Definition
Community rating	The principle of equitable access to health insurance and the prevention of discriminating between peoples based on criteria described in Part 55-5 of the PHI Act.
PHI Act	*Private Health Insurance Act 2007*
Plus products (Basic Plus, Bronze Plus and Silver Plus)	Private health insurance products that offer cover for additional clinical categories above the minimum requirements set out in the Schedule 4 of the Complying Product Rules.
Prostheses list	Schedule of the Private Health Insurance (Prostheses) Rules (Search 'Prostheses Rules' on www.legislation.gov.au)
Restricted cover/ restricted benefits	Services that attract benefits set out in the table at s72-1(2) of the PHI Act. That is: • minimum benefits towards the cost of accommodation as set out in the Benefit Requirement Rules; • 25 percent of the MBS Schedule Fee; and • minimum benefits for a prosthesis on the Prostheses List, where an MBS item is payable for the service. • May incur out of pocket costs for theatre fees, additional hospital fees, accommodation and medical costs.
Risk equalisation pool	Risk Equalisation Special account for the levy imposed under the Private Health Insurance (Risk Equalisation Levy) Act 2003
The Complying Product Rules	Private Health Insurance (Complying Product) Rules 2015
The Benefit Requirements Rules	Private Health Insurance (Benefit Requirements) Rules 2011

Acronym	Definition
MSAC	Medical Services Advisory Committee
MBS	Medicare Benefit Schedule
PHI	Private Health Insurance
PHIO	Private Health Insurance Ombudsman

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All information in this publication is correct as at December 2021