



Medicare Benefits Schedule Review Taskforce

Telehealth Recommendations 2020

Important notes

1. This report constitutes the final MBS Review Taskforce Telehealth recommendations to Government.
2. This report does not constitute the final Telehealth position on these recommendations remain, which are subject to consideration by:
 - the Minister for Health; and
 - Government.

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Introduction

The Medicare Benefits Schedule (MBS) Review Taskforce (the Taskforce) is reviewing 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 The Taskforce also seeks to identify any services that may be unnecessary, outdated or potentially unsafe.

MBS Review Taskforce approach

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

1. **Affordable and universal access**—the evidence demonstrates that the MBS supports very good access to primary care services for most Australians, particularly in urban Australia. However, despite increases in the specialist workforce over the last decade, access to many specialist services remains problematic, with some rural patients being particularly under-serviced.
2. **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 Taskforce (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.
3. **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 and preferences, provide real clinical value and do not expose the patient to unnecessary risk or expense.
4. **Value for the health system**—achieving the above elements of the vision will go a long way to achieving improved value for the health system overall. Reducing the volume of services that provide little or no clinical benefit will enable resources to be redirected to new and existing services that have proven benefit and are underused, particularly for patients who cannot readily access those services currently.

The Taskforce endorses a methodology whereby the necessary clinical review of MBS Items is undertaken by clinical committees and working groups.

The Telehealth Working Group

The Taskforce formed a Telehealth Working Group (the Working Group) of six Taskforce members.

This report represents the final views of the Taskforce on MBS Telehealth informed by the outcomes of the Working Group.

Working Group Membership

Prof. Steve Hambleton (Chair)
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Disclosed conflicts of interest

Prof. Steve Hambleton (Chair) also chairs the Primary Health Reform Steering Group.

Scope of the Telehealth Working Group

The scope and objectives of the working group were to:

- 1) Consider telehealth as a broader concept
- 2) Provide observations and recommendations to the Government on MBS and non-MBS telehealth models
- 3) Develop a set of MBS Telehealth Principles (the Principles)
- 4) Apply the Principles to the referred recommendations from various clinical committees (Appendix C)
- 5) Provide telehealth recommendations for consideration and endorsement by Taskforce for provision to Government

Expert consultation:

The Telehealth Working Group consulted a range of telehealth experts from a variety of professions, including dermatology, nursing, midwifery, allied health (including speech pathology and physiotherapy), psychiatry, psychology, optometry and ophthalmology, geriatric services and wound care. Further detail can be found in Appendix B.

Context

Defining Telehealth

Telehealth is often broadly defined and sometimes referred to telemedicine or virtual health care.

These terms generally refer to the connecting of clinicians, patients, care teams to provide health services, support patient self- management and coordinate care across the care continuum at-a-distance.

The Department of Health website uses the International Organisation for Standardisation telehealth definition: “[the] use of telecommunication techniques for the purpose of providing telemedicine, medical education and health education over a distance”¹.

The Centre of Research Excellence in Telehealth from University of Queensland defines telehealth as “the delivery of health services in circumstances involving separation in location and/or time, using information and communication technologies”².

Telemedicine is defined by international sources as “the use of technology to deliver health-care services at a distance”³.

The structural requirements of MBS items necessitate a more specific definition for “MBS Telehealth”. In the MBS context, at the date of writing this report, excluding bushfire relief and COVID-19 items, MBS eligible telehealth items relate to clinical consultations via visual and audio links, with a small number of services permitted by phone, between practitioners and patients in real time who are both in eligible areas of Australia.

For the purposes of reviewing the referred MBS telehealth items and in defining the Principles and developing the recommendations for Government, the Taskforce has defined MBS Telehealth as “real time video and telephone consultations”.

It is recognised there are successful international models of the more broadly defined telehealth underpinned by various funding models. There are many elements that provide clinical efficacy and convenience (e.g. remote monitoring, secure messaging, store and forward) that may be best supported by payment models other than MBS fee-for-service.

Bushfires 2019 and COVID-19

The Australian Government established temporary MBS items for people living in drought-declared communities (expiring 30 June 2020), and for people affected by the 2019/2020 bushfires (expiring 31 December 2021). In addition, the COVID-19 pandemic has resulted in the Australian Government’s introduction of more than 270 temporary MBS Telehealth items,

¹ International Organisation for Standardisation definition <https://www1.health.gov.au/internet/main/publishing.nsf/Content/e-health-telehealth>

² Centre of Research Excellence in Telehealth, Final Report, The University of Queensland https://cretelehealth.centre.uq.edu.au/files/675/CentreResearchExcellenceTelehealth_FinalReport_DIGITAL.pdf

³ Policy Recommendations to Guide the Use of Telemedicine in Primary Care Settings: An American College of Physicians Position Paper. <https://annals.org/aim/fullarticle/2434625/policy-recommendations-guide-use-telemedicine-primary-care-settings-american-college>

which will continue until 30 September 2020. A list of these telehealth items is provided at www.mbsonline.gov.au.

Telehealth services have been effective for the bushfire and COVID-19 response items, and the Australian community is receptive to telehealth consultations being provided more broadly. However, these items and the use of telehealth require formal assessment and evaluation. It has not been in the Taskforce's remit, nor has it been possible to review these temporary MBS items.

The temporary MBS Telehealth items have altered the approach to delivering Medicare services in Australia, changing them from an almost entirely face-to-face service to one that has an increased level of non-face-to-face services delivered. This approach has also permitted more widespread use of telephone consultations, without a video element. Historically this has not been permitted as part of MBS telehealth.

These changes pose additional risks, such as commercialisation of high throughput low value telehealth services that have no intention to provide face-to-face services or to ensure holistic care of the patient. The Principles and recommendations in this report have been developed to mitigate the risks and support improved, safe and equitable Telehealth services and MBS Items.

MBS Telehealth Principles

Policy makers should adopt the following principles when considering Telehealth now and in the future.

The Principles listed below are intended to be cohesive and considered together.

MBS Telehealth Principles

Telehealth items in the MBS should give consideration to the following:

1. Should be patient-focused, and based on patient need, rather than geographical location.
2. Must support and facilitate safe and quality services that demonstrate clinical efficacy for patients.
3. Should be provided in the context of continuity of care between patient and practitioner.
4. Must not create unintended consequences or perverse incentives that undermine the role of face-to-face care.
5. Should prefer video over phone, as video offers richer information transfer, with fewer limited exceptions being allowed over time.
6. Support optimal clinical engagement with the patient by allowing clinician participation at both ends of the MBS telehealth consultation.
7. Should be implemented and modified through time limited transition arrangements.
8. Supports different funding models consistent with patients' need, clinical specialty and purpose.
9. Should be guided by contemporary relevant guidelines and principles.
10. Require ongoing data collection, research and evaluation into outcomes and utility.

Considerations

Application of the Principles may impact other rules within the MBS. This is considered a matter for Government in responding to the recommendations and should be addressed during implementation.

The Principles seek to minimise the risk of rapid throughput, low value telehealth under the guise of increasing convenience by putting the service provision in the context of continuity of care. As noted, face-to-face care is acknowledged as the benchmark standard of healthcare.

Principle 1

Should be patient-focused, and based on patient need, rather than geographical location.

Until the COVID-19 pandemic response, MBS Telehealth had been designed to provide rural, remote and regional communities with improved access to healthcare.

This Principle changes the historic, largely geographic approach for MBS Telehealth items to one based on patient need. This is consistent with the MBS Review goal of affordable and universal access for all Australians.

This Principle additionally recognises MBS Telehealth services should where possible, be patient led, not provider led and support an informed consent model.

MBS Telehealth items currently universally include geography as a condition for claiming i.e. requiring “[the patient] must be located in a telehealth eligible area at the time of the attendance; and [the patient must be] located at least 15km by road from the specialist.”

Telehealth eligible areas are currently defined as Australian Standard Geographical Classification Remoteness Area (ASGC-RA) classifications, 2-5 in some instances, or Modified Monash Model (MMM) 4-7 in others. Telehealth Eligible Service Areas are defined at www.mbsonline.gov.au/telehealth_eligible_areas.

MBS Telehealth should be available to patients who have a clinical need for this type of service and where face-to-face consultations are not possible. Access to MBS Telehealth by primary care and specialist providers allows:

- Patients who need care to receive it in a timely manner
- Access for remote and isolated patients
- Access after-hours

MBS Telehealth plays an important role in delivering quality services to rural, remote and regional Australians and this Principle is not designed to reduce these services.

Access to MBS Telehealth should not be based solely on geographic location of the patient and provider, should not be based solely on convenience, should be based on a patient’s need to access clinical services but for some services to provide clinical efficacy, a face to face visit will be required.

MBS Telehealth should still be geographically restricted to Australia. There is still a role for a broad geographic restriction that MBS Telehealth services should be rendered entirely within Australia, with both the patient and practitioner located in Australia.

Further Consideration

To align with the work and recommendations of the Consumer Panel in this area, patient need, values and preferences will need to be defined in partnership between the patient and doctor, as a shared judgement that supports an informed consent model of agreement.

Risks

Business models that focus on high turnover and throughput may generate excessive and/or inappropriate services, rather than responding to genuine patient need for an alternative to face-to-face care.

Providers entering the market promoting MBS Telehealth services without sufficient links to established, face-to-face services.

Mitigation to address these include setting clear expectations and a compliance framework.

Case Examples

A patient who lives in a metropolitan area but is a two hour drive away from an appointment and is able to contact the practitioner remotely should be able to receive a quality clinically appropriate service via MBS Telehealth.

A patient with serious mental health issues well known to a psychiatrist should be able to access care via MBS Telehealth from that psychiatrist even though both are located in an urban area.

Principle 2

Must support and facilitate safe and quality services that demonstrate clinical efficacy for patients.

Ongoing review of MBS Telehealth will be required to confirm telehealth items have:

1. resulted in quality clinical outcomes
2. are acceptable to both patients and providers
3. provision for an appropriate compliance framework for detection of risk and misuse cases.

Measurements might include patient reported outcomes (Proms) and patient reported experience measures (Prems) to assess value and whether the services underpin the Quadruple Aim.

The technology platforms that should be used for MBS Telehealth are not explicitly defined, provided the technology meets legislated clinical, privacy, safety, security and evidentiary standards. This should acknowledge the medico-legal implications of patient data transfer and adhere to *the MBS Privacy Checklist for Telehealth Services*⁴.

All MBS Telehealth items need to include written records and communication consistent with GN.15.39 of the MBS. All practitioners who provide, or initiate, a service for which a Medicare benefit is payable, should ensure they maintain **adequate** and **contemporaneous** records.

Case Example

A GP provides a GP Management Plan review to a well-known patient by a video consultation. The patient's blood sugar, blood pressure and weight are measured at home and shared with the doctor. The GP can give appropriate clinical advice and update the Management Plan, the practice records, provide prescriptions and any further referral for the patient.

The same patient follows up three months later with their regular endocrinologist as recommended in the management plan. That consultation also takes place by MBS Telehealth. The consultant reviews the case, provides updated advice and writes a letter back to the GP.

⁴ [PRIVACY CHECKLIST FOR TELEHEALTH SERVICES](http://www.mbsonline.gov.au) – www.mbsonline.gov.au

Principle 3

Should be provided in the context of continuity of care between patient and practitioner.

Continuity of care is a long-standing feature of healthcare, especially of general practice. It is associated with increased patient satisfaction, increased take-up of health promotion, greater adherence to medical advice and decreased use of hospital services and lower mortality.⁵

MBS Telehealth should form part of the way providers and consumers who have an existing relationship interact.

MBS Telehealth should support integrated care and be underpinned by informed consent.

The Taskforce considers that MBS Telehealth is not appropriate for ad-hoc consultations with patients who do not have an ongoing relationship with their health care provider.

The Taskforce recommends MBS Telehealth be accessible if:

- a patient meets the definition of an active patient as set out in respective guidelines i.e. the RACGP definition of an 'active patient' or
- the service is provided with the treating health provider and the referred health provider present, for handover, (recognising it is not always possible for a patient to be an active patient with a referred health provider) or
- the patient is located in a rural location and it enables access to a health service not available in that region, from a health professional that regularly provides services remotely to that region i.e. an exemption from the active patient definition and requirements.

Telehealth is a valuable mechanism for the delivery of after-hours services particularly by the usual doctor. Where patients are unable to access services from their regular GP after hours (either face-to-face or telehealth) there is the potential for patients to access after-hours primary care through a range of face-to-face options and telehealth through a Deputising Service or HealthDirect.

MBS Telehealth item numbers need to specifically state that if a patient in the course of a telehealth consultation is requested to attend for a face-to-face consultation on the same day (e.g. in order to allow a more complete physical examination or for a vaccination etc.) that the face-to-face visit is not a new episode of care and co-claiming of both a telehealth consultation and a face-to-face consultation is prohibited.

Further Consideration

There are likely to be different telehealth funding frameworks for referred specialties and non-referred services, for both telehealth and MBS Telehealth. There are examples of non-referred telehealth interactions provided outside of MBS Rebates, for example virtual Emergency Departments.

⁵ BMJ Open 2018 Jun 28;8(6):e021161

Principle 4

Must not create unintended consequences or perverse incentives that undermine the role of face-to-face care.

MBS Telehealth must reflect the place of face-to-face care and should not create unintended consequences or incentives that decrease the role of appropriate face-to-face care. MBS Telehealth is not a 'substitute for service' but is intended to be a 'complementary service' to the normal face-to-face visits. Face-to-face visits allow a more comprehensive physical assessments of the patients and support the formation and consolidation of ongoing health professional-patient relationships.

The arguments for clinical efficacy provided by Clinical Committees have been noted but the Taskforce believes that there is an ongoing role for Professional Groups and Colleges to develop advice to maximise the quality of consultations delivered via telehealth.

The Taskforce is cognisant that low value and high throughput models of care can be facilitated by telehealth and that there is a need to minimise this risk.

Case Example

Antenatal care should be consistent with the Pregnancy Care Guidelines (www.health.gov.au/pregnancycareguidelines) and many of the activities that are recommended to be undertaken at antenatal appointments such as measuring blood pressure, a clinical assessment of foetal growth and testing for hyper glycaemia and anaemia would not be clinically appropriate to be provided solely via telehealth.

Case Example

Proposed examples of appropriate consultations that could be delivered by telehealth suggested by the Mental Health Reference Group (MHRG) include patients with physical disability or severe agoraphobia where attending face-to-face consultations is not practical. Another example is a patient who requires treatment from a psychiatrist, competent to deliver MBS Telehealth located a significant distance away. The MHRG report provided evidence demonstrating clinical efficacy for these telehealth consultations.

Principle 5

Should prefer video over phone, as video offers richer information transfer, with fewer limited exceptions being allowed over time.

Real time simultaneous video and audio supported consultation is the preferred mode of delivery for MBS Telehealth because of the richer information transfer compared with telephone consultations alone. The Taskforce acknowledges that there will be circumstances where a video connection will not be possible and that use of the telephone alone should be the exception rather than the rule.

Other forms of virtual health care that include text, secure messaging, image storing and forwarding and remote monitoring may also provide clinical efficacy and be good communication tools but they are not a good fit with MBS Telehealth fee-for-service items but may be funded through other mechanisms.

This Principle is underpinned by Principle 2 in relation to safety quality and efficacy.

Principle 6

Support optimal clinical engagement with the patient by allowing clinician participation at both ends of the MBS telehealth consultation.

MBS payments are currently available to patients who are in geographically eligible locations to support clinicians at both ends of a telehealth consultation. This usually occurs with a single specialist or consultant physician attending to the patient with the general practitioner at the patient end.

Input from several of the clinical committees and experts recommend an expansion of these telehealth services, where a GP would act as the consultant when allied health, nurse practitioner or eligible midwives are patient-side. The Taskforce notes that this may provide a clinically appropriate service but has recommended further evaluation before broader implementation.

At present no MBS claiming is allowed unless the provider at both ends of the video conference are MBS Rebate eligible. Expansion of this eligibility is supported so if one of the clinicians either at the patient end or the consultant end are MBS Rebate eligible then a rebate is available. This would allow a rebate for a GP at the patient end to consult with a specialist in a public hospital outpatient department.

Note: MBS payments are for clinically appropriate services provided directly to patients. Informal clinician communications by telephone between clinicians without the patient present are not eligible for MBS Rebates.

Principle 7

Should be implemented and modified through time limited transition arrangements.

Telehealth, especially after the effects of the COVID-19 pandemic, is a rapidly changing area of health provision. Telehealth through telephone consultation has been rapidly adopted by a wide variety of clinicians and has provided unprecedented access to health care.

Despite this rapid transition significant changes in funding or requirements should be introduced over time with ongoing monitoring to assess the impact of these changes.

This Principle links with Principle 10 regarding data collection to assess the impact of the changes.

Transitioning gradually to telehealth services will also allow the introduction of technology in those areas that have not previously used telehealth, such as allied health services.

Where there has been funding to support and accelerate implementation and the decision is made to reduce it, it should be gradually phased out over time to avoid locking in perverse incentives against face-to-face services. In future practices should be advised that funding for implementation is time limited so they can plan ahead.

The phased approach should encourage the incorporation of digital mediums including My Health Records, secure messaging and ePrescribing to improve provider workflows and productivity.

Case Example

The Psychiatry Clinical Committee recommended a gradual reduction in the financial loading for psychiatry telehealth which was endorsed.

This encompassed a package of measures to remove the uptake incentive payment, implement time tiered consultations with amended rebates and consider introducing another incentive payment (likely outside the MBS) to incentivise the provision of affordable services in regional and remote areas.

Principle 8

Support different funding models consistent with patients' needs, clinical specialty and purpose.

The changing health-care needs of the population require various models of care during the patient's health care journey. On some occasions, discrete services at a point in time will be needed, and at others, a period of monitoring with multiple touch points will best serve the patient. To avoid perverse incentives, funding modes need to align with the model of care.

The MBS Schedule will be appropriate for some of these models, block or blended payments will be appropriate for others, and formal patient enrolment will be a gateway to other payments.

Considering the range of needs of allied health, nurse practitioners and eligible midwives demonstrates there will be varying funding models needed to support effective and high value virtual health care.

Case Examples

Currently MBS Rebates are available for some allied health services that are part of a GP Management Plan / Team Care Arrangement for a patient with a chronic disease. The Primary Care Recommendations highlight that it is appropriate to allow some MBS item face-to-face services to be delivered via telehealth. This is further supported by the Bushfire and COVID-19 items.

PHNs that directly fund telehealth Psychologist services for patients' outside of the MBS has improved access to psychological services by minimising gap payments.

Tele-dermatology is currently funded via block payments and a salaried arrangement that underpins the service which includes the non-real-time review of images (store and forward).

Principle 9

Should be guided by existing relevant guidelines and principles.

There are a number of guidelines developed for telehealth by various entities that should guide delivery of MBS Telehealth services. Examples of these are detailed below.

MBS Telehealth services should abide by the guidelines relevant to the clinical specialty.

MBS Telehealth must be in line with the four goals of the MBS Review Taskforce: affordable and universal access, best practice health services, value for the individual patient and value for the health system.

Examples include:

- Medical Board of Australia's Good Medical Practice: [a Code of Conduct for Doctors in Australia and the Guidelines for Technology-based Patient Consultations](#)
- [Australian Commission on Safety and Quality in Health Care](#) ACSQHC's digital mental health standards⁶
- [Australian Physiotherapy Association Telehealth Guidelines](#)⁷
- [RACGP Telehealth Video Consultations Guide](#)
- [ACRRM Telehealth Guidelines](#)

Principle 10

Require ongoing data collection, research and evaluation into outcomes and utility.

As per Principle 8, the landscape of telehealth service provision is quickly changing. Research into service provision, funding and structures is therefore valuable to ensure best practice.

Examples of research areas include:

- Cost efficiency of MBS Telehealth services
- Quality of MBS Telehealth services
- Patient outcomes after MBS Telehealth services
- Flexibility in adapting to technologies

These type of research questions may be referred to the new research body recommended in Part 2 of the Taskforce's Final Report *Harnessing innovation to deliver contemporary care*.

⁶ <https://www.safetyandquality.gov.au/standards/national-safety-and-quality-digital-mental-health-standards>

⁷ <https://australian.physio/sites/default/files/APATelehealthGuidelinesCOVID190420FA.pdf>

Taskforce Recommendations

These recommendations are informed by the Telehealth Working Group review process, agreed telehealth principles and consideration of telehealth recommendations referred from Taskforce Clinical Committees and Working Groups at Appendix C.

Recommendation 1

Establish a National Strategy for Virtual Health Care, including telehealth, and an action plan for Australia.

Rationale

Virtual health care describes the collection and/or exchange of information electronically between doctors, allied health and patients in both synchronous and asynchronous modes. Synchronous video and telephone consultations are the subset of virtual healthcare that is referred to as MBS Telehealth in this report.

Various forms of virtual health care are in use across Australia with a recent acceleration in use as a result of the recent COVID-19 Pandemic responses.

Telehealth must be considered holistically to ensure a strategic, coordinated, consistent approach across the entire health system, underpinned by appropriate funding models to support the delivery of high value patient care.

It is recommended that the MBS Telehealth Principles underpin and serve as a basis to analyse and assess telehealth provision more broadly. Particularly when considering the referred recommendations and when reflecting on the information arising from the Bushfire and COVID-19 responses.

A National Virtual Health Care Strategy would include evidence gathering and appropriate identification and delineation between the different health funding roles, systems and layers. It will also provide a consistent way for traversing everything from primary care, acute care, specialist services and local area services along with residential and other community care.

Recommendation 2

Establish and implement MBS Telehealth policy and guidelines using the MBS Taskforce Telehealth Principles as a framework.

Rationale

Medical best practice and advances in health technology rapidly change. MBS Telehealth items have traditionally been designed to provide rural, remote and regional communities with better access to health care. This, along with the bushfire and COVID-19 related expansion of telehealth, and the referred recommendations underline the need for a structured consideration of telehealth.

There are a number of factors that need to be taken into account when considering the future including the potential for misuse and ensuring that fundamental legislative rules of Medicare such as prohibitions on screening are not breached.

The establishment process will consider and address the underlying themes from the referred telehealth recommendations including:

- Appropriate high value expansion for improved access to services for patients from their known credentialed health providers within recognised scope of practice.
- New MBS Telehealth item fee and service structures.
- The preservation of clinical efficacy with varying modalities of service delivery.
- Allowing telehealth consultations to take place via telephone where clinically appropriate and video connection is not practical.
- The role of telehealth in case conferencing.
- Transitional arrangements for change that allow:
 - alignment over time to minimise unintended consequences
 - time for providers, consumers and systems to accommodate change
 - adjust and respond to relevant research and data, including future commissioned research.

The cross-cutting nature of the referred recommendations to this committee from Taskforce Clinical Committees and Working Groups demonstrated a need for consistency. The Taskforce's work analysing telehealth identified a need for clear guidance and a quality approach that is adaptable to changes in service and health technology. The six domains of quality include, safety, patient centered, timely, effective, efficient and equitable.⁸ This led to the development of the Principles contained in this document.

Reforms will provide a consistency across specialities. Caution will be required to ensure services are not lost in rural and remote areas and are in line with current item number structuring. Reforms should also take into consideration specialist services with a clinician supporting the patient and consultation when the patient is alone.

This recommendation is consistent with Principles 1-9.

Report examples

Telehealth items for Nurse Practitioners could be considered following the resolution of credentialing and scope of practice issues as detailed in the Primary Care Report. (Referred from NPRG Recommendation 13).

Nurse Practitioners could also gain access to telehealth through different funding models which might include VPE or Health Care Homes blended funding.

Case conferences

Many of the Clinical Committees in particular the Pain Management and Wound Management Committee have requested new item numbers in relation to multidisciplinary assessment of patients. There is a need for a coordinated consistent approach to case conferencing⁹ where

⁸ Institute of Medicine (IOM). Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, D.C: National Academy Press; 2001.

⁹ A case conference can occur face-to-face, by phone or by video conference, or through a combination of these. The minimum three care providers (including the GP) must be in communication with each other throughout the conference. <https://www1.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-caseconf-factsheet.htm>

clinicians can attend by video or telephone. Eligible clinicians should include medical, nursing and allied health depending on the clinical needs of the patient.

The Nurse Practitioners Reference Group Recommendation 14 and Psychiatry Clinical Committee Recommendation 4 discuss, “Telehealth by phone”. Video consultations are preferred, with telephone as the exception because of the richer information transfer available with video.

Recommendation 3

Evaluate, research and review models of telehealth and virtual health care to ensure the MBS item structures are appropriate for the Australian setting.

Rationale

This research should consider:

- Permanent and temporary MBS telehealth items
- Alternative funding models, barriers and opportunities
- Issues including asynchronous store and forward information transfer
- Clinical efficacy and modality of telehealth service delivery in allied health
- Models of care
- Mobility access community and RACF
- Standards and scope of practice
- Patient end clinical support services provided by allied health professionals where GPs act as consultants
- Explore appropriate alternative funding models to provide high value care in such scenarios

Several of the committees and working groups have suggested further research on telehealth in the Australian setting. In particular the Allied Health and Mental Health Reference Groups because of the expansion of access announced for mental health and drought, and now the Bushfire and COVID-19 items. These recommendations highlight the need to gather national evidence and build on existing research to explore the use and utility of virtual health care in the medical, allied health and mental health sectors.

Important issues have been raised that need evaluation and analysis for primary, specialist and allied health, such as the appropriate place for fee for service MBS payment, alternative funding models, the place of asynchronous care, MBS Item structures for specialists and allied health and information storage and transfer.

Evaluation and research should build on current activities and learnings from current and previous examples of telehealth models. This includes models funded by block payment and salaried arrangements such as in areas including optometry, ophthalmology, and dermatology.

The outcomes of this evaluation and research will guide decisions on the most appropriate funding for the desired model of care. This is consistent with Principle 10 requiring ongoing data collection and research and evaluation into its outcomes and utility.

Report examples

Several of the referred recommendations identify the need for evaluation or review to improve the structure or availability of existing telehealth items.

Pain and Wound Management Committees, suggested reviewing the case conferencing item numbers and updating them to ensure that they provide telehealth access to appropriate multidisciplinary services.

The allied health working group recommended that new interim MBS telehealth items be made available whilst undertaking ongoing research to inform ongoing use. The Taskforce's view is to undertake the research first to inform a broader strategy.

Referred recommendations from the Specialist and Consultant Physician Clinical Committee Recommendation 9, and the Psychiatry Clinical Committee Recommendation 3 and 4 discuss reforming or developing a new framework for telehealth. Transition to a new structure of items should be managed with particular consideration of Principle 7 that recommends implementation via time limited transition arrangements.

Reforms for specialists should include consideration of services with a clinician supporting the remote patient and consultation when the patient is alone.

Recommendation 4

Establish a process to review all MBS telehealth items on a regular basis.

Rationale

All MBS telehealth items should be subject to a regular review after implementation to ensure they are meeting the objectives of the telehealth principles, including providing high value care and avoiding perverse incentives. It is important that these are monitored and managed to mitigate any risks to quality and safety for patients.

Report examples

The recommendations from eating disorders required items to be telehealth enabled in alignment with MBS mental health items. Following evaluation these items should be aligned to the Principles over time.

The Gynaecology Clinical Committee's Recommendation 10 deletes an MBS Telehealth item. This recommendation has already been submitted to Government and while this item has not been claimed in 5 years. It is recommended given the current environment telehealth rebates may well become available for Gynaecologists as part of the framework for all referred Specialties in accordance of the Principles.

Recommendation 5

Subject to clinical efficacy and clinical appropriateness, expand telehealth eligibility to patients in defined situations who may otherwise be unable to receive face-to-face care.

Rationale

The GPPCCC recommended expanding telehealth to patients could not easily attend their GP face to face. Other Clinical Committees and Reference Groups also highlighted some clinical situations where consideration could be given to appropriate access to telehealth services.

The Taskforce supports this recommendation provided it is introduced in a way that is consistent with Principles 1, 2 and 3 of this Report. The Taskforce further notes that this should be underpinned by robust clinical evidence of appropriate situations Convenience should not

over ride clinical efficacy. Voluntary Patient Enrolment is one way to reduce the risk of low value care to these patients.

The Taskforce notes this recommendation could be considered for broader clinical situations where patients may benefit from telehealth services due to mobility issues.

Recommendation 6

Subject to proven clinical efficacy and service modality, allow MBS telehealth access to substitute for the MBS rebates authorised by chronic disease items or health assessment items.

Rationale

This links strongly with the overall theme of this report, especially the expectation of MBS Telehealth reform.

The Taskforce recommends improved access for some allied health services in line with practitioners who can deliver services in accordance with Principles 1-5.

This recommendation recognises that there is an opportunity to improve delivery of allied health care particularly for rural and remote populations. However, it will be important that specific credentialing, scope of practice and compliance restrictions are clear to ensure that the MBS Items do not create perverse incentives and unsafe practice.

Should the allied health service be clinically appropriate one or more of the five allied health rebates authorised by a GP Management Plan and Team Care Arrangement or one or more of the five allied health rebates authorised by an Aboriginal Health Assessment could be eligible for MBS Telehealth.

Recommendation 7

Create a new MBS Telehealth framework for Specialists consistent with the Principles.

Rationale

The current Specialist telehealth descriptors are inconsistent and inefficient in several instances.

Reforms will provide consistency across specialities. Caution will be required to ensure services are not lost in rural and remote areas and are in line with current item number structuring. Alternate or blended funding models that support patient access to effective and safe specialist services should also be considered.

Reforms should take into consideration specialist services with a clinician supporting the patient as well as direct patient consultations when the patient is alone.

The reforming of these telehealth arrangements should consider Principles 1-5.

Appendix A: Additional Definitions

Access

Access is understood as the availability of good, affordable and informed health services within reasonable reach of those who need them when they need them”¹⁰.

Clinical Efficacy

Clinical efficacy refers to a consultation providing a quality clinical outcomes regardless of modality, .e.g. a video consultation or a face-to-face consultation.

While telephone and video consultations can both offer clinical efficacy the Taskforce has determined as a reference point that face-to-face consultations are the benchmark standard for healthcare service delivery, in line with MBS Review Taskforce Goal 2 *Best practice health services*.

Clinically Appropriate

Clinically appropriate is care that is:

- provided in a timely manner and meets professionally recognised standards of acceptable medical care;
- delivered in the appropriate clinical setting; and
- the least costly of multiple, equally effective alternative treatments or diagnostic modalities.

The World Health Organization defines appropriateness from a system’s perspective as care that is effective, efficient and in line with ethical principles of fair allocation¹¹

To determine if telehealth video consultations are appropriate consideration should be given to¹²:

- patient safety
- patient clinical need
- clinical effectiveness
- patient preference
- location of the practice
- availability
- training and skills of practice staff
- equipment required (hardware and software)
- appropriate auditing and compliance mechanisms
- Contemporaneous note taking

¹⁰ [World Health Organization definition of accessibility](#)

¹¹ [Anonymous Proceedings of the Appropriateness in Health Care Services . 23–25 March 2000; Koblenz, Germany. Copenhagen: World Health Organization; 2000.](#)

¹² Adapted from <https://www.racgp.org.au/running-a-practice/technology/clinical-technology/telehealth/telehealth-video-consultations-guide/introduction>

In some circumstances Telehealth may improve the quality of care, as it can be:

- safer i.e. wherever there is a risk of infection to either party from face-to-face contact
- more equitable by providing improved accessibility
- more patient centered with appropriate consents
- more efficient, convenient and timely for patient and provider

Low Value Care

Low Value Care is considered to be *'care that confers no benefit or benefit that is disproportionately low compared with its cost is of low value and potentially wastes limited resources¹³'*.

Health system payment structures and models of care must set up to minimise the risk of low value care.

Primary Health Networks

PHNs are independent meso- level primary health care organisations, located throughout Australia. They are funded to undertake activities and commission services to address the health care needs of their communities and to improve efficiency, effectiveness and coordination of care. They are well positioned to support the implementation and review of telehealth and to support the broader provision of virtual health care.

Value

Value is understood to be health benefit for individuals and the community for the resources invested.

Value for the individual patient—supports the delivery of services that are appropriate to the patient's needs and preferences, provide real clinical benefit and do not expose the patient to unnecessary risk expense or inconvenience.

Value for the provider—achieve efficiencies and greater patient satisfaction.

Value for the health system—enables resources to be directed to services that have proven benefit.

Quadruple Aim

The Quadruple aim is a well-regarded framework for optimising health system performance.

The Quadruple Aim is¹⁴:

1. Improving the patient experience of care (including quality and satisfaction);
2. Improving the work life of health care providers;
3. Improving the health of populations; and
4. Improving the cost-efficiency of the health system.

¹³ [In search of professional consensus in defining and reducing low-value care | The Medical Journal of Australia](#)

¹⁴ The first three aims were popularised by the Institute for Healthcare Improvement, beginning with the work of Berwick, Nolan and Whittington (2008). Bodenheimer and Sinsky (2014) proposed the fourth aim, emphasising that the attainment of the other aims relies on positive engagement and improved experiences for service providers and clinicians.

Appendix B: Research and expert advice

A range of experts and a diversity of research and publications regarding telehealth was considered in relation to telehealth in the Australian health system.

Michael Gill in “A National Telehealth Strategy for Australia” states:

‘Telehealth as a concept is interchangeable with telemedicine in terms of utility and addresses the collection and/or exchange of information electronically between doctors, allied health and patients in both synchronous and asynchronous modes. It ranges from telephone call centres to vital sign monitoring to video imagery for the delivery of health-at-a-distance. Telehealth has particular relevance for aged care, disaster situations, individual clinician support and for team based support for complex conditions¹⁵’.

The Taskforce recognised that MBS Telehealth items numbers would only fund a subset of more broadly defined telehealth.

Dr Jim Muir (Tele-Derm National)

Dr Muir has run a combined telehealth service since 2003 called Tele-Derm National. Tele-Derm uses a store-and-forward modality. This modality allows the dermatologist to provide education to the referring GP and the dermatologist is not required to be in a live virtual room and can attend cases when they need to. Tele-Derm services are freely available for members of the Australian College of Rural and Remote Medicine (ACRRM) and clinicians in sufficiently rural and remote areas. The funding is provided over 3 years by the Federal Government as a block payment to ACRRM, who then pay a salary to Dr Muir.

Additional information on Tele-Derm National is available at:

<http://www.ehealth.acrrm.org.au/provider/tele-derm>

Prof Len Gray

Prof Gray is the Director of the Centre for Health Services Research within the Faculty of Medicine at the University of Queensland and has been working in telemedicine since 2007. Prof Gray proposed a multi-modal delivery strategy. Prof Gray proposed inclusion of telephone, email and messaging as well as videoconferencing, as each modality offers something different to assist the patient, noting that telehealth modalities provide benefits outside the care given, examples given were the patient time savings from transport, monetary savings from not having to pay for parking, patients not needing to take time off work. Prof Gray identified a limitation of current telehealth modalities is that if a practice nurse is required at the patient-end of the consult (example given if the patient is cognitively impaired) the nurse is not paid for their time.

Katherine Isbister

Ms Isbister is an employee of CRANA, who represent remote area nurses, midwives and allied health professionals. She noted in her experience telehealth services have meant people do not need to leave their family or community and this has multiple cultural safety advantages, including easier access to family and support people. Remote telehealth services can also

¹⁵ [A National Telehealth Strategy for Australia – For Discussion Michael Gill](#)

prevent hospitalisation - which saves the system money because of the reduced need for aeromedical retrieval. Ms Isbister noted limitations of telehealth at present include lack of resourcing, lack of patient understanding and poor infrastructure and connectivity in some locations. She recommended investments in infrastructure with a focus on ease of use, and still upskilling to manage this infrastructure. She also noted store-and-forward capabilities are required. Examples given were an ECG or patient history transmitted before a telehealth consult.

Dr George Margelis

Dr Margelis has 15 years' experience in telehealth and provided input on telehealth access restrictions. Dr Margelis provided examples where the physical presence of the practitioner does not add value to the consult. Dr Margelis further discussed limitations of telehealth modalities and noted one of the key things from a clinician's perspective is the need for seamless integration of new telehealth modalities. Telehealth service delivery will need to be the ability to seamlessly switch between a telehealth visit vs. an in-person visit vs. a medication review.

Miranda Shaw & Dr Owen Hutchings

Ms Shaw and Dr Hutchings provided information to the Working Group about a virtual model of care being developed by NSW Health. They discussed the benefits and limitations of the new model being trialed and provided input on patient access restrictions, funding models, education and training options for clinicians and role of telehealth as part of the primary care landscape of Australian health into the future.

Dr Jenny Prentice

Dr Prentice is a clinical nurse consultant specialising in wounds, skin and ostomy care. Dr Prentice declared a conflict of interest, she is a current employee of Hall and Prior Aged Care Group and additionally currently works for an employer that provides wound management telehealth. Dr Prentice provided the Working Group information on current wound care service provided by real-time telehealth consultations via a nurse with a tablet at the patient's bedside. Dr Prentice also provided the Working Group information on synchronous and asynchronous modalities for telehealth.

A/Prof Angus Turner

A/Prof Turner is an ophthalmologist and discussed with the Working Group the role of telehealth in Optometry, which was included on the MBS Schedule in 2015. A/Prof Turner noted that an on-call service has increased Aboriginal and Torres Strait Islander community participation, and demonstrated reductions in non-attendance of consults, and surgical wait lists. A/Prof discussed the need for mixed funding models and multi-modal telehealth delivery, including phone consultations and store-and-forward methodologies.

Phillip Hermann

Mr Hermann is a representative from Allied Health Australia and discussed the need for telehealth modalities to be flexible for different disciplines, citing the differences between speech pathology and psychology as examples. Mr Hermann discussed the need for national integration of services to allow clinicians to access services and for greater consistency in access.

Prof Mal Hopwood

Prof Hopwood is a psychiatrist and Chair of the Psychiatry Clinical Committee. Prof Hopwood discussed the role of telehealth in psychiatry services, particularly in rural and remote areas. Prof Hopwood particularly noted a lack of consistent approach in telehealth provision of services and discussed the role of private versus public funding models for psychiatry telehealth options.

General Practice and Primary Care Clinical Committee (GPPCCC)

The GPPCCC considered a range of payment options for telehealth early in stage 2 of its deliberations. Initially it considered an open fee for service model but concerns were raised about the potential risk of low value care. A number of caveats were considered to minimise this risk and they included a number of potential constraints. For example, convenience alone should not be a driver of telehealth, telehealth should initially start in rural areas, must be a regular patient of a practice, must have seen the doctor at least twice that year, must live more than 30km away from the practice and a maximum of two rebates per patient per year applies. The committee did not proceed along these lines in view of the potential red tape burden and the inability to deliver a reasonable compliance framework.

The GPPCCC ultimately considered the main strategy to minimise low value care was to link access to telehealth to voluntary patient enrolment. The committee felt a VPE gateway would maximise the benefits to the patient who would be interacting with a known provider who would be in a position to provide an equivalent value service.

Its rationale for this included the following:

Evidence indicates that having a regular GP is beneficial for patient outcomes, patient experience and value for the system.

Patient enrolment will encourage practices to build continuity of care into their business models, ensuring support for longitudinal care and population health as well as acute, episodic care.

Enrolment will lead to stronger GP stewardship, with GPs supported to drive data-driven improvements in quality of care, and in referral and prescribing practices leading to potential downstream savings from preventable hospitalisations.

The GPPCCC recognised that many members of the community including those living with disability and/or with transport issues, and people living in rural and remote communities, face challenges in attending general practices and believed this group would benefit from flexible access including non-face-to-face access (e.g. telephone, email, video consulting, telehealth, etc).

The committee noted that there is strong evidence that non-face-to-face care can increase access, without compromising patient outcomes.

Other considerations

The Working Group has also considered other pieces of work relating to telehealth, including the work of the Primary Health Care Reform Steering Committee, and papers by Len Gray and Prof. Besser

Appendix C: Referred Recommendations

These recommendations are provided as they were specified by the Clinical Committees and Reference Groups.

Allied Health Reference Group

Recommendation 13 – Improve access to allied health services via telehealth

The Reference Group recommended:

- a. undertaking a follow-on piece of work detailing the highest-value opportunities for telehealth integration into allied health care, to gather national evidence, building on existing research on telehealth interventions conducted at the state and territory level and in federally funded trials and to identify:
 - (i) Telehealth interventions provided by allied health professionals with evidence for comparable or superior clinical outcomes (compared with face-to-face interventions).
 - (ii) Cost savings associated with using telehealth in allied health care.
 - (iii) The views of consumers and feedback on telehealth use in allied health care.
 - (iv) Exploring the use of telehealth interventions to complement existing models of care, especially for rural and remote areas.
- b. in the interim, creating a new MBS item for the provision of telehealth services for patients consulting with an allied health professional via teleconference, with the following restrictions:
 - (i) The patient must not be an admitted patient.
 - (ii) The patient must be located both within a telehealth-eligible area and at least 15 kilometers from the Allied Health Professional.
 - (iii) The patient must reside in a rural or remote region (defined as Modified Monash Regions 4 to 7).
 - (iv) The allied health professional must be a primary health care provider for the patient, defined as having had at least two consultations with the patient.

and

- c. that the new item should only be claimable for types of allied health professionals who can deliver comparable outcomes via teleconference as in face-to-face consultations to ensure that there is no compromise in service delivery or standard of care.

Rationale 13

This recommendation focuses on improving access to effective telehealth services. It is based on the following:

- The Reference Group acknowledged that telehealth could be used to improve delivery of allied health care for rural and remote populations. However, it also noted that the current fee-for-service system under the MBS does not always create the right incentives for telehealth.

- There are 382 allied health professionals per 100,000 people in metropolitan areas, compared to just 136 in remote/very remote areas. (46) In rural and remote areas, one in five patients report that they experience longer-than-acceptable waits to access health services (47).
- The Reference Group agreed that this recommendation has the following benefits:
- It would increase allied health service provision in remote, regional and rural areas. This would decrease the need for patients in rural and remote communities to travel (and take time off work) to receive allied health care.
- For providers already providing telehealth services, the recommendation would reduce out-of-pocket fees by allowing rebates for patients. This would relieve the financial burden on patients who already face the hardships of distance, limited service provision and inequitable access to services.
- The recommendation would increase local employment by creating opportunities for locally based allied health assistants (who may provide patient-side support).
- There is some evidence to support telehealth interventions in allied health care. A recent Australian review of allied health video consultation services found that clinical outcomes have generally been similar to outcomes for usual care, although it acknowledged large differences in the breadth and quality of evidence between different allied health professionals (48).

There is evidence that telephone counselling by a dietitian achieves dietary behaviour change and improves metabolic parameters in individuals with metabolic syndrome. Swanepoel and Hall (2010) conducted a systematic review of telehealth applications in audiology and found that outcome measures for conventional face-to-face services and remote telehealth services were similar, with no negative impact on patients who received telehealth services. Various types of audiological assessment were found to be viable, such as otoscopy, pure-tone audiometry, impedance audiometry, otoacoustic emission, and auditory brainstem response audiometry, with no clinically significant differences in results compared to face-to-face administration of these assessments (49)

General Practice and Primary Care Clinical Committee

Recommendation 11 Enable GP telehealth consultations and expand GP telehealth eligibility to patients with mobility concerns who cannot easily be seen face-to-face

The Committee recommended:

- The Committee recommends that the descriptors of items 99 and 82220-82222 be expanded to make GPs eligible to provide a telehealth consultation, in addition to other specialists and consultants. Provision of these GP telehealth services should be restricted to a patient's usual provider.
- The Committee recommends that new items be created to reimburse GPs for their time for telehealth consultations (similar to items which currently exist to reimburse other specialists) to support Nurse Practitioners and Aboriginal and Torres Strait Islander Health Practitioners consulting with patients in remote and rural settings.

Rationale 11

This recommendation focuses on increasing patient access to, and usage of, telehealth services. It is based on the following observations:

- The requirement for telehealth services to take place with specialists/consultations limits patient access to telehealth items. A survey of 73 Nurse Practitioners (NPs) working in primary care and accessing MBS indicated that only 12% used telehealth items, and identified that the main reason for non-use of the telehealth items was the stipulation of having a specialist or consultant present. ⁽¹⁶⁾
- The addition of GPs as eligible telehealth providers will increase patient access to GPs, particularly in remote areas where GP access is more limited. The restriction to a patient's usual provider will ensure rural and remote practice sustainability. Rigorous consultation should be undertaken with rural and remote providers in the implementation of this recommendation.
- Expanding GP telehealth eligibility criteria to include patients with mobility concerns, such as patients who are elderly and frail, will increase patient access to essential services.

The GPPCC notes that the Nurse Practitioner Reference Group supports this recommendation.

Mental Health Reference Group

Recommendation 14 – Increase access to telehealth services

The Reference Group recommends a review of the recent announced expansion of access to mental health telehealth services in rural and remote areas in two years to:

- (i) Assess whether it has delivered the hoped-for outcomes, and
- (ii) Ensure that the change is a permanent one and is not seen as a temporary emergency fix.

Rationale 14

This recommendation notes the Reference Group's agreement with a recent decision to increase availability of telehealth services. It is based on the following:

The Reference Group agreed that telehealth services were high value care for patients. However, the Reference Group agreed that there was a risk that this decision reflected a temporary change given the current state of drought, and emphasised that this decision should permanently enable all Better Access sessions to be offered via telehealth.

- The Reference Group discussed the recent announcement expanding access to telehealth services in rural and remote areas. The change, effective from 1 September 2018, allows eligible patients in rural and remote areas to access all of their Better Access sessions via videoconference (as opposed to seven out of 10 sessions) (21).
- The Reference Group supports telehealth access for people with disabilities, frail and elderly people and those residing in rural and remote areas, when accessed through their usual GP.

¹⁶ Currie et al., 2018

Nurse Practitioners Reference Group

Improving patient access to telehealth services - The role of telehealth

The Reference Group acknowledged that the role of non-face-to-face communications is an increasingly important one in health services and patient care. For NPs acting as a primary care giver, as well as those in more specialised roles, telehealth offers an opportunity to provide high-value care to patients who may not be able to see their health provider in person.

The Reference Group noted that the long-term solution for telehealth support, as part of a comprehensive suite of health services, may not be through a fee-for-service MBS. However, it felt it was important to include actionable, shorter-term recommendations for specific items, both existing and new, that could address the current service gap in telehealth.

The Reference Group considered various restrictions on proposed telehealth items in order to ensure that they are not abused, and that telehealth is only used when it is a mechanism for providing high-value care to a patient. These included:

- **Rurality:** Ensure that patients who use telehealth services are not easily able to access a relevant health provider for a face-to-face consultation.
- **Usual practitioner:** Ensure that patients receive telehealth support from a provider who is focused on the patient and is providing telehealth support because it is the best medium available (rather than being focused on telehealth and providing a service to a patient simply because the option is available).
- **Follow-up care:** Ensure that patients only receive telehealth support when the attendance is in relation to a clinical issue already discussed at a face-to-face consultation.
- **Patient-side support:** Ensure that, where relevant, an appropriate practitioner is physically in attendance with the patient during their telehealth consultation.

Ultimately, the Reference Group decided against identifying the specific conditions associated with these dimensions, as several exceptions could be found for each of them. Some suggestions are included with each of the recommendations below, as a starting place for implementation.

The advantages of telehealth

For patients, the main benefit of using telehealth services is increased access to health care, with non-inferior outcomes, where clinically appropriate. Evidence for this includes the following:

- Surveys have consistently found high patient satisfaction with telehealth consultations (34) (35) (36).
- Compared to usual care, a range of telehealth interventions have been found to produce at least equivalent outcomes in the management of asthma (37) (38), blood pressure (39) and depression, and in overall quality of life (40).

A systematic literature review of telehealth services in rural and remote Australia reviewed models of care and factors influencing success and sustainability. Funding for general medical and other practitioners for the provision of telehealth services is limited or non-existent (41).

In a study in the United States, the transaction costs of in-clinic consultations and telehealth presentations were compared for chronic pain management provided by community-based providers including NPs, primary care physicians and physician assistants. Although similar in terms of cost, telehealth consultations demonstrated preliminary evidence for improved patient satisfaction with treatment, improved provider satisfaction with the consultation process, reduced wait times and reduced health care utilisation (42).

Recommendation 11 - Add GPs as eligible participants in NP patient-side telehealth services

The Reference Group recommended:

- a. adding GPs as eligible participants in NP patient-side telehealth services (items 82220, 82221 and 82222)
- b. including all Aboriginal and/or Torres Strait Islander peoples, not only patients of Aboriginal Medical Services or Aboriginal Community Controlled Health Services with a 19(2) exemption, and
- c. amending the item descriptors along the lines of the following example:

Item 82220 – example text

A professional attendance lasting less than 20 minutes (whether or not continuous) by a participating NP that requires the provision of clinical support to a patient who:

- a) is participating in a video consultation with a specialist, consultant physician, or general practitioner; and
- b) is not an admitted patient of a hospital; and
- c) is located:
 - (i) both:
 - (A) within a telehealth eligible area; and
 - (B) at the time of the attendance - at least 15 kms by road from the specialist, consultant physician or general practitioner mentioned in paragraph (a); or
 - (ii) in Australia if the patient is of Aboriginal or Torres Strait

Note: The Reference Group recognises that this item would require GPs to have access to reimbursement for telehealth service provision, whether through an MBS item number or a different funding model.

Rationale 11

This recommendation focuses on increasing patient access to, and use of, telehealth services. It is based on the following:

- Telehealth services provide high-quality care options for Australians.

- GP-to-patient telehealth items with an NP on the patient side would help to fill current access gaps and allow for the provision of clinically effective, high-value services to patients, including:
 - GPs as eligible telehealth providers will increase patient access to primary care, particularly in remote areas where such access is more limited. NPs are well placed to support these telehealth services due to their relatively higher presence in remote areas (compared to GPs).
 - GPs would also decrease wait times to see the GP (by enabling consultation at the time of need), minimise cost for the patient (by mitigating the need to travel to the GP) and enhance buy-in from remote sites (43).
 - Limiting the video telehealth attendance to clinical support with a specialist or consultant physician restricts patient access to health care providers when an NP is seeking consultation with a patient and a GP. Often it is more appropriate, cost-effective and efficient to consult with a collaborating GP, rather than a specialist or consultant physician, especially for people who are geographically marginalised (living in Modified Monash Model areas 4 to 7), people in aged care and people in palliative care who are being managed at home.
- The current structure of telehealth items limits NP uptake. A survey of 73 NPs who work in primary care and access the MBS indicated that only 12 per cent had ever used telehealth items. It identified the requirement to have a specialist or consultant present as the main reason for non-use of telehealth items (44). MBS data showed that there were only 1,033 telehealth rebate claims in 2016/17 (less than 0.3 per cent of NP services for the year).
- GP telehealth items enable collaborative relationships between NPs and GPs, as NPs support from the patient side to facilitate care.
- The Royal Australian College of General Practitioners has developed clinical guidelines to enable the implementation of video consultations in general practice. These guidelines provide valuable insight and strategies to mitigate risk (45).
- Access to telehealth items for Aboriginal and/or Torres Strait Islander peoples in all regions, from urban to remote, may help to improve uptake of services where low cultural safety limits their ability to access services.

Recommendation 12 - Add patients in community aged care settings to residential aged care telehealth items

The Reference Group recommends adding patients in community aged care settings to residential aged care telehealth items (82223, 82224 and 82225) with the proposed descriptors as follows:

“... patients in receipt of, or assessed as eligible for, Government-funded Home Care Packages.”

Rationale 12

This recommendation focuses on increasing access to, and use of, telehealth services for patients who face difficulties accessing their primary health provider despite living in urban areas. It is based on the following:

- NPs often provide services to older people living in RACFs and those who are still living at home but in receipt of (or assessed as eligible for) Government-funded HCP.
- Patients receiving funding through the HCP program have similar levels of frailty and dependence to those living in residential aged care. Despite living in urban areas, they often have mobility and illness limitations, which impede their ability to access medical and nurse practitioner services.

Recommendation 13 – Create new MBS items for direct NP-to-patient telehealth consultations

The NP Reference Group recommended:

- a. creating new MBS items for direct NP-to-patient telehealth consultations (items 8222A, 8222B and 8222C) with the proposed descriptors (using item 8222A as an example):

New Item 8222A – example text

A professional attendance lasting less than 20 minutes (whether or not continuous) by a participating NP practising in MMM 2-7 that requires the provision of clinical support to a patient who:

- a) is participating in a video consultation with the NP; and
- b) is not an admitted patient; and
- c) is located:
 - (i) both:
 - (A) within an MMM 2-7 area; and
 - (B) at the time of the attendance - at least 35 kilometres from the NP's location (a); or
 - (ii) in Australia if the patient is of Aboriginal or Torres Strait Islander descent.

- b. these items should parallel the time-tiers of existing patient-side items (i.e. less than 20 minutes, at least 20 minutes and at least 40 minutes), and
- c. there should be no requirement for any particular health service professional to be patient-side.

Rationale 13

This recommendation focuses on increasing patient access to, and use of, telehealth services. It is based on the following:

- Telehealth services are high-quality care options for Australians.
- Telehealth sessions between an NP and a patient will improve access to timely care, reduce fragmentation, reduce or avoid the need for patients to be transferred to access required care, and allow for clinically effective, high-value services for patients. For example:
 - Telehealth services could be used for managing a patient who may already have medications/dressing available, to triage for the need for a physical consult, and/or to follow up on a face-to-face consult.

- Telehealth services can increase access for patients in isolated areas. For example, a patient based at a cattle station will require access to care for an initial contact, for urgent or emergent care, or for follow-up care. If provided face-to-face, patients would face barriers including cost, travel and time away from community.
- Telehealth consultations can help improve access for patients with physical disabilities (who may find it difficult to get to an NP's office) and for patients with intellectual disabilities (who may not respond well to unfamiliar surroundings).
- Telehealth consultations can support NPs in providing primary care across the aged care sector. Enabling aged care nurses to access the support of NPs, particularly after hours, would further enhance NPs' contribution to improving health outcomes and avoid deterioration in health status for older people.
- The Reference Group acknowledges that there could be benefit in a patient-side attendance by an RN, an Aboriginal and Torres Strait Islander health worker or health practitioner, an allied health professional, an enrolled nurse, or other health care providers.

Recommendation 14 allow telehealth consultations to take place via telephone where clinically appropriate

Allowing telehealth consultations to take place via telephone where clinically appropriate (i.e. without requiring a video connection) (items 82220, 82221, 82222, 82223, 82224, 82225, 8222A, 8222B and 8222C).

Rationale 14

This recommendation focuses on increasing patient access to, and use of, telehealth services. It is based on the following:

- Requiring video connections between patient and practitioner has been shown to limit patient access to telehealth services (46) (47).
- Patients may be unable to undertake video communication due to:
 - Poor internet connections, often due to remoteness.
 - Lack of access to necessary technology.
 - Lack of understanding of or comfort with technology.
- Telephone communication for telehealth services offers non-inferior outcomes, where clinically appropriate (47) (48).

Participating Midwives Reference Group Recommendations

Table 1: Items 82150–82152

Item	Descriptor	Schedule fee (AUD)	Services FY2016/17	Benefits FY2016/17 (AUD)	Services 5-year annual avg. growth
82150	A professional attendance lasting less than 20 minutes (whether or not continuous) to a patient who is participating in a video consultation with a specialist / consultant in paediatrics or obstetrics	28.30	1	24	-24.2%
82151	A professional attendance lasting at least 20 minutes (whether or not continuous) to a patient who is participating in a video consultation with a specialist / consultant in paediatrics or obstetrics	53.70	2	91	-16.7%
82152	A professional attendance lasting at least 40 minutes (whether or not continuous) to a patient is participating in a video consultation with a specialist / consultant in paediatrics or obstetrics	78.95	15	1,007	NA

Note: There were no claims for item 82152 in 2011/12 to calculate a growth rate

Recommendation 11 – Include GPs as eligible specialists for existing telehealth items

Amending the item descriptors (items 82151 and 82152) to include GPs in the list of doctors who can participate in the video consultation, as follows (changes in bold):

Item 82151

A professional attendance lasting less than 20 minutes (whether or not continuous) to a patient who is participating in a video consultation with a specialist / consultant in paediatrics, obstetrics **or general practice**.

and

Item 82152

A professional attendance lasting at least 40 minutes (whether or not continuous) to a patient participating in a video consultation with a specialist / consultant in paediatrics or obstetrics **or general practice**.

Rationale 11

This recommendation focuses on ensuring that the MBS provides adequate access to high-quality clinical services for women. It is based on the following:

- The Reference Group agreed that there is a need to expand midwifery services to rural and remote populations. There is a clear relationship between distance to maternity services and poorer clinical and psychosocial outcomes (31; 32). Key Australian maternity documents cite rural and remote maternal location as a barrier to quality maternity care (16; 33). The Australian Rural Birth Index project found that maternity services in Australia do not match population need (34).
- The Reference Group agreed that telehealth items are one way to drive increased access to midwifery services for rural and remote populations.
- Current midwifery telehealth items are underutilised. MBS data shows that items 82150–82152 were claimed a total of 18 times in 2016/17. The Reference Group proposed two reasons for this low service volume:
 - Telehealth attendances must include a specialist obstetrician or paediatrician, who often does not have the time to undertake telehealth consultations on an ad-hoc basis.
 - Claims for items 82150–82152 require the participating paediatrician or obstetrician to have submitted an MBS claim for their participation in the teleconference. Reference Group members with experience using these items highlighted that specialist practitioners do not always bill for these attendances as they are a small part of their scope of practice. As such, MBS service volumes may be artificially low.
- The Reference Group agreed that including GPs in the descriptors for current telehealth items would be beneficial to women accessing midwifery care. GPs (especially those with a sub-specialisation in obstetrics) are well placed to deliver medical advice to women and their caring midwives during pregnancy. The Reference Group identified two potential use cases for this:
 - Women who live in rural or remote regions may have their early antenatal care primarily with their GP and may plan to birth in the city with midwifery continuity of care. There may be occasions when a telehealth consult will occur between the woman, the GP who is providing her antenatal care and the intended midwife for intrapartum and birth care.
 - There may be occasions when the women and her primary midwife will benefit from access to their regular GP for a team discussion. This discussion may include the results and implications of recent tests or detail on the ongoing management of

chronic conditions. Ensuring key clinicians such as the woman's GP are actively involved in her pregnancy will optimise outcomes.

- GPs are better dispersed across Australian rural and remote areas than obstetricians and paediatricians. As such, women and their midwives may be able to undertake telehealth consultations with GPs more proximal to women's homes. The Reference Group agreed that this may drive more local continuity of care for women and these practitioners. The number of practitioners eligible to deliver these services will increase, driving increased access and overcoming the time constraints of specialists.
- The Reference Group agreed that use of this item should be reviewed in 12 to 24 months.

Recommendation 12 – Facilitate telehealth consultations between women and midwives in the antenatal and postnatal period.

The PM Reference Group recommended:

- a. creating three new telehealth items (821FF, 821GG and 821HH) for women consulting with a midwife via teleconference, with a nurse, Aboriginal and Torres Strait Islander health worker or professional, or another midwife on the patient side
- b. creating time tiers for these new items in line with items 82150–82152, and
- c. that proposed new item descriptors be as follows:

New Item 821FF – example text

A professional attendance lasting less than 20 minutes (whether or not continuous) to a patient, supported by a nurse, Aboriginal Health Worker/Professional or midwife, who is participating in a video consultation with a participating midwife.

New Item 821GG

A professional attendance lasting at least 20 minutes (whether or not continuous) to a patient, supported by a nurse, Aboriginal Health Worker/Professional or midwife, who is participating in a video consultation with a participating midwife.

New Item 821HH

A professional attendance lasting at least 40 minutes (whether or not continuous) to a patient, supported by a nurse, Aboriginal Health Worker/Professional or midwife, who is participating in a video consultation with a participating midwife.

and

- d. adding the following restrictions, in line with items 82150–82152:

- (i) The woman must not be an admitted patient.
- (ii) The woman must be located both within a telehealth-eligible area, and at least 35 kilometres by road from the participating midwife mentioned in the above descriptors.
- (iii) The woman must reside in a rural or remote region (defined as Modified Monash Model areas 4–7).
- (iv) The midwife must be intending to undertake the woman’s birth, or in the case of postnatal care, be the primary provider of postnatal care or breastfeeding support for the woman.

Rationale 12

This recommendation focuses on ensuring that consumers in remote and rural areas can access high-quality, cost-effective maternity care. It is based on the following.

- As noted in Recommendation 9, the Reference Group agreed that there is a need to expand midwifery services to rural and remote populations.
- Members of the Reference Group who work primarily with Indigenous women or remote/rural services report that most of these women have access to a health worker such as a nurse. The identified telehealth need is for that worker and the women to be able to consult with a midwife.
- The Reference Group agreed that there are multiple instances where a participating midwife could provide high-value care to a woman via telehealth without the participation of a medical professional. For example:
 - Women who live or work in rural or remote areas (for example, Anangu Pitjantjatjara Yankunytjatjara [APY] lands) but are planning to come to the city to birth can access midwife care regularly throughout their pregnancy and build rapport with their midwife before seeing them face-to-face. This provides opportunities for explanation and education.
 - A woman residing in a remote area might attend a number of antenatal consultations via telehealth with a participating midwife who is her intended midwife for labour and birth. Due to the remote location, all antenatal consults cannot be attended face-to-face.
 - Women returning to remote areas after birth can consult via telehealth with the known birthing midwife, providing continuity of care.
 - Women who live several hours away from their midwife can check in for antenatal discussion and education. A local health worker can perform a basic clinical examination.
- The Reference Group agreed that having practitioners on the patient side during these consultations is important to enable appropriate observations and basic examinations during the attendance.
- The Reference Group agreed to include midwives in the list of eligible practitioners on the patient side under this item. The Reference Group agreed that a participating midwife consulting with another midwife via teleconference would be particularly useful when women are planning on moving to a metropolitan area to give birth. For example:

- Women may move from a rural/remote area to the city for birth. Telehealth offers the opportunity for midwives to introduce rural and remote women to the participating midwife who will be undertaking their birth in a metropolitan region. This allows familiarity for those who are unable to meet their participating midwife face-to-face.
- Women who live in rural or remote regions may be experiencing breastfeeding challenges. The remote area midwife may not have any additional training in this area and may request help from a specialised midwife in the city. Together with the woman, they may be able to provide an assessment of attachment, remedial assistance and support to enable ongoing breastfeeding.
- The Reference Group noted the importance of continuity of care in ensuring high-value use of telehealth items in a fee-for-service system and has targeted its recommendations to promote this.

Ophthalmology Clinical Committee

Recommendation 12 - Remove item 99's association with item 104 or 105, and instead have three item numbers that include asynchronous options.

The Committee acknowledges that telemedicine items are not within its area of responsibility, and that the Optometry Clinical Committee will determine the final recommendations. However, the Committee has suggested an approach to restructuring MBS telemedicine items for the consideration of the Optometry Clinical Committee. It noted that telemedicine has a crucial role to play in improving rural and remote eye health, given the maldistribution of the ophthalmology workforce and limited uptake in the current system.

Restructuring telemedicine items

Recommendation 12

- Remove item 99's association with item 104 or 105, and instead have three item numbers that include asynchronous options:
 - Item A: Videoconference with patient and referrer present, independently claimed, for bulk billing only.
 - Item B: Virtual "home visit" via telephone or video with only patient present, for optometry referrals only.
 - Item C: Asynchronous management advice via report to optometrist and patient, for optometry referrals only, with a requirement to send a formal report to the optometrist and patient.

Rationale for Recommendation 12

This recommendation aims to increase the uptake of telehealth services and promote a coordinated and asynchronous approach to eye health care. It is based on the following.

- The current system presents difficulties in coordination, requiring three people to be present at once. This means that if someone is running late, it affects everyone. Asynchronous health care is important and has been proven internationally to be effective in the coordination of telehealth.

- There is significant maldistribution in the ophthalmology workforce across Australia, with 84 per cent of ophthalmologists working in metropolitan areas.²²
- Ophthalmology telehealth services have a single referral group: optometrists. This is an unusual primary care source with advanced equipment. Ophthalmologists often receive multiple scans, images or field tests in a patient referral, which require asynchronous interpretation of results.

Optometry Clinical Committee

Recommendation 3 - Convene a Departmental working group to explore the barriers and opportunities offered by telehealth across all areas of Health. In the case of Optometry, to develop an appropriate MBS item to meet the requirements of Optometry and Ophthalmology.

Rationale for Recommendation 3

- This recommendation focusses on the Committee discussion that acknowledged the value and importance of telehealth in providing access to patients across Australia.
- The Committee acknowledged the potential for telehealth to be applied in consultations, improving patient access and offering potential asynchronous consultations between patient, referrer and practitioner.
- The Committee noted the broad application and potential of telehealth across all of the providers operating within the MBS as its benefits are not just limited to optometry. To ensure consistency and avoid duplication of effort and to invest sufficient time and effort to develop a comprehensive understanding of the rapidly changing technology, it was suggested that a cross discipline working group be established.

Pain Management Clinical Committee

Recommendation 28 - Telehealth items should be available for multi-disciplinary assessment and review for pain management patients.

The Committee recommends that telehealth items should be available for multidisciplinary (medical, nursing and/or allied health professionals) assessment and review for pain management patients. This could be achieved via generic telehealth or pain specific item numbers.

Rationale 28

This recommendation focuses on ensuring continuing effective access to rural and remote patients. It is based on the following assessment (McGeary, McGeary, & Gatchel, 2012) (Pronovost, Peng, & Ker, 2009) (Eccleston, et al., 2014):

- Under the current MBS arrangements telehealth provides a means of accessing specialist services when consumers are located in rural and remote areas with no local service.
- Telehealth funding could better support access to complete pain services in regional areas including education for consumers and health practitioners.

- The inability to access effective multidisciplinary pain management, especially in rural and remote areas, costs the health system more in the long term and carries a substantial economic burden through lost productivity and increase health care utilisation (Keogh, Rosser, & Eccleston, 2010).
- People who live in urban areas and have severely limited mobility, due to pain or other reasons, may also benefit from telehealth consultations. Telehealth has the potential to address one of the key factors that currently inhibit patient access to tertiary pain management services.
- The advantages of telehealth are that it enables provision of a service with a high level of specialist expertise, but in a mode that is highly accessible without the costs and challenges involved in transport and accommodation (Keogh, Rosser, & Eccleston, 2010).
- The creation of telehealth items for the assessment and review of pain management treatment plans would:
 - Aid in the triage process and guide planning
 - Engage consumers and local primary care services
 - Support local staff in modifying a pain management plan
 - Be potentially used for the purpose of MDT Review (NSW Agency for Clinical Innovation, n.d.), and
- The Committee notes this is a whole-of-MBS issue, which the Committee hopes will be considered as applicable to the practice of pain medicine.

Psychiatry Clinical Committee

Telehealth

Table 2: 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%

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

The Committee recommended:

- removing item 288 from the MBS.
- a new suite of time-tiered items be introduced 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. that 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.

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.

- If opting not to introduce an incentive payment or similar, item 288 should be gradually withdrawn rather than removed, as a means to avoid any sudden retreat from its use and to allow the system time to readjust.

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

The Committee recommended:

- 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, 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).

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 difficulty 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 difficulty 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.

Telepsychiatry

Table 3: 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

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

The Committee recommended:

- a. retaining the telepsychiatry items on the MBS, as they are still providing a high value service to patients who currently access these services,
- 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, and
- c. re-evaluating the need for these services in the next review of psychiatry items.

Rationale 4

The telepsychiatry items provide for consultations with psychiatrists over the phone 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 who could not otherwise access consultations face-to-face or over videoconference.
- 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 as many patients will have access to a telephone, including a mobile phone, but may not be able to reliably access video consultations 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 the phone, particularly when video conferencing can be used.

Specialist and Consultant Physician Clinical Committee

Current telehealth framework

The MBS has 17 telehealth attendance items with 67,000 services provided in conjunction with an existing consultation item in FY2016/17.¹⁷ These items include:

¹⁷ See item-level data for all telehealth attendances in Appendix - A.3.

- Nine telehealth loading items valued at 50 per cent of the schedule fee for the attendance item with which they are co-claimed, accounting for more than 98 per cent of telehealth service volume and spend.
- Eight items for telehealth attendances under 10 minutes,¹⁸ accounting for just 159 services in 2016/17.

The Committee noted that the 2011 telehealth incentive scheme and loading items have been successful in capturing early adopters, with almost 2,000 providers using these items in 2016/17. However, the Committee recognises that barriers to uptake persist, as evidenced by the significant slowing of growth in services (from 167 per cent growth in the first year of implementation down to 8 per cent growth last year).

There are currently two applications of telehealth in Australia:

- Patient supported by a health professional: A health professional (for example, a GP, nurse practitioner or physiotherapist) is with the patient for the telehealth attendance. This creates a communication bridge between consumers, primary care and consultant specialists, minimises the number of times a patient has to “tell their story”, and allows for a more complex examination than can be undertaken if the patient is alone.
- Directly with the patient: This item is better suited to providing ongoing or follow-up care, is more cost-effective, and increases access by patients to consultant specialist services.

Benefits of telehealth

The Committee recognises that there are huge benefits to be gained from the uptake and appropriate use of telehealth, including:

- Increased access for patients in rural and remote areas, and for those who may find it difficult to attend consulting rooms or a hospital (for example, consumers with significant mobility challenges, or parents who have a child with a disability).
- Reduced travel time and costs for patients, resulting in patient savings, fewer travel grants and less time off work.
- Reduced travel time and costs for clinicians, resulting in saved clinician days.

Barriers to telehealth growth

Recognising the significant slow-down in growth of services, the Committee has noted significant barriers to the increased adoption of telehealth, particularly patient and primary care awareness and consultant specialists’ perception of telehealth.

- Patients may not have access to information about when to request telehealth, how to access it, and a clear understanding of its benefits.
- GPs may not be aware of the patient population groups that would benefit most from telehealth, when to recommend it to these patients, and how to integrate it into their practice. Likewise, consumers may be unaware this service option is available.

¹⁸ One item each for specialists, consultant physicians, occupational medicine, pain medicine, palliative care, neurosurgery, addiction medicine and sexual health medicine.

- Primary care workers may not be aware of existing MBS items for providing clinical support to a patient who is participating in a telehealth attendance.
- Clinicians may be unwilling to change their clinical practice to adopt telehealth and may not be convinced of its effectiveness (4). There may be a lack of understanding of the functionality and security of telehealth.

Telehealth also requires additional technology and administrative support to enable efficient delivery, such as telehealth equipment, scheduling software, and mechanisms to collate and email patient records and investigation results. These technical issues may be regarded as significant barriers to access to potential provider users.

Recommendation 9 – A new framework for telehealth

The Committee recommended:

- Removing the eight specialty-specific telehealth attendance items (items 113, 114, 384, 2799, 3003, 6004, 6025, and 6059) from the MBS;
- incrementally reducing derived fee for the nine telehealth loading items loading items (items 99, 112, 149, 389, 2820, 3015, 6016, 6026, and 6060) to zero;
- undertaking annual analysis of the phase out so to identify potential unintended consequences; and
- introducing new telehealth-specific attendance items (after the nine loading items have been removed) that mirror the standard time-tiered attendance items, with the same fees, and with item descriptors that describe recommended activities to be performed in each tier.

Table 6: Telehealth attendance item descriptors

Level (item) ¹⁹	Duration	Item descriptor
Level B (THB)	6-20 minutes	<p>Professional attendance of more than 5 minutes but not more than 20 minutes by a consultant specialist in the practice of his or her specialty if:</p> <ol style="list-style-type: none"> the attendance is by video conference; and the patient is not an admitted patient; and the patient: <ol style="list-style-type: none"> is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance--at least 15 km by road from the consultant specialist; or is a care recipient in a residential care service; or is a patient of: (a) an Aboriginal Medical Service; or (b) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the act applies. <p>An attendance including any of the following that are clinically relevant:</p>

¹⁹ Item numbers listed here indicate a structure for the DHS to follow when assigning item numbers.

		<ul style="list-style-type: none"> a) a focused patient history b) implementing a management plan c) outcomes documented and communicated in writing to the referring practitioner
Level C (THC)	21-40 minutes	<p>Professional attendance of more than 20 minutes but not more than 40 minutes by a consultant specialist in the practice of his or her specialty if:</p> <ul style="list-style-type: none"> d) the attendance is by video conference; and e) the patient is not an admitted patient; and f) the patient: <ul style="list-style-type: none"> iv. is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance--at least 15 km by road from the consultant specialist; or v. is a care recipient in a residential care service; or vi. is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19(2) of the act applies. <p>An attendance including any of the following that are clinically relevant:</p> <ul style="list-style-type: none"> a) detailed patient history of a major single or multiple minor conditions b) single or multiple minor diagnostic problems considered c) a non-complex management plan and, if required; d) discussion of multiple treatment options available, including; <ul style="list-style-type: none"> i. Discussion of treatment options to assess pros and cons of each option given patient characteristics and medical history ii. Consideration and discussion of necessary referrals to other health professionals iii. Written documentation made available for the patient and/or carer that facilitates informed consent, such as treatment options, costs, and information on associated risks and benefits e) outcomes documented and communicated in writing to the referring practitioner
Level D (THC)	41-60 minutes	<p>Professional attendance of more than 40 minutes but not more than 60 minutes by a consultant specialist in the practice of his or her specialty if:</p> <ul style="list-style-type: none"> g) the attendance is by video conference; and h) the patient is not an admitted patient; and i) the patient: <ul style="list-style-type: none"> vii. is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance--at least 15 km by road from the consultant specialist; or viii. is a care recipient in a residential care service; or ix. is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19(2) of the act applies.

		<p>An attendance including any of the following that are clinically relevant:</p> <ul style="list-style-type: none"> a) comprehensive patient history of multiple conditions or a complex single condition b) multiple diagnostic problems considered c) a comprehensive management plan and, if required; d) discussion of multiple treatment options available, including; <ul style="list-style-type: none"> i. Discussion of treatment options to assess pros and cons of each option given patient characteristics and medical history ii. Consideration and discussion of necessary referrals to other health professionals iii. Written documentation made available for the patient and/or carer that outlines treatment options and information on associated risks and benefits e) Outcomes documented and communicated in writing to the referring practitioner
Level E (THE)	More than 60 minutes	<p>Professional attendance of more than 60 minutes by a consultant specialist in the practice of his or her specialty if:</p> <ul style="list-style-type: none"> j) the attendance is by video conference; and k) the patient is not an admitted patient; and l) the patient: <ul style="list-style-type: none"> x. is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance--at least 15 km by road from consultant specialist; or xi. is a care recipient in a residential care service; or xii. is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19(2) of the act applies. <p>An attendance including any of the following that are clinically relevant:</p> <ul style="list-style-type: none"> a) extensive history of multiple complex conditions b) multiple complex diagnoses considered c) a comprehensive management plan and, if required; d) discussion of multiple treatment options available, including; <ul style="list-style-type: none"> i. Discussion of treatment options to assess pros and cons of each option given patient characteristics and medical history ii. Consideration and discussion of necessary referrals to other health professionals iii. Written documentation made available for the patient and/or carer that outlines treatment options and information on associated risks and benefits e) Outcomes documented and communicated in writing to the referring practitioner

Recommendation 10 – Reinvest in telehealth

The Committee recommended:

Reinvesting all savings from removing the telehealth loading towards mechanisms designed to increase uptake of telehealth services in Australia. Both MBS and non-MBS mechanisms should be considered, and options could include the following:

- a. increase utilisation of telehealth services among consumers, GPs and PHNs, by:
 - i. developing and sharing the value proposition of telehealth with consumers, including the potential savings in time, travel and other costs;
 - ii. funding PHNs and consumer representatives (community champions) to carry out telehealth education and awareness building in targeted communities (for example, where GPs already provide telehealth);
 - iii. educating GPs and PHNs to identify and promote telehealth with patient population groups that would most benefit from telehealth attendances—both those held directly with the consultant specialist (for example, follow-up care) and those supported by a health professional (for example, more complex cases or where further support with health literacy is needed);
 - iv. investing in education and training of primary care workers, including telehealth training days and the development of training material (for example, online modules); and
 - v. promoting the use of MBS items that already exist for primary care workers to provide clinical support to patients participating in consultant specialist telehealth attendances (Category 8 of the MBS, Groups M12, M13, and M14).
- b. increasing the supply of telehealth services offered by consultant specialists, by:
 - i. developing the value proposition of telehealth for providers and sharing this with provider population groups that are most likely to offer telehealth services;
 - ii. educating consultant specialists to identify and promote telehealth with patient population groups that would most benefit from telehealth attendances;
 - iii. developing materials on how to set up and run telehealth services;
 - iv. coordinating with Colleges to promote telehealth education and training, including awarding CPD points for telehealth training;
 - v. encouraging Colleges to educate consultant specialists on the benefits of telehealth, how to set it up, and when it should be used; and
 - vi. developing guidelines and tools to determine and resolve any clinical governance issues and concerns.

Rationale 9 & 10

This recommendation focuses on removing an MBS telehealth loading that is no longer effective and reinvesting this saving to increase uptake of, and targeted access to, telehealth services. It is based on the following reasons:

- Telehealth is already a cost-effective way of delivering care. A number of systematic reviews have found that telehealth is a cost-effective way of delivering care, and follow-up via telehealth has been shown to have lower associated costs than in-person clinic

assessment (4) (5). A study by Marsh et al (6). in 2014 showed that patients followed up after hip surgery via telehealth travelled less (28km versus 104km) and had lower associated costs (\$10 versus \$21), and that attendances took less total time to complete (122 minutes versus 229 minutes).

- The Committee also noted that many countries and health services, including Finland (7), British Columbia and the UK (8), have built successful telehealth services without providing any financial incentive to physicians (Figure 5).

FIGURE 5: HOW ARE TELEHEALTH ATTENDANCES REIMBURSED IN OTHER GEOGRAPHIES

Location	Payment mechanism	Tariff	Requirements/ Restrictions
 Germany	Item on reimbursement catalogue since April 17	Additional technology subsidy of 4.21 EUR for every hour of video consultation provided up to 800 EUR annually on top of the reimbursement for a standard in person attendance	<ul style="list-style-type: none"> ▪ Can only be used by certain doctor groups (GPs, ophthalmologists) ▪ Only for certain suitable indications (e.g. Visual postoperative follow-up of an operation wound)
 Finland	KELA (Finnish Social Insurance Institution) started reimbursement for digital appointments in 2016	Cost of tele-consultations varies from EUR10.5 per 10 min up to EUR27 for 60 min, same as for face-to-face visits	<ul style="list-style-type: none"> ▪ No restrictions stated
 British Columbia (Canada)	The medical service commission payment schedule includes telehealth consultation items (in specialty chapters)	Varies by specialty but is the same as the standard consultation item for that specialty	<ul style="list-style-type: none"> ▪ "Telehealth Service" is defined as a medical practitioner delivered health service provided to a patient
 United Kingdom	Teleconsultations (video or phone) for outpatient specialist care have been available since 2008-09, and are funded with the same DRG code as face-to-face appointment	Diagnoses-related group payment that differs by specialty, and by single vs multiple professional and first vs follow up appointment. No telehealth uplift.	<ul style="list-style-type: none"> ▪ No restrictions stated ▪ Currently, 2-3% of outpatient consultation are coded as teleconsultations (2% for 1st attendance, 3% for follow-up) ▪ The majority are telephone consultations

- Telehealth loading is not the optimal mechanism to incentivise physician uptake. In Australia, growth in utilisation of telehealth for consultations has slowed significantly since the introduction of the loading items in 2011²⁰, indicating that they are not incentivising appropriate provider uptake of telehealth. Physicians cite a lack of acceptance of telehealth as the main barrier to uptake.²¹
- Consumers lack awareness of telehealth services. Bradford et al. (9) conducted a study in rural Queensland in 2015 which showed that 60 per cent of participants were aware of telehealth, but only 13 per cent had used telehealth services. The authors observed that

²⁰ MBS data 2011/12 to 2016/17

²¹ Wade et al. (2014) conducted a qualitative study of 36 Australian telehealth services and concluded that physician acceptance of telehealth was the main driver of low uptake.

trust is required for telehealth to be an acceptable application for patients, and concluded that greater public awareness and understanding of the potential benefits of telehealth was needed.

Wound Management Working Group

Recommendation 8: Remote and non-face-to-face services (real time or asynchronous)

The Working Group recommended:

Where appropriate, consideration should be given to the use of remote and non-face-to-face services (real time or asynchronous) and an appropriate funding model investigated.

Ideally a healthcare provider would attend a patient face-to-face, however, the Working Group agrees that telehealth is an appropriate alternative in many situations, particularly to assist referral to a wound care specialist.

The situation of obtaining an expert/specialist opinion is one that in the opinion of the Working Group is well suited to asynchronous telehealth, which would increase potential access to specialist services and also in many cases be more convenient for the patient, without any reduction in clinical value.

This treatment modality may be appropriate in a number of situations, including rural and remote settings and RACFs, as well as to assist established teams working within different location.

Rationale for Recommendation 8

This recommendation focuses on increasing access to best practice wound management services, including value for the patient and the health system.

It is based on the following:

- Telehealth should not be a substitute for face-to-face care, however can play an important role in the management of chronic wounds.
- Utilisation of remote and non-face-to-face services has been proven beneficial in a number of clinical situations, including in the provision of remote specialist wound consultations (46) (55) (48) (57) (58). These services have been used for a number of years in remote areas in Australia, addressing many of the key challenges to providing health care in Australia.
- Telehealth is a recognised modality of providing equitable access to wound care expertise. Use of telehealth has been observed to reduce hospitalisations, improve wound healing, reduce cost of care and assist with facilitating inter-professional practice between GPs, allied health, specialists and the acute sector (60) (61) (62) (63) (55) (65), and should be considered in a number of situations, including RACFs.
- This recommendation is in line with the General Practice and Primary Care Clinical Committee (GPPCCC) draft recommendation supporting flexible access to services, including utilisation of asynchronous and non-face-to-face technologies.

Recommendation 14 - Access to wound care experts in RACF

The Working Group recommended improved access to wound experts, including service teams (on-site or telehealth-enabled, where appropriate), to assist RACF staff to provide evidence-based wound management of chronic wounds for residents. This should take into account existing services (variable across States and locations) that currently support RACF staff through provision of expert wound care services.

The model for such a service may parallel the Government's existing [Dementia Management and Advisory Services \(DBMAS\) program](#), which provides assessment, clinical support, short term case management and mentoring/clinical supervision of care providers within RACF.

Rationale for Recommendation 14

This recommendation focuses on providing universal access to best practice wound management services.

It is based on the following:

- As the Working Group has recommended (see Rec 7), improvement in a wound must be observed or referral to an appropriate specialist wound care practitioner mandated. A wound may be classified as non-healing after appropriate assessment (59), as is often the case with malignant wounds or wounds that arise during end stages of life. For instance, malignant wounds (fungating or ulcerating) seldom heal yet require specific treatment to ameliorate symptoms such as pain, bleeding, exudate and malodour. These wounds are often challenging to manage due to their location, frequency of dressing changes and amount of dressing products used at any one time to manage the wound (43) (45). As such, ensuring access to wound experts when appropriate is an essential element in any setting in which a wound is being managed. This is particularly the case in RACFs where RACF staff have various levels of skills and experience in wound management (40).
- Telehealth is a recognised modality of providing equitable access to wound care expertise (see Rec 8) (60) (61) (62) (63) (55) (65).
- This recommendation should be read in line with Recommendation 22, defining credentialing requirements of specialists in wound management.

Eating Disorders Working Group

NOTE: This Recommendation has been implemented.

The Working Group recommended:

The services referred to in recommendation 1.2 be allowed to be provided via telehealth (under the same eligibility requirements that exist for other MBS services) in order to increase access to services for patients in rural and remote areas.

Recommendation 1.2: The Working Group recommends the introduction of a new suite of items to provide a comprehensive stepped model of care for:

- o all patients with anorexia nervosa; and
- o patients with bulimia nervosa, binge-eating disorder and other specified feeding or eating disorders who have complex needs, have not responded to treatment at a lower level of intensity and are assessed as 'high-risk' of serious medical and psychological complications.

The new items would provide for:

- o the development and review of a treatment and management plan by a medical practitioner (such as a GP).
- o This item would trigger eligibility for a comprehensive model of care, consisting of an initial and more intensive course of psychological and dietetic treatment depending of the patient's needs.

Initial course of treatment

- o Triggered by the development of a treatment and management plan by a medical practitioner (GP):
 - an initial course of up to 20 psychological sessions; and
 - an initial course of up to 10 dietetic sessions.
- o The GP will assess the patient throughout the treatment process, but should assess whether the patient should progress beyond 10 psychological sessions and 5 dietetic sessions by conducting a review consultation (with a New Item Number) before or around 9 or 10 sessions completion mark, to approve and trigger another course of 10 psychological sessions and 5 dietetic services (up to 20 psychological sessions and up to 10 dietetic sessions). This review item will involve a full medical and psychological history, a full physical examination and ordering and reviewing relevant investigations.
- o The mental health professional involved in the patients treatment will be required to formally report back to the practitioner before or around the 9 to 10 services completion mark to certify the patient's diagnosis and confirm that the patient requires a further course (an additional 10 psychological sessions) of treatment.

More intensive treatment

If the patient has not responded to treatment at a lower intensity, upon formal review and assessment of the patient by a psychiatrist or paediatrician, the patient would be eligible for:

- o an additional course of up to 20 psychological sessions (40 sessions in total per year) ; and
- o an additional course of up to 10 dietetic sessions (20 sessions in total per year).

GP reviews

It is expected that as the central care provider, the GP will review the patient throughout the treatment process, performing the necessary medical assessments, including ordering and reviewing the required tests, and assessing the patient's response to treatment.

Reports back to the GP from the mental health professional and dietitian.

It will be a requirement that the mental health professional and dietitian delivering care to the patient provide written reports back to the managing GP after each set of services (that is, after each set of 10 psychological services and 5 dietetic services).

Gynaecology Clinical Committee

1.1 Professional attendance (items 13209 and 13210)

Table 9: Item introduction table for items 13209 and 13210

Item	Descriptor	Schedule fee	Volume of services FY2015/16	Services 5-year-average annual growth	Total benefits FY2015/16
13209	Planning and management of a referred patient by a specialist for the purpose of treatment by assisted reproductive technologies or for artificial insemination payable once only during 1 treatment cycle	\$84.70	78,387	3.7%	\$6,154,271
13210	Professional attendance on a patient by a specialist practising in his or her specialty if: (a) the attendance is by video conference; and (b) item 13209 applies to the attendance; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance—at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an Aboriginal Medical Service; (b) or an Aboriginal Community Controlled Health service for which a direction made under subsection 19 (2) of the act applies	\$42.35	-	0.0%	\$-

Recommendation 10

- △ Item 13209: No change.
- △ Item 13210: Delete item.

Rationale

This recommendation focuses on modernising the MBS. It is based on the following.

- △ Item 13209:
 - This item remains appropriate for contemporary care.
- △ Item 13210:
 - MBS data shows that item 13210 was not claimed at all in FY2015–16 or within the past five years. The Committee appreciates the intention to extend access to the patients detailed in the descriptor, but it notes that this has not yet resulted in any use of the item.