Medicare Benefits Schedule Review Taskforce

Taskforce Endorsed Report from the Psychiatry Clinical Committee

2020

IMPORTANT NOTES

1. This report does not constitute the final position on these items, which is subject to:
   - consideration by the Minister for Health, and
   - the Government.
2. The views and recommendations in this report originated from the clinical committee. Following consultation with stakeholders, the clinical committee made amendments and presented this report to the MBS Review Taskforce for its consideration.
3. Any eliminations, amendments or commentary from the MBS Review Taskforce are noted in boxed comments in the body of the report:

> **[Group] Recommendation [#] – Taskforce's Advice**
>
> [The Taskforce's rationale behind their decision.]

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1. Executive summary

1.1 Introduction

The Medicare Benefits Schedule (MBS) Review Taskforce (the Taskforce) is undertaking a program of work that considers how more than 5,700 items on the MBS can be aligned with contemporary clinical evidence and practice and improve health outcomes for patients. The Taskforce will also seek to identify any services that may be unnecessary, outdated or potentially unsafe.

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

- Affordable and universal access
- Best practice health services
- Value for the individual patient
- Value for the health system.

The Taskforce has endorsed a methodology whereby the necessary clinical review of MBS items is undertaken by clinical committees and working groups.

1.2 Review of Psychiatry MBS items

The Psychiatry Clinical Committee (the Committee) was established in 2018 to make recommendations to the Taskforce on the review of MBS items in its area of responsibility, based on rapid evidence review and clinical expertise. Section 3 of this report sets out the membership of the Committee, its area of responsibility and a summary of its approach to the clinical review of MBS items.

The Committee reviewed 53 psychiatry MBS items comprised of 52 consultation and attendance items, in addition to one procedural item. In the financial year 2016/17 these items accounted for approximately 2.4 million services and $347 million in benefits.

Over the past five years, service volumes for these items have grown by 2.9% and total cost of benefits paid has increased by 4.2%.

1.3 Key issues

The Committee noted that many of the psychiatry items (24 of the 53 items) were performing as intended and presented no specific concerns regarding safety, access, value or contemporary best practice.

The Committee identified that the remaining 29 items should be further examined. These covered areas of high growth or reductions in use, as well as presenting a broad set of clinical issues from definitional considerations to the effect of changes in technology and/or practice. These items included:

- GP-requested management plans (Items 291 and 293)
- Telehealth (Item 288)
- Telepsychiatry (Items 353-370)
- Consultation for complex patients (Item 319)
- Electroconvulsive therapy (Item 14224)
- Interviews with non-patients (Items 348-352)
- Group therapy (Items 342, 344 and 346)
- Management plans for children with complex disorders (Item 289)
- Case conferencing (Items 855-866)

At their December 2019 meeting, the Taskforce formed a sub-group of Taskforce members, the Telehealth Working Group, to develop a separate report that considers both telehealth as a broader concept and the telehealth recommendations from thirteen committee reports, including three from the Psychiatry report.

1.4 Key recommendations

The Psychiatry Report makes 10 recommendations which are summarised below:

1. **Continue arrangements for items 291 and 293 - development of GP-requested management plans**

   The Committee agreed that these items are functioning as intended and are successfully giving GPs and nurse practitioners (with the appropriate scope of practice) access to high quality management plans for their patients.

2. **Reform arrangements for item 288 - delivering telehealth consultations to regional and remote patients**

   The Committee recommends replacing the current loading item (item 288) with a suite of new time-tiered items. The initial consultation under these items will be remunerated at a higher fee to recognise the additional time and complexity associated with delivering this service. This will ensure patients are able to keep accessing these services, at a fee that recognises the time and complexities associated with delivering these services.

NOTE: This recommendation has been referred to the Taskforce's Telehealth Working Group for consideration and inclusion in their report.

3. **New items to provide telehealth consultations to patients in major cities of Australia** The Committee recommends introducing new items to provide telehealth consultations to patients in major cities with severe physical disabilities, mental health disorders or psychosocial stress that prevent them from attending face-to-face consultations.

   NOTE: This recommendation has been referred to the Taskforce's Telehealth Working Group for consideration and inclusion in their report.

4. **Continue arrangements for items 353 to 370 - consultations with psychiatrists in regional and remote areas**

   The Committee agreed that these items are still providing a high value service to the limited number of patients accessing them. Therefore, the Committee recommends the items should remain on the MBS but at a fee similar to other telehealth items.

   NOTE: This recommendation has been referred to the Taskforce's Telehealth Working Group for consideration and inclusion in their report.

5. **Remove the stigma associated with item 319 – complex and severe mental health disorders**

   The Committee agreed the references to specific mental health disorders in the descriptor for item 319 can be stigmatising for patients, and therefore recommend they be removed. The Committee recommends restrictions remain in place to ensure only patients who could benefit from this service receive this service.

6. **Revise the schedule fee for item 14224 - electroconvulsive therapy**

   The Committee recommends that the fee for electroconvulsive therapy be revised to better account for the time and complexity associated with delivering this service.

   NOTE: This recommendation may be impacted by a pending application to MSAC for listing of transcranial magnetic stimulation on the MBS.

7. **Greater flexibility of arrangements for items 348, 350 and 352 - non-patient interviews**

   Psychiatrists routinely conduct interviews with people close to patients (usually family members) to aid in the assessment of a patient, as well as to provide education to those people to assist in the patient's ongoing management. The Committee agreed there is evidence to support greater use of these services for certain populations, particularly for children and adolescents. Therefore, the Committee recommends introducing new time- tiered items and increasing the service cap to encourage their use and promote flexibility.

8. **Clarify arrangements for item 346 - mother-infant group therapy**

   The Committee agreed there is evidence to support the effectiveness of mother-infant group therapy. The Committee therefore recommends introducing an explanatory note to clarify that item 346 (for group therapy of 2 or more patients) can be used for this purpose, if both the mother and infant have been referred by a GP for this service.

9. **Aligning item 289 with best practice - management plans for children and adolescents with complex disorders**

   The Committee agreed the term 'pervasive developmental disorder' is an obsolete term and should be removed from the MBS. Therefore the Committee recommends removing the term 'pervasive development disorder' from item 289 and replacing it with the term

   'neurodevelopmental disorders'. This will allow the item to align with best practice and current evidence. The Committee recommends increasing the age limit for eligible patients from 13 to 25.

10. **Aligning items 855 to 866 with best practice - case conferencing**

    The Committee recommends aligning these items with the changes to specialist and consultant physician items, as proposed by the Specialist and Consultant Physician Consultation Clinical Committee, to ensure there is as little impediment as possible to health professionals forming multi-disciplinary teams.

1.5 Other Issues

The Committee noted an application to MSAC was pending for the listing of transcranial magnetic stimulation on the MBS. The Committee were supportive of this application, as it considers it to be a safe, efficacious and clinically relevant service already being utilised in the Australian community.

1.6 Consumer impact

All recommendations have been summarised for consumers in Appendix C - Summary for consumers. The summary describes the medical service, the recommendation of the clinical experts and the rationale behind the recommendations.

2. About the Medicare Benefits Schedule (MBS) Review

2.1 Medicare and the MBS

2.1.1 What is Medicare?

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

Introduced in 1984, Medicare has three components: free public hospital services for public patients,

- subsidised drugs covered by the Pharmaceutical Benefits Scheme (PBS), and
- subsidised health professional services listed on the MBS.

2.2 What is the MBS?

The MBS is a listing of the health professional services subsidised by the Australian Government. There are more than 5,700 MBS items that provide benefits to patients for a comprehensive range of services, including consultations, diagnostic tests and operations.

2.3 What is the MBS Review Taskforce?

The Government established the MBS Review Taskforce (the Taskforce) as an advisory body to review all of the 5,700 MBS items to ensure they are aligned with contemporary clinical evidence and practice and improve health outcomes for patients. The Taskforce will also modernise the MBS by identifying any services that may be unnecessary, outdated or potentially unsafe. The MBS Review (the Review) is clinician-led, and there are no targets for savings attached to the Review.

2.3.1 What are the goals of the Taskforce?

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

- **Affordable and universal access**—the evidence demonstrates that the MBS supports very good access to primary care services for most Australians, particularly in urban Australia. However, despite increases in the specialist workforce over the last decade,

  access to many specialist services remains problematic, with some rural patients being under-serviced.

  Best practice health services—one of the core objectives of the Review is to modernise the

MBS, ensuring that individual items and their descriptors are consistent with contemporary best practice and the evidence base when possible. Although the Medical Services Advisory Committee (MSAC) plays a crucial role in thoroughly evaluating new services, the vast majority of existing MBS items pre-date this process and have never been reviewed.

Value for the individual patient—another core objective of the Review is to have an MBS that supports the delivery of services that are appropriate to the patient's needs, provide real clinical value and do not expose the patient to unnecessary risk or expense.

- **Value for the health system**—achieving the above elements will go a long way to achieving improved value for the health system overall. Reducing the volume of services that provide little or no clinical benefit will enable resources to be redirected to new and existing services that have proven benefit and are underused, particularly for patients who cannot readily access those services currently.

2.4 The Taskforce's approach

The Taskforce is reviewing existing MBS items, with a primary focus on ensuring that individual items and usage meet the definition of best practice. Within the Taskforce's brief, there is considerable scope to review and provide advice on all aspects that would contribute to a modern, transparent and responsive system. This includes not only making recommendations about adding new items or services to the MBS, but also about an MBS structure that could better accommodate changing health service models.

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

As the Review is clinician-led, the Taskforce decided that clinical committees should conduct the detailed review of MBS items. The committees are broad-based in their membership, and members have been appointed in an individual capacity, rather than as representatives of any organisation.

The Taskforce asked the committees to review MBS items using a framework based on Professor Adam Elshaug's appropriate use criteria (1) . The framework consists of seven steps:

1. Develop an initial fact base for all items under consideration, drawing on the relevant data and literature.
2. Identify items that are obsolete, are of questionable clinical value[1], are misused[2] and/or pose a risk to patient safety. This step includes prioritising items as "priority 1", "priority 2", or "priority 3", using a prioritisation methodology (described in more detail below).

3. Identify any issues, develop hypotheses for recommendations and create a work plan (including establishing working groups, when required) to arrive at recommendations for each item.
4. Gather further data, clinical guidelines and relevant literature in order to make provisional recommendations and draft accompanying rationales, as per the work plan. This process begins with priority 1 items, continues with priority 2 items and concludes with priority 3 items. This step also involves consultation with relevant stakeholders within the committee, working groups, and relevant colleagues or colleges. For complex cases, full appropriate use criteria were developed for the item's explanatory notes.
5. Review the provisional recommendations and the accompanying rationales, and gather further evidence as required.
6. Finalise the recommendations in preparation for broader stakeholder consultation.
7. Incorporate feedback gathered during stakeholder consultation and finalise a Clinical Review Report, which provides recommendations for the Taskforce.

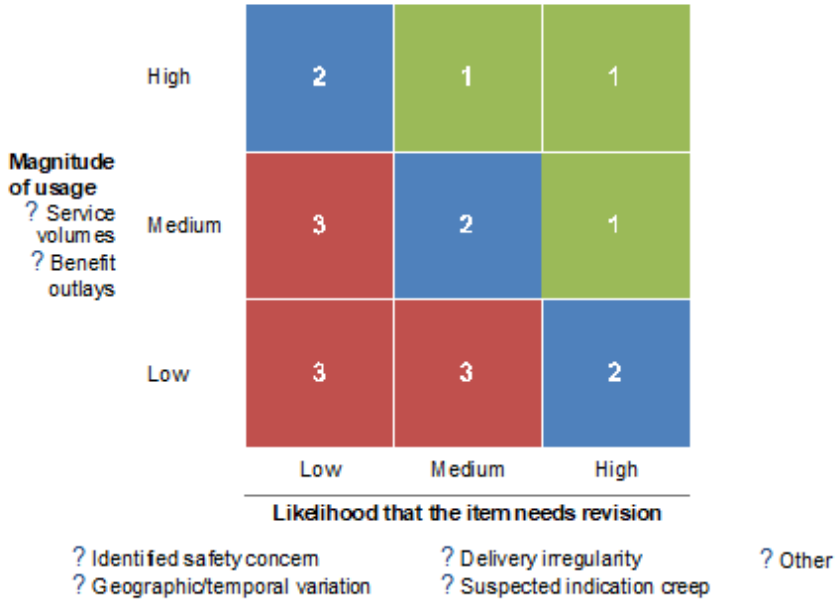
All MBS items will be reviewed during the course of the Review. However, given the breadth of and timeframe for the Review, each clinical committee has to develop a work plan and assign priorities, keeping in mind the objectives of the Review. Committees use a robust prioritisation methodology to focus their attention and resources on the most important items requiring review. This was determined based on a combination of two standard metrics, derived from the appropriate use criteria:

- Service volume.
- The likelihood that the item needed to be revised, determined by indicators such as identified safety concerns, geographic or temporal variation, delivery irregularity, the potential misuse of indications or other concerns raised by the clinical committee (such as inappropriate co-claiming).

[1] The use of an intervention that evidence suggests confers no or very little benefit on patients; or where the risk of harm exceeds the likely benefit; or, more broadly, where the added costs of the intervention do not provide proportional added benefits.

[2] The use of MBS services for purposes other than those intended. This includes a range of behaviours, from failing to adhere to particular item descriptors or rules through to deliberate fraud.

Figure 1: Prioritisation matrix



For each item, these two metrics were ranked high, medium or low. These rankings were then combined to generate a priority ranking ranging from one to three (where priority 1 items are the highest priority and priority 3 items are the lowest priority for review), using a prioritisation matrix (Figure 1). Clinical committees use this priority ranking to organise their review of item numbers and apportion the amount of time spent on each item.

3. About the Psychiatry Clinical Committee

The Psychiatry Clinical Committee (the Committee) was established in 2018 to make recommendations to the Taskforce on the review of MBS items within its remit, based on rapid evidence review and clinical expertise.

The MBS psychotherapy items were divided between Psychiatry (handled by this committee) and psychology (handled by the Mental Health Reference Group (MHRG)). Consideration has been given to the MHRG report when determining the Psychology Clinical Committee's recommendations.

3.1 Psychiatry Clinical Committee members

The Committee consists of 13 members, whose names, positions/organisations and declared conflicts of interest are listed in Table 1.

Table 1: Psychiatry Clinical Committee membership

Name	Position/organisation	Declared conflict of interest
Professor Malcolm Hopwood	Professor of Psychiatry, Ramsay Health Care; Member of the Board of the Sumner Foundation; Member of the Board of Phoenix Australia	Provider of MBS services
Professor Philip Boyce	Professor of Psychiatry at Westmead Hospital; Head of Perinatal Psychiatry Clinical Research Unit at Westmead Hospital	Provider of MBS services
Dr Michelle Atchison	Psychiatrist, private practice; Chair, Section of Private Psychiatry, Royal Australian and New Zealand College of Psychiatrists (RANZCP)	Provider of MBS services
Professor Peter Jenkins	Clinical Director, Child & Youth Mental Health Service, Mental Health Program, Eastern Health	Board Director of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) Chair of the MBS Review Working Group of RANZCP
A/Professor Beth Kotze	Executive Director Mental Health, Western Sydney Local Health District	None
Dr Ingrid Butterfield	Psychiatrist, private practice	Provider of MBS services

Dr James Oldham	Specialist Psychiatrist	Provider of MBS services
Ms Sian Pritchard	Nurse Practitioner Mental Health; Director at Pritchard Health	None
Ms Ros Knight	Clinical and Counselling Psychologist; President of the Australian Psychological Society; Board Member of Sydney North Primary Health Network; Clinic Director at Macquarie University's Psychology Clinic	President of the Australian Psychological Society.
Professor Jane Gunn	General Practitioner; Deputy Dean, Faculty of Medicine, Dentistry and Health Science, University of Melbourne; Board Director of the Eastern Melbourne Primary Health Network; Director, Peter MacCallum Cancer Centre	None
Dr Caroline Johnson	General Practitioner	Provider of MBS services not in scope for this Committee
Ms Janne McMahon OAM	Consumer representative; Chair and Executive Officer of the Private Mental Health Consumer Carer Network (Australia)	None
A/Professor Richard Brightwell	Consumer representative; Former Vice President and Board Member of Paramedics Australia; Former Chair of the Australasian College of Paramedicine	None
Dr Lee Gruner	Taskforce *ex officio* member	

3.2 Conflicts of interest

All members of the Taskforce, clinical committees and working groups are asked to declare any conflicts of interest at the start of their involvement and reminded to update their declarations periodically. A complete list of declared conflicts of interest can be viewed in Table 1 above.

It is noted that the majority of the Committee members share a common conflict of interest in reviewing items that are a source of revenue for them (i.e. Committee members claim the items under review). This conflict is inherent in a clinician-led process, and having been acknowledged by the Committee and the Taskforce, it was agreed that this should not prevent a clinician from participating in the review of items.

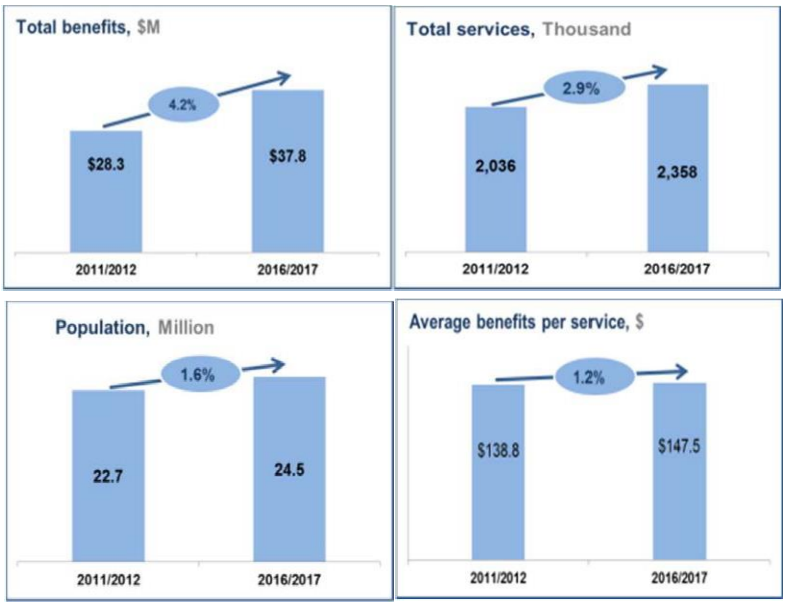
3.3 Areas of responsibility of the committee

The Committee reviewed 53 psychiatry MBS items comprised of 52 consultation and attendance

items, in addition to one procedural item. In the financial year 2016/17 these items accounted for approximately 2.4 million services and $347 million in benefits.

Over the past five years, service volumes for these items have grown by 2.9% and total cost of benefits paid has increased by 4.2%. The population increased by 1.6% for this period.

Figure 2: Key Data – 2011/12 to 2016/17



3.4 Summary of the Committee's review approach

The Committee completed a review of its items across three full committee meetings, during which it developed the recommendations and rationales contained in this report.

The review drew on the information provided by the Taskforce and various types of MBS data, including:

- data on utilisation of items (services, benefits, patients, providers and growth rates);
- service provision (type of provider, geography of service provision);
- patients (demographics and services per patient); co-claiming or episodes of services (same-day claiming and claiming with specific items over time); and
- additional provider and patient-level data, when required.

The review also drew on data presented in the relevant literature and clinical guidelines, all of which are referenced in the report.

The Committee recognised that other groups across the Review of the MBS would share areas of

interest and would need to maintain open communications on any areas of shared interest, particularly with the:

- Specialist and Consultant Physician Consultation Clinical Committee (SCPCCC)
- Mental Health Reform Group, and
- Eating Disorders Working Group.

After an initial review of the full suite of psychiatry items, the Committee identified 29 items for further examination, including:

- GP-requested management plans (Items 291 and 293)
- Telehealth (Item 288)
- Telepsychiatry (Items 353-370)
- Consultation for complex patients (Item 319)
- Electroconvulsive therapy (Item 14224)
- Interviews with non-patients (Items 348-352)
- Group therapy (Items 342, 344 and 346)
- Management plans for children with complex disorders (Item 289)
- Case conferencing (Items 855-866)

The items chosen for further examination provide a broad set of clinical issues from definitional considerations to the effect of changes in technology and/or practice. The items also include the top six items with the highest growth rates by service volume between 2011/12 and 2016/17 (items 288, 864, 348, 855, 352 and 861) and items with reducing use
by service volume (items 346, 319 and 342).

Section 4 below sets out the Committee's recommendations and rationale for change.

3.5 No change

The Committee's examination indicated a number of items where the Committee's review did not identify specific concerns regarding safety, access, value or contemporary best practice (24 of the 53 items- refer to the list at Appendix B).

3.6 Other Issues

3.6.1 Transcranial magnetic stimulation

The Committee noted an application to MSAC was pending for the listing of transcranial magnetic stimulation on the MBS.

The Committee was supportive of this application, considering it to be a safe, efficacious and clinically relevant service already being utilised in the Australian community.

3.6.2 Australian Government Productivity Commission Mental Health Draft Report

The Committee noted the Australian Government Productivity Commission Mental Health Draft Report was yet to be finalised and considered by Government. The Committee wished to acknowledge the work of the Productivity Commission, however noted it would not be completed in time to be considered by the Committee.

4. Recommendations

4.1 Management plans

Table 2: Items 291 and 293

Item	Short item descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
291	Assessment and development of a management plan by psychiatrist for GP or participating nurse practitioner	$452.65	37,626	$14,518,448	13.4%
293	Review of management plan in item 291	$282.95	7,568	$1,826,388	16.0%

4.1.1 Recommendation 1 - Continue arrangements for items 291 and 293 - development of GP-requested management plans

The Committee recommends no change to items 291 and 293 as they are functioning as intended.

4.1.2 Rationale 1

The purpose of item 291 and 293 is to allow GPs and participating nurse practitioners, with the appropriate scope of practice, access to high-quality psychiatric assessments and management plans for their patients.

This recommendation focuses on ensuring that the MBS continues to support access to, and best practice under, GP and nurse practitioner, with the appropriate scope of practice - requested management plans. It is based on the following assessment:

- The Committee initially noted concerns that patients may not be returning to their referring practitioner following the assessment.

- The Committee noted the majority of patients (72%) return to their referring practitioner after receiving a management plan under item 291. The Committee further noted that 20% of patients return to the psychiatrist following a service under item 291; however, the Committee believed this small number was appropriate in instances where the patient should receive care by a psychiatrist.
- The Committee agreed that while it would be preferable for all patients to return to their referring practitioner, there were no options available through the MBS to support a patient to do so and it was uncertain that the MBS was a suitable vehicle for this purpose.

4.2 Telehealth

Table 3: Item 288

Item	Short item descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
288	Telehealth add on for psychiatrist	Derived fee	37,626	$10,759,694	62.2%

4.1.3 Recommendation 2 - Reform arrangements for item 288 - delivering telehealth consultations to regional and remote patients

The Committee recommends a package of measures to reform the arrangements for delivering telehealth consultations, and ensure that telehealth consultations continue to be delivered to patients in regional and remote Australia. This package involves:

a. removing item 288 from the MBS by incrementally reducing the derived fee to zero and undertaking annual analysis of the phase out so to identify potential unintended consequences;
b. introducing a new suite of time-tiered items to provide for telehealth consultations to regional and remote areas (RA2–5), with:
    - remuneration at the same rate as standard consultation items (300–308 (2)), with the exception of the initial consultation, which should provide additional remuneration to reflect the increased time and complexity associated with this service, and
    - the initial consultation item split into two time tiers mirroring the standard initial consultations items 296 and 297 (2);
c. introducing an incentive payment, or another similar funding mechanism designed to support the delivery of telehealth services to patients in regional and remote Australia, and mitigate the risk of a reduction in services due to the removal of the telehealth loading (item 288). Both MBS and non-MBS mechanisms should be considered.

Taskforce Note

The Taskforce referred the Psychiatry Clinical Committee's telehealth recommendations to its Telehealth Working Group, which considered the remaining telehealth recommendations from across the MBS Review and developed a set of guiding principles and recommendations to underpin future use and reform of telehealth. These are set out in the Taskforce's Telehealth Report.

4.1.4 Rationale 2

Item 288 provides for a 50% loading for all consultations delivered via video conference to telehealth eligible areas in Australia (RA2–5).

This recommendation focuses on ensuring that the MBS is used as intended while ensuring that patient outcomes are not compromised. It is based on the following assessment:

- The Committee noted that the original intent of this loading was to accelerate the adoption of telehealth by all specialists and consultant physicians, including psychiatrists. The Committee acknowledged the loading was introduced as a time- limited incentive.

  The Committee noted that while psychiatrists had been the most successful in terms of adoption, the uptake of new providers had slowed from an initial growth of 256% in the first year to just 8% between the 2015/16 and 2016/17 financial years. The Committee noted this could indicate the loading was no longer stimulating the uptake of telehealth by new providers.

  The Committee noted advice from the Taskforce and its Principles and Rules Committee that MBS items should recognise only the time and complexity associated with delivering that service, and that additional loadings to incentivise service delivery to regional and remote areas should be provided outside the MBS.

- The Committee agreed that there were additional complexities associated with delivering a telehealth consultation to a new patient and that extra remuneration should be available to ensure providers can effectively deliver this service. These additional complexities include:
  - Increased time spent building relationships with regional and remote referrers.
  - Increased time spent orienting patients on the use of technology and troubleshooting connection and audio-visual issues.
  - Greater difficulty in conducting a physical examination of the patient.
  - More onerous reporting and prescribing requirements following the initial consultation.

- The Committee noted concerns that these changes could lead to a decrease in telehealth services or significantly alter service delivery, such as for the production of management plans for regional and remote GPs to implement. Therefore, the Committee agreed the Taskforce should consider recommending an incentive payment or another similar funding mechanism be instituted to continue to stimulate services in regional and remote areas.

4.1.5 Recommendation 3 - New items to provide telehealth consultations to patients in major cities of Australia

The Committee recommends:

a. introducing a new suite of items to provide for time-tiered telehealth consultations (via videoconference) to patients in major cities (RA1), to be remunerated at the same rate as consultation items 300–308 (2).

b. access to these items should be triggered by an initial assessment by a psychiatrist via videoconference, on referral from a GP or nurse practitioner, with the appropriate scope of practice, where an assessment of the patient is conducted and it is concluded the patient would benefit from telehealth for reasons of either severe physical disability, a mental health disorder that prevents them from attending a face-to-face consultation, or psychosocial stress (for instance if a patient cannot take time off from work).

c. telehealth services in major cities be restricted to 12 services per calendar year per patient, including the initial assessment and that these 12 consultations contribute to a patient's annual service cap (50 sessions or 160 for complex patients).

d. the new item descriptors specify neurodevelopmental disorders and include patients with significant brain injury and other acquired cognitive disorders.

Taskforce Note

The Taskforce referred the Psychiatry Clinical Committee's telehealth recommendations to its Telehealth Working Group, which considered the remaining telehealth recommendations from across the MBS Review and developed a set of guiding principles and recommendations to underpin future use and reform of telehealth. These are set out in the Taskforce's Telehealth Report.

4.1.6 Rationale 3

This recommendation focuses on providing access to alternative delivery mechanisms to meet the needs of patients with appropriate needs. It is based on the following assessment:

- The Committee agreed that face-to-face consultations represent a higher value service in psychiatry, in terms of being able to provide more comprehensive physical assessments of patients, as well as in the formation of the psychiatrist-patient relationship.

- However, the Committee agreed that it is challenging for some patients in major cities to

access a psychiatrist and for those patients consultations via videoconference are preferential to ensure they are receiving adequate care. This includes, for example, patients with severe agoraphobia and physical disabilities, such as quadriplegia, that would impact their ability to access transport.

- All members of the Committee have experience with patients being unable to attend an appointment for physical health, social or psychiatric reasons.
- While there hasn't been a study and therefore no resulting evidence that people with physical disability have difficultly accessing psychiatry services, there is good evidence that physical disability is a risk factor for mental illness, which in turn creates demand for psychiatry services. Holmes et al. (3) found that persistent disability is a risk factor for late-onset mental disorder after serious injury. Other evidence shows that people living with physical disabilities are at least three times more likely to experience depression compared to the general population (4).
- In 2017, the Australian Institute of Health and Welfare reported that nearly 2 in 5 (38%) people with a disability (aged 5-64 years) had difficultly accessing buildings or facilities in the last 12 months (5). This report does not specifically refer to access to psychiatry, only medical specialists.
- There is evidence that telehealth consultations can be effective in treating these populations (6). Significant improvements in coping skills and strategies, community integration, and depression were observed immediately after tele-health consultations, with modest improvements in quality of life maintained at 12 months post- intervention.
- In relation to people with agoraphobia, Rees and Mclaine (7) conclude that videoconference-delivered therapy for anxiety disorders is supported by evidence of effectiveness, and results that are comparable with in-person provision of treatment. The authors note that '*given that anxiety disorders tend to be characterised by avoidance and low help-seeking behaviour, it is critical that continued efforts to improve access to efficacious psychological treatments are pursued'.* Lindner et al. (8) demonstrated evidence for videoconferencing as an effective tool in treatment delivery for panic disorder with agoraphobia.
- The Committee agreed that patients should have an appropriate balance of face-to-face and telehealth consultations. The Committee noted that for the patient populations in question, it would be counter-productive to mandate for the first consultation to be face-to-face. The Committee also agreed that it would be difficult to set milestones whereby patients would be required to have a face-to-face consultation (e.g. every fourth consultation).
- The Committee affirmed that the new items should not be used for convenience and that

eligible patients should have a genuine unmet need that can be addressed via video conference consultations.

- The Committee has specified that these attendances should not replace face to face consultations, but should supplement them in particular circumstances and that there should be no loading on telehealth item numbers for urban consultations.
- The Committee anticipates that telehealth consultations for urban-based patients would have a relatively low uptake.
- A model for telehealth consultations might include limiting eligibility for a referral to specific patients (including patients with physical disability, severe agoraphobia, and other health conditions whereby attending face-to-face consultations is not practical or efficient), or for patients who require treatment from a psychiatrist located in another city (for example, patients who are temporarily located interstate).
- These criteria should be included in the explanatory notes for the item with the number of sessions to be capped at 5 in a 12-month period.

4.2 Telepsychiatry

Table 4: Items 353–370

Item	Short item descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
353	Telepsychiatry consultation < 15 mins	$57.20	342	$17,415	7.6%
355	Telepsychiatry consultation > 15 mins < 30 mins	$114.45	887	$91,513	0.7%
356	Telepsychiatry consultation > 30 mins < 45 mins	$167.80	944	$141,379	14.0%
357	Telepsychiatry consultation > 45 mins < 75 mins	$231.45	621	$133,427	4.0%
358	Telepsychiatry consultation > 75 mins	$282.00	47	$12,696	13.5%
359	Telepsychiatry review of referred patient assessment and management	$325.35	10	$2,809	-41.3%
361	Telepsychiatry initial consultation with new patient > 45 mins	$299.30	75	$19,337	31.6%

364	Attendance by psychiatrist after telepsychiatry consultation < 15 mins	$43.35	4	$195	N/A
366	Attendance by psychiatrist after telepsychiatry consultation > 15 mins < 30 mins	$86.45	11	$809	29.7%
367	Attendance by psychiatrist after telepsychiatry consultation > 30 mins < 45mins	$133.10	25	$3,044	90.4%
369	Attendance by psychiatrist after telepsychiatry consultation > 45 mins < 75 mins	$183.80	141	$25,794	52.7%
370	Attendance by psychiatrist after telepsychiatry consultation > 75 mins	$213.15	2	$665	N/A

4.1.7 Recommendation 4 - Continue arrangements for items 353 to 370 - consultations with psychiatrists in regional and remote areas

The Committee recommends:

a. retaining the telepsychiatry items on the MBS, as they are still providing a high value service to patients who currently access these services, and
b. aligning the schedule fees for these items with the consultation items 300–308, and items 296 and 297 for the initial consultation item via telepsychiatry.

Taskforce Note

The Taskforce referred the Psychiatry Clinical Committee's telehealth recommendations to its Telehealth Working Group, which considered the remaining telehealth recommendations from across the MBS Review and developed a set of guiding principles and recommendations to underpin future use and reform of telehealth. These are set out in the Taskforce's Telehealth Report.

4.1.8 Rationale 4

The telepsychiatry items provide for consultations with psychiatrists in regional and remote areas (RA3-5).

This recommendation focuses on ensuring continued access to services relevant to patient need. It is based on the following assessment:

- The Committee noted low service volumes for these items, but additionally noted the number of services had not decreased between 2011/12 and 2016/17.
- The Committee agreed these services were still providing high value care to patients.
- Moffatt and Eley (9) reported on the benefits of telehealth for rural Australians, finding that

patients in rural and remote locations in Australia are reported to benefit from telehealth by increased access to health services and up-skilled health professionals. Their review findings suggest that the increased use of telehealth has the potential to reduce the inequitable access to health services and the poorer health status that many rural Australians experience.

- Hareriimana, Forchuk & O'Regan (10) reported on the beneficial impacts on health outcomes for telehealth involving older adults with depression, finding that telehealth for mental health care among older adults demonstrates a significant impact on health outcomes, including reduced emergency visits, hospital admissions, and depressive symptoms, as well as improved cognitive functioning.
- The Committee found it is necessary to retain these items in regional and remote areas. The Committee agreed removing these items from the MBS could have unexpected consequences that would be detrimental to patients currently receiving these services.
- The Committee agreed, in line with other recommendations, that a face-to-face consultation is a higher value service and there should not be a financial incentive to conduct consultations via telepsychiatry.

4.4 Consultations for complex patients

Table 5: Item 319

Item	Short item descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
319	Attendance by psychiatrist > 45 mins for complex patients if patient has had less than 160 attendances in a calendar year	$183.65	46,985	$10,849,908	-3.6%

4.1.9 Recommendation 5 - Remove the stigma associated with item 319 – complex and severe mental health disorders

The Committee recommends:

a. amending the item descriptor to remove the references to specific mental health disorders and the requirement for patients to be assessed and meet a certain threshold on the Global Assessment of Functioning (GAF) scale.

b. the following changes to the descriptor (changes in bold):

c. the Department review this amendment 12 months after it is implemented.

Item 319

Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance of more than 45 minutes in duration at consulting rooms, if the patient has **a complex and severe mental health disorder for which there is an evidence base to support intensive psychotherapy as an effective treatment and** if that attendance and another attendance to which any of items 296, 300 to 319, 353 to 358 and 361 to 370 applies **has** not exceeded 160 attendances in a calendar year for the patient

4.1.10 Rationale 5

The item provides for consultations with psychiatrists for patients with complex and severe disorders and includes descriptions of the allowed disorders.

This recommendation focuses on ensuring care for the patient is not compromised through stigmatisation. It is based on the following assessment:

- The Committee agreed that the current inclusion of specific mental health disorders in the item's descriptor is stigmatising for patients, particularly those attempting to re-join the workforce.
- Further, the Committee agreed that some patients may not perfectly meet the diagnostic criteria for the disorders currently outlined in the descriptor, but intensive psychotherapy is still indicated as the best modality of treatment for them. An example includes patients with severe non-melancholic depression who have not responded to biological treatments (i.e. medication and electroconvulsive therapy).
- However, the Committee noted that intensive psychotherapy was not indicated for all patients and therefore restrictions should be put in place to ensure only patients who will benefit from this modality of treatment access this service, without reference to specific disorders in the item's descriptor.
- The Committee noted that where intensive psychotherapy is indicated (e.g. eating disorders) there is a large evidence base to support this modality of treatment (11).
- The Committee agreed that the Global Assessment of Functioning (GAF) scale in the descriptor was outmoded and seldom used in practice. GAF is not used in DSM-5.
- The Committee agreed that the requirement for a functional assessment should be removed, as:
    - Some patients should start intensive psychotherapy before they experience a decline in functioning, and

- There is no simple robust standard measure currently available that is used universally within clinical psychiatric practice.

- The Committee agreed that the use of a functional assessment measure should be reviewed, if validated and user friendly measures become available. The Committee suggested the Department monitor this item following changes to its descriptor to ensure it does not lead to a large increase in services.

4.5 Electroconvulsive therapy

Table 6: Item 14224

Item	Short item descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
14224	Electroconvulsive therapy, with or without the use of stimulus dosing techniques, including any electroencephalographic monitoring and associated consultation (Anaes.)	$70.35	32,708	$1,729,003	4.7%

4.1.11 Recommendation 6 - Revise the schedule fee for item 14224 - electroconvulsive therapy

The Committee recommends the schedule fee for electroconvulsive therapy (item 14224) be increased to align with the schedule fee for cardioversion by electrical stimulation (item 13400). Should the fee for Transcranial Magnetic Stimulation (rTMS) be increased as a result of a pending Medical Services Advisory Committee (MSAC) application, the Committee recommends reviewing the fee for item 14224 – electroconvulsive therapy (ECT).

4.1.12 Rationale 6

This item provides for electroconvulsive therapy, including monitoring and associated consultation.

This recommendation focuses on ensuring that the MBS reflects the complexity of delivery of best practice electroconvulsive therapy. It is based on the following assessment:

- The Committee agreed the current schedule fee for electroconvulsive therapy does not appropriately recognise the level of complexity associated with delivering this service, in particular the skills required to deliver this service were not in line with standards set by national guidelines and RACP's clinical practice guidelines (12) (13).

- The Committee agreed that the complexity associated with delivering this procedure has changed significantly since it was first introduced, as new modalities have since become available and varying standards have evolved in different state and territory jurisdictions.

- The Committee noted the Taskforce's preferred approach of assessing fee increases against comparable services already on the MBS. The Committee agreed that while it was difficult to

locate a comparable service in the MBS, that cardioversion by electrical stimulation (2) is the most comparable available service, noting similarities in the:

- Time taken to perform the procedure,
- Requirement for anaesthesia/sedation,
- Level of procedural difficulty and risk, and
- Equipment used to perform the procedures.

- The Committee noted that the fee would rise from the current fee of $70.35 for item 14224 to the $96.80 fee provided for item 13400.

4.6 Interviews with non-patients

Table 7: Items 348–352

Item	Short item descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
348	Interview by psychiatrist of person other than a patient < 45 mins	$126.75	21,035	$2,230,759	31.4%
350	Interview by psychiatrist of person other than a patient > 45 mins	$175.00	14,744	$2,250,162	24.8%
352	Interview by psychiatrist of person other than a patient > 20 mins, no more than 4 in 12 month period	$126.75	29,917	$3,268,212	28.7%

4.1.13 Recommendation 7 - Greater flexibility of arrangements for items 348, 350 and 352 - non-patient interviews

The Committee recommends:

a. removing items 348 and 350 and introducing two new time-tiered items to complement item 352 with the time tiers and remuneration for these new items mirroring that of items 300, 302 and 304 (2),

b.

c. the explanatory note attached to these items (AN.0.32) be amended to clarify that these items can be claimed for the provision of psychoeducation that aids in the ongoing management of a patient, or other family-based interventions that do not constitute group therapy or therapy to those family members,

d. services under these new items should be limited to 15 services per calendar year per

patient, and

e. usage of these new items be reviewed after 12 months.

4.1.14 Rationale 7

These items provide for interviews of varying lengths by psychiatrists of a person other than a patient.

This recommendation focusses on ensuring the MBS aligns with current best practice in the treatment of patients with mental health disorders by allowing flexibility for psychiatrists in the involvement of people other than the patient in a patient's ongoing treatment. It is based on the following:

- Psychiatrists routinely perform interviews with non-patients, usually family members, in the assessment of a patient and their relationship with those people, as well as in the provision of education to aid in the patient's treatment or management.
- The Committee noted that interviews with family members are particularly important in delivering care to people aged 25 years and under.
    - International guidelines and literature support family-based interventions (the provision of psychoeducation) in the treatment of a range of mental health disorders in children, adolescents and young adults (12) (13) (14).
    - MBS data shows that item 352 is used most often in association with a patient aged between 11 and 20 years, and that of those patients that reach the current annual cap of four services, this was also for patients aged between 11 and 20 years (in 33% of cases).
- Rice et. al (15) describe a family-based intervention approach in strengthening family/caregiver relationships as part of the young person's recovery from severe and complex depression. Their study found that *for some, a family-based intervention, delivered either by the treating team or through the integration of a specialist family worker, offers an important adjunct in supporting the recovery of the young person* (15).
- The Committee also noted evidence that the provision of psychoeducation to family members of adult patients with certain disorders is crucial to the ongoing management of those patients. These patient populations include but are not necessarily limited to patients with:
    - Psychotic disorders
    - Dementia
    - Personality disorders

- Eating disorders
- Substance abuse.

- For example, Gearing found that *Family psychoeducational interventions have consistently been found to impact families positively and reduce relapse rates in individuals with psychotic disorders... family psychoeducation interventions underscore the importance of working with youth and their families through a clear, concrete, and*

  delineated structure. Adapted and manual-based family psychoeducational programs have effectively demonstrated the success of adult interventions that incorporate education, coping skills and problem-solving strategies (16).
- Yuen et al. (17) provide an overview of the importance of clinician recognition in optimising caregiver health literacy to promote positive health outcomes. Klages et al. (18) outline the findings of a literature review which revealed a need for mental health professionals to generate more collaborative relationships with family members of parents of adult children with schizophrenia.
- The Schizophrenia Patient Outcomes Research Team (PORT) identified family psychoeducation as an evidence-based practice that should be offered to all families (19). This and other research studies have shown reduced rates of relapse and lower rates of hospitalisation among consumers and families involved in these programs. Other outcomes included increased rates of patient participation in vocational rehabilitation programs and employment; decreased costs of care; and improved well- being of family members.
- RANZCP Clinical Practice Guidelines for the management of schizophrenia and related disorders (20) stress the importance of family engagement in ongoing treatment and support. This includes specific information on family support and psychoeducation as follows 'Effective support for families is crucial, since for many people with schizophrenia, survival and recovery depend on their family relationships'.
- The Committee believe that an annual cap of 15 sessions each year will ensure psychiatrists have flexibility in involving people other than the patient to aid in the effective management of the patient. This was based on a consensus around family based interventions for diverse adult and younger persons' mental health problems. Patients with complex or severe presentations require a lot of support and information/education about how best to provide care.
- The Committee stated that these items should not provide benefits for group therapy or for therapy to the persons being interviewed – group therapy and standard consultation items should be claimed in these instances.

4.7 Group therapy

Table 8: Items 342, 344 and 346

Item	Short item descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
342	Group psychotherapy by psychiatrist for 2 - 9 patients or family group psychotherapy of more than 3 patients, each patient	$49.30	33,294	$ 1,470,347	-2.4%
344	Family group psychotherapy on group of 3 patients, each patients	$65.45	565	$ 42,802	-13.9%
346	Family group psychotherapy on group of 2 patients, each patient	$96.80	5,812	$ 664,477	-5.8%

4.1.15 Recommendation 8 - Clarify arrangements for item 346 - mother-infant group therapy

The Committee recommends introducing the following explanatory note for item 346:

Explanatory note for item 346

This item refers to family group therapy supervised by consultant psychiatrists. To be used, these items require that a formal intervention with a specific therapeutic outcome, such as improved family function and/or communication, is undertaken. An infant can count as a patient for the purposes of this item if the infant has been separately referred for this service and the above criteria are met.

4.1.16 Rationale for Recommendation 8

These items provide for psychotherapy by a psychiatrist for groups, including family groups.

The recommendation focuses on ensuring there is clarity in the coverage of the item to aid appropriate use by consultant psychiatrists. It is based on the following assessment:

- The Committee noted concerns that it was unclear whether an infant (a child less than 12 months) could be considered a patient for the purposes of group therapy item 346.
- The Committee noted evidence on the effectiveness of mother-infant therapy on infant attachment and post-partum depression (21) (22) (23). Specifically, Barlow et al. discussed in the Cochrane review that, "*parent-infant psychotherapy (PIP) is a dyadic intervention that works with parent and infant together, with the aim of improving the parent-infant relationship and promoting infant attachment and optimal infant development. PIP aims to achieve this by targeting the mother's view of her infant, which may be affected by her own experiences, and linking them to her current relationship to her child, in order to improve the parent-infant*

relationship" (21).

- The Committee noted advice from the Department that infants were not specifically precluded from claiming this item, so long as they had been referred separately for this service by a GP or Nurse Practitioner, with the appropriate scope of practice (NP). It recommends GP and NP education on the group therapy process.
- The Committee agreed that the current system was appropriate, but agreed an explanatory note should be introduced to make these requirements clear as PIP is a promising model in terms of improving infant attachment security, especially in high- risk families (21).

4.7 Management plans for children with autism and other pervasive developmental disorders

Table 9: Item 289

Item	Short item descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
289	Assessment and Development of management plan for child under 13 with autism or PDD for GP or participating nurse practitioner	$263.90	346	$ 82,771	8.5%

4.1.17 Recommendation 9 -Aligning item 289 with best practice - management plans for children and adolescents with complex disorders

The Committee recommends:

a. removing the term 'pervasive developmental disorder' from item 289 and replacing it with 'neurodevelopmental disorders'

b. increasing the age limit for eligible patients from 13 to 25

c. the explanatory note for item 289 should contain a suggested, but not exhaustive, list of example conditions for which the item is intended, and instances where it should not be used

d. that the requirement to confirm a diagnosis at the assessment should be changed to "for the purposes of diagnosis", as confirming diagnosis may require multiple attendances, and

e. that as item 289 shares a similar purpose to item 135 the items should be aligned for ease of use and best practice.

Note: See Appendix D for the draft recommended wording of the item descriptor and explanatory note. The Committee is seeking further expert discussions within the consultation process prior to

finalising the wording.

4.1.18 Rationale 9

Item 289 provides for the assessment, diagnosis and preparation of a treatment and management plan for a patient under 13 years with autism or another pervasive developmental disorder.

The recommendation focuses on providing additional clarity, increasing ease of use and reflecting best practice. It is based on the following assessment:

- The Committee was asked by the Department to consider whether foetal alcohol spectrum disorder (FASD) qualified as a pervasive developmental disorder for the purposes of claiming item 289.
- The Committee agreed FASD is a significant and complex neurodevelopmental disorder that warrants the creation of a management plan by a consultant psychiatrist and subsequent allied health sessions to aid in the treatment and ongoing management for a child with this disorder.
- However, the Committee agreed the term 'pervasive developmental disorder' is an obsolete term and should be removed from the MBS.
- The Committee agreed that the term 'pervasive developmental disorder' should be replaced with the term 'neurodevelopmental disorders' as it is considered to be an appropriate umbrella term, which encapsulates a wide range of conditions that should be eligible based on functional severity and complexity. Examples of individual disorders should be included as a list in the item's explanatory note, to ensure the item is used appropriately.

4.9 Case conferencing

Table 10: Items 855–866

Item	Short item descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
855	Community case conference >15 mins <30 mins	$ 139.10	1,652	$ 193,459	30.1%
857	Community case conference >30 mins <45 mins	$ 208.70	321	$ 56,177	7.5%
858	Community case conference >45 mins	$ 278.15	508	$ 120,665	8.2%

861	Discharge case conference >15 mins <30 mins	$ 139.10	5,977	$ 626,897	25.6%

Item	Short item descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
864	Discharge case conference >30 mins <45 mins	$ 208.70	562	$ 88,419	36.2%
866	Discharge case conference >45 mins	$ 278.15	814	$ 170,008	16.5%

4.1.19 Recommendation 10 - Aligning items 855 to 866 with best practice - case conferencing

The Committee recommends aligning psychiatry-specific case conferencing items with the changes to specialist and consultant physician items proposed by the SCPCCC.

4.1.20 Rationale 10

These items provide for discharge and community case conferencing.

This recommendation focuses on ensuring the adoption of best practice multi-disciplinary approaches. It is based on the following assessment:

- The Committee acknowledged the importance of and need for case conferencing in modern practice, but expressed concerns that the current requirements make organising and participating in a case conference prohibitively difficult.
- The Committee noted the common misbelief that all clinicians participating in a case conference must be present in the same room to claim the items. Therefore, the Committee supports amending descriptors to clarify that case conferences can take place via phone and videoconference as well as via face-to-face.
- The Committee supports the introduction of new items to provide remuneration to allied health professionals, as well as nurse practitioners, with the appropriate scope of practice and mental health nurses, to enable them to participate in case conferences. The Committee agreed that these professionals are an important part of a care team for patients with mental health disorders and should be remunerated for their time participating in a case conference.
- The Committee support the introduction of requirements that support the inclusion of GPs in case conferences.
- The Committee noted that psychiatry has the greatest uptake of case conferencing, therefore it supports the alignment of rules and requirements across case conference items for different professions. This will ensure there is as little impediment as possible to health professionals forming multi-disciplinary teams.

- The Committee was supportive of the SCPCCC's recommendations of a new case conference framework that would structure case conference items into three categories, and allow access to all consultant specialists. The proposed framework consists of:
    - Discharge planning case conferences;
    - Community case conferences; and
    - Treatment planning case conferences.
- The SCPCCC proposed new and amended case conferencing items that would allow access to all consultant specialists. The SCPCCC recommended changes to the discharge and community case conferencing items (see Appendix E) that include:
    - Requirement of mandatory GP (or delegate) participation OR review of outcomes and communication of any proposed changes to the patient and to the case conference organiser.
    - Requirement of mandatory patient (or delegate) invitation to participate.
    - Requirement that outcomes be documented in writing.
    - Stipulate that participants have the option to attend face to face, by videoconference, or over the telephone.
    - Recommend that outcomes be uploaded to My Health Record by the GP (or delegate).
- As part of the SCPCCC's recommendations, a new time tier for case conferences of less than 15 minutes duration would be introduced, as case conferences where the treatment plan was straightforward often lasted just 5-10 minutes. Correspondingly new psychiatry-specific items with this shorter time tier should be added to the MBS for consistency.

5. Impact statement

It is anticipated the recommendations from the Committee to the Taskforce will have a positive impact for both patients and providers.

The recommendations from the Committee focus on supporting equitable access to consultant psychiatrists for all Australians. In particular, the recommendations on telehealth will open new pathways for patients in major cities who have severe physical disabilities and mental health disorders to consult with a psychiatrist via videoconference.

The recommendations on telehealth will ensure rebates are still provided to patients accessing psychiatric services via videoconference in regional and remote areas, though at fees commensurate with the time and complexity associated with delivering these services. While in line with the function of and the principles underpinning the MBS, the Committee notes this could have a significant impact on service delivery. The Committee agrees this recommendation could result in a lower number of telehealth consultations being performed, or a fundamental shift to a model where psychiatrists perform assessments of patients and provide management plans to GPs to implement locally. Therefore, the Committee has also recommended the Taskforce consider a new incentive payment or similar funding mechanism to encourage use of telehealth services in regional and remote areas of Australia.

The proposed changes to item 289 will ensure patients with complex neurodevelopmental disorders, such as foetal alcohol spectrum disorder, receive high quality management plans from psychiatrists and are supported in their ongoing management by Medicare-funded allied health visits.

The recommendations are also anticipated to benefit providers, with a number of recommendations to provide clarity around the rules and requirements underpinning various items in the psychiatry section of the MBS.

The recommended changes will also benefit GPs and allied health professional providers. In particular, the proposed changes to case conferencing items will make it easier for GPs and psychiatrists to form multidisciplinary teams and coordinate care for their patients in the community.

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7. Glossary

Term	Description
CAGR	Compound annual growth rate or the average annual growth rate over a specified time period.
Change	When referring to an item, 'change' describes when the item and/or its services will be affected by the recommendations. This could result from a range of recommendations, such as: (i) specific recommendations that affect the services provided by changing item descriptors or explanatory notes; (ii) the consolidation of item numbers; and (iii) splitting item numbers (for example, splitting the current services provided across two or more items).
Committee, the	The Psychiatry Clinical Committee of the MBS Review Taskforce
Department, the	Australian Government Department of Health
DHS	Australian Government Department of Human Services
ECT	Electroconvulsive therapy
GAF	Global Assessment of Functioning Scale has been widely used for scoring the severity of illness in psychiatry
GP	General practitioner
High-value care	Services of proven efficacy reflecting current best medical practice, or for which the potential benefit to consumers exceeds the risk and costs.
Inappropriate use / misuse	The use of MBS services for purposes other than those intended. This includes a range of behaviours, from failing to adhere to particular item descriptors or rules through to deliberate fraud.
Low-value care	Services that evidence suggests confer no or very little benefit to consumers; or for which the risk of harm exceeds the likely benefit; or, more broadly, where the added costs of services do not provide proportional added benefits.
MBS	Medicare Benefits Schedule

MBS item	An administrative object listed in the MBS and used for the purposes of claiming and paying Medicare benefits, consisting of an item number, service descriptor and supporting information, schedule fee and Medicare benefits.
MBS service	The actual medical consultation, procedure or test to which the relevant MBS item refers.
Misuse (of MBS item)	The use of MBS services for purposes other than those intended. This includes a range of behaviours, from failing to adhere to particular item descriptors or rules through to deliberate fraud.
MSAC	Medical Services Advisory Committee
New service	Describes when a new service has been recommended, with a new item number. In most circumstances, new services will need to go through the MSAC. It is worth noting that implementation of the recommendation may result in more or fewer item numbers than specifically stated.
No change or leave unchanged	Describes when the services provided under these items will not be changed or affected by the recommendations. This does not rule out small changes in item descriptors (for example, references to other items, which may have changed as a result of the MBS Review or prior reviews).
Obsolete services / items	Services that should no longer be performed as they do not represent current clinical best practice and have been superseded by superior tests or procedures.
PBS	Pharmaceutical Benefits Scheme
RA1	Major Cities of Australia
RA2	Inner Regional Australia
RA3	Outer Regional Australia
RA4	Remote Australia
RA5	Very Remote Australia
RANZCP	Royal Australian and New Zealand College of Psychiatrists
Review, the	The MBS Review
SCPCCC	Specialist and Consultant Physician Clinical Committee of the MBS Review Taskforce
Services average annual growth	The average growth per year, over five years to 2016/17, in utilisation of services. Also known as the compound annual growth rate (CAGR).

Taskforce, the	The MBS Review Taskforce
Total benefits	Total benefits paid in 2016/17 unless otherwise specified.

Appendix A Index of Items

Item #	Recommendation	Section
288	*Delete*	*4.2*
289	*Change descriptor*	*4.8*
291	*No change*	*4.1*
293	*No change*	*4.1*
296	*No change*	*3.5*
297	*No change*	*3.5*
299	*No change*	*3.5*
300	*No change*	*3.5*
302	*No change*	*3.5*
304	*No change*	*3.5*
306	*No change*	*3.5*
308	*No change*	*3.5*
310	*No change*	*3.5*
312	*No change*	*3.5*
314	*No change*	*3.5*
316	*No change*	*3.5*
318	*No change*	*3.5*
319	*No change*	*3.5*
320	*No change*	*3.5*
322	*No change*	*3.5*
324	*No change*	*3.5*
326	*No change*	*3.5*
328	*No change*	*3.5*
330	*No change*	*3.5*
332	*No change*	*3.5*
334	*No change*	*3.5*
336	*No change*	*3.5*
338	*No change*	*3.5*
342	*No change*	*4.7*
344	*No change*	*4.7*

Item #	Recommendation	Section
346	*Add explanatory note*	*4.7*
348	*Delete*	*4.6*
350	*Delete*	*4.6*
352	*Change descriptor*	*4.6*
353	*No change*	*3.5*
355	*No change*	*3.5*
356	*No change*	*3.5*
357	*No change*	*3.5*
358	*No change*	*3.5*
359	*No change*	*3.5*
361	*No change*	*3.5*
364	*No change*	*3.5*
366	*No change*	*3.5*
367	*No change*	*3.5*
369	*No change*	*3.5*
370	*No change*	*3.5*
855	*Change descriptor*	*4.9*
857	*Change descriptor*	*4.9*
858	*Change descriptor*	*4.9*
861	*Change descriptor*	*4.9*
864	*Change descriptor*	*4.9*
866	*Change descriptor*	*4.9*
14224	*Revise schedule fee*	*4.5*

Appendix B Items requiring no change

Item	Short item descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
296	Initial consultation of new patient by psychiatrist > 45 mins in consulting rooms	$260.30	114,872	$26,317,494	4.1%
297	Initial consultation of new patient by psychiatrist > 45 mins, hospital	$260.30	21,674	$4,231,899	9.7%
299	Initial consultation of new patient by psychiatrist > 45 mins, home visit	$311.30	2,504	$664,183	12.7%
300	Interview by psychiatrist of person other than a patient < 45 mins	$126.75	21,035	$2,230,759	31.4%
302	Interview by psychiatrist of person other than a patient > 45 mins	$175.00	14,744	$2,250,162	24.8%
304	Interview by psychiatrist of person other than a patient > 20 mins, no more than 4 in 12 month period	$126.75	29,917	$3,268,212	28.7%
306	Attendance by psychiatrist > 45 mins < 75 mins if patient has had less than 50 attendances in a calendar year	$183.65	631,726	$119,752,181	0.0%
308	Attendance by psychiatrist > 75 mins if patient has had less than 50 attendances in a calendar year	$213.15	34,473	$6,998,773	1.6%
310	Attendance by psychiatrist < 15 mins if patient has had more than 50 attendances in a calendar year	$21.60	58	$1,548	21.4%
312	Attendance by psychiatrist > 15 mins < 30 mins if patient has had more than 50 attendances in a calendar year	$43.35	429	$30,390	16.5%
314	Attendance by psychiatrist > 30 mins < 45 mins if patient has had more than 50 attendances in a calendar year	$66.65	760	$141,475	1.5%

Item	Short item descriptor	Schedule fee	Services FY2016/17	Benefits FY2016/17	Services 5-year annual avg. growth
316	Attendance by psychiatrist > 45 mins < 75 mins if patient has had more than 50 attendances in a calendar year	$91.95	15,023	$3,525,004	-1.5%
318	Attendance by psychiatrist > 75 mins if patient has had more than 50 attendances in a calendar year	$106.60	333	$78,766	7.5%
319	Attendance by psychiatrist > 45 mins for complex patients if patient has had less than 160 attendances in a calendar year	$183.65	46,985	$10,849,908	-3.6%
320	Attendance by psychiatrist < 15 mins in hospital	$43.35	15,454	$503,019	2.8%
322	Attendance by psychiatrist > 15 mins < 30 mins in hospital	$86.45	129,401	$8,391,466	4.5%
324	Attendance by psychiatrist > 30 mins < 45 mins in hospital	$133.10	151,321	$15,108,856	8.2%
326	Attendance by psychiatrist > 45 mins < 75 mins in hospital	$183.65	96,792	$13,332,666	6.4%
328	Attendance by psychiatrist > 75 mins in hospital	$213.15	16,800	$2,686,278	12.6%
330	Attendance by psychiatrist < 15 mins, home visit	$79.55	1,535	$104,984	10.7%
332	Attendance by psychiatrist > 15 mins < 30 mins, home visit	$124.65	7,543	$800,503	17.6%
334	Attendance by psychiatrist > 30 mins < 45 mins, home visit	$181.65	7,809	$1,213,009	13.9%
336	Attendance by psychiatrist > 45 mins < 75 mins home visit	$219.75	5,438	$1,046,004	5.5%
338	Attendance by psychiatrist > 75 mins home visit	$249.55	795	$171,547	-6.2%

Appendix

CSummary for consumers

This table describes the medical service, the recommendations of the clinical experts and why the recommendations have been made.

Recommendation 1: Continue arrangements for the development of GP-requested management plans (items 291 and 293)

Item	What it does	Committee recommendation	What would be different	Why
291-293	This item provides rebates for psychiatrists to make comprehensive assessments of patients and provide management plans back to GPs.	The Committee recommends no changes to this item.	No changes.	The Committee initially raised concerns that patients were not returning to their GP after the plan had been provided back to the relevant GP. The Committee considered data that showed around 72% of patients did return to their GP. While the Committee was concerned that 28% of patients did not return, they decided there were no changes that could be made to ensure patients saw their GP following the development of the plan.

Recommendation 2: Reform arrangements for item 288 - delivering telehealth consultations to regional and remote patients

Item	What it does	Committee recommendation	What would be different	Why
288	This item provides an additional 50% fee on top of a normal consultation to incentivise psychiatrists to provide telehealth services to regional and remote patients.	The Committee recommends creating a new suite of telehealth items to replace the current loading item. The items will have the same fee as standard consultation items, with the exception of the initial consultation, which will have a higher fee to recognise the extra time and complexity associated with delivering this service. The Committee also recommends that a new mechanism be investigated to continue to incentivise services to regional and remote areas.	Patients in regional and remote areas will continue to have access to rebates.	The Committee noted that the loading was a time-limited incentive, and that MBS items should be based only on the time and complexity associated with delivering that service. The Committee noted that there are extra complexities associated with delivering an initial consultation via telehealth, and have therefore recommended these items have a higher fee.

Recommendation 3: New items to provide telehealth consultations to patients in major cities of Australia

Items	Committee recommendation	What would be different	Why
New	The Committee recommends creating new items to allow patients with severe physical disabilities, mental health disorders or psychosocial stress in major cities to access psychiatric services via videoconference.	Patients with severe physical disabilities, mental health disorders or psychosocial stress that prevent them from having a face-to-face consultation will be able to see a psychiatrist via videoconference (e.g. via Skype or Facetime).	The Committee agreed it is difficult for some patients to attend face-to-face consultations, even in major cities. The Committee agreed that it is preferable that these patients are able to access psychiatric services via videoconference than not at all. This recommendation will ensure all Australians have equitable access to a psychiatrist, no matter their circumstances.

Recommendation 4: Continue arrangements for items 353 to 370 - consultations with psychiatrists in regional and remote areas

Item	What it does	Committee recommendation	What would be different	Why
353–370	These items provide rebates for consultations with psychiatrists via telepsychiatry. These items can only be claimed by patients in regional and remote areas.	The Committee recommends no changes at this time, but recommends aligning the schedule fees for these items with the consultation items 300–308, and items 296 and 297 for the initial consultation item via telepsychiatry.	No changes.	The Committee agreed that these services are currently providing high value to those patients that currently access them.

associated with item 319 – complex and severe mental health disorders

Item	What it does	Committee recommendation	What would be different	Why
319	This item provides up to 160 sessions with a psychiatrist for patients with specific mental health disorders, including: eating disorders, severe personality disorders, dysthymic disorder, substance-related disorders, somatoform disorder and pervasive development disorders.	The Committee recommends removing the references to the specific disorders from the item, as well as removing the requirement for patients to have to meet a certain threshold of functioning on the Global Assessment of Functioning (GAF) scale.	The same population of patients will still be able to access intensive psychotherapy (up to 160 sessions a year) each year.	The Committee agreed that the references to specific mental health disorders in the item's descriptor can be stigmatising for some patients, particularly those attempting to rejoin the workforce. The Committee additionally agreed the GAF is obsolete, but should not be replaced as there currently isn't a single functional assessment tool that is used across modern psychiatric practice.

Recommendation 6: Revise the schedule fee for item 14224 - electroconvulsive therapy

Item	What it does	Committee recommendation	What would be different	Why
14224	This item provides rebates for electroconvulsive therapy (ECT). ECT is a procedure used to treat certain psychiatric conditions by passing a carefully controlled electric current through the brain.	The Committee recommends the rebate amount be revised.	Patients would receive a higher rebate from Medicare when they receive this procedure.	The Committee believed the current rebate didn't reflect the time and complexity associated with the procedure. Therefore, the Committee believed this restricted patient access mostly to the public system or resulted in high out-of-pocket costs for the patient.

Recommendation 7: Greater flexibility of arrangements for items 348, 350 and 352 - non-patient interviews

Item	What it does	Committee recommendation	What would be different	Why
348–352	These items provide rebates to patients when a psychiatrist interviews a person other than the patient, such as a family member of that patient.	The Committee recommends changing the current items into three time-tiered items that can be used at any time in a patient's ongoing management (limited to 15 sessions per year).	Psychiatrists would be able to conduct more interviews with a patient's family and support system each year.	The Committee believes this change will ensure the MBS aligns with current best practice in the treatment of patients with mental health disorders, and that increasing the annual cap to 15 sessions each year will allow flexibility for psychiatrists in involving people other than the patient to aid in the effective management of the patient.

Recommendation 8: Clarify arrangements for item 346 - mother-infant group therapy

Item	What it does	Committee recommendation	What would be different	Why
346	This item provides rebates for group therapy sessions with two patients and a psychiatrist.	The Committee recommends introducing an explanatory note to clarify that this item can be used for the purposes of providing mother-infant therapy, so long as both the mother and the infant have both been referred.	It would be clearer that this can be claimed for the purposes of mother-infant therapy.	The Committee noted it was currently unclear whether this item could be claimed for an infant, for the purposes of conducting a group therapy session between a mother and infant. The Committee agreed there is evidence that mother-infant therapy is an effective form of therapy for the treatment of post-partum depression and attachment problems.

Recommendation 9: Aligning item 289 with best practice - management plans for children and adolescents with complex disorders

Item	What it does	Committee recommendation	What would be different	Why
289	This item provides for the assessment, diagnosis and preparation of a treatment and management plan for a patient under 13 years with autism or another pervasive developmental disorder.	The Committee recommends removing the term 'pervasive development disorder' from item 289 and replacing it with the term 'neurodevelopmental disorder'.	Examples of individual disorders will be included in the explanatory note of the item to ensure the item is used appropriately.	The Committee agreed the term 'pervasive developmental disorder' is an obsolete term and should be removed from the MBS. This will allow the item to align with best practice and current evidence.

Recommendation 10: Aligning items 855 to 866 with best practice - case conferencing

Item	What it does	Committee recommendation	What would be different	Why
855-866	These items provide rebates for case conferences involving a psychiatrist, within a multidisciplinary case conference team.	The Committee recommends aligning these items with the changes to specialist and consultant physician items as proposed by the Specialist and Consultant Physician Consultation Clinical Committee.	All consultant specialists within a multidisciplinary case conference team, including allied health professionals, would be able to access these items. This will also include new items for case conferences of less than 15 minutes duration.	The Committee supports the alignment of rules and requirements across case conference items for different professions to ensure there is as little impediment as possible to health professionals forming multi-disciplinary teams.

Appendix D Additional information - recommendation 9

Item 289 - Management plans for children with autism and other pervasive developmental disorders

In Section 4.8 of this report the Committee recommended, as Recommendation 9:

a. removing the term 'pervasive developmental disorder' from item 289 and replacing it with 'neurodevelopmental disorders',
b. the explanatory note for item 289 should contain a suggested, but not exhaustive, list of example conditions for which the item is intended, and instances where it should not be used,
c. that the requirement to confirm a diagnosis at the assessment should be changed to "for the purposes of diagnosis", as confirming diagnosis may require multiple attendances, and
d. that as item 289 shares a similar purpose to item 135 the items should be aligned for ease of use and best practice.

This Appendix provides draft recommended wording for the item descriptor and explanatory note.

The Committee noted that this wording is to prompt further expert discussion before finalisation.

Draft Item 289 Descriptor

Professional attendance of at least 60 minutes in duration at consulting rooms or hospital, by a consultant physician in the practice of his or her specialty of psychiatry, following referral of the patient to the consultant by a referring practitioner, for assessment, diagnosis and preparation of a treatment and management plan for a patient aged under 13 years with autism or another neurodevelopmental disorder, if the consultant psychiatrist does all of the following:

a. undertakes a comprehensive assessment for the purposes of making a diagnosis (if appropriate, using information provided by an eligible allied health provider);
b. develops a treatment and management plan, which must include the following:
    i. an assessment for the purposes of making a diagnosis of the patient's condition;
    ii. a risk assessment;
    iii. treatment options and decisions;
    iv. if necessary-medical recommendations;
c. provides a copy of the treatment and management plan to:
    i. the referring practitioner; and
    ii. one or more allied health providers, if appropriate, for the treatment of the patient;

(other than attendance on a patient for whom payment has previously been made under this item or items 137 and 139).

Draft Item 289 Explanatory Note

The item is intended for the initial assessment of patients where the complexity of the condition is characterised by multi-domain cognitive and functional disabilities, delay or impairment; and the severity of the condition is characterised by significant psychosocial impairment.

The following conditions are examples of neurodevelopment disorders for which the item is intended (but not limited to):

a. Autistic Spectrum Disorder
b. Foetal Alcohol Syndrome Disorder (FASD)
c. Fragile X Syndrome
d. Rett's Syndrome
e. Lesch-Nyhan Syndrome
f. Cornelia de Lange Syndrome
g. Prader-Willi Syndrome
h. Angelman Syndrome
i. 22 q deletion Syndrome (previously Velocardiofacial Syndrome)
j. Smith-Magenis Syndrome
k. Williams Syndrome
l. Tic disorders (e.g. Tourette's Syndrome)

The following conditions are examples of conditions for which the item is not intended, as they can be assessed with a standard psychiatric consultation:

a. Stand-alone diagnosis of Attention Deficit Hyperactivity Disorder without other severe neurodevelopmental co-morbidities or co-existing multi-domain disabilities.
b. Behavioural disturbance such as oppositional defiant disorder.
c. Externalising behaviour associated with family system dysfunction.
d. Conduct Disorder.
e. Emotional Disorders with onset specific to childhood.

Appendix E Additional information – recommendation 10

Specialist and Consultant Physician Consultation Clinical Committee - Draft Discharge and Community Case Conference Item Descriptors

Item	Duration	Role	New item descriptor
82X **(new)**	<15 minutes	Organise and coordinate	Attendance by a consultant specialist in the practice of his or her specialty to [insert role] a **community case conference** of at least [X] minutes but less than [X] minutes, requiring: a) Specialist input to the management of a complex patient in the community; and b) Mandatory GP (or delegate) invitation and i) participation, or ii) review of outcomes and communication of any proposed changes to the patient and to the case conference organiser; and c) Mandatory patient (or delegate) invitation and to make it possible for them to attend; and d) At least 2 other formal care providers of different disciplines to be present; and e) Outcomes to be documented in writing, including shared decisions made and informed consent sought; and f) A copy of the case conference outcomes to be uploaded to My Health Record, unless patient consent is withdrawn, and where reasonably achievable. All participants must be in communication with each other throughout the conference, either face-to-face, by telephone or by videoconference, or a combination of these
820	15–30 minutes		
822	30–45 minutes		
823	> 45 minutes		
82Y **(new)**	<15 minutes	Participate	
825	15–30 minutes		
826	30–45 minutes		
828	>45 minutes		
83X **(new)**	<15 minutes	Organise and coordinate	Attendance by a consultant specialist in the practice of his or her specialty to [insert role] a **discharge case conference** of at least [X] minutes but less than [X] minutes, requiring: a) The development and approval of a discharge management plan for transfer of care to the community setting and self-management; and b) Mandatory GP (or delegate) invitation and i) participation, or ii) review of outcomes and communication of any proposed changes to the patient and to the case conference organiser; and c) Mandatory patient (or delegate) invitation and to make it possible for them to attend; and d) At least 2 other formal care providers of different disciplines; and e) Outcomes to be documented in writing, including shared decisions made and informed consent sought; and f) A copy of the case conference outcomes to be uploaded to My Health Record, unless patient consent is withdrawn, and where reasonably achievable. All participants must be in communication with each other throughout the conference, either face-to-face, by telephone or by videoconference, or a combination of these
830	15–30 minutes		
832	30–45 minutes		
834	> 45 minutes		
83Y **(new)**	<15 minutes	Participate	
835	15–30 minutes		
837	30–45 minutes		
838	More than 45 minutes		

Source: Table5: Case Conference item descriptors, from MBS Review Taskforce Report from the SCPCCC