



Medicare Benefits Schedule Review Taskforce

Second report from the Principles and Rules Committee

November 2019

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Abbreviations and acronyms

Act, The	<i>Health Insurance Act 1973</i>
Committee, the	MBS Principles and Rules Committee
Department, The	Australian Government Department of Health
CP	Consultant physician
CSCC	Cardiac Services Clinical Committee
CT	Computed tomography
DICC	Diagnostic Imaging Clinical Committee
DIST	Diagnostic Imaging Services Table
GP	General Practitioner
GMST	General Medical Services Table
MBS	Medicare Benefits Schedule
MSAC	Medical Services Advisory Committee
MSR	Multiple services rule
‘NR’ services	Non-referred (diagnostic imaging) services
‘R’ services	Referred (diagnostic imaging) services
RANZCR	Royal Australian and New Zealand College of Radiologists
Taskforce, the	MBS Review Taskforce

1. Committee information

1.1 The Principles and Rules Committee

The Medicare Benefits Schedule (MBS) Review Taskforce (the Taskforce) established the Principles and Rules Committee (the Committee) to assist with the Taskforce's programme of work to consider how more than 5,700 items on the MBS can be aligned with contemporary clinical evidence and practice and improve health outcomes for patients. Specifically, the Committee assists the Taskforce with:

- examination, and updating where appropriate, of the legislative and regulatory framework underpinning the MBS;
- broader questions about the principles, objectives and boundaries shaping the MBS's conceptual approach and its impact in practice; and
- design of principles to guide clinical committees in forming their recommendations.

1.2 First report of the Principles and Rules Committee

The Committee's first report was released for public consultation in August 2016. The finalised report provided six recommendations to Government, three of which were implemented in full on 1 November 2017 and three of which are pending Government decision.

A summary of first report recommendations and subsequent action is provided at [Appendix A](#).

1.3 Purpose of this report

This, the Committee's second report is not intended to be released for public consultation and is provided to the Taskforce to:

- i) Provide transparency over point in time advice provided by the Committee to both the Taskforce and its clinical committees ([Appendix B](#));
- ii) Deliver a recommendation and suggestions for Department of Health action; and
- iii) Deliver considerations for future MBS review activity.

1.4 Other relevant public consultation – surgical assistant services

In September 2018 the Committee developed and consulted on draft principles and recommendations that centred on remuneration for surgical assistants. Over 100 submissions were received from peak bodies, individual clinicians, nurses and billing agencies during stakeholder consultation.

Following the consultation period the Taskforce recommended to Government the formation of a working group to examine the issue in greater depth. At the time of writing, Government decision is pending.

2. Committee membership

The Committee's membership comprises nine clinicians, a consumer representative, and a health policy expert, and includes two *ex officio* Taskforce members.

Table 1: Principles and Rules Committee members

Name	Position/title	Declared conflict of interest
Professor Michael Grigg (Chair)	Past President, Royal Australasian College of Surgeons; Past President, Australia and New Zealand Society of Vascular Surgery; Private practitioner (vascular surgery)	Nil
Associate Professor Lourens Bester	Interventional radiologist	Nil
Dr Penny Browne	General Practitioner; Chief Medical Officer, Avant Mutual Group Ltd	Nil
Dr Eleanor Chew	General Practitioner; Member, MBS Review Taskforce; Member, Professional Service Review Committee; Board member, Australian Digital Health Agency; Board member, General Practice Training Queensland; Clinical Lead, Integrated Care, Sonic Clinical Services; Member, RACGP Queensland; Member, AMAQ Council of General Practice; Member, Diagnostic Imaging Advisory Committee; Member, General Practice Mental Health Standards Collaboration	Positions held in organisations listed.
Dr Michael Coglin	Chief Medical Officer, Healthscope Ltd	Nil
Professor Adam Elshaug (ex officio)	Professor of Health Policy; <i>HCF Research Foundation Professorial Research Fellow; Co-Director, Menzies Centre for Health Policy, School of Public Health</i>	Nil
Associate Professor Alex Hunyor	Associate Professor of Ophthalmology, University of Sydney; Director, Retina Associates; Previous Chair and current Member, Medicare Advisory Committee, Royal Australian & New Zealand College of Ophthalmologists; Board Member, Australian Society of Ophthalmologists; Chair, Medical Committee, Macular Disease Foundation Australia	Nil
Dr Gerard Ingham	Rural General Practitioner; Member, Professional Services Review	Nil
Ms Debra Kay PSM	Consumer representative; Member, Medical Services Advisory Committee and Health Technology Assessment Consumer Consultative Committee	Nil
Dr Matthew McConnell (ex officio)	Public health physician; Clinical Planning Team, Country Health SA Local Health Network	Nil
Associate Professor Ken Sikaris	Chemical pathologist, Melbourne Pathology; Director of Clinical Support Systems, Sonic Healthcare; Associate Professor, Pathology, University of Melbourne	Nil

Conflicts of interest

All members of the Committee were asked to declare any conflicts of interest at the start of their involvement and were reminded to update their declarations periodically. A complete list of declared conflicts of interest can be viewed in the table above.

It is noted that the majority of the participants in the MBS Review share a common conflict of interest, in reviewing items that are a source of revenue for them (i.e. committee members claim the MBS items under review).

This conflict is inherent in a clinician-led process and, having been acknowledged by the Committee and the Taskforce, it was agreed that this should not prevent a clinician from participating in the review.

3. Guiding principles

Since inception the Committee has continued to articulate and adopt principles about the intent of the MBS and the medical practices it endorses, to achieve real patient-centred care.

The following principles are intrinsic to all Committee deliberations, providing a foundation for the Committee's advice.

3.1 MBS function

The Committee maintains that the MBS:

- Is a taxpayer-funded insurance system that financially contributes to the cost of care for eligible patients, incurred from eligible health professionals, for clinically relevant services.
- Promotes best clinical practice and is receptive to changes in medical practice.
- Supports medical professionalism.
- Seeks to support medical professionalism by being intolerant of exploitive and fraudulent behaviour.
- Aims to provide universal access to high-value, cost-effective essential care.
- Places the patient's needs and outcomes at the centre of the MBS scheme.

The MBS should be designed to meet patient needs, not the needs of the clinician

3.2 Stewardship – the role of the General Practitioner

The Committee seeks to protect the integrity of the General Practitioner (GP) role, maintaining that the GP provides:

- The primary source of knowledge relating to a patient's history and clinical conditions.
- Access to clinically necessary specialist services.
- Valuable contributions to high quality patient care and a sustainable and cost-effective healthcare system.
- Stewardship of Australia's healthcare system¹.

GPs are the key contributor to quality, patient-centred health care – providing coordination of, and access to, necessary specialist services

The Committee recognises GPs' knowledge of local health systems, essential to the delivery of holistic, longitudinal and patient-centred care in the community.

¹ GP stewardship principle: as outlined in the 2017 phase 1 report and the 2018 phase 2 report from the General Practice and Primary Care Clinical Committee at: <https://www1.health.gov.au/internet/main/publishing.nsf/Content/MBSR-closed-consult>

3.3 The complete medical service and the three item ‘rule’

To support transparency for the patient and ensure claims are consistent across all providers, the Committee has continually advocated for delivery of an MBS that provides a single MBS item for a discrete, and complete, medical service. Such an MBS would, in practice, mean that a clinician would submit a claim for a single MBS item for a patient’s medical service. Only when there are sound clinical reasons would a claim be made for multiple MBS items.

The Committee, in its first draft report, publically consulted on a proposed ‘complete medical service’ principle and a ‘three item rule’ recommendation.

The ultimate aim of the complete medical service principle was to design MBS items that accurately and completely describe the provision of a specific service, reducing and restricting the need to claim multiple MBS items for a single procedure. The three item rule recommendation aimed to limit a practitioner’s claim for a single surgical procedure to three items.

Patients want an MBS that is easy to understand

The consultation period for the first report resulted in concern across the sector on the practical application of the three item rule. The Taskforce determined that further consideration of the three item rule was required and should be informed by decisions made within the MBS Review’s clinical committees.

The recommendation pertaining to the complete medical service and the three item rule was subsequently removed from the first report and not submitted to Government. However, the concept of a ‘complete medical service’ was formally endorsed by the Taskforce and advice was provided to newly formed clinical committees that they must acknowledge the complete medical service principle in their decision-making

The acceptance of the principle has varied across clinical committees but it is evident that there has been a significant refinement of item descriptors that restricts the ability for a clinician to make an inappropriate co-claim.

Throughout subsequent deliberations, the Committee refined this guiding principle, reaching the position that a clinician should not be making a claim to the MBS for correction of any unexpected, yet standard, event during surgery. This means that, in practice, if a clinician, when performing a service encounters an unusual or unexpected event during the planned procedure, that does not require attendance by a clinician of another specialty and does not alter the intent of the procedure, they are not entitled to make a claim to the MBS for the procedure necessitated to correct the unusual event. In this instance only the primary, intended, procedure should be claimed.

3.4 The consumer perspective

The Committee has maintained consideration of how its deliberations and advice will impact upon the consumer. Very early in the MBS Review the Committee designed an Appropriate Use Criteria (AUC) methodology (endorsed by the Taskforce in March 2016) for use by all clinical committees, to guide their deliberations regarding MBS items (see [Appendix B](#) for full details).

The Committee sought to align the AUC with established best practice models, including the work of the Department’s Health Technology Assessment Consumer Consultative Committee to

incorporate consumer evidence and perspectives. However it was unachievable, at that time, to fully incorporate consumer evidence and perspectives as standard.

In early 2016, the Taskforce established the Consumer Panel². The Panel developed a set of Consumer Principles (listed in full at [Appendix C](#)) to be applied by each clinical committee in their deliberations and decision making. The principles were intended to ensure that clinical committee decisions were made by consensus and consumer perspectives were not merely an annotation to clinical decision-making. The Committee actively supported early adoption of these principles.

Throughout this report, in all advice and recommendations the reader will find implicit and explicit reference to the consumer. Examples include but are not limited to:

- The *MBS function* (see 5.1 above) reinforces the patient's centrality to the MBS by explicitly stating that the MBS is funded by consumers (taxpayers) and enacts the government's commitment to universal access to high value, cost-effective essential care.
- At 6.6 below, the recommendation pertaining to use of online specialist referrals, balances respect for patient access and convenience with the evidence supporting the role of the GP.
- Committee attempts to better define MBS remuneration for surgical services that aim to minimize variability across patients and maximise transparency for the consumer in terms of the service provided and billing. When making design recommendations the Committee noted that taxpayers do not want unnecessary and inconsistent billing, nor do they want to incur multiple gap payments.
- The final position on the use of loadings (see [Appendix B](#)) was designed to ensure that every patient has access to an equal rebate for a specific service, regardless of the location of service provision.
- Deliberations and resulting action on urgent after-hours services (see [Appendix B](#)) strongly supported consumer access to safe, quality after-hours health services.
- Consultation on surgical assistant remuneration (see [Appendix B](#)) aimed to put in place a principles-based approach to remuneration of assistants that emphasises the importance of informed financial consent and of comparability of fees for similar services.
- Advice provided by the Committee on adoption of the Modified Monash Model (see [Appendix B](#)) aimed to equalise access to health workers in remote and smaller communities: a valuable contribution to equity of service access for consumers.

In addition, when investigating specific issues, referred for Committee advice by clinical committees or the Taskforce, the Committee has made several recommendations for further exploration of an issue, in a whole of MBS context. One example is the practice of performing bilateral surgery on separate days which led to the Committee's recommendation at 6.4 below. Ensuring the MBS acknowledges best practice while minimising patient inconvenience and potential safety issues.

3.5 Fee transparency

The Committee holds a strong conviction to protect patients from inappropriate billing practices and supports the work and progress made to date to improve fee transparency.

² Consumer Panel Members have served on approximately 31 clinical committees throughout the life of the MBS Review.

In a consumer-led healthcare market consumers need clear and transparent information to give their full, informed consent to services

During the life of the MBS Review the need for transparency across the private healthcare sector has gained momentum. On 2 January 2018 the Ministerial Advisory Committee on Out-of-Pocket Costs was established to provide advice to the Minister for Health on possible reforms covering:

- Best practice models for the transparency of in-hospital medical out-of-pocket costs, and associated medical services in the community;
- Legislation and regulatory barriers to consumer transparency of out-of-pocket medical costs; and
- Other related issues as directed by the Minister.

The Advisory Committee report, released in November 2018 made a number of recommendations and on 2 March 2019, the Government announced its plan to tackle transparency of out of pocket costs, committing to implement all of the recommendations of the Advisory Committee. The announced out of pocket costs transparency activities will provide consumers with access to easy to understand information about the cost of medical specialist treatment to support them in choosing a specialist in consultation with their referring doctor. It will:

- publish on the Department's webpage by end of 2019 the range of medical specialists costs for common treatments within a geographic area, using aggregated Government held data;
- develop a website for specialists to voluntarily disclose their individual billing practices, providing nationally searchable information for use by patients and referring doctors when choosing a specialist; and
- deliver a complementary education initiative to better inform patients and assist in the referral process. Specialists will also be educated on the impact of unreasonable and sometimes 'hidden' booking fees.

The Department has resourced a dedicated team to progress the findings of the Advisory Committee and has advised that consultation is underway for both websites. A Reference Group, consisting of members from peak organisations for medical professionals, hospitals, insurers and consumers met on 18 July 2019. The group discussed Government data collections; the type of data to be published; requirements for searching and displaying aggregated data; and the education initiative.

4. Recommendations for Taskforce consideration

4.1 Improving compliance – outstanding recommendation

The MBS is an uncapped, activity reward system whereby patients are reimbursed for medical services from a recognised (by way of a provider number) healthcare professional. In general, once a particular service is included on the MBS, its utilisation is largely a matter for health professionals and their clinical decision making, in consultation with their patients³.

Understandably, and comfortingly, in everyday practice, provider awareness of MBS rules regarding billing for MBS services is often a secondary consideration for the clinician whose primary consideration is providing the best care possible for the patient.

There is an inherent expectation that healthcare providers will act professionally in the best interests of their patients. There is evidence that the vast majority of Medicare providers do act appropriately and adhere to the legislated responsibilities to act in line with Medicare Law.

Clinicians need to fully understand their responsibilities before they are able to make a claim to the MBS

As with any financial system, there is a need for a compliance regimen to detect and prevent incorrect claiming, inappropriate practice and fraud by health care providers and suppliers⁴.

The Department of Human Services, the entity responsible for administration of MBS payments, provides a range of screen readers and interactive provider education modules on its website. Providers may use these resources to self-educate in the use of the MBS but there is currently no compulsion for providers to consult this resource.

In its first report, the Committee made a recommendation to mandate provider education on compliant use of the MBS and this recommendation is maintained.

The Committee strongly supports the notion that the clinician has an obligation to acquire knowledge of the MBS rules and billing requirements and that this form of education be made compulsory through an assessable online resource, for those seeking to enter practice.

The Committee feels that acceptance of this recommendation would have obvious benefits for providers, patients and the Australian taxpayer alike.

³ What is the MBS and Medicare? <http://www.msac.gov.au/internet/msac/publishing.nsf/content/factsheet-03>

⁴ Health Professional Compliance <http://www.health.gov.au/internet/main/publishing.nsf/Content/health-compliance>

4.2 Improving compliance – new recommendations

Given population growth and the increased demand on the MBS, the Committee makes a general recommendation that resources for the Department are increased to improve compliance, via the avenues outlined below.

Audit and compliance activity needs to keep pace with increasing healthcare expenditure and demand

The Committee suggests an enhancement of the current AskMBS service offering, to include, at a minimum, an online repository of Frequently Asked Questions and common queries and the policy response provided by the Department.

This suggestion acknowledges the Department's role as the primary source of information on MBS policy and takes into consideration the beneficial effects the current MBS Review process will have on clarity in all reviewed item descriptors.

The Committee is aware that clinicians report difficulties in obtaining timely, specific advice via the AskMBS service and that there is currently a service delay when seeking interpretation of existing MBS item descriptors and explanatory notes. Often advice received is non-specific and is often framed around what is 'clinically and professionally appropriate as applies to your discipline and your peers'.

Clinicians need access to a responsive and unambiguous source of advice for MBS queries

The Committee feels that an increase in AskMBS's capacity to rapidly respond to information requests would have a beneficial effect on MBS compliance. The proposed online repository of past responses would provide a self-guided resource for a first triage of clinician questions and could include links to specific item numbers, appropriate fact sheets and explanatory material.

Acknowledging the delicate balance between ensuring there is sufficient detail in item descriptors to provide clarity of the intent and delivering an item descriptor that is overly prescriptive or so extensive as to become incomprehensible, the Committee suggests a resource increase to support the Department's continuous improvement model to update descriptors of concern. The Committee is confident that this mechanism to quickly identify and rectify MBS items that are proving to be easily misused, whether by design or accident, is an important measure in improving compliance.

The Committee initially suggested an increase in use of peer groups in an advisory capacity to provide advice on item use. However, the Department has stated that this has the potential to affect timeliness of decision making processes and may pose a risk to the Director of the Professional Services Review's ability to convene committees of peers to determine peer views in regard to compliance and prevention of inappropriate practice.

Noting that a strong compliance program is currently in place to protect Australia's health payments system, the Committee feels that more emphasis should be placed on preventative

education. In particular sharing of proven episodes of non-compliant behaviour and the penalty imposed.

Not only would this be beneficial in improving compliance as a deterrent, it would serve a secondary, educational purpose.

Proven incidents of inappropriate MBS use should be more actively shared with the profession

The Committee is aware that the Professional Services Review (PSR) already provides information on the outcomes of review processes here: <https://www.psr.gov.au/about-the-psr-scheme>. In addition, the Department publishes its compliance processes at: <http://www.health.gov.au/internet/main/publishing.nsf/Content/health-compliance>. However, the Committee would like to see regular publication of peer group interpretations of the legislation, when determining episodes of ‘inappropriate practice’⁵.

The Committee seeks to increase involvement of patients, carers and professionals in compliance activity and recommends that the Department increase the public profile of the existing public complaints mechanism, the Provider Benefits Integrity Hotline⁶.

Consumers have a right to exert influence over provider behaviour

Although the Hotline is currently available to both patients and practitioners to report possible misuse of the MBS payment system, the Committee would like to see greater visibility of the existing Hotline in the public domain.

It is expected that this will not only increase use of the resource but will have a secondary, deterrent effect on provider behaviour.

4.3 Raising the profile of Explanatory Notes

The Committee recommends no change to the legal status of Explanatory Notes within the MBS but recommends that the Department undertake work to clarify the legal status of Explanatory Notes, possibly via inclusion of the following statement to the MBS preamble:

*Clinicians **must** refer to an item’s associated Explanatory Notes when making a determination on the appropriate item to be claimed for a service provided. Explanatory Notes contain important information on applicability.*

⁵ Inappropriate practice: rather than being attributed to a *mistake*, inappropriate practice is a deliberate servicing activity that would be unacceptable to the general body of peers.

⁶ Provider Benefits Integrity Hotline (tip-offs) 1800 314 808 provider.benefits.integrity@health.gov.au
<https://www1.health.gov.au/internet/main/publishing.nsf/Content/health-provider-tip-off>

In a policy context the Committee is aware also that Explanatory Notes are considered by clinicians to represent the policy position of the Department and therefore carry a degree of evidentiary weight and context to the intent of the MBS item.

Clinicians need to be made aware of the legal value of Explanatory Notes

The Committee makes this recommendation to ensure that clinicians take into consideration pertinent information contained in an Explanatory Note when claiming for a service provided and are made aware of the use of Explanatory Notes in compliance activity.

4.4 Ineligible services – improving clarity

Seeking to rationalise and modernise the MBS, at its meeting of 12 August 2018 the Committee sought Taskforce views on removal of the current ineligible services list, proposing to replace the list with a set of principles and rules, used to govern the eligibility or non-eligibility of services.

The Committee advised that use of a proscriptive list was impracticable, in that the MBS ineligible services list had failed to keep pace with ongoing change in a modern health care sector. One such example can be found in the replacement of the Pap test with the more effective Cervical Screening Test, which, due to a time lag in legislative change, resulted in the Cervical Screening Test being temporarily ineligible under the MBS.

The Committee also advised that significant simplification of the existing ineligible services list could be achieved by including a statement that *if a service does not have an associated MBS item it can be deemed as not supported by the MBS and is therefore ineligible for payment*.

During discussion of the advice, it was agreed that an exclusion list should be retained, to ensure that a service was not able to attract an MBS benefit on a consultation basis but that the current list requires review. One such example is current exclusion of testing of fitness to undergo physical training, vocational activities or weight reduction programs, which have the potential to positively impact the obesity epidemic.

The Committee recommends that the Department undertakes a comprehensive review of the MBS content related to excluded, eligible and ineligible services. The Committee provides the following principles and excluded items for consideration in this review.

The MBS should support health professional services which are:

1. *Clinically relevant⁷. These are consultations, diagnostics and procedures whose dominant purpose is the management of a clinical condition, and which are likely to provide health benefit and conform to contemporary professional standards.*
2. *Preventative. These are a core component of primary care and the appropriate delivery of these services through the MBS should be encouraged. However, services provided to asymptomatic patients (and in particular diagnostic services) should only be MBS funded when supported by evidence or supported by the general body of peers.*

⁷ 'Clinically Relevant' as defined in the *Health Insurance Act 1973*

3. *Safe. Novel health professional services and technologies should only be MBS funded if they meet contemporary standards for safety, effectiveness and cost effectiveness as determined by the Medical Services Advisory Committee.*
4. *Beneficial for the wider community. Medical examinations or tests which may not have direct benefit to the patient, but have potential flow-on safety or public health benefits to the wider community should be funded through the MBS.*

The following are excluded services:

- *Telephone consultations.*
- *Issue of repeat prescriptions when the patient does not attend the surgery in person.*
- *Group attendances (unless otherwise specified in the item, such as items 170, 171, 172, 342, 344 and 346).*
- *Non-therapeutic cosmetic surgery.*
- *Euthanasia and any service directly related to the procedure. However, services rendered for counselling/assessment about euthanasia will attract benefits.*
- *A service that is a pre-employment screening service other than where it is a medical or optometrical examination provided to a person who is an unemployed person (as defined by the Social Security Act 1991), as the request of a prospective employer.*
- *Compulsory examinations and tests to obtain a flying or commercial driving or other licences other than age or health related medical examinations to obtain or renew a licence to drive a private motor vehicle.*
- *Services for the purposes of legal proceedings.*
- *Services rendered to a doctor's dependants.*
- *Counselling of relatives that does not occur at the time of patient attendance.*
- *Recording clinical notes or writing referrals other than at the time of attendance.*
- *"Never Events" – when a clinician provides a service that that results in the patient receiving the correct procedure on an incorrect site; receiving an incorrect procedure; or retaining a surgical instrument the clinician must not levy a claim to the MBS or the patient for the service. A claim may be made to the MBS, by a second clinician, when undertaking a procedure necessary to correct error from the primary service.*

4.5 Implementing Taskforce endorsed principles

The Committee has presented several principles to the Taskforce that have received formal endorsement. The Committee recommends that, in line with its Terms of Reference, that the Taskforce recommends to the Minister that these principles should be enacted, within the Department's program of work.

Bilateral surgery: at the Taskforce meeting of 12 August 2019 the Taskforce endorsed the Committee's proposal to incentivise best practice healthcare by encouraging evidence-based bilateral surgery.

Bilateral surgery is preferred in a number of situations, e.g. in the treatment of varicose veins. However, under the MBS Multiple Operation Rule⁸, bilateral surgery is paid as follows:

- 100% for the item with the greatest Schedule fee; plus
- 50% for the item with the next greatest Schedule fee.

⁸ More information on the Multiple Operation Rule can be found at:

<http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=TN.8.2&qt=noteID&criteria=TN%2E8%2E2>

When two or more operations performed on the one occasion have Schedule fees which are equal, one of these amounts shall be treated as being greater than the other. Therefore, when performing identical bilateral surgery, the clinician is entitled to 150% of the total fee for the two procedures.

The Committee recommends an increase in bilateral surgery fees from 150% to 175%, being 100% of the fee payable for the first side and 75% of the total fee payable for the second side.

The Committee feels that, as there is no significant difference between aftercare for either a unilateral or bilateral procedure that an increase to 175% would adequately remunerate for any necessary aftercare service provided.

The Orthopaedics Clinical Committee (OCC) made reference to incentivising bilateral surgery in recommendation 28 of their report dated 2017. The OCC recommended a split of an existing MBS item to two new items, one for unilateral unicompartmental arthroplasty and one for bilateral. The OCC recommended that the fee for the bilateral procedure be set at 175% of the fee for a unilateral procedure.

The rationale for this change was to ensure the MBS included an item for simultaneous bilateral procedures, to reduce the incentive for surgeons to perform two separate operations over different days.

Patients deserve an MBS that incentivises best practice and pays for procedures that support improved patient outcomes

Two surgeon operations: at the Taskforce meeting of 12 August 2019, the Taskforce endorsed the Committee's recommendation to equitably remunerate surgeons when it is best practice to have two surgeons in attendance, to perform a single procedure. The associated principle is as follows:

When a clinical committee deems that best practice for a specific procedure requires attendance by two surgeons from the same speciality, each surgeon may submit a separate claim to Medicare for the procedure performed. The multiple operation rule will not apply when two surgeons perform the procedure, each surgeon will be remunerated at 100% of the MBS fee claimed.

If the procedure is performed by a single surgeon the fee paid to the single surgeon will not be greater than the higher fee of the two surgeons. The item number descriptor must indicate that the two surgeon rule applies, otherwise the second surgeon is regarded as an assistant.

If it is clinically appropriate for two procedures to be performed simultaneously by two surgeons from differing specialities, each surgeon may submit a separate claim to Medicare for the procedure they have performed. The multiple operation rule will not apply, each surgeon will be remunerated at 100% of the MBS fee claimed.

"Figurehead billing"⁹: every healthcare practitioner eligible to levy a claim to the MBS for a service provided has a provider number. The Committee has concerns that there are situations where a

⁹ "Figurehead billing" definition: Every healthcare practitioner eligible to levy a claim to the MBS for a service provided has a provider number. There are situations where a provider's number is used by a third party, often a corporate entity, to create an MBS claim. This is termed "Figurehead" billing.

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At the Taskforce meeting of 12 August 2019, the Taskforce endorsed the Committee's recommendation to prohibit non-compliant figurehead billing, to protect the integrity of claims to Medicare, made against an individual's provider number.

The associated principle is as follows:

Noting that figurehead billing arrangements for Pathology and Diagnostic Imaging, in the Health Insurance Regulations 2018 remain unaffected, other billing by a third party using a practitioner's provider number is permissible only if:

- i. the service is provided by the practitioner whose provider number was used in the invoice;*
- ii. the service provided meets the elements of the MBS item number descriptor;*
- iii. the practitioner has provided express consent for his/her provider number to be used by the third party.*

In the event that the billing is found to be incorrect, both the practitioner and the third party have responsibility.

The practice of figurehead billing, although widely practiced, is non-compliant with MBS provisions and is at odds with professional standards.

Aside from exceptions for some pathology services and certain services provided for and on behalf of medical practitioners, Medicare regulations require that the practitioner rendering the service must be the practitioner submitting a claim to Medicare.

There is a need to increase provider accountability regarding claims to Medicare using their provider number

In addition to implementing the principle, the Committee seeks wide publication of the penalties associated with figurehead billing (that Medicare benefits paid as a result of a false or misleading statement, whether intentional or merely factually incorrect, can be recovered as a debt from the person who made the statement) and investigation of more severe penalties for proven episodes.

4.6 Referrals – evidencing clinical need

The Committee is concerned that increasing use of online referral services has the potential to damage the GP's stewardship role and poses a risk to patient safety by effecting sustainability of the healthcare system.

There is a need to guard against models that fragment patient care and limit the value of the GP as the care coordinator

The Committee recommends that the Taskforce implement the following principle, to limit acceptance of referrals that circumnavigate GP involvement, as follows:

A referral must be provided by the patient's usual GP or a GP working in the same practice as the patient's usual GP with access to the patient's history. If the referring GP does not have access to the person's medical history then a personal attendance that includes appropriate history and examination is required for the initiation of a referral.

This recommendation applies initially to specialist referrals but could be equally applied to pathology (and other diagnostic) requests.

4.7 “Never Events” – protecting patients from errors during surgery

Although “never events” during surgery are known to be relatively rare in Australia’s high quality medical sector, the Committee wishes to formalise a position on eligibility of claims made to the MBS in these instances.

The Committee recommends that the MBS contains explicit reference to “never events” by including the following item in the *services specifically excluded from MBS funding* list (see item 4.6 below):

*“Never Events” – when a clinician provides a service that that results in the patient receiving the correct procedure on an incorrect site; receiving an incorrect procedure; or retaining a surgical instrument the clinician **must not** levy a claim to the MBS or the patient for the service. A claim may be made to the MBS, by a second clinician, when undertaking a procedure necessary to correct error from the primary service.*

The MBS should never be used to pay for a clinician’s error

In making this recommendation the Committee acknowledges that patients affected by never events have continued access to existing complaint and redress avenues, including through hospitals, Australian Health Practitioner Regulation Agency (AHPRA), and the criminal and civil courts. In more unfortunate events, the patient’s family has access to the coroner.

4.8 Unexpected Events – restricting opportunistic claiming

The Committee seeks to operationalise the principle of the complete medical service by restricting a clinician’s ability to claim MBS items to correct any unexpected, yet standard, event during surgery.

In practice, if a clinician, when performing a service encounters an unusual or unexpected event during the planned procedure, that does not require attendance by a clinician of another specialty and does not alter the intent of the procedure, they are not entitled to make a claim to the MBS for the procedure necessitated to correct the unusual event. In this instance only the primary, intended, procedure is claimable.

The Committee seeks to restrict the ability to claim an additional MBS item in relation to unexpected pathology discovered during a procedure that requires an amendment to the intended procedure. This is particularly pertinent when the unexpected pathology is created by the performance of the intended procedure itself.

5. Considerations for future MBS Review activity

5.1 Remunerating for surgery – is there a better way to pay?

The Committee recommends that any future MBS Review undertake further investigation into the payment of items within the T8 section seeking to determine if there is a more appropriate, safe and financially sustainable model.

Is there a better, more sustainable way to fund T8 items?

Time-based surgery: presently, when a new procedure is added to the MBS it is subject to a defensible, replicable, evidence-based process. However, there are currently over 2,500 discrete MBS items in the T8 group and it is unclear how many of these items were created without objective rigour.

Given new technology and techniques have simplified previously complex and time consuming operations, the Committee is seeking to modernise the fee structure for T8 procedures and is investigating options to deliver a fair, simple and replicable way of remunerating surgeons, into the future.

One possible option is the use of 'time based' remuneration. This model would track the time taken to perform specific procedures across Australia¹⁰; calculate the average, or median, time taken and apply an hourly rate accordingly.

The Committee is aware that private hospitals already gather data on operating theatre usage and there is a possibility that the data can be obtained through the Australian Private Hospital Association. Public hospital data would not be used in the calculation.

Aftercare: in order to increase taxpayer value for money, the Committee has previously investigated options for payment of aftercare.

On 1 November 2017, the Committee's recommendation to remove restrictions on the claiming of aftercare services was implemented by Government. From this date GPs have been able to claim an MBS fee for the provision of aftercare services.

At present there is no ability to track how often aftercare is delivered when a patient presents to their GP. Many T8 items were created in the 1970s, with the payment of aftercare 'built in' as a component of the fee for the surgical procedure. There is some general acceptance that the split was based on a 75/25% ratio. However the Department advises that historical information is not available to confirm this.

Given that T8 expenditure is approximately \$2billion per year, the payment of aftercare can be estimated as being approximately \$500 million per year. As the Committee is aware that some surgeons routinely 'outsource' provision of aftercare to an alternative clinician this gives rise to significant concerns over taxpayer value for money.

¹⁰ Time taken would begin when the prepared patient entered the operating theatre (not the theatre complex) and would end when the patient leaves the operating theatre for recovery.

There is an option to create a dedicated MBS item for delivery of aftercare, as this would provide some data but this would need to be contextualised, likely through consultation with all surgical craft groups.

An alternative would be to make changes to aftercare contingent upon the introduction of timed specialist consultations.

5.2 Future health system design – valuing the consumer

The Committee recommends that any future MBS Review consider ways to actively include the consumer in review activities.

It has been part of the Committee's role to assist the Taskforce's clinical committees by providing guidance on the design of proposed new MBS items where these arise from clinical committee recommendations. This guidance is intended to promote the internal coherence of individual items and overall consistency across committees.

The Taskforce's terms of reference¹¹ include the following commitment: *The Taskforce will engage with health consumers, medical professionals, peak bodies and other stakeholders to seek their views about appropriate review approaches and processes.*

The Committee has been mindful of this commitment and has sought to provide support for the Taskforce in delivery of a modernised MBS that delivers benefit to current and potential patients and their carers.

As outlined at [Appendix B](#), the Committee designed an Appropriate Use Criteria (AUC) methodology that was endorsed by the Taskforce in March 2016, and subsequently employed by clinical committees, to guide their deliberations regarding items under their review.

Future MBS review activity needs to place emphasis on the consumer and include consumer perspectives and evidence in all decision making processes

The Committee aligned the AUC developed for the Taskforce's clinical committees, as closely as possible to best practice approaches but it was unachievable, at that time, to incorporate consumer evidence and perspectives as standard.

To accommodate for this, the Taskforce's Consumer Panel developed a set of Consumer Principles to be applied by each clinical committee in its deliberations and decision making. Early adoption of the principles helped to demonstrate a shared understanding and acceptance of consumer views and helped to ensure that decisions were made by consensus and consumer perspectives were not merely an annotation to clinical decision-making.

The Committee recommends that any future MBS review activity enhance the AUC methodology employed in this MBS Review by fully incorporating consumer evidence and perspectives into all decision making processes and guidance.

¹¹ MBS Review Taskforce Terms of Reference: <https://www1.health.gov.au/internet/main/publishing.nsf/Content/MBSR-tor>

In making this recommendation the Committee acknowledges the importance placed on acknowledging and incorporating consumer impact to all recommendations made to Government. The Committee also acknowledges the Consumer Panel's expressed view that application of the Consumer Principles across all clinical committee outcomes was variable and the Committee supports the Consumer Panel's wish to see:

1. Further development of consumer principles to include principles related to reporting, disclosure, transparency and regulatory oversight as well as communication and informed (financial) consent. *For example:*
 - Not every health service has a consumer cost reimbursement via the MBS
 - Practitioners that exploit the MBS are reported to the regulatory authority
 - Simplicity where possible in the MBS supports professional conduct – and identification and management of alleged unprofessional conduct.
2. Genuine, structured and supported consumer feedback in Review reports, to ensure inherent clinician conflicts of interest have been successfully managed as well as to ensure the recommendations work in the best interests of the consumers to whom the reimbursements will be paid.

Appendix A

Principles and Rules Committee first report (2016)

The Committee's first report was released for public consultation in August 2016. The finalised report provided six recommendations to Government, three of which were implemented in full on 1 November 2017 and three of which (at the time of writing) are pending Government decision.

Recommendation 1: introduce mandatory health provider education and assessment on MBS rules and procedures to assist providers with appropriate billing of MBS services.

Action taken: no action taken, Government decision pending.

Recommendation 2: provide clarification on the appropriate claiming of initial and subsequent specialist and consultant physician attendance items within a single course of treatment.

Action taken: no action taken, Government decision pending.

Recommendation 3: remove the differential fee structure for the 34 remaining MBS items with different Schedule fees depending on whether the service is performed by a General Practitioner or specialist (the 'G&S' items) and setting a single MBS fee at the current specialist rate.

Action taken: Implemented in full, as recommended by the Committee on 1 November 2017. MBS benefits paid for these minor procedures when performed by GPs were increased so that patients receive the same level of MBS benefit regardless of whether a specialist or GP performs the procedure. The change benefitted consumers by providing a fairer system, with the reimbursement paid dependent on the procedure, rather than the practitioner performing the procedure. The change also delivered greater consumer choice by equalising the reimbursement across provider groups.

Recommendation 4: prohibit the claiming of specialist and consultant physician subsequent attendance items with certain pre-planned procedures.

Action taken: implemented on 1 November 2017, with modifications to the recommendation made by the Committee. The change prohibited the co-claiming of subsequent attendance items with any item in Group T8 of the MBS, if the Group T8 item has a schedule fee of equal to or greater than \$300, and if the same items are provided by the same practitioner on the same day. The \$300 threshold was specifically chosen as a proxy for complexity, recognising that procedures above this level are more likely to be the primary purpose of the episode.

This change reinforced Medicare's universality by ensuring that patients receive the same MBS benefits for the same service, and that the amount of benefit is not dependent on the practitioner's discretion to bill a consultation item as an adjunct to the primary procedure. Patients who genuinely require an unscheduled procedure, for example an emergency operation following a consultation on the same day, are not affected.

Recommendation 5: remove current restrictions on the claiming of aftercare services.

Action taken: implemented on 1 November 2017, with modifications to the recommendation made by the Committee. The change removed a restriction that prevented GPs making claims to the MBS for the provision of aftercare.

The change benefitted GPs, by reducing administrative burden. Prior to the change GPs providing aftercare services were required to provide evidence to the Department of Human Services that the service was outside of the patient's aftercare period. Patients also benefitted through improved access to aftercare service, particularly important in rural areas or locations where it was difficult for patients to access ongoing specialist post-operative care.

Recommendation 6: maintain the existing three-month time limit on specialist-to-specialist referrals.

Action taken: no action taken, Government decision pending.

Appendix B

Guidance provided by the Principles and Rules Committee

Over the MBS Review the Principles and Rules Committee (the Committee) has provided guidance for all clinical committees for use in the review of their MBS items. The matters outlined below were endorsed by the MBS Review Taskforce (the Taskforce) and have been set out in this report to provide transparency over internal MBS Review decisions. The language and data used reflect the point in time at which the relevant work was undertaken.

B.1 Appropriate Use Criteria

Following on from the first tranche of MBS Review clinical committee deliberations, the Committee explored options to set a path for Taskforce clinical committee deliberations and decisions regarding the design or revision of MBS items. The Committee was also eager to ensure individual clinical committee judgements were formally documented in a format that carefully articulate any decisions reached with rigour that could be revisited in any future review activity.

In order to ensure the MBS Review applied best practice, the Committee was committed to the design and application of a standardised framework, to guide committees through a replicable process, resulting in a quality, evidence-based review (where necessary). The Committee was confident that application of a framework would provide the Taskforce with assurance that clinical committee recommendations, to be submitted to Government were based on solid evidence.

There is significant variation in the content of item descriptors in the MBS, as would be expected with a large register that has evolved over time. To address this variability in the current review and into the future, the Committee explored the viability of applying Appropriate Use Criteria (AUC) to the design of new MBS items and revision of existing item descriptors. AUC specify when it is appropriate to perform a medical procedure or service, with "appropriate" being a procedure for which the expected health benefits exceed the expected health risks by a wide margin. Being aware that AUC are ideally evidence-based, the Committee recognised that, in the absence of sufficient evidence, 'appropriate' may be derived from a consensus of expert opinion.

In early 2016, the Committee commissioned a paper from the Menzies Centre for Health Policy at the University of Sydney. The paper set out in detail when AUC is appropriate and when AUC is unachievable, for example in the absence of reliable evidence of a procedure's efficacy and also outlined the opportunity to align MBS Review activity with the Medical Services Advisory Council's (MSAC) best practice use of AUC. The paper provided the Committee with a proposed approach for the adoption of AUC to the Review and recommended the use of the flowchart below to assist with triaging of items, indicating which items might be best suited to follow an evidence-review path, plus or minus AUC incorporation in MBS item 'hard rules' (item descriptors) and 'soft rules' (explanatory notes).

On 8 February 2016, the Committee agreed to present the paper to the Taskforce for discussion and provide the paper to MSAC for comment. At its meeting of 1 March 2016 the Taskforce agreed to trial an AUC approach. Second tranche clinical committees were then provided with a standard template that included the flowchart below and supporting forms posing questions about the item/s under consideration to focus and guide committee deliberations.

A list of options for clinical committees to consider when making recommendations for amendments to MBS items was also provided.

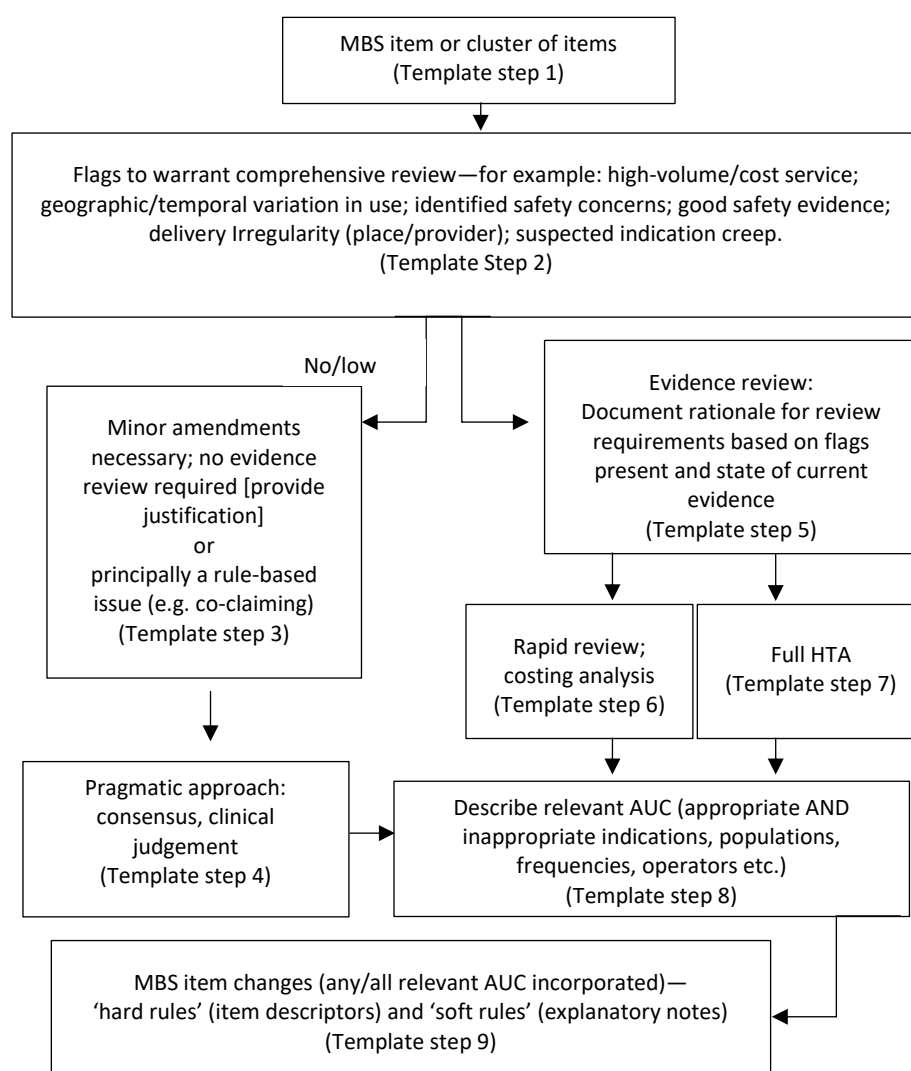
Application of the methodology ensured that each clinical committee was guided to undertake evidence-based review (where necessary), and used evidence to carefully articulate AUC-based revisions to existing and novel MBS item descriptors.

In terms of outcomes of the entire MBS Review process, the Committee felt that this standardised approach to clinical committee operation would produce detailed information on clinical deliberations and judgements of each individual clinical committee. It was hoped that this documentation would:

- support clinical committees' evidence-based review of MBS items;
- provide a basis for further revision of decisions made;
- provide the Taskforce with assurance that clinical committee recommendations were based on sound deliberations; and
- provide a reference point for any future MBS Review activity.

The Taskforce's Consumer Panel raised concerns that this methodology did not incorporate, to an acceptable level, consumer views and perspectives in decision making processes. The Committee acknowledges this concern and has acknowledged a need for refinement to the model, in the body of this report.

Flow chart for triaging which items might be best suited to follow an evidence-review path, plus or minus AUC formulation in to hard and soft rules (item descriptors and explanatory notes)



B.2 Design of MBS items for surgical services

This advice builds upon the framework introduced above in item A.1 and refers directly to the review of MBS items for surgical services. Surgical services account for a very high proportion of MBS items but a relatively low proportion of overall services and MBS expenditure. In 2015–16, surgical services (excluding consultations) accounted for approximately \$1.7 billion of the overall MBS spend of \$21 billion. Orthopaedic procedures are covered under 580 items (more than 10% of all items) but account for only \$190 million (about 1 per cent) of expenditure.

As outlined in A.1 above, early clinical committee review of surgical items produced variable outcomes, leading to the introduction of a guidance framework for second tranche committees. This standardisation was found to be essential for the review of surgical items, given the sheer volume of items and widespread variation in the use of them by surgeons. In addition to this, as the MBS has evolved over an extended time period, the Committee acknowledged that the MBS contained an unknown number of long-standing and well-established surgical services with little or no clinical trial evidence to support their use.

When reviewing the MBS, surgical clinical committees were asked to critically evaluate MBS data and other available evidence and, where there is evidence to suggest variation in use of items that is detrimental to patients (clinically or financially), they should identify potential remedies. Also, where clinical issues are identified, inclusion of appropriate use criteria into item descriptors or explanatory notes should be considered.

Change to MBS items could be recommended independently of any clinical reason for change, if the amendment was identified as a means to modernise the MBS. However, clinical committees were informed that large structural redesign of the MBS would need to be justified and a case made to the Taskforce about the need for major redesign or minor changes to large numbers of items, based on demonstrable clinical benefit to patients, reduced variation in billing and/or enhanced compliance. This information would be necessary for the Taskforce to determine whether the magnitude of the change would provide sufficient overall benefit to justify the use of resources to effect the change.

The Committee deliberated on specific instruction for surgical clinical committees and delivered the following principles endorsed by the Taskforce at its 26 July 2017 meeting.

Principles: surgical item design

In designing surgical MBS items, clinical committees should observe the following principles:

- An item should represent a 'complete medical service'. There should be no need to develop items that cannot be used for a stand-alone purpose. All of the necessary components of a service are included in the item and, whenever possible, all of the necessary components should be included in the item.
- Items should be described simply and without ambiguity.
- There should be a consistent and logical approach.
- Complexity tiers should be kept to a minimum. The default item (the one with broadest applicability) should be the least complex item in a tier. This ensures that there are no gaps in coverage for a specified surgery (e.g. hip arthroplasty or cholecystectomy).
- Where there is evidence of low-value clinical care, and there is good evidence or consensus, descriptors (or explanatory notes) should reference appropriate use criteria.
- Items should be available for necessary services but should be removed if the service is obsolete, meaning that it no longer reflects contemporary practice and/or has been superseded by a better treatment.

- Recommendations about fee adjustments should be cost neutral within a group of items or within the suite of items reviewed by the committee. For instance, where a surgical service has a number of complexity tiers upwards, adjustments for more complex items need to balance with downwards adjustment of less complex items.

Rules for surgical items (MBS Group T8)

To give effect to these principles and to ensure that the revised MBS has an internal logic, surgical committees should adopt the following rules when revising items:

- Only revise items if there is an identified problem (identified either by the committee or the Taskforce).
- Do not increase the overall number of items.
- Consolidate items where possible.
- Have no more than three complexity tiers for any given surgical service.
- Anticipated service volumes for any item should be at least 100 services per year unless that item covers a stand-alone and necessary service for an uncommon condition that is not otherwise covered in the MBS (e.g. hindquarter amputation or operation for bladder extrophy).

The Committee's first report discussed the conflict within the MBS, between the notions that all MBS items constitute a 'complete medical service' and the multiple operation rule¹². The report provided an evidence-based overview of claiming patterns of multiple MBS items for a single episode of care and sought to achieve greater guidance on this matter by recommending the implementation of a 'three item rule'.

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

Following a consultation period on the first report, the Taskforce determined that further consideration of the three item rule should be deferred until more of the MBS Review's clinical committees had completed their work. The recommendation was not submitted to Government.

Although the recommendation for a three item rule was not endorsed by Government, the 'complete medical service' principle was revisited by the Taskforce and at its meeting of 7 March 2018 the Taskforce endorsed the following principles:

- With respect to surgical procedure item numbers (T8 section of the MBS), an individual item number refers to a discrete complete medical service. It is not appropriate to claim additional item numbers in relation to procedures that are intrinsic to the performance of a procedure nor is it appropriate to claim additional item numbers for additional procedures that might arise out of the performance of the primary procedure unless these are claimed by a specialist from another surgical discipline.
- Where more than one MBS item is claimed in relation to the provision of a discrete medical service, the number and type of those MBS items should be consistent across all providers, resulting in the same level of Medicare benefit for all patients.

¹² More information on billing multiple MBS items is available at:

<https://www.humanservices.gov.au/organisations/health-professionals/topics/education-guide-billing-multiple-mbs-items/33231>

B.3 Surgical assistance

In 2017 the Committee undertook investigation of surgical assistant services and fees, as part of the Committee's commitment to consider patient out of pocket experiences.

The Committee identified concerns about two main issues affecting the relationships between primary surgeon, surgical assistant, and patient:

- The separate billing of the patient by the surgeon and assistant, and the surgeon's frequent lack of visibility of their assistant's billing practices; and
- Wide variability in the amounts of out-of-pocket costs charged by assistants, including:
 - instances where the assistant charged a higher fee than the surgeon; and
 - large differences between the lowest, average and highest fees charged by assistants as a cohort.

These issues result in different patients paying varying amounts for the same surgical services, and/or being unaware in advance of the total cost of the surgery. The Committee considered changes intended to benefit patients through improved fee transparency and consistency, while maintaining assistants' capacity to negotiate fair payment for their services and embedding proper fee relativities between primary surgeons and their assistants.

These changes centred on the surgeon having full responsibility for the billing of both the primary procedure and any assistance service. The surgeon would co-claim a new assistance item which would have a variable fee, derived from the fee/s for the surgery item/s and set at a fixed percentage of the total, which would dictate the amount of patient benefit. The amount the surgeon pays the assistant over and above this fee would be a matter for them, noting that the assistant will have considerable bargaining power in this transaction.

The Committee developed principles and recommendations to give effect to this approach, this proposal was endorsed by the Taskforce for consultation. Over 100 submissions were received from peak bodies, individual clinicians, nurses and billing agencies during stakeholder consultation.

Due to the large response rejecting the proposal, the Taskforce made a request to the Minister for Health to form a working group to examine in greater depth the issues and provide options moving forward. Government decision on this matter is pending at the time of this report.

B.4 Urgent after-hours services

In early 2016, in response to significant concerns raised by professional medical bodies, Medicare data was reviewed that exposed an increase in the use of, and expenditure on, MBS items for urgent after-hours home visits. This increase was far in excess of population growth. The Taskforce decided to conduct a priority review of those items. As a first step, the Taskforce referred the matter to the Committee for its views.

The Committee first considered the issue in June 2016, noting the inordinately high growth in ostensibly urgent after-hours home visits, and the high proportion of services provided by non-vocationally registered (VR) GPs employed by medical deputising services (MDSs). The high growth in urgent after-hours services had coincided with the emergence of corporatised MDSs offering dedicated after-hours home visiting services promoted by direct to consumer advertising.

The Committee also noted the medical profession's concerns about the quality of services provided by unsupervised non-VR GPs, and apparent lack of a formal relationship between the MDS and the patient's usual general practice, disrupting continuity of care.

The Committee decided to appoint a Subcommittee to consider the issue further and develop options for action. In August 2016 the Subcommittee tabled a paper, assessing several options and recommending the following course of action:

Strengthen the wording around the exclusion in the MBS explanatory notes that the urgent after-hours items are not available to doctors who predominantly work in the after-hours period i.e. remove the qualification 'at consulting rooms'. This is likely to reduce the claiming for urgent after-hours attendances when those services are provided by home deputising services as most of their doctors do not work predominantly 'in-hours'.

Concurrently with the Subcommittee developing its paper, an After-Hours Working Group had been established, reporting directly to the Taskforce. Its membership included representatives of the peak medical professional organisations as well as the Subcommittee. The Committee agreed to provide the Subcommittee's paper to the Working Group for its consideration.

The Government shared the Taskforce's view that the urgent after-hours items should be used only in genuinely urgent circumstances, and that funding should be appropriate to the level of care being provided. However, the Government's response was more moderate, adopting most of the Taskforce's recommendations on the use of urgent after-hours items, but not prohibiting the use of the items by predominantly after-hours service providers.

The Government's approach involved gradually introducing a fee reduction for urgent after-hours items provided in metropolitan areas by doctors who are not fully qualified GPs.

Changes introduced on 1 March 2018, included the introduction of four new urgent after-hours-only MBS items and the removal of two existing urgent after-hours items, greater detail of these measure can be found on the MBS.

B.5 MBS fee loadings

Throughout the course of the Review, a number of clinical committees and reference groups discussed the issue of applying additional financial loadings to the fees (and patient benefits) for particular MBS items. While the rationales for loading varied, discussions generally reflected three broad categories:

1. **Incentives:** A loading intended to promote the uptake of items, or service delivery in areas with access issues (such as loadings for services in rural and remote areas). These generally have the effect of creating different levels of fee and patient benefit for the same service, depending on the patient's location.
2. **Complexity:** A loading intended to reflect increasing levels of complexity from a 'base' service, usually surgical in nature—for example, loadings for services provided to paediatric patients which may involve direct patient, as well as parent/family discussions. These generally result in different levels of fee and patient benefit for effectively different services.
3. **Infrastructure:** A loading intended to recognise additional input costs associated with delivering a service. There are historical instances where loadings have, for example, addressed additional costs associated with the delivery of non-face-to-face patient interactions, such as through telehealth.

Across MBS Review activity there was uncertainty about whether loadings are appropriate, under a fee-for-service model, for some of these purposes. The Principles and Rules Committee considered that application of a loading within a fee-for-service model may lead to an over-rewarding of clinicians that 'specialise' in particular modes of delivery, as opposed to clinicians that deliver fewer of the same services, but nonetheless have similar input costs.

It has been a long-standing principle of Medicare that, for the purpose of paying patient benefits, it would be inappropriate to differentiate between patients based on location (or any other criteria). This is inconsistent with the idea of universal access. There is no compelling argument against this principle being maintained in general, noting there are some pragmatic exceptions.

At its meeting of 14 August 2018 the Committee agreed on the following principles, endorsed by the Taskforce at its meeting of 18 September 2018. The principles were subsequently circulated to clinical committees to clarify the circumstances under which MBS fee loadings are appropriate.

1. An MBS item describes a unique, discrete service which should be employed consistently across a range of provider and patient settings.
2. MBS fee loadings should not be used for purposes such as:
 - incentivising the uptake of new MBS services;
 - promoting service delivery in locations which may have access issues (such rural and remote areas); and
 - compensating for additional capital or other costs associated with delivering a service.

This generally results in different levels of fee and benefit being paid for the same service, depending on the circumstances of service delivery, which is inconsistent with the principles of Medicare. Targeted, non-MBS, mechanisms are a more appropriate and efficient method of addressing such factors.

Over time, innovations or changed clinical complexities may occur. In these situations, either a modified item with a revised descriptor and adjusted fee, or an entirely new item, may need to be introduced.

B.6 MBS geo-classification standard—The Modified Monash Model

The Committee was asked, by the Department, to consider the replacement of two existing rural classification standards¹³ with a new, single standard – the Modified Monash Model¹⁴. The change was recommended to ensure that claiming of the MBS items in the table below that are subject to geographical restrictions, are based on current, rather than outdated, population data.

Service	Item/s	Classification standard
Remote bulk bill incentive	10991	RRMA
Telehealth items	various	ASGC-RA
Pathology remote bulk bill incentive	74991	RRMA
Aboriginal Medical Service remote antenatal service	16400	RRMA
Telepsychiatry items	353-370	RRMA
Diagnostic imaging remote bulk bill incentive	64991	RRMA
All diagnostic imaging 'capital sensitivity' services	various	ASGC-RA

¹³ Standards replaced were the Rural and Remote Metropolitan Areas (RRMA) – developed using 1991 Census data; and the Australian Standard Geographical Classification – Remoteness Areas (ASGC-RA) – developed using 2006 Census data.

¹⁴ More information on the Modified Monash Model can be found at: <https://www.health.gov.au/health-workforce/health-workforce-classifications/modified-monash-model>

The Committee considered the matter on 15 May 2017 and agreed to recommend to the Taskforce that the Modified Monash Model be adopted across the MBS, with no grandfathering of current arrangements. The Taskforce endorsed this approach on 8 June 2017.

B.7 Repeat prescriptions and specialist-to-specialist referral

In January 2018 the Minister for Health raised two existing policy concerns with the Taskforce, seeking advice to respond to public concerns. The Taskforce requested consideration of this issues by the Committee and the General Practice and Primary Care Clinical Committee (GPPCCC).

The Committee considered the matters at its meeting on 22 May 2018 and provided the following advice to Taskforce:

Repeat prescriptions:

The Committee confirmed that:

- there is a perception among consumers that a GP attendance for a 'routine' renewal of a referral and/or prescription is inconvenient, particularly when, in the patient's view, their clinical condition has not changed;
- there is a need to uphold the GP's role as care coordinator, particularly to control potential adverse outcome of medication misadventure¹⁵;
- evidence suggests visits to GPs motivated by medication requests often resulted in the GP affording additional health care, including management of other issues, providing education and advice and preventative care¹⁶; and
- the Pharmaceutical Benefits Scheme (PBS) recommends that medication review should be undertaken every six months to safeguard optimal medication management.

The Committee's final advice to Taskforce was for no change to the current arrangements, i.e.:

- GP attendance is necessary for the issue of a repeat prescription; and
- prescriptions remain valid for a maximum of 6 months from date of issue (acknowledging that there are mechanisms in place to alter this where it is clinically safe (e.g. 12 months for lipids and oral contraceptives)).

Specialist to specialist referrals:

The Committee confirmed that:

- there is an apparent need to increase understanding within the sector relating to unnamed and indefinite referrals;
- the ongoing communication between a GP and a specialist, or a review of a referral at 12 months does not constitute a 'new referral'; and
- there are current mechanisms in place to ensure that the GP's coordinator role is maintained (e.g. under current arrangements, a patient referred to an oncologist by a surgeon will be required to see their GP within 3 months, facilitating access to social

¹⁵ Medication misadventure can lead to serious outcomes and account for 2-3% of hospital admissions.

Reference <https://www.safetyandquality.gov.au/wp-content/uploads/2014/02/Literature-Review-Medication-Safety-in-Australia-2013.pdf>

¹⁶ Reference <https://www.mja.com.au/journal/2018/208/3/administrative-encounters-general-practice-low-value-or-hidden-value-care>

supports, psychological counselling and review in relation to the patient's other medical conditions).

The Committee's final advice to Taskforce reiterated two of the Committee's earlier recommendations, taken from the Committee's 2016 report to Government. The recommendations were that:

- specialists should claim one initial attendance for the patient when the patient is receiving a single course of treatment, regardless of the duration of the course of treatment. All further attendances are to be considered 'subsequent'; and
- MBS provider knowledge on referral rules should be improved through mandatory education.

B.8 Volume-based incentive payments within a medical practice

In September 2017, the Minister for Health requested advice in relation to reports¹⁷ that an assisted reproduction company was giving high-performing doctors a bonus if they instigated more than 400 cycles of IVF a year over three years.

The Committee considered the matters at its meeting on 30 November 2017 and agreed that volume-based incentive models were at odds with ethical medical practice, in that they have the potential to:

- damage the doctor/patient relationship;
- generate provision of clinically unnecessary services;
- increase patient out of pocket costs;
- result in harm; and
- breach the *Health Insurance Act 1973*.

The Committee's advice to Taskforce was to refer the matter for compliance investigation to uncover, monitor and investigate any inappropriate billing behaviour in this sector. The Taskforce endorsed the Committee's advice and responded to the Minister on this matter.

B.9 Specialist and consultant physician attendance items

In mid-2017 the Committee considered current MBS arrangements for specialist and consultant physician (CP) attendances in order to develop an alternative model, for Taskforce action.

The Committee's review of MBS expenditure and bulk-billing data, revealed that:

- specialist and CP attendances account for a significant proportion of MBS expenditure (2015–16 > \$1.86 billion or 8.8 per cent of total MBS expenditure / 2011–12 and 2015–16 expenditure increased by \$371.9 million or 25 per cent (compared to growth in overall MBS expenditure of around 26 per cent), contributing around 8.5 per cent to overall growth in expenditure);
- the main standard specialist attendance items (Group A3) and the standard CP items (Group A4), accounted for 35 per cent and 60 per cent respectively of total expenditure on specialist attendances, with A4 providing higher rebates than A3 items;

¹⁷ Reference <https://www.smh.com.au/opinion/ivf-the-only-bonus-paid-should-be-a-baby-bonus-20170911-gyertn.html>

- bulk billing for specialist and CP attendances is not high in comparison to other areas (around 40 per cent of out-of-hospital services bulk billed, compared to GP services with a bulk billing rate of 84 per cent);
- a proportion of bulk billed services are provided by doctors who bulk bill all their patients at the one location, indicating they are provided at public facilities (2015–16, more than 7.6 million people received a specialist or CP attendance (around 31 per cent of the population) with the average number of attendances per person (who received a service) in 2015–16 being 3.9 services, and the average benefit per person being \$300.90);
- creation of the associated MBS items was undertaken in the 1970s, without review or change since that time raising the question if the items remained fit for purpose, given the recognition of new speciality groups and the introduction of new attendance items specifically for that speciality;
- there had been an introduction of high-priced items to address specific issues (e.g. increased benefits for geriatricians) that had further led to a disjointed approach to the structure of specialist attendance items and a distortion in the level of benefits available to the different specialties;
- more than 100 MBS items could be used interchangeably, for example, a palliative care CP could charge item 110 (initial consultant physician attendance), item 132 (planning and management of a patient with multiple co-morbidities) or item 3005 (initial consultation – palliative medicine) for the same service;

The Committee found a lack of justification for a differing fee structure for one specialist group over another and recommended replacement of the current MBS arrangements with one that mirrored current GP/consultant remuneration, i.e. using time-based consultation remunerations for specialists and CPs.

The Committee recommended that separate items or modifiers could be introduced to be claimed when the consultation occurs via telehealth (with or without a fee loading) or for a home visit. For example, specialist consultations could be standardised and remuneration be based on time as follows (pending review of appropriateness of the times):

Brief	less than 5 minutes
Standard	5–20 minutes
Long	21–40 minutes
Prolonged	41–60 minutes
Extended	more than 60 minutes

The Committee recommended further investigation into the actual remuneration or MBS fee for each specialist consultation type (e.g. brief, standard, long, prolonged and extended), suggesting the use of analysis of existing data and the general principle that each consultation should attract a ‘flag fall’ (standard amount across all consultations to account for time getting patient in and out of consultation room, retrieving patient record etc.) and a dollar-per-time-unit amount based on the time interval for the item.

Other principles for consideration included:

- To claim an attendance item, a professional attendance must occur—merely being available for a professional attendance would not be sufficient.
- All other qualifiers e.g. new or review, or the type of specialist, would no longer be used.
- The time claimed for the attendance must be exclusive i.e. the consultation times of different patients cannot overlap. For example, if more than one patient is being managed at the same time the maximum attendance that can be claimed for each is a brief consultation (this particularly refers to emergency physicians).

- Where a procedure is carried out at the same time as the consultation, the procedural time should not 'extend' the attendance time used for billing.

The proposal was provided to the Taskforce in mid-2017. The Taskforce referred the matter (and the Committee's initial proposal) to the Specialist and Consultant Physician Consultations Clinical Committee for the Clinical Committee to progress the issue and make a recommendation to Government¹⁸.

B.10 Referrals from the Diagnostic Imaging Clinical Committee

B.10.1 Self-referrals by diagnostic imaging providers

The Diagnostic Imaging Clinical Committee (DICC) identified issues around the provisions of the *Health Insurance Act 1973* that allow specialists (other than specialist radiologists) to provide diagnostic imaging services without a request from another practitioner.

In the Diagnostic Imaging Services Table (DIST) there are a number of items that have referred ('R') and non-referred ('NR') equivalents. R-type services generally need to be rendered by specialists and at the request of a medical practitioner or allied health practitioner, such as a physiotherapist, for a prescribed range of services.

The DICC identified concerns around self-referral by specialists (other than specialist radiologists) - that is, specialists being able determine a service to be necessary and providing it themselves e.g. cardiologists doing echocardiograms. The DICC questioned why there are no NR items (items that can be rendered without a request from another practitioner) for cardiac, vascular and urological ultrasound, when other items have both NR and R items (items that, subject to certain exemptions, need a request from another practitioner). The DICC felt that this was inconsistent and referred the matter to the Committee for advice.

As noted above, the NR schedule fee is lower than the fee for the equivalent R item. The reason for this is unclear but it would appear that, for x-rays at least, the higher rate is applied when specialist radiologists rendered these services to reflect their level of expertise (and charges). Historically, the NR items covered imaging procedures which GPs might commonly report on. For the NR ultrasound items, it is likely that the lower rate applied because the service was rendered by practitioners on their own patients and thus did not have any external reporting requirements.

Under the exemption to the requesting provisions in section 16B of the Act, GPs in remote areas (and certain GPs who had been providing a significant number of services before May 1991) can render R-type services without a request (commonly referred to as self-determining) as long as those services do not have NR equivalents. A spine x-ray is an example of an item without an NR equivalent. Where a service has an NR equivalent, the NR item must be claimed.

The anomaly that arises with the GP exemption provision is that the same level of benefit is payable for services rendered by GPs and specialists for R services without NR equivalents, yet a lower benefit is paid for GP rendered services where an NR equivalent item applies. It could be argued that, if the same service is being provided either the same benefit should be paid, or there should be NR equivalents for all services GPs render.

¹⁸ Draft report of the Specialist and Consultant Physician Consultation Clinical Committee can be found at: <https://www1.health.gov.au/internet/main/publishing.nsf/Content/MBSR-closed-consult>

In 2015–16, there were 395,675 NR items claimed totalling \$14.9 million in Medicare benefits. 17 per cent of these were claimed by GPs (GPs 66,669 and specialists 329,006). By far the largest number of NR services are rendered by GPs to patients in major cities, with the most-claimed item being the 12 week pregnancy scan.

Another exemption in the Act from the requesting provisions for R-type services is that specialists other than specialist radiologists can self-determine the need for these services on their own patients. However, the item descriptors for R ultrasound services, in association with the item descriptors for the NR services, guide specialists to use the NR item through the use of the phrase ‘where the patient is not referred by a medical practitioner’ and R ultrasound items include the phrase ‘the patient is referred by a medical practitioner...’. Such phrases do not exist in NR and R x-ray items. They simply describe the service in the same way, but include the NR or R annotation.

This appears to cause confusion for specialists as to which items they are able to claim. In 2015–16, over 70 per cent of the 322,761 specialist-rendered NR ultrasound services were provided by obstetricians, gynaecologists and surgeons.

Removing NR services, together with deleting references to the referral requirements in R-type ultrasound (as for R-type x-rays) would clarify the entitlement of specialists to claim the R items. It would also allow specialist radiologists to claim the R ultrasound items instead of the NR equivalent when they do additional necessary services—for example, an ultrasound of the breasts following mammography.

An alternative is to create NR items for cardiac, vascular and urological services at a lower fee for when these services are self-determined. This would require changes to the Act to ensure there is no inconsistency between it and the DIST in relation to requesting of these services.

Specialist radiologists claiming NR services

Specialist radiologists are not able to self-determine R-type services under the Act (except in emergencies, for additional services and other specific circumstances) but, like any other medical practitioner, are able to self-determine NR-type services. Data for the period 2006–07 to 2015–16 show that the claiming of NR items by specialist radiologists is not high—85,412 services (mostly x-rays of the extremities) in 2015–16 out of over 24 million diagnostic imaging services—and that growth has generally been in line with diagnostic imaging services overall. Because they are NR items, no details about who may have ‘requested’ them are held in the Medicare claims system.

It is understood that some allied health practitioners—e.g. physiotherapists—were ‘requesting’ services such as knee x-rays which are beyond the scope of their prescribed services. The services which physiotherapists are able to explicitly request are x-rays of the hip joint, pelvic girdle and a number of spine items, which are all R items without NR equivalents. Physiotherapists cannot request for Medicare purposes any other items, including other services with NR equivalents as noted above.

A ‘request’ for an NR service has no basis in legislation. An argument could be made therefore that billing of NR services has the effect of allowing Medicare funding for services that are beyond the explicit requesting rights of such practitioners. Furthermore, if a radiologist provides an NR service when asked by a physiotherapist (or other provider with restricted requesting rights), the radiologist is the person who is responsible for the clinical relevance of the service, that is, the radiologist is required to have turned their mind to the need for the service.

The Committee designed the following principles that were subsequently endorsed by the Taskforce at its meeting on 18 September 2018 and delivered to DICC for use in its draft report and recommendations to Government¹⁹:

- Diagnostic imaging services rendered by practitioners on their own patients (self-determined services) should attract a lower rebate than requested diagnostic imaging services.
- Before a Medicare funded diagnostic imaging service is rendered, there must be a request form.
- All practitioners providing Medicare funded diagnostic imaging services must have qualifications and credentials relevant to, and appropriate for, the services they are providing.
- The findings of a self-determined service must be recorded in the patient's record. Diagnostic imaging reports and the findings of any self-determined services should be made available in the patient's Myhealth record.

B.10.2 Multiple services rules in diagnostic imaging

DICC was keen to resolve a known issue where, in some instances, patient and provider claims for restricted items were being rejected under multiple service restrictions²⁰. In some instances the restriction had a logical explanation; for example, a benefit not being payable within 24 hours of a previous service for both the urinary tract (item 55038) and abdominal ultrasound (item 55036) is because item 55036 also includes a urinary tract examination.

For other restrictions the reasoning was less clear. These included restrictions on claiming:

- abdominal ultrasound and pelvic ultrasound (item 55065) at the same time;
- general ultrasound (except the interventional items), obstetric and gynaecological ultrasound and musculoskeletal ultrasound with either cardiac or vascular ultrasound.
- cardiac ultrasound with vascular ultrasound, even where entirely different body areas are being examined.
- vascular ultrasound with urological ultrasound (which covers prostate examinations only).
- general interventional ultrasound items (items 55026 and 55054) with other general 'diagnostic' ultrasound items.
- any other diagnostic imaging item being claimed with the interventional CT items, items 57341 and 57345. A similar restriction applies to fluoroscopy interventional items 60506, 60507, 60509, 60510, 61109 and 61110.

DICC was concerned that, in practice, restrictions made it necessary for the patient to attend on two separate days, which incurred additional out of pocket costs and associated expense for the patient and their family members or carers and a propensity for patients to not re-present for a second procedure.

At its meetings in March and June 2018, DICC developed eight draft recommendations around proposed changes to item level restrictions. These recommendations were referred to the Taskforce for consideration at its meeting on 2 August 2018, with the Taskforce referring the

¹⁹ Draft report of the Diagnostic Imaging Clinical Committee can be found at:

<https://www1.health.gov.au/internet/main/publishing.nsf/Content/MBSR-closed-consult>

²⁰ More information on multiple services restrictions can be found at:

<https://www.humanservices.gov.au/organisations/health-professionals/topics/education-guide-billing-multiple-mbs-items/33231#a2>

recommendations to the Committee for advice, in the context of multiple services rules and item level restrictions on diagnostic imaging services more broadly.

The eight draft recommendations provided for Committee advice were:

Amend the item descriptors for items 55065 and 55067 (ultrasound of the pelvis) to remove co-claiming restrictions with items 55014 and 55036 (ultrasound of the abdomen).

Amend the item descriptors for general ultrasound (not including interventional items), obstetric and gynaecological and musculoskeletal ultrasound to remove co-claiming restrictions with cardiac or vascular ultrasound (with the exception of lower leg ultrasound).

Create separate items for unilateral and bilateral musculoskeletal ultrasound items with an appropriate fee for each.

Amend the item descriptors for interventional CT (items 57341 and 57345) and interventional fluoroscopy (items 60506, 60507, 60509, 60510, 61109 and 61110) to change the restriction with a diagnostic imaging service of any type to only services in their own subgroups.

Create a new item for MRI for the evaluation of cervical cancer for initial staging or re-staging with a time period restriction of two services per 12-month period.

Create a new item for MRI for the evaluation of rectal cancer for initial staging or re-staging with a time period restriction of two services per 12-month period.

The time period restriction on MRI for PIP breast implants be changed from 1 service per 12 months to 1 service every 24 months.

The word “lifetime” be removed from the DIST with regards to time period restrictions on imaging services for cancer patients.

The Committee delivered the principles below for Taskforce endorsement at the meeting of 18 September 2018. Taskforce endorsed the principles, for DICC’s consideration when finalising recommendations in their draft report.

- The MBS should not discourage or prevent clinically necessary services being performed.
- Multiple service rules should not discourage or prevent multiple services being performed on a single occasion where clinically appropriate.
- Multiple service rules should not promote the disaggregation of ‘single’ services where this is not clinically appropriate and motivated by financial concerns.
- Multiple service rules should take account of financial efficiencies for providers.
- Multiple service rules should not impact adversely on patient convenience.
- Multiple service rules should apply with respect to the request form rather than when the intervention is undertaken i.e. If the request form is for right and left sides, the multiple service rule is applied whenever the tests are performed.

B.10.3 Imaging test substitution by radiologists

At its meeting of 21 June 2018, the DICC considered the issue of imaging test substitution and, in particular, a proposal that proposed a mechanism be developed to allow radiologists (and other imaging specialists who analogously undertake arm’s length referral for imaging) to substitute the requested test with a clinically more appropriate test.

DICC identified that the proposal had significant potential to enhance delivery of individual patient care, specifically that:

- Patients should undergo the most appropriate diagnostic imaging examination (or a combination of examinations) to address a specific problem or answer the clinical question safely, effectively, accurately, and in the least number of steps; with due regard to radiation protection, patient preference, and locally available skills and resources.
- It is clinically suboptimal, and may fail the principle of radiation exposure justification, for the patient to undergo an inappropriate (or even futile) imaging examination.

- The clinical radiologist is the suitably trained and logically positioned medical specialist to arrest inappropriately requested examinations, and to substitute appropriate ones.

The DICC was keen to ensure that:

- The imaging investigation that the radiologist substitutes should be the most appropriate to answer the clinical question at hand, given considerations of radiation safety, patient safety, accuracy of imaging test for the differential diagnosis or clinical task at hand, patient preference and local expertise.
- The substitution should happen on direct instruction by the radiologist, with appropriate documentation of the justification as above.
- The funding for the substituted test should be the same as for the test which is being substituted; this is in order to prevent any real or perceived perverse incentive to substitute tests.
- Such substitution should be allowed to happen at the clinical judgement and discretion of the supervising radiologist unless an exception occurs.
- The substitution should be discussed with the patient, including the justification and the reasons for the substitution, and be acceptable to the patient. Noting that any change would need to take into consideration the time required to discuss and select an imaging test.
- Paperless and electronic request forms should have a mechanism for the referrer to indicate that the referrer does not wish for substitution to happen without prior consultation with the referrer; this mechanism is analogous to the PBS prescription mechanism which states medication substitution is not to occur.
- Any change would not affect the current process to change a referral, i.e. change occurs following direct contact between the referrer and the supervising radiologist and case discussion.
- Education on any change should be promoted and advocated. This should include decision support algorithms based on valid clinical evidence as these two approaches for raising the quality of patient care are complementary to one another.
- Any education should also seek to improve information recorded on the request form to ensure the receiving party has sufficient information on which to base a clinical decision.

The Committee determined that the current MBS inadvertently encourages less than optimal patient care by limiting the ability of the radiologist to select another test that would be 'better'. The Committee made the following recommendations, Taskforce endorsed the principles at its meeting of 18 September 2018, for DICC's consideration when finalising recommendations in their draft report.

1. A clinical radiologist may substitute a requested diagnostic imaging examination with a more appropriate examination, provided that:
 - a) the substitution is in the patient's best interest
 - b) all reasonable efforts have been made to discuss the substitution with the referrer*
 - c) the decision to substitute has been made by the clinical radiologist and may not be delegated
 - d) the clinical radiologist must discuss the substitution with the patient and obtain consent for the substitution. This discussion cannot be delegated.

**If contact with the referrer does not occur, substitution can still proceed, but the lower Medicare rebate of the referred examination and the substituted examination will apply.*
2. Where the clinical radiologist is able to contact the referrer, the rebate for the substituted test applies. A record of the conversation between the clinical radiologist and referrer must be made in the imaging report and this will replace the need for an altered referral.

3. Where the clinical radiologist is unable to contact the referrer, the reason for the substitution must be recorded in the imaging report and the lower Medicare rebate of the referred test and the substituted test applies.

B.10.4 Computed tomography angiography frequency limits

The DICC reviewed MBS item 57350 (CT spiral angiography). At the time of review, the item descriptor was:

COMPUTED TOMOGRAPHY - spiral angiography with intravenous contrast medium, including any scans performed before intravenous contrast injection - 1 or more spiral data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy recording of multiple projections, where:

- (a) the service is not a service to which another item in this group applies; and
- (b) the service is performed for the exclusion of arterial stenosis, occlusion, aneurysm or embolism; and
- (c) the service has not been performed on the same patient within the previous 12 months; and
- (d) the service is not a study performed to image the coronary arteries (R) (K) (Anaes.)

Bulk bill incentive

Fee: \$510.00 **Benefit:** 75% = \$382.50 85% = \$433.50

(See para [IN.0.19](#) of explanatory notes to this Category)

The DICC agreed that the current restriction for the item of one service per 12-month period was inadequate. One example was for computed tomography angiography (CTA) of the vessels of the head and neck in the setting of cerebrovascular accident, where it was agreed a limit of one service per 12 months is insufficient.

DICC liaised with the Neurosurgery and Neurology Clinical Committee (NNCC) and Vascular Clinical Committee (VCC) regarding their view on appropriate time period restrictions for CTA for different anatomical regions and requested consideration by the Committee.

The Committee acknowledged that limits had been placed in response to 'over ordering', however the Committee advised that the number of interventions or investigations should not be limited over prescriptive time periods, given that clinical situations could be envisaged where these limitations could compromise optimal individual patient care. The Committee proposed the use of alternative limitations, e.g. limiting abdominal, cerebral and lower limb angiography ordering to specialists.

The Committee outlined its advice to DICC for noting at the Taskforce meeting of 18 September 2018.

B.11 Referral from the Cardiac Services Clinical Committee

B.11.1 Standby services

The Cardiac Services Clinical Committee's (CSCC) draft report to the Taskforce included a recommendation to divide existing MBS item 38358 into two. At the time of review the item descriptor was:

Extraction of chronically implanted transvenous pacing or defibrillator lead or leads, by percutaneous method where the leads have been in situ for greater than six months and require removal with locking stylets, snares and/or extraction sheaths in a facility where cardiac surgery is available, in association with item 61109 or 60509 (Anaes.) (Assist.)

Fee: \$2,913.95 **Benefit:** 75% = \$2,185.50

CSCC recommended that 2 items be created. Item 38358 would remain but the fee would be reduced to 60 per cent of the existing MBS fee, claimable by a non-cardiac surgeon for the lead extraction. The new item would 'mirror' 38358, but would provide 40 per cent of the existing MBS fee and be claimable by a separate, stand-by cardiac surgeon, called on to operate if required. This recommendation was deemed necessary to provide for situations where the stand-by cardiac surgeon is required to be present for the full duration of lead extraction, excluding low risk pre and post-extraction phases, and be able to immediately scrub and perform a thoracotomy if major complications should occur.

The CSCC were of the view that the role of a surgeon who is physically present and on stand-by for the procedure is not the same as the role of an assistant (although it is similar) and if a cardiac surgeon performs the procedure, a stand-by surgeon is not required or billable.

This recommendation was provided for Taskforce consideration at the meeting of 7 March 2017 and again on 11 April 2018. The Taskforce did not support the creation of a new MBS item for a cardiac surgeon to be on stand-by for the extraction of chronically implanted leads.

Cardiac surgeons subsequently expressed concern with the Taskforce decision, on the grounds a stand-by surgeon is a requirement endorsed in guidelines of the Cardiac Society of Australia and New Zealand and the Australia and New Zealand Society of Cardiothoracic Surgeons.

The Taskforce requested advice from the Committee to consider the matter in relation to MBS principles and rules around MBS funding for stand-by services. The Committee discussed the CSCC recommendation at its meeting of 26 June 2018. Members noted that the procedure at issue is both hazardous and rare. In 2016-17, there was a total of 139 uses of item 38358 across Australia. Even if a cardiac surgeon were on stand-by, there would still be a potentially harmful delay in the surgeon and that the procedure should be performed by a specialist cardiac surgeon to ensure the capacity to perform a thoracotomy and other subsequent surgery as necessary. Members also noted that the adoption of the proposal would set a highly undesirable precedent in paying a Medicare benefit for a service which does not meet the definition of 'clinically relevant'.

The Committee did not support the recommendation and provided advice to the Taskforce that the introduction of stand-by items in any clinical setting and, in relation to item 38358 in particular, should be rejected.

B.12 Referral from the Department of Health

B.12.1 Compliance Budget measure

In the 2017-18 Budget, the Government announced its intention to strengthen the legislation for Medicare compliance activities. The *Guaranteeing Medicare – Medicare Benefits Schedule – Improved Compliance* measure contained relevant amendments to the *Health Insurance Act 1973* (HIA), the *Dental Benefits Act 2008* (BBA), and the *National Health Act 1953* (NHA).

The Department provided the proposed legislative amendments to the Committee for consideration at the Committee's meeting of 11 July 2017.

The legislative amendments aimed to address:

- a growing corporate presence in the medical system requiring a shift in legislative focus from only individual providers to corporate entities with provider employees;
- inconsistencies between the three Acts whereby doctors and other MBS providers were subject to varying accountability and penalties; and
- the need for strengthened recovery provisions for providers that were found to have made non-compliant MBS claims.

Appendix C

Consumer principles

The Taskforce's Consumer Panel developed the following set of Consumer Principles, to be applied in deliberations and decision-making to ensure a consumer-centred MBS

1. The MBS Review, and ongoing MBS management is co-designed.
Evidence-informed consumer engagement is integrated in the design, implementation, monitoring and evaluation of the MBS to ensure it meets the needs, values and preferences of consumers and the community²¹, not just clinicians, industry and policy makers.
2. The MBS Review supports the development of an Australian health care system that is safe and high quality; provides equity of access and outcome for patients; delivers improvements in patient outcomes; supports the efficient and effective use of resources; and is sustainable.
3. Design and use of MBS Items support safe, evidence-based, high quality consumer-centred care.
 - *MBS items with significant potential health impacts are linked to contemporary clinical practice guidelines, each of which has a plain English version.*
 - *The MBS allows sufficient flexibility to tailor treatments and care to the specific needs of individual patients, which may not align directly with Guidelines, but where the variation is well considered and appropriate.*
4. Design and use of MBS items supports fair and equitable access and outcomes for all.
It will:
 - *Address geographic location as a barrier by proactively looking at scope of practice of more than one clinical group, and reimbursement for clinical services that reflects the cost of service provision in regional and remote settings*
 - *Ensure changes to the MBS do not drive an unreasonable increase in out-of-pocket expenses, particularly for vulnerable groups such as people with, or at risk of, multiple chronic diseases.*
5. The MBS ensures equality of access to medical services, regardless of whether it is provided in the public or private sector.
6. MBS review processes encompass assessment of individual and systemic health quality and economic benefit
 - *Real out of pocket (OOP) expenses for consumers are calculated when determining (relative) Item costs; a total OOP is calculated where multiple services are associated with the condition being treated; and for long term conditions the OOP is calculated for a longer period and potentially for the entire patient journey.*
 - *Quality and economic benefit (or cost effectiveness) are two different things to be balanced one against the other, and not assessed as one parameter.*
7. The MBS is a dynamic and responsive system that only funds services that improve health outcomes, noting that this may require new systems of data collection and analysis and new ways of public reporting.
8. Use of MBS data is maximised for public benefit, and with appropriate governance to ensure that public benefit does not cause harm to the individual

²¹ As per the definition of consumer-centred care from the Australian Commission on Safety and Quality in Health Care at www.safetyandquality.gov.au

- *Ongoing monitoring /post-market surveillance/data availability for research purposes is integrated into the use of the MBS to support evaluation and review for quality assurance.*
- 9. Lack of evidence does not always mean that an item is not effective and removed. It does confirm the imperative for data collection and post market surveillance that can meaningfully track the appropriate use of MBS items.
- 10. The MBS Review does not remove access to a service where it is appropriate for the care of a small, defined patient group.
 - *If necessary, the descriptor can be amended to ensure Item use is targeted to the appropriate patients, and only accessed by the appropriately trained clinicians.*
- 11. Patient Reported (Adverse) Outcomes Measures (PR[A]OMs), Patient Reported Experience Measures (PREMS) and other quality of life measures are considered along with clinical outcomes measures when determining safety, quality, efficiency, efficacy, access and currency of MBS Items.
- 12. Implementation of the MBS:
 - *Supports business practices that enable consumers to make fully informed decisions including clinical information and cost comparisons across public and private options*
 - *Inhibits listing of multiple Items for single consultations/treatments*
 - *Addresses conflict of interest and full disclosure regarding any recommended device/service*
 - *Uses the MBS to fund universal access to safe health care, particularly for the most vulnerable – and not simply convenience of access*
 - *Is reported upon publicly in ways that ensure clinicians and corporate beneficiaries of Medicare are accountable to consumers as patients and taxpayers*
 - *Is quality assured and incentivised through professional practice measures such as training.*

Additional considerations

The Consumer Panel notes that:

1. Further development of consumer principles is likely to include principles related to reporting, disclosure, transparency and regulatory oversight as well as communication and informed (financial) consent. For example:
 - Not every health service has a consumer cost reimbursement via the MBS
 - Practitioners that exploit the MBS are reported to the regulatory authority
 - Simplicity where possible in the MBS supports professional conduct – and identification and management of alleged unprofessional conduct.
2. All practitioners in the Review can be considered to have a Conflict of Interest: this is inevitable. Genuine, structured and supported consumer feedback in Review reports is required to ensure the conflicts have been successfully managed as well as to ensure the recommendations work in the best interests of the consumers to whom the reimbursements will be paid.