
Medicare Benefits Schedule Review Taskforce

Interim report from the General Practice and Primary Care Clinical Committee

April 2017

Important note

The views and recommendations in this interim report have been submitted in order to provide the Taskforce with a progress update on the work of this Clinical Committee. The report is not intended for release for public consultation.

Many issues/suggestions relating to items assigned to other Clinical Committees have been directed to those Clinical Committees for their consideration. (For example, requestor perspectives on Pathology and Diagnostic Imaging items have been submitted to the Diagnostic Medicine Clinical Committee). These Clinical Committees are expected to make recommendations directly to the Taskforce.

The General Practice and Primary Care Clinical Committee expects to submit a further report to the Taskforce, containing a full set of recommendations on MBS items allocated to the Committee (i.e., items rendered by General Practitioners), for the Taskforce's consideration and public consultation.

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1. Executive summary

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 The Taskforce also seeks to identify any services that may be unnecessary, outdated or potentially unsafe.

The Taskforce is committed to providing recommendations to the Minister for Health that will allow the MBS to deliver on the following goals:

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

The Taskforce has endorsed a methodology whereby the necessary clinical review of MBS items is undertaken by Clinical Committees and Working Groups. The Taskforce has asked the Clinical Committees to undertake the following tasks:

1. Consider whether there are MBS items that are obsolete and should be removed from the MBS.
2. Consider identified priority reviews of selected MBS services.
3. Develop a program of work to consider the balance of MBS services within its remit and items assigned to the Committee.
4. Advise the Taskforce on relevant general MBS issues identified by the Committee in the course of its deliberations.

The views and recommendations in this interim report are not intended for release for public consultation. In particular, many issues/suggestions relating to items assigned to other Clinical Committees have been directed to those Clinical Committees for their consideration. (For example, the Committee has submitted requestor perspectives on Pathology and Diagnostic Imaging items to the Diagnostic Medicine Clinical Committee [DMCC].) These Clinical Committees are expected to make recommendations to the Taskforce directly. The General Practice and Primary Care Clinical Committee (the Committee) expects to submit a further report to the Taskforce, containing a full set of recommendations on MBS items allocated to the Committee (i.e., items rendered by General Practitioners [GPs]).

1.1 Areas of responsibility of the General Practice and Primary Care Clinical Committee

The Committee was established in October 2016 to make recommendations to the Taskforce regarding MBS items in its area of responsibility, based on clinical expertise and rapid evidence review. The Taskforce asked the Committee to review prioritised items for services rendered, referred (e.g., secondary or tertiary care services, such as Consultant Physician attendances) and requested (e.g., Diagnostic Imaging and Pathology services) by GPs; and to develop recommendations on supporting GPs as stewards of the healthcare system.

This interim report outlines the Committee's recommendations regarding mechanisms that could support GP stewardship, MBS items covering services referred and requested by GPs, and an initial set of MBS items covering services rendered by GPs. The Committee prioritised 111 MBS items¹ for

¹ Note that the number of items does not include "NK" items. See Glossary for full definition of "NK" items.

review in this first phase of work, which culminated in this interim report. In the 2014/15 financial year (FY), these items accounted for approximately 29 million services and \$1.6 billion in benefits.

1.2 Recommendations and requests directed to other Clinical Committees

The Committee has highlighted its most important recommendations, requests and statements below, including those directed to other Clinical Committees participating in the MBS Review. Five recommendations were made to strengthen GP stewardship. Of the 111 MBS items² prioritised by the Committee for review, changes were identified for 92 items and 19 items were left unchanged. The complete recommendations and accompanying rationales for all items can be found in Sections 3 to 7.

Section 3 – Stewardship recommendations

- △ *Consumer partnership:* Strengthen communication between General Practice and consumers at all points in the clinician–consumer interaction journey, from providing information before a consultation, to strengthening communication during a clinician–consumer interaction, to resolving outstanding issues. This recommendation focuses on ensuring the relationship between General Practice and consumers support effective stewardship.
- △ *Service delivery systems:* Support Primary Health Networks (PHNs) to educate and encourage the use of case conferencing where appropriate, and support the use of flexible models (such as asynchronous case conferencing) that do not require the GP to be present at the time of the case conference. This recommendation focuses on ensuring that care is integrated across all domains, involving the consumer where possible.
- △ *Decision support, educational enablers and clinical governance:* Support the efforts of PHNs to develop care pathways, in collaboration with local clinicians and consumers that integrate with decision-support tools and electronic requesting/referring mechanisms. This recommendation focuses on ensuring that consumers receive best-practice, high-value care, in the right place, at the right time and by the right clinician, in the context of local resources and challenges.
- △ *Data transparency:* Provide data to GPs (including individual GPs, general practices and PHNs) on carefully selected metrics that provide feedback and a chance to reflect on their requesting, referring and prescribing behaviours, compared to a benchmark of their peers. Data delivery should be as close to ‘real-time’ as possible, with accompanying educational materials provided where appropriate. Alternative mechanisms should also allow GPs to ‘pull’ data that reflects their particular interests and quality improvement priorities. The initial metrics should focus on utilisation and continuity of care, account for local demographic contexts and use readily available data. This recommendation focuses on providing GPs with opportunities to reflect on their performance as stewards of the health system.
- △ *Leadership and role-modelling:* Encourage training organisations and PHNs to take on greater responsibility for promoting and encouraging stewardship and leadership through formal mentorship, core learning modules and leadership programs. This recommendation focuses on reinforcing GP stewardship through formal and informal education.

Section 4 – Rendered services recommendations and requests directed to various Clinical Committees and the Taskforce

- △ *Acupuncture items:* Delete item 173, which does not require the clinician to be appropriately credentialed to provide acupuncture services. Revise the item descriptors for items 193–199 to

² Note that the number of items does not include “NK” items. See Glossary for full definition of “NK” items.

allow appropriately credentialed Medical Practitioners (not only GPs) to provide services, and clarify that the service duration requirement applies to the physical attendance time. This recommendation focuses on ensuring that acupuncture attendance items reflect the level of high-quality care funded by the MBS.

- △ *Wound repair items:* Revise the item descriptors to differentiate between wound lengths of not more than 5 cm and wound lengths of more than 5 cm (i.e., make the cut-off point a wound length of 5 cm, rather than the current 7 cm). This recommendation focuses on ensuring that item descriptions (and the associated MBS benefits available to consumers) accurately reflect differences in the level of professional involvement required.
- △ *Assistance-at-operation items:* The Committee requests that the Principles and Rules Committee (PARC) considers recommendations to combine benefits for “assistance at operation” items 51300 and 51303 with the relevant operation (i.e., consolidate items 51300 and 51303 with the MBS items for the relevant operations). This request focuses on improving financial transparency for both consumers and the primary Surgeon, thereby reducing variation in out-of-pocket costs to the consumer. It also encourages the Surgical Specialist to ensure that Surgical Assistants are only used where clinically indicated, which in turn ensures high-value use of MBS resources.
- △ *Telehealth:* Consider introducing items for GP direct-to-patient teleconferencing for the purpose of providing consulting services to consumers in rural and remote areas, and to frail elderly and persons with disability (wherever they reside); and consider whether the MBS should include patient-end clinical support services provided by Allied Health Practitioners for telehealth consultations with Specialists or Consultant Physicians. These recommendations focus on supporting equitable access to health services, regardless of a consumer’s geographical status.
- △ *Removal of foreign bodies from the eye:* The Committee requests that the Ophthalmology Clinical Committee considers revising items to clarify that “embedded” is defined as foreign bodies that are “not easily removed by irrigation or with use of a cotton bud.” It also recommends stipulating within the explanatory notes that appropriate follow-up and after-care must be provided, including the use of fluorescein to confirm removal of the foreign body. These recommendations focus on ensuring that item descriptors are unambiguous and reflect best-practice health services.
- △ *Ankle/wrist: brachial indices:* The Committee requests that the Vascular Surgery & Interventional Radiology Clinical Committee considers revising items to stipulate that MBS benefits are payable only where an ankle/wrist: brachial index service is “for the evaluation of a symptomatic patient, or for monitoring in the context of an established diagnosis of peripheral vascular disease.” This recommendation focuses on preventing low-value care by clarifying that the items are not intended to cover screening of asymptomatic patients.
- △ *Sclerosant injection into varicose veins:* The Committee requests that the Vascular Surgery & Interventional Radiology Clinical Committee considers introducing a frequency restriction (i.e., that it specifies the minimum time between services) to prevent potential item misuse by clinicians who unnecessarily separate service provision across multiple episodes. This request focuses on improving value for consumers and the community and ensuring that consumers receive appropriate and convenient care.
- △ *Bladder catheterisation:* The Committee requests that the Urology Clinical Committee considers splitting this item into two separate items, differentiated by levels of complexity, in order to create a higher complexity item for services (a) performed on a male and (b) requiring the use of a guidewire and local anaesthetic. This request focuses on ensuring that item descriptions (and the associated MBS benefits available to consumers) accurately reflect differences in the level of professional involvement required.

Section 5 – Referred services request directed to the Consultation Services Clinical Committee

- △ The Committee requests that the Consultation Services Clinical Committee considers recommendations to revise the item descriptors for items 132 and 133 in order to ensure services (a) support integrated care and coordination with the consumer's nominated GP, and (b) represent high value care to both the consumer and community. In particular, to consider revisions that (a) focus on multi-organ system assessment and the development of comprehensive treatment and management plans that are provided to the consumer's nominated GP, and (b) stipulate both the appropriate frequency of service and that the service should be upon specific referral for the development of a comprehensive treatment and management plan.

Section 6 – Requests directed to the Diagnostic Medicine Clinical Committee regarding diagnostic imaging

- △ Prevent early *imaging for non-specific lower back pain* unless red-flag indications exist, to prevent unnecessary radiation exposure. (A desire for patient reassurance is not a red flag.)
- △ Consider developing appropriate use criteria for *ultrasound and CT imaging of the abdominal region*, with the goal of improving the safety and value of MBS-funded services for the patient.
- △ Minimise residual use of *head CT imaging* in children by considering the clinical indications that warrant the use of CT instead of MRI in children. Where clinical indications warrant the use of MRI instead of CT, amend the corresponding GP-requested MRI item (63507) descriptor to ensure that MBS benefits are payable for those indications.
- △ Focus the use of *GP-requested adult MRI* (item 63551) on indications where imaging is likely to result in a change in management. The current phrasing ("unexplained chronic headaches with suspected intracranial pathology") lacks specificity, prompting concern that the item may be used to investigate common chronic headache presentations.
- △ Restrict co-claiming of *x-ray and ultrasound of the shoulder* and consider mechanisms that support better requesting (including improving feedback within reports) in order to prevent indiscriminate imaging, resulting in over-diagnosis.
- △ Include appropriate use criteria in items for *ultrasound of the hand/wrist* (55800–55803) to prevent the use of imaging to diagnose certain tendon and ligament conditions (e.g., carpal tunnel syndrome, tenosynovitis, and rupture/avulsion injuries). Imaging for these indications reflects low-value use of resources.
- △ Prevent *ultrasound of the neck* in the absence of clinically palpable thyroid abnormalities, except where clinical examination is impossible due to documented anatomical barriers (e.g., obesity, torticollis). This will encourage high-value use of imaging in the presence of thyroid disease and avoid detection of incidental findings.
- △ Prevent the use of *ultrasound of the hip/groin* for clinically evident hernia, given that only cases of obscure pain and/or doubtful swelling in the groin require further diagnostic investigation. This will improve the value of MBS-funded services for the consumer and the community.
- △ Specify more appropriate clinical indications for the use of *paediatric hip examination by ultrasound* to prevent universal ultrasound screening for developmental dysplasia of the hip, recognising that this practice is not recommended.
- △ Specifically exclude the use of *ultrasound of ankle/hind foot* for the assessment of reduced bone mineral density and plantar fasciitis, and restrict co-claiming (for the same consumer within the same day) of both x-ray and ultrasound of the ankle. This request focuses on improving the value of MBS-funded services for the consumer and the community.

Section 7 – Pathology Working Group recommendations

- △ Stipulate the following when testing for *iron* deficiency (noting that the Pathologist should assume that the request is for iron deficiency if no indication is recorded): (a) A ferritin test is performed first, followed by a Pathologist-determined test for full iron studies if ferritin levels are either normal or raised (regardless of whether the request is for a ferritin test or iron studies); and (b) restrict follow-up testing (either a ferritin test or iron studies) to four times a year.
- △ Alter *coagulation panel* test items to ensure discriminate testing by (a) separating items for D-Dimer and international normalised ratio (INR) tests (commonly indicated single tests); and (b) stipulating the clinical indications for which more than four tests are done (the ‘full panel’) or deleting items for more than two tests. In addition, stipulate indications for repeat testing and how often this should occur for each item.
- △ Apply appropriate use criteria to *urine examination* to prevent culture without of urinary tract infection, and stipulate that culture is only performed if microscopy is positive, except in children, during pregnancy or prior to instrumentation of the urinary tract.
- △ Apply a 12-month frequency restriction to the *vitamin B12* marker item (66839) so that it has the same restriction as the vitamin B12 item it is meant to support. Consider what constitutes “low” and “equivocal” levels of vitamin B12, as there is currently no agreed cut-off point. This will reduce suspected inappropriate use and improve the value of services funded by the MBS.
- △ Apply an 11-month frequency restriction to *HDL testing* for screening purposes, and apply a twice-per-year frequency restriction for monitoring when consumers have a change in management (including lipid-lowering therapy and dietary change).
- △ Apply a frequency restriction for *PSA screening* (item 66655), limiting it to once every 23 months. Alter the explanatory notes to reference the National Health and Medical Research Council (NHMRC) guidelines on PSA testing; remind clinicians that PSA may be elevated due to non-malignant conditions (e.g., benign prostatic hypertrophy); and encourage health practitioners to discuss the potential benefits and harms of PSA testing prior to screening a healthy man.
- △ Apply a 12-month frequency restriction to *folate testing*, and develop appropriate-use criteria for the clinical indications for quantification of folate, stipulating that these should be detailed within the request.
- △ Perform an evidence review on *vitamin D testing* with a view towards restricting testing under item 66833 to once every one to two years, unless specific clinical circumstances apply. Update the current appropriate-use criteria to reflect changes in clinical evidence and guidelines.

2. About the General Practice and Primary Care Clinical Committee

The Committee is part of the third tranche of Clinical Committees. It was established in October 2016 to make recommendations directly to the Taskforce, and to other Clinical Committees (from a GP provider and requester perspective), based on clinical expertise and rapid evidence review. The Taskforce asked the Committee to review MBS items pertaining to services rendered, referred and requested by GPs.

The Committee consists of 20 members and an ex-officio representative from the Taskforce. Members' names, positions/organisations and declared conflicts of interest are listed in Section 2.1.

2.1 Committee members

Table 1. General Practice and Primary Care Clinical Committee members

Name	Position/Organisation	Declared interests
Prof Tim Usherwood (Chair)	Head of the Department of General Practice, Sydney Medical School Westmead, University of Sydney Visiting Professorial Fellow, the George Institute for Global Health Clinical Academic, Westmead Hospital GP, Sydney West Aboriginal Health Service	Employee of The University of Sydney Employee at Sydney West Aboriginal Health Service (MBS bulk-billing) Health consumer entitled to MBS rebates Board Member, Western Sydney Primary Health Network (WentWest Ltd) Chair, Diagnostics Expert Advisory Panel, NPS MedicineWise
Prof Jon Adams	Professor of Public Health Australian Research Council (ARC) Future Fellow Director of the Australian Research Centre in Complementary and Integrative Medicine (ARCCIM) at the University of Technology Sydney	None.
Ms Karen Booth	Registered Nurse and Accredited Immuniser Current President, Australian Primary Health Care Nurse Association Primary Health Care Nurse and Nurse Manager in General Practice since 1998 Member of the National Immunisation Committee, the Advisory Committee for Safety of Vaccines, GP Round Table 2015–2016 Member, Primary Health Care Advisory Group Member of advisory groups for the Royal Australian College of General Practitioners (RACGP) and the Australian Commission on Safety and Quality in Health Care (ACQSHC)	None.
Ms Thy Cao	President of the New South Wales Branch of the Australian Physiotherapy Association Current Chair of the University of Technology Sydney Physiotherapy Industry Advisory Board Member, State Insurance Regulatory Authority (SIRA) Allied Health 2014–2016 Member, Allied Health Practitioner Management Framework Review Working Party	Australian Physiotherapy Association President (knowledge of submissions made)
Mr Peter Gooley	Alzheimer's and Dementia Coach Lead of a diabetes support group in the Hawkesbury area	Involved with a Community Advisory Committee for Nepean Blue Mountains Primary Health Network

Name	Position/Organisation	Declared interests
	Member, Community Board of Advice at the St John of God Hawkesbury Hospital, Part of the Nepean Blue Mountains PHN (NBMPHN) Working Group, Hawkesbury Member of the Community Advisory Committee, NBMPHN Administrator, Memory People President of local community centre management committee Vice President, not-for-profit group encouraging and purchasing defibrillators, Hawkesbury local government area	
Dr Noel Hayman	GP and Clinic Director, Inala Indigenous Health Service Associate Professor, University of Queensland School of Medicine	General Practitioner accessing MBS items No work or shares in any corporate medical health settings
Prof Claire Jackson	Director, Centre for Health System Reform and Integration Professor in Primary Care Research Past Chair, Brisbane North Primary Health Network Past President, RACGP	Clinical GP using MBS billing Past Chair Brisbane North Primary Health Network Director HCF
Prof Steve Jan	Head of the Health Economics and Process Evaluation Program, the George Institute for Global Health Professor, Sydney Medical School Associate, Menzies Centre for Health Policy and the Poche Centre for Indigenous Health Chief Investigator, NHMRC Australian Partnership Prevention Centre	None.
Dr Emma Kennedy	Senior Lecturer, General Practice, Northern Territory Clinical School	General Practitioner accessing MBS items Chair of the Northern Territory regional training program for GPs
A/Prof Caroline Laurence	Associate Professor and Head of the School of Public Health, University of Adelaide Health Services Researcher	Director, Adelaide Unicare Pty Ltd.
Prof Lyn Littlefield	Executive Director, Australian Psychological Society Professor of Psychology, La Trobe University Chair, Allied Health Professions Australia Chair, Mental Health Professions Australia	None.
Dr Elizabeth Marles	Director, Hornsby-Brooklyn GP Unit Past President, RACGP Member, Pharmaceutical Benefits Advisory Committee Director, Therapeutic Guidelines	Employee Staff Specialist GP with NSW Health, billing GP item numbers Director, GP Synergy, training provider for GP training
Dr Ewen McPhee	General Specialist in General Practice with the Australian Health Practitioner Regulation Agency (AHPRA), with Advanced Diploma of Obstetrics Contractor to Central Highlands Health Pty Ltd—a social enterprise company chaired by the Deputy Mayor of the Central Highlands Regional Council (CHRH) and Chair of the Central Queensland Hospital and Health Service (CQHHS)	Registered General Specialist in General Practice with AHPRA, and hold an Advanced Diploma of Obstetrics. Contractor to Central Highlands Health PTY LTD a social enterprise company chaired by the Deputy Mayor of Central Highlands Regional Council (CHRH) and Chair of the Central Queensland Hospital and Health Service (CQHHS). The building I work from is the result of a GP Super clinics grant

Name	Position/Organisation	Declared interests
	<p>President of the Rural Doctors Association of Australia (RDAA)</p> <p>Vice Chair of the Central Queensland, Wide Bay and Sunshine Coast Primary Health Network Central Queensland Clinical Council</p> <p>Senior Fellow with Generalist Medical Training, James Cook University</p> <p>Assistant Director of Medical Training General Practice Training Queensland (GPTQ)</p> <p>Board Member of the Australian College of Rural and Remote Medicine (ACRRM)</p>	<p>Vice chair of the Central Queensland, Wide Bay and Sunshine Coast Primary Health Network CQ Clinical Council.</p> <p>President of the Rural Doctors Association of Australia (RDAA).</p> <p>Senior Fellow with Generalist Medical Training (GMT) James Cook University (JCU).</p> <p>Assistant Director of Medical Training General Practice Training Queensland (GPTQ).</p> <p>Board Member of the Australian College of Rural and Remote Medicine (ACRRM)</p> <p>Member of the Queensland Liberal National Party</p>
Ms Nadia Moffatt	<p>Non-Executive Director, Brain Injury SA (voluntary)</p> <p>Non-Executive Director, Australian Communications Consumer Action Network (ACCAN) (voluntary)</p> <p>Stroke Foundation, Consumer Council Member (voluntary)</p> <p>Consumer Consultative Forum Member, Australian Communications Media Authority (ACMA)</p>	<p>Non-executive director, Brain Injury SA (voluntary)</p> <p>Non-executive director, Australian Communications Consumer Action Network (ACCAN) (voluntary)</p> <p>Stroke Foundation, consumer council member (voluntary)</p> <p>Consumer consultative Forum member, Australian Communications Media Authority (ACMA).</p> <p>As a company director, I understand the importance of declaring any possible conflicts of interest and removing oneself from any situation that may pose a conflict of interest</p>
Dr Mark Morgan	<p>Associate Professor, Bond University, Queensland</p> <p>Associate GP, Eastbrooke Family Clinic, Burleigh Waters, Queensland</p> <p>Member of the RACGP Expert Committee for Quality Care</p> <p>Member of the MBS Review Diagnostic Medicine Clinical Committee and After Hours Working Group</p> <p>Member of the Health Care Homes Implementation Advisory Committee</p> <p>Member of the Digital Patient Safety Expert Advisory Group</p>	None.
A/Prof Kathryn Panaretto	<p>Clinical Director, Gidgee Healing, Mt Isa GP, QUT Medical Centre</p> <p>Adjunct Associate Professor, School of Medicine, University of Queensland</p> <p>Adjunct Associate Professor, School of Medicine, James Cook University</p> <p>Adjunct Associate Professor, Mt Isa Centre for Rural and Remote Health</p> <p>Board Member, North West Health and Hospital Service, Queensland</p>	None.
Mr Tim Perry	<p>Consultant Pharmacist</p> <p>Member of the Western Sydney PHN Clinical Council</p>	<p>Pharmacist working in General Practice and therefore have views supporting correct remuneration of both Pharmacists and GPs</p> <p>Working in several practices that have Pathology collection services but I have</p>

Name	Position/Organisation	Declared interests
		no relationship with, or interest in, their work Former traditional Chinese medicine practitioner, biased against MBS funding GPs doing acupuncture
Mr Gary Smith	Practice Manager Past National and New South Wales State President, Australian Association of Practice Management Ltd (AAPM) Advisor to the Commonwealth Government on the management of health reform Member of various advisory groups on behalf of AAPM Hold Board positions with: • Australian General Practice Accreditation Ltd (AGPAL; provides accreditation to general practices in Australia) • Quality in Practice, Chair (QIP; provides quality accreditation programs consistent with international standards to all sectors of business, both in Australia and internationally) • Nepean Blue Mountains Local Health District (LHD; appointed by the New South Wales Government to provide strategic oversight and monitor the LHD financial and operational performance under the state-wide performance framework, against the identified performance measures) • General Practice Workforce Tasmania (GPW; facilitates the recruitment and retention of General Practitioners and Allied Health in rural and remote areas in the state of Tasmania) Surveyor with AGPAL and an International Surveyor with the International Society of Quality Health (ISQua)	Have Pathology collection centre on site at our practice
Prof Simon Willcock	GP Clinical Director of Primary Care and Wellbeing Services, Macquarie University Chairman, Avant Mutual Group Member, Sydney North Primary Health Network Board	I work in a practice that is part of the Macquarie University Integrate Health Sciences Centre, which incorporates the university-owned private hospital, my primary care clinic, Specialist and Allied Health clinics, Pathology services and a Diagnostic Imaging service. The General Practice component has no financial arrangement with either the Radiology or Pathology services beyond our group association as described above. Member of Health Insurer Board
Dr Steve Hambleton (Ex-Officio)	GP Past President of the Australian Medical Association Past Chair of the Primary Health Care Advisory Group Senior Responsible Owner within the Australian Digital Health Agency Member of the Atlas Advisory Group of the Australian Commission on Safety and Quality in Health Care	None.

2.1.1 Conflicts of interest

All members of the Taskforce, Clinical Committees and Working Groups are asked to declare any conflicts of interest at the start of their involvement and are reminded to update their declaration periodically. It is noted that the majority of Committee members share a common conflict of interest in reviewing items that are a source of revenue for them (i.e., Committee members may perform services attracting benefits captured by 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. Other declared interests are noted above.

2.2 Summary of the Committee's review approach

This interim report synthesises the Committee's recommendations on both GP stewardship and the 111 MBS items³ within the scope of its first phase of work. The Committee developed the recommendations on GP stewardship, and the item-level reviews took place within Working Groups, with final approval granted by the Committee.

Work was performed across five full Committee meetings and seven Working Group meetings, during which the Committee developed the recommendations and rationales outlined in Sections 3–7. The review drew on various types of MBS data, including data on utilisation of items (services, benefits, consumers, clinicians and growth rates); service provision (type of clinician, geography of service provision); consumers (services per consumer); co-claiming or episodes of services (same-day claiming and claiming with specific items over time); and additional clinician and consumer-level data, when required. The review also drew on data presented in the relevant published literature, all of which is referenced in the report.

All recommendations (including recommendations and suggestions directed to other Clinical Committees) focus on the objectives of the MBS Review: improve access to medical services, encourage best practice, increase value for consumers and the health system, and simplify the MBS to improve both consumer and clinician experience (for example, through improved transparency around services billed), as well as the efficiency with which the MBS is administered.

The suggested recommendations from both the Pathology Working Group and the Diagnostic Imaging Working Group have been forwarded in a memorandum to the DMCC, set up by the Taskforce to consider the perspectives of both providers and requesters on selected Pathology and Diagnostic Imaging items.

2.2.1 Working Group structure

The Committee reviewed 111 items⁴ in total and made recommendations, requests and statements based on the best available evidence and clinical expertise, in consultation with relevant stakeholders, Specialists and Consultant Physicians. The Committee's four working groups are outlined below:

- △ Rendered Services Working Group (RenWG)
- △ Diagnostic Imaging Working Group (DIWG)
- △ Pathology Working Group (PWG)
- △ Referred Services Working Group (RefWG)

³ Note that the number of items does not include "NK" items. See Glossary for full definition of "NK" items.

⁴ Note that the number of items does not include "NK" items. See Glossary for full definition of "NK" items.

In addition, members of the Consumer Panel and the Committee formed a Consumer Joint Working Group to develop recommendations on GP stewardship.

3. Stewardship recommendations

Australia performs well on health outcomes—including having one of the highest life expectancies at birth—and its population has high levels of self-perceived health. (1)(2) However, these benefits are not equitably distributed across the population, with worse outcomes evident in remote and rural areas, and among Aboriginal and Torres Strait Islander Australians. Although healthcare spending is increasing as a proportion of GDP, (3) there is still considerable geographic variation in the use of many health professional services. This suggests that there are opportunities to improve the consistency of access to high-value, best-practice health services, and to reduce low-value care and waste in health resources.⁵

High-quality primary care is the cornerstone of a high-performing healthcare system, and GPs have a central role as gatekeepers—a principle strongly supported by the health industry in Australia. The central nature of the GP's role within the healthcare system is reflected in the volume of services directly initiated by GPs, which represent over half of all MBS and Pharmaceutical Benefits Scheme (PBS) activity and expenditure. (4) With this in mind, the Committee sought to identify mechanisms that would enable the best use of healthcare resources at the individual clinician level, whilst ensuring best-practice care.

Both in Australia and overseas, there has been interest in supporting the role of GPs as stewards of healthcare resources. According to a position statement by the Australian Medical Association, stewardship in this context involves maximising the quality of care and protecting consumers from harm while ensuring affordable care remains available in the future (e.g., by avoiding or eliminating wasteful healthcare expenditure). (5) With this in mind, the Committee has developed a set of recommendations to support GP stewardship, all of which are designed to complement the MBS changes suggested within the item-level reviews.

The Committee considered a number of complementary mechanisms that could support better GP stewardship and, where possible, has identified practical actions that could be implemented with this goal in mind (see Figure 1). The Committee started by identifying seven possible areas in which stewardship could be enabled, and it then considered levels of impact and feasibility for each area. The Committee also considered whether it was the best body to make recommendations in these areas. The resulting recommendations offer solutions to issues the Committee particularly wanted to highlight within these seven areas.

The Committee acknowledges that parallel primary care reform is well underway in other domains. Important changes that have already occurred will complement the changes recommended here.

⁵ Low-value care is defined as “services that evidence suggests confer no or very little benefit to consumers; or for which the risk of harm exceeds the likely benefit; or, more broadly, where the added costs of services do not provide proportional added benefits.”

Figure 1: Mechanisms to support GP stewardship

	Key examples
① Consumer partnership	<ul style="list-style-type: none">▪ Support shared, informed decision-making (including financial consent)▪ Strengthen availability of health information for consumers▪ Strengthen pathways for non-adversarial complaints resolution
② Service delivery systems	<ul style="list-style-type: none">▪ Support case conferencing, to improve integration of care (both prior to and at the point of hospital discharge, as well as in the community)
③ Decision support and educational enablers	<ul style="list-style-type: none">▪ Support development of locally tailored clinical guidelines/pathways (through HealthPathways)▪ Integrate HealthPathways with decision-support tools and electronic requesting/referring mechanisms
④ Clinical governance and data transparency	<ul style="list-style-type: none">▪ Provide transparency on GP practice patterns to aid in self-reflection and quality improvement, including information on requesting, referring and prescribing
⑤ Leadership and role modelling	<ul style="list-style-type: none">▪ Encourage GP training organisations and PHNs to promote and develop stewardship and leadership in primary care; such as through mentorship and supervision relationships, training modules, and leadership programs

Developed by the General Practice and Primary Care Clinical Committee

3.1 Consumer partnership

Partnering with consumers is central to the stewardship model, reflecting both the role that consumers play in health resource utilisation and the extent to which their actions enhance (and at times diminish) appropriate stewardship of healthcare resources. The General Practice–consumer consultation is intended to foster this partnership. Ideally, the GP elicits and discusses the consumer’s ideas and beliefs about their health, as well as their fears and concerns about current problems and their expectations regarding their healthcare. The GP then outlines the relative risks of differential diagnoses and management options, seeking to partner with the consumer in his or her decision-making. The overall aim of the consultation is to address the consumer’s presenting concerns and existing health problems, (6) while also reducing the risk of future problems through evidence-based health promotion and disease prevention strategies. (7)

The consumer partnership recommendations seek to ensure that consumers are knowledgeable about their healthcare options, understand their rights under the MBS, are informed about potential out-of-pocket costs and have access to a process for resolving any disputes. They were developed based on the deliberations of a Consumer Joint Working Group, which consisted of members from the Consumer Panel and the Committee, operating within the MBS Review.

Recommendation 1

- △ Strengthen the availability of health information for consumers, both through Commonwealth Government publications and through the HealthPathways currently being developed by PHNs and their partners (including Local Health Districts [LHDs]/Local Hospital Districts [LHNs]).
 - Through Commonwealth Government publications:
 - Develop and raise awareness of
 - a) Consumer-friendly descriptors of MBS services.

- b) Consumer-friendly interfaces for understanding what is and is not covered by the MBS (similar to the online MBS item search aimed at clinicians).
 - c) A consumer-guide to the MBS in the form of a booklet, available at primary care practices and online.
- Make government funding of clinical guidelines contingent on the production of an accompanying plain language version aimed at consumers.
- Through Primary Health Networks:
 - Consider the development of consumer-focused, publicly accessible versions of PHN/LHN HealthPathway guidelines, co-designed by consumers and clinicians

Rationale

- △ Providing plain language written resources about the MBS and locally relevant healthcare pathways will enhance the health literacy of the Australian community and empower consumers to be more active participants in their own healthcare choices.

Recommendation 2

- △ Mandate informed consent for MBS-reimbursable services, including financial consent. This should involve:
 - Providing and discussing treatment options, including alternative clinicians (where relevant and available).
 - Disclosing expected out-of-pocket costs.
 - Encouraging all healthcare professionals who offer MBS-reimbursable services to provide their fees and bulk-billing policies online.

Rationale

- △ Out-of-pocket costs are a major barrier to equitable healthcare, impeding access and reducing adherence to agreed management plans.
- △ The Royal Australian College of General Practitioners' (RACGP) Standards for General Practice require that practices "inform patients about the potential for out-of-pocket expenses for healthcare provided within [the] practice and for referred services," but they do not mandate that the practice provide details regarding the latter.
- △ Other professional bodies also encourage the provision of financial information, including expected out-of-pocket costs, prior to treatment.

Recommendation 3

- △ Develop a non-adversarial system for resolving complaints about consumers' out-of-pocket healthcare costs and disagreements about clinicians' charges.

Rationale

- △ At present, there are insufficient opportunities for consumer complaints to be handled in an independent and non-adversarial manner.
 - Current complaints processes can be adversarial in nature, which does not tend to encourage mediation and communication. This results in missed opportunities to improve healthcare.

- Although there are bodies established to handle health outcome, quality and malpractice complaints, there are no completely independent bodies that handle complaints focused purely on failure to provide financial consent, or that allow consumers to report issues regarding costs of services.

Additional Comments

In addition to the formal recommendations listed above, the Joint Working Group identified the following opportunities for consumer partnership.

- △ Encourage consumers to build on their health literacy and take greater ownership of their own healthcare. For example, consumers could be encouraged to:
 - Ask the five questions suggested by Choosing Wisely:
 - (a) Do I really need this test or procedure?
 - (b) What are the risks?
 - (c) Are there simpler, safer options?
 - (d) What happens if I don't do anything?
 - (e) What are the costs?
 - Take systematic notes during health interactions (e.g., use structured templates or exercise book note-taking during clinical interactions to record the reasons for a treatment or drug they are taking).
 - Use apps that provide access to clinical information in electronic health records (such as My Health Record).
- △ Include consumer-friendly indications on prescriptions.
 - This should *not* be mandated, as some consumers have confidentiality and privacy concerns. Instead, the consumer should be left to decide whether he or she would prefer consumer-friendly indications to be included.
- △ Encourage the use of brief exit surveys for consumers, covering questions such as:
 - (a) Based on your experience today, would you recommend this practice to a family member or friend?
 - (b) Were your healthcare needs met today?
 - (c) Do you understand the actions you must take related to your care following today's visit?
 - (d) Were you included in decisions about your health today?

3.2 Service delivery systems

Service delivery systems include infrastructure and processes through which consumers receive clinical care (for example, how team care is arranged and delivered). The recommendation below relates to case conferencing specifically, which the Committee decided should be an area of focus. The Committee prioritised case conferencing because (a) it is an area in which care can be improved, (b) it is an area where recommendations are feasible and will have an impact, and (c) the Committee is best placed to make recommendations in this area.

Recommendation 4

- △ Support PHNs in educating people about and encouraging the use of case conferencing where appropriate—both prior to and at the point of hospital discharge, as well as in the community—to ensure that care is integrated across all domains. Consumers should be involved where possible so that health practitioners can partner with them and help them to participate actively in their care and navigate the healthcare environment. Where a care plan already exists for a consumer, the case conference outcomes should be integrated into that care plan.
- △ Support the use of flexible models, including:
 - Asynchronous case conferencing, which does not require all participants to take part at the same time. For example, decisions made during a multidisciplinary hospital team conference prior to hospital discharge would be discussed with the GP (e.g., through a doctor–doctor conversation via telephone or email) in a dynamic way that provides the GP with an opportunity to contribute to and/or alter the discharge plan. The GP could then bill a case conferencing item number for his or her contribution.
 - Alternative representatives, which allows the Practice Nurse or other suitable health professional to represent the GP if he or she is unable to participate in a case conference.

Request 1

- △ The Committee requests that the Allied Health Clinical Committee considers recommendations to improve the participation of Allied Health Practitioners in case conferencing where appropriate.

Rationale

This recommendation aims to support access to best-practice health services. It is based on the following observations.

- △ There is evidence that GP involvement in the care of consumers in hospital—both for discharge planning and coordination (as part of a multidisciplinary integrated care team)—leads to better outcomes. (8) In addition to improving integration of care, improving the use of case conferencing MBS items would strengthen both relationships and communication between GPs and other medical specialists.
- △ The Committee formed the view—based in part on usage statistics, including geographical distribution and changes over time—that case conferencing is currently underutilised, and that it has the potential to enhance consumer outcomes.
- △ PHNs are the most appropriate bodies to encourage and promote case conferencing (both across care settings and within the community) due to their understanding of local health resources, systems and challenges, as well as their close ties with local GPs and LHNs/LHDs.
- △ Case conferencing is not easily organised within the GP workflow because it is often difficult to coordinate with other clinicians' schedules. As a result, a major barrier to case conferencing is the logistical challenge of scheduling meetings between hospital-based practitioners, GPs and other community-based health clinicians, and consumers. Access to discharge case conferencing for consumers with complex care needs, in particular, could be improved if this logistical challenge could be surmounted.
- △ The Committee believes that it is important for clinicians to be able to decide how best to involve consumers on a case-by-case basis, but with a default expectation that the consumer will attend a case conference.

- In some circumstances, real-time consumer participation in a case conference may not be clinically appropriate. For instance, some clinical details or work-in-progress discussions may be confronting. Alternatively, the consumer's presence may discourage the frank exchange of views and suggestions between health practitioners due to the potential for misinterpretation.
- In situations where a consumer does not participate in real time, there should be a requirement that details of the discussion are communicated to the consumer. This will keep the consumer informed of the options considered by the team and let him/her have input into the management plan.

3.3 Decision support and educational enablers

Recommendation 5

- △ The Committee supports the efforts of PHNs to develop HealthPathways clinical guidelines in collaboration with LHNs/LHDs, other local clinicians, and consumers. HealthPathways are web-based and provide detailed recommendations for the evidence-based management of a wide range of common conditions, taking into account local resources and offering links to local clinicians, both public and private. HealthPathways are evolving to integrate with decision-support tools and electronic requesting/referring mechanisms.

Rationale

This recommendation aims to ensure that consumers receive best-practice, high-value care, delivered in the right place, at the right time and by the right clinician, in the context of local resources. It is based on the following observations.

- △ Decision-support, education and clinical governance mechanisms can help clinicians and consumers to confidently navigate the health system. In particular, they can help to identify relevant local health resources and initiate appropriate investigation and treatment pathways in that context.
- △ PHNs, in collaboration with their corresponding Local Hospital Networks (LHNs), are the most appropriate bodies for developing and integrating care pathways. Indeed, they are already doing so in many regions of Australia.
 - Care pathways should be developed in collaboration with local health practitioners, and they should reflect local systems and health resources, as well as the relevant evidence and guidelines.
 - Decision-support tools (both for diagnostic and therapeutic services) and requesting/referring mechanisms should be suitable for the local health systems and resources and relevant to local care pathways.

3.4 Clinical governance and data transparency

In the context of stewardship, data transparency allows clinicians to see and reflect on the care they provide. This is an essential component of clinical governance. There is ongoing advocacy for greater transparency in healthcare, covering broad-reaching areas with varied goals and outcomes, and there are already international examples of providing cost, quality and outcome data to a wide range of participants, from clinicians to payers to consumers. In 2012, the Australian Commission on Safety and Quality in Health Care reiterated the need for greater transparency for consumers and funders as part of the national primary healthcare strategy. (9) In the context of enabling and

encouraging stewardship behaviours, the Committee focused on changes that are feasible and will have the most impact in terms of promoting stewardship.

Recommendation 6

- △ Provide data to GPs on carefully selected metrics that measure their requesting, referring and prescribing behaviours, compared to a benchmark of their peers. This should be implemented in the following way:
- Begin by using MBS, PBS and Practice Incentives Program (PIP) data sources that are readily available and understood. In the future, other sources may be available.
 - Initially focus on GPs as recipients (including as individual GPs, as well as groupings such as general practices and PHNs) as a way of providing an opportunity for GPs to reflect on their performance (relative to their peers) as stewards of the healthcare system.
 - Provide data in a way that supports GPs to reflect on their performance. Specifically, this involves:
 - Providing accompanying educational materials where appropriate, such as clinical guidelines or evidence-based resources on requesting behaviours.
 - Delivering the data as immediately as possible, so that it reflects the GP's current practice patterns and supports engagement in quality improvement programs.
 - Supplementing this method of 'pushing' data to GPs with a mechanism (such as a data portal) that allows GPs to 'pull' data that reflects their interests and quality improvement priorities.
 - Start with metrics that are obvious representations of unexplained variation or that provide evidence of inappropriate use of healthcare resources (e.g., repeat testing).
 - Include, where relevant, methods to support appropriate interpretation in recipient GPs' particular contexts (for example, by capturing variability in the socioeconomic status of a practice's local area).
 - In particular, metrics should focus on (a) utilisation and (b) continuity of care. This focus should then broaden to include carefully developed 'quality' metrics. For example, utilisation metrics could focus on variations in Pathology and Diagnostic Imaging requesting patterns or repeat testing, and continuity metrics could focus on the proportion of a consumer's primary care provided by the particular GP. Selected metrics should be:
 - Relevant: There should be strong evidence that the metric is valid—i.e., that it reflects an outcome of interest or provides clearly desirable data (e.g., the percentage of consumers with type 2 diabetes whose HbA1c is less than 8 per cent).
 - Accurate and reliable: The metric should be well defined and consistently interpreted (e.g., standardised), and presented with appropriate risk adjustment to account for differences in patient populations.
 - Readily available: The data should be consistently obtainable across clinicians/consumers without undue administrative burden.
 - Usable: The metric should provide tangible and timely feedback for decision-making (e.g., practice change or referral choice), with a clear line of accountability for the specific clinician (i.e., it is attributable).
 - Appropriate/non-distortionary: Monitoring the metric should not create perverse incentives or cause unintended consequences. (This may be achieved by balancing complementary indicators.)

Rationale

- △ Focusing on a small set of metrics for GPs (based on available MBS, PBS and PIP data sources) will ensure that implementation of this recommendation is achievable.
 - As previously noted, GPs are central to the healthcare system, directly initiating services that represent over half of MBS and PBS costs. (4) Providing GPs with the opportunity to reflect on their performance will drive ownership of their role as stewards of healthcare resources.
 - Introducing feasible and easily attainable metrics and gradually increasing transparency (e.g., from de-identified to identified, from internal use to publicly shared) will allow the health community to gain experience in understanding the data and adjusting practice patterns appropriately. It will also afford clinicians an opportunity to engage with the ongoing design of transparency efforts.
- △ In recognition of the different socioeconomic make-up of general practices, it may be necessary to 'risk-adjust' results against benchmarks. For example, metrics on the rate of requesting/referrals need to be interpreted in the context of local demographics at the practice level.
- △ Targeted data highlighting GP practice patterns, relative to peers, has been successful in supporting GPs to re-evaluate practice. For example, previous individually targeted feedback on requesting habits has been useful in reducing unnecessary requests.(10)
- △ In contrast, untargeted data release has occasionally led to unexpected responses. For example, use of percentile charts on public websites may result in across-the-board increases in requesting, regardless of the clinician's original practice pattern.

3.5 Leadership and role-modelling

Recommendation 7

- △ Encourage GP training organisations and PHNs to take greater responsibility for promoting and developing stewardship and leadership. This could be achieved by increasing the focus on:
 - Formal mentorship and supervision relationships in GP registrar training programs.
 - Core modules for clinicians that focus on (a) the importance of developing critical clinical reasoning skills and (b) taking responsibility for access to the healthcare system (and the impact of such access) for the community as a whole.
 - Specific leadership programs.

Rationale

- △ Although principles of leadership and stewardship can be taught, experiencing good stewardship in action is the most powerful and effective way of learning how to be a role model.
- △ Recognising teachers as leaders is important, because leadership and role-modelling go hand in hand with teaching. The current method of delivering leadership teaching is not enabling good leaders in stewardship specifically, despite college curricula that place emphasis on teaching and the development of leaders.
- △ Promotion of leadership is critical. This could be achieved by creating opportunities to obtain joint qualifications—for example, Fellow of the RACGP/Fellow of the Australian College of Rural and Remote Medicine [ACRRM] in conjunction with a graduate degree.

- △ The importance of good leadership should be formally acknowledged, and the notion of stewardship should be more overt within curricula. The respective colleges have a critical role to play in updating their curricula to focus more on developing stewardship through their mentorship programs.
- △ There are opportunities to improve the clinical reasoning skills of Primary Care Clinicians. For instance, MBS data illustrates wide variation in the volume of pathology and radiology tests requested. Addressing this variation would lead to more individualised use of healthcare resources.

4. Rendered services recommendations and requests directed to various Clinical Committees and the Taskforce

4.1 Rendered Services Working Group membership

The Committee formed a Working Group to consider services and other consultations directly rendered by GPs. This Working Group prioritised items that are primarily provided by GPs (both vocationally registered and non-vocationally registered) and have high service volumes. The Working Group included the members listed in Table 2.

Table 2. Rendered Services Working Group members

Name	Position/Organisation
Prof Simon Willcock (Chair)	GP Clinical Director of Primary Care and Wellbeing Services, Macquarie University Chairman, Avant Mutual Group Member, Sydney North Primary Health Network Board
Prof Jon Adams	Professor of Public Health Australian Research Council (ARC) Future Fellow Director of the Australian Research Centre in Complementary and Integrative Medicine (ARCCIM) at the University of Technology Sydney
Ms Karen Booth	Registered Nurse and Accredited Immuniser Current President, Australian Primary Health Care Nurse Association Primary Health Care Nurse and Nurse Manager in General Practice since 1998 Member of the National Immunisation Committee, the Advisory Committee for Safety of Vaccines, GP Round Table 2015–2016 Member, Primary Health Care Advisory Group Member of advisory groups for the Royal Australian College of General Practitioners (RACGP) and the Australian Commission on Safety and Quality in Health Care (ACQSHC)
Dr Emma Kennedy	Senior Lecturer, General Practice, Northern Territory Clinical School
Prof Lyn Littlefield	Executive Director, Australian Psychological Society Professor of Psychology, La Trobe University Chair, Allied Health Professions Australia Chair, Mental Health Professions Australia
Prof Tim Usherwood (Committee Chair)	Head of the Department of General Practice, Sydney Medical School Westmead, University of Sydney Visiting Professorial Fellow, the George Institute for Global Health Clinical Academic, Westmead Hospital GP, Sydney West Aboriginal Health Service

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

The RenWG developed the following recommendations. Recommendations 8–10 are final recommendations to the Taskforce and will be included in the Committee’s final report to the Taskforce. Requests 1 to 26 are suggested recommendations that have been proposed (via letter) to the relevant Clinical Committees for their consideration. The Committee then endorsed all recommendations unanimously.

4.2 Recommendations for acupuncture attendances (items 173–199)

The MBS currently has five items that cover the provision of acupuncture by Medical Practitioners.

- △ Item 173 applies to acupuncture services provided by any Medical Practitioner. It attracts a smaller fee than items 193, 195, 197 and 199.
- △ Four items (193, 195, 197 and 199) may only be performed by GPs who are “qualified medical acupuncturists,” where the Medicare Australia Chief Executive Officer (CEO) has received a written notice from the RACGP stating that the person meets the skill requirements for the provision of acupuncture. These items differentiate between individual and group (hospital) therapy. Items for individual therapy in consulting rooms (193, 197 and 199) are time-tiered, while the fee for group hospital therapy (item 195) is based on the number of consumers in the group.
- △ All five items include any consultation service provided on the same occasion as the acupuncture service, and any other attendance on the same day for the condition for which acupuncture was given.
- △ For the purpose of payment of MBS benefits, acupuncture is interpreted as including treatment by means other than the use of acupuncture needles where the same effect is achieved without puncture (for example, by application of ultrasound, laser beams, pressure or moxibustion).

Table 3: Item introduction table for items 173–199

Item	Descriptor	Schedule fees	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
173	Attendance at which acupuncture is performed by a Medical Practitioner by application of stimuli on or through the surface of the skin by any means, including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture was performed.	\$21.65	43,807	\$1,142,800	-11.6%
193	Professional attendance by a general practitioner who is a qualified medical acupuncturist, at a place other than a hospital, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for 1 or more health-related issues, with appropriate documentation, at which acupuncture is performed by the qualified medical acupuncturist by the application of stimuli on or through the skin by any means, including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture is performed.	\$37.05	373,525	\$14,802,075	0.1%
195	Professional attendance by a general practitioner who is a qualified medical acupuncturist, on 1 or more patients at a hospital, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for 1 or more health-related issues, with appropriate documentation, at which acupuncture is performed by the qualified medical acupuncturist by the application of stimuli on or through the skin by any means, including any consultation on the same occasion and any other	The fee for item 193, plus \$25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 193 plus \$2.00 per patient.	6	\$284	-31.6%

Item	Descriptor	Schedule fees	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
	attendance on the same day related to the condition for which the acupuncture is performed.				
197	Professional attendance by a general practitioner who is a qualified medical acupuncturist, at a place other than a hospital, lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for 1 or more health-related issues, with appropriate documentation, at which acupuncture is performed by the qualified medical acupuncturist by the application of stimuli on or through the skin by any means, including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture is performed.	\$71.70	105,964	\$7,918,635	6.7%
199	Professional attendance by a general practitioner who is a qualified medical acupuncturist, at a place other than a hospital, lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for 1 or more health-related issues, with appropriate documentation, at which acupuncture is performed by the qualified medical acupuncturist by the application of stimuli on or through the skin by any means, including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture is performed.	\$105.55	9,031	\$1,035,954	6.8%

Unpublished data, extract based on date of service (Department of Health).

Recommendation 8

- △ Delete item 173, which does not require the clinician to be appropriately credentialed to provide acupuncture services.

Recommendation 9

- △ Revise item descriptors to:
 - Define the credentialing required to attract MBS benefits for acupuncture services to include all Medical Practitioners (rather than specifying GPs only).
 - Clarify that the service duration refers to the period of time during which the clinician is physically present in attendance with the individual patient (and not the ‘needle time’), as is the case for other MBS attendance items.

The proposed item descriptors and explanatory notes are below.^{6,7}

⁶ The reference to acupuncture items within Explanatory note A.5 should also be removed as the table of acupuncture attendance items will not be for the exclusive use of GPs.

⁷ These recommended changes are made in the context of section G.12.1. “PROFESSIONAL SERVICES”, which applies to all Category 1 items, of which acupuncture items are a part.

Item 193:

PROFESSIONAL ATTENDANCE AT A PLACE OTHER THAN A HOSPITAL

Professional attendance at which ACUPUNCTURE is performed

- (a) by a Medical Practitioner who holds endorsement of registration for acupuncture with the Medical Board of Australia or is registered by the Chinese Medicine Board of Australia
- (b) at a place other than a hospital
- (c) by the application of stimuli on or through the surface of the skin by any means
- (d) including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture was performed
- (e) **involving less than 20 minutes** of physical attendance by the Medical Practitioner to the individual patient (whether continuous or non-continuous).

Item 197:

PROFESSIONAL ATTENDANCE AT A PLACE OTHER THAN A HOSPITAL

Professional attendance at which ACUPUNCTURE is performed

- (a) by a Medical Practitioner who holds endorsement of registration for acupuncture with the Medical Board of Australia or is registered by the Chinese Medicine Board of Australia
- (b) at a place other than a hospital
- (c) by the application of stimuli on or through the surface of the skin by any means
- (d) including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture was performed
- (e) **involving at least 20 minutes** of physical attendance by the Medical Practitioner to the individual patient (whether continuous or non-continuous).

Item 199:

PROFESSIONAL ATTENDANCE AT A PLACE OTHER THAN A HOSPITAL

Professional attendance at which ACUPUNCTURE is performed

- (a) by a Medical Practitioner who holds endorsement of registration for acupuncture with the Medical Board of Australia or is registered by the Chinese Medicine Board of Australia
- (b) at a place other than a hospital
- (c) by the application of stimuli on or through the surface of the skin by any means
- (d) including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture was performed
- (e) **involving at least 40 minutes** of physical attendance by the Medical Practitioner to the individual patient (whether continuous or non-continuous).

Item 195:

CONSULTATION AT A HOSPITAL

Consultation at which ACUPUNCTURE is performed

- (a) by a Medical Practitioner who holds endorsement of registration for acupuncture with the Medical Board of Australia or is registered by the Chinese Medicine Board of Australia

- (b) at a hospital
- (c) on one or more patients on one occasion
- (d) by the application of stimuli on or through the surface of the skin by any means
- (e) including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture was performed

Explanatory notes (A.18.) for acupuncture attendance items (193–199):

The service of “acupuncture” must be performed by a Medical Practitioner and itemised under item 193, 195, 197 or 199 to attract benefits. These items cover not only the performance of the acupuncture but include any consultation on the same occasion and any other attendance on the same day for the condition for which acupuncture was given.

Items 193, 195, 197 and 199 may only be performed by a Medical Practitioner who also has endorsement of registration for acupuncture with the Medical Board of Australia (see credentialing requirements from Medical Board of Australia for a definition). Other items in Category 1 of the Schedule should not be itemised for professional attendances when the service “acupuncture” is provided.

For the purpose of payment of Medicare benefits “acupuncture” is interpreted as including treatment by means other than the use of acupuncture needles where the same effect is achieved without puncture, e.g., by application of ultrasound, laser beams, pressure or moxibustion, etc.

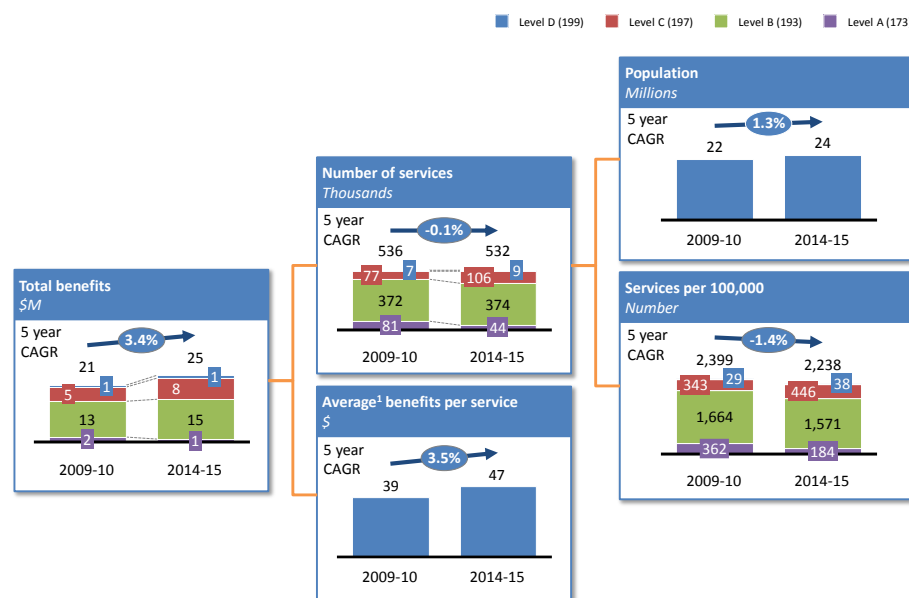
Note that details of the process through which acknowledgement of credentials occurs should be determined by the Department of Human Services in consultation with the Department of Health.

Rationale

This recommendation focuses on ensuring that acupuncture attendance items reflect the level of high-quality care funded by the MBS.

- △ There is sufficient clinical evidence of safety and efficacy to justify the continued listing of MBS items for acupuncture services. (11)
- △ In order to promote high-quality acupuncture in the primary care setting, defining credentials clearly (rather than the type of clinician) will enable quality assurance. Credentialing requirements for service clinicians is the most appropriate way of ensuring access to high-quality services. Credentialing implies awareness of appropriate clinical indications.
 - The Committee considered stipulating appropriate use criteria to ensure the provision of high-quality, evidence-based care. However, it decided against using appropriate use criteria due to the rapidly evolving nature of the evidence base for clinical indications for acupuncture.
 - Item 173 does not differ from the other individual therapy items (193, 197, 199), other than allowing laxity on credentialing requirements. Item 173 therefore does not add to the other acupuncture items present.
- △ Practitioners providing these acupuncture services may be seeing more than one consumer at once and claiming the longer duration items (Level C and D) because of the effect this has on the duration of the consult. For this reason, a definition should be provided for duration spent with the consumer.

Figure 2: Drivers of growth in acupuncture items (FY2009/10 to FY2014/15)



CAGR: compound annual growth rate. Unpublished data, extract based on date of service (Department of Health).

4.3 Statement on intrauterine device introduction and removal (items 35503 and 35506)

The MBS currently has three items related to intrauterine devices (IUDs): two relate to introduction of the device (items 35502 and 35503) and one relates to its removal (item 35506). The two items relating to introduction of the device are differentiated by purpose—i.e., the control of idiopathic menorrhagia (item 35502; hence why endometrial biopsy is included in the service) or contraception (item 35503). GPs currently provide half of all services for items 35503 (56 per cent) and 35506 (48 per cent), but they only provide 7 per cent of services under item 35502.

Table 4: Item introduction table for items 35502–35506

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
35502	Intrauterine device, introduction of, for the control of idiopathic menorrhagia, and endometrial biopsy to exclude endometrial pathology, not being a service associated with a service to which another item in this Group applies (Anaes.)	\$80.15	3,448	\$254,146	16.4%
35503	Intrauterine contraceptive device, introduction of, if the service is not associated with a service to which another item in this Group applies (other than a service mentioned in item 30062) (Anaes.)	\$53.55	62,771	\$3,027,750	11.3%
35506	Intrauterine contraceptive device, removal of under general anaesthesia, not being a service associated with a service to which another item in this Group applies (Anaes.)	\$53.70	2,868	\$131,115	8.0%

Unpublished data, extract based on date of service (Department of Health).

Statement 1

The Committee noted the following:

- △ The insertion and use of IUDs represents a safe and effective service in the primary care setting. Over the last 20 years, IUDs have become more popular due to mounting high-quality research that highlights their global safety and effectiveness. (12,13) This evidence also supports their use in populations traditionally viewed as ‘high risk’ (e.g., nulliparity), (14) as well as the development of progestogen-containing devices (e.g., Mirena), which have transformed the control of heavy menstrual bleeding. (15)
- △ At present, access to IUD insertion services in the primary care setting is inadequate.
 - In other developed countries (such as the United States, the United Kingdom and France), IUDs are used by up to 18.4 per cent of ‘contracepting couples,’ compared to less than 2 per cent in Australia. (16)
 - Data from the Bettering the Evaluation and Care of Health (BEACH) program indicates that only 6.9 per cent of all contraception consultations recorded the use of a long-acting reversible contraceptive (LARC). (17)
 - The 12 per cent year-on-year growth in MBS benefits paid for IUD insertion services is likely to be accounted for by the recent introduction of non-copper IUDs, and it has occurred within the context of continued inadequate access overall.
- △ A significant barrier to primary care provision of IUD services is access to GP training, which limits the supply of GPs performing this service.
 - There are a limited number of training clinicians, and the cost of training is high. Although training is not directly within the remit of the MBS Review, a review of the MBS fee for IUD introduction may change the cost–benefit incentive in favour of clinicians investing in such training.
 - However, the barrier may be self-perpetuating. For example, inadequate primary care access may lead to a preference for specialist provision of these services. This exacerbates the de-skilling of GPs because it prevents them from performing a sufficient number of services to maintain the skill required to (a) have enough confidence to perform the procedure, and (b) minimise the risk of perforation and other adverse events. A recent report in *Australian Family Physician* found that low consumer numbers was a significant barrier to incorporating IUD insertion into a GP’s practice. (18)
- △ Although training is the most significant barrier, other barriers to primary care provision of IUD services include the following:
 - Consumer perceptions and a poorly informed medical community: Pockets of poorly informed Specialists and GPs perpetuate ‘medical myths’ that suggest that an IUD is not a high-quality contraceptive or an appropriate treatment for heavy menstrual bleeding. (19)(20)
 - Consumer persistence and affordability: Two consultations are recommended prior to introduction of the device and one consultation is recommended following introduction. Specifically, consumers receive a long consultation around choice (describing the introduction process), a consultation for introduction of the device and a follow-up consultation.
 - Cost of supplies and assistance required: Current national family planning guidelines suggest that the clinician who introduces the device should have a Nurse or Assistant available throughout the procedure to manage the rare complication of cervical shock if

necessary (\$40–\$50/hour). Insertion kits cost approximately \$12–\$33 (disposable, single use) or \$200 plus sterilisation costs (re-usable), in addition to other supplies required. The schedule fee of \$53.55, with the rebate of \$45.55 for bulk-billed GP consumers, does not account for these costs.

- Length of time required: Simple insertions take approximately 30 minutes, but complex insertions take much longer. This includes Medical Practitioner and Nursing Assistant time.

Request 2

The Committee would like the Nurse Practitioners Clinical Committee to consider whether IUD and hormone implant insertion and removal items should be included as services provided by Nurse Practitioners, either through an amendment to the existing items or by replicating these items in the part of the MBS that covers services provided Nurse Practitioners.

Rationale

- △ Nurse Practitioners currently perform IUD introduction and hormone implantation and removal procedures in the primary health care setting.
- △ The lack of access to Medicare rebates for these services potentially disadvantages consumers who seek services from a Nurse Practitioner, particularly in circumstances where a Nurse Practitioner is the only suitably qualified health professional who is readily accessible to deliver those services (e.g., in rural and remote locations).

4.4 Recommendation regarding repair of wounds (items 30026–30049)

The MBS currently has 10 items that cover Medical Practitioner services for repairing wounds requiring suture, tissue adhesive resin or clips. These items do not cover the repair of a wound at the time of surgery. Three factors differentiate the ten items: wound length, wound depth and wound location (on the face or not on the face). There are also separate items for deeper wounds (items 30041/42 and 30048/49).⁸

Table 5: Item introduction table for items 30026–30049

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
30026	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, not on face or neck, small (not more than 7cm long), superficial, not being a service to which another item in Group T4 applies (Anaes.)	\$52.20	99,359	\$4,314,561	0.7%
30029	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, not on face or neck, small (not more than 7cm in length), involving deeper tissue, not being a service to which another item in Group T4 applies (Anaes.)	\$90.00	25,615	\$1,928,537	-1.3%

⁸ These items differ depending on the type of provider performing the procedure, denoted “G” for GPs and “S” for Specialists. Note that the MBS Review PARC has made recommendations to remove this “G” and “S” distinction from the MBS, consolidating items into a single set with fees at the current higher “S” level.

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
30032	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, on face or neck, small (not more than 7cm long), superficial (Anaes.)	\$82.50	36,927	\$2,566,887	-0.6%
30035	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, on face or neck, small (not more than 7cm long), involving deeper tissue (Anaes.)	\$117.55	9,116	\$900,748	-3.3%
30038	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, not on face or neck, large (more than 7cm long), superficial, not being a service to which another item in Group T4 applies (Anaes.)	\$90.00	8,010	\$597,866	1.3%
30041 (G)	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, not on face or neck, large (more than 7cm long), involving deeper tissue, not being a service to which another item in Group T4 applies (Anaes.)	\$144.00	5,985	\$724,826	-0.2%
30042 (S)	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, other than on face or neck, large (more than 7cm long), involving deeper tissue, not being a service to which another item in Group T4 applies (Anaes.)	\$185.60	166	\$21,451	0.2%
30045 (S)	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, on face or neck, large (more than 7cm long), superficial (Anaes.)	\$117.55	1,285	\$127,523	-1.4%
30048 (G)	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, on face or neck, large (more than 7cm long), involving deeper tissue (Anaes.)	\$149.75	947	\$120,799	-4.6%
30049 (S)	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, on face or neck, large (more than 7cm long), involving deeper tissue (Anaes.)	\$185.60	40	\$5,433	-4.7%

Unpublished data, extract based on date of service (Department of Health).

Recommendation 10

- △ Revise the item descriptors to differentiate between wound lengths of not more than 5 cm and wound lengths of more than 5 cm (i.e., make the cut-off point a wound length of 5 cm, rather than the current 7 cm).

Rationale

This recommendation focuses on ensuring that item descriptors (and the associated MBS benefits available to consumers) accurately reflect differences in the level of professional involvement required. It is based on the following observations.

- △ Wound depth, size, location and contamination status are appropriate factors for discriminating between the different levels of professional involvement required in wound repair.
- △ A cut-off point of 5 cm is a more accurate reflection of the differences in professional skill required to repair small and large wounds. The existing 7 cm cut-off does not discriminate adequately between large wounds of 6–7 cm and smaller wounds.

The Committee also noted the following:

- △ Provision of this service in the primary care setting is just as safe and effective as in the Emergency Department setting and may be more cost-effective.
 - GPs currently provide 92–97 per cent of services for these 10 MBS items. It is difficult to ascertain what proportion of services performed in the Emergency Department setting could be performed in General Practice (noting that the vast majority of emergency attendances are in public hospitals and are therefore not funded by the MBS).
- △ The current MBS fee for wound repair may be inadequate for financially sustainable provision of this service in the primary care setting. This may prompt some general practices to redirect consumers to the Emergency Department.
 - Supplies and assistance are a significant outlay. This includes sterile packs, suturing kits and additional practice resources (such as nursing assistance).
 - The nature of the presenting complaint also disrupts the scheduling of appointments in General Practice, taking considerable unplanned time.

Request 3

The Committee would like the Nurse Practitioners Clinical Committee to consider whether wound repair items should be included as services provided by Nurse Practitioners, either through an amendment to the existing items or by replicating these items in the part of the MBS that covers services provided by Nurse Practitioners.

Rationale

- △ Nurse Practitioners currently perform suturing in primary health care settings and are appropriately qualified to provide high-quality care.
- △ The lack of access to Medicare rebates for these services potentially disadvantages consumers who seek services from a Nurse Practitioner, particularly in circumstances where a Nurse Practitioner is the only suitably qualified health professional who is readily accessible to deliver those services (e.g., in rural and remote locations).

4.5 Requests directed to other Clinical Committees regarding items for assistance at operations (items 51300–51318)

The MBS currently has seven items that cover Medical Practitioners providing surgical assistance services to Specialists performing operations, where the MBS item for the operation is denoted by the word “assist.” Of these seven items, five relate to assistance at specific procedures (e.g., cataract and intraocular lens surgery) and two relate to assistance at all other procedures (items 51300 and 51303). Of these two items, item 51300 relates to assistance for operations where the MBS fee for the operation does not exceed \$558.30, and item 51303 relates to operations where the MBS fee does exceed \$558.30.

Table 6: Item introduction table for items 51300–51318

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
51300	Assistance at any operation identified by the word "assist." for which the fee does not exceed \$558.30 or at a series or combination of operations identified by the word "assist." where the fee for the series or combination of operations identified by the word "assist." does not exceed \$558.30	\$86.30	81,754	\$5,298,995	1.5%
51303	Assistance at any operation identified by the word "assist." for which the fee exceeds \$558.30 or at a series of operations identified by the word "assist." for which the aggregate fee exceeds \$558.30.	One fifth of the established fee for the operation or combination of operations	370,854	\$68,472,622	3.7%
51306	Assistance at a delivery involving Caesarean section	\$124.65	24,203	\$2,282,539	-2.2%
51309	Assistance at a series or combination of operations which have been identified by the word "Assist." and assistance at a delivery involving Caesarean section	One fifth of the established fee for the operation or combination of operations	1,666	\$296,334	5.3%
51312	Assistance at any interventional obstetric procedure covered by items 16606, 16609, 16612, 16615, 16627 and 16633	One fifth of the established fee for the procedure or combination of procedures	2	\$149	-7.8%
51315	Assistance at cataract and intraocular lens surgery covered by item 42698, 42701, 42702, 42704 or 42707, when performed in association with services covered by item 42551 to 42569, 42653, 42656, 42725, 42746, 42749, 42752, 42776 or 42779	\$272.40	485	\$99,027	33.1%
51318	Assistance at cataract and intraocular lens surgery where patient has: - total loss of vision, including no potential for central vision, in the fellow eye; or - previous significant surgical complication in the fellow eye; or -pseudo exfoliation, subluxed lens, iridodonesis, phacodonesis, retinal detachment, corneal scarring, pre-existing uveitis, bound down miosed pupil, nanophthalmos, spherophakia, Marfan's syndrome, homocysteinuria or previous blunt trauma causing intraocular damage	\$179.75	1,515	\$203,783	-4.2%

Unpublished data, extract based on date of service (Department of Health).

Request 4

- △ The Committee requests that the PARC considers the following recommendation:
- Combine benefits for “assistance at operation” items 51300 and 51303 with the relevant operation (i.e., consolidate items 51300 and 51303 with the MBS items for the relevant operations).

Rationale

This request focuses on supporting access to high-value, best-practice health services, and on improving financial transparency for both consumers and the primary Surgeon. It is based on the following observations.

- △ Items 51300 and 51303 account for 94 per cent of assistance-at-operation services, and GPs provide the majority of these services.
- △ Combining the fee for assistance with the Surgeon's fee is expected to improve value for the patient and the community by:
 - Supporting informed financial consent and transparency for consumers (and the Surgeon) by reducing the number of separate clinicians and out-of-pocket costs involved.
 - Encouraging the Surgical Specialist to ensure that Surgical Assistants are only used where clinically indicated, which in turn ensures high-value use of MBS resources. For example, in some cases, the use of a Surgical Assistant may be dependent on the Surgeon rather than the consumer's clinical circumstances.
 - Allowing flexibility to choose the most appropriate Surgical Assistant, who may or may not be a Medical Practitioner. In particular, the Committee noted that a suitably trained and experienced Surgical Assistant can provide a high-quality, high-value service, regardless of whether he or she is a Medical Practitioner.

Request 5

- △ The Committee requests that the Orthopaedic Clinical Committee, General Surgery Clinical Committee, Gynaecology Clinical Committee and (where relevant) other Clinical Committees participating in the MBS Review examine the "assist." component of item descriptors for their allocated MBS items. In particular, the Committee asks them to consider:
 - The circumstances in which an Assistant is clinically necessary.
 - Whether such an Assistant must be a Medical Practitioner.

Rationale

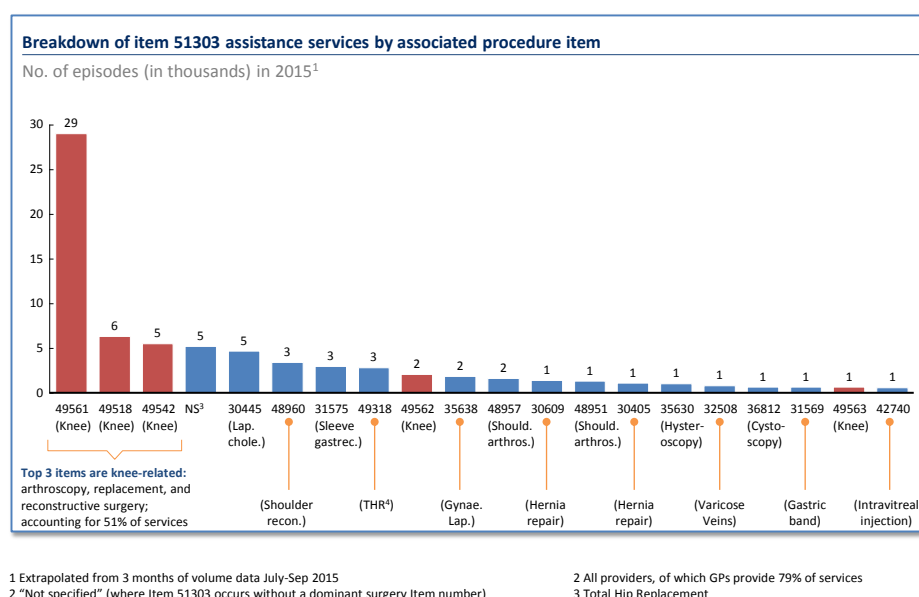
This request focuses on supporting high-value care and best-practice health services. It is based on the following observations.

- △ The Orthopaedic Clinical Committee, General Surgery Clinical Committee and Gynaecology Clinical Committee are responsible for items that account for the vast majority of operations in which an MBS benefit is paid for a Medical Practitioner Assistant.
 - Of assistance services provided under items 51300 and 51303:
 - Orthopaedic procedures accounted for 30 per cent and 68 per cent, respectively.
 - General Surgery procedures accounted for 49 per cent and 16 per cent, respectively.
 - Obstetrics and Gynaecology procedures accounted for 10 per cent and 5 per cent, respectively.
- △ In particular, knee procedures accounted for more than 50 per cent of operations where assistance was provided under item 51303.
 - The majority of these (more than 30,000 episodes) were for knee arthroscopy.

Of all knee procedures occurring within the top procedures claimed with item 51303 (see

- Figure 3; items 49561, 49518, 49542, 49562 and 49563), more than three quarters were associated with surgical assistance under item 51303.

Figure 3: Top 20 procedures (by service volume) co-claimed with item 51303



Co-claiming: MBS services claimed within an episode. Extract taken from service volumes for July–September 2015, extrapolated to a 12-month service volume equivalent.

4.6 Recommendation and request directed to other Clinical Committees regarding telehealth items for patient-end clinical support (items 2100–2220)

The MBS currently has 12 items that cover Medical Practitioners providing clinical support to their patients during video consultations with Specialists or Consultant Physicians. Although telehealth specialist services can be provided when there is no patient-end clinical support service, these items also allow for the participation of another Medical Practitioner at the patient-end of the consultation. There are equivalent items for patient-end clinical support by other types of health practitioner, such as participating Optometrists, Nurse Practitioners, Midwives, Practice Nurses, Aboriginal and Torres Strait Islander Health Practitioners or Aboriginal Health Workers.

The items are both time-tiered and location-dependant. There are also various stipulations within the MBS that define appropriate claiming of these items, including eligible geographical areas (for those not residing in a residential aged care service or at an Aboriginal Medical Service) and the requirement for both an audio and visual link.

Table 7: Item introduction table for items 2100–2220

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
2100	Level A - Telehealth attendance at consulting rooms. Professional attendance at consulting rooms of at least 5 minutes in duration (whether or not continuous) by a Medical Practitioner providing clinical	\$22.90	633	\$14,525	-

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
	support to a patient who: is participating in a video conferencing consultation with a specialist or Consultant Physician; and is not an admitted patient; and either: is located both: within a telehealth eligible area; and at the time of the attendance at least 15 kms by road from the specialist or physician mentioned in paragraph (a); or is a patient of: an Aboriginal medical service; (B) or an Aboriginal community controlled health service for which a direction made under subsection 19 (2) of the act applies.				
2122	Level A - Telehealth attendance other than at consulting rooms. Professional attendance not in consulting rooms of at least 5 minutes in duration (whether or not continuous) by a Medical Practitioner providing clinical support to a patient who: is participating in a video conferencing consultation with a specialist or Consultant Physician; and is not an admitted patient; and is not a care recipient in a residential care service; and is located both: within a telehealth eligible area; and at the time of the attendance at least 15 kms by road from the specialist or physician mentioned in paragraph (a); for an attendance on one or more patients at one place on one occasion each patient.	\$0.00	15	\$774	-
2125	Level A - telehealth attendance at a residential aged care facility. A professional attendance by a Medical Practitioner (not being a service to which any other item applies) lasting at least 5 minutes (whether or not continuous) that requires the provision of clinical support to a patient who is a care recipient receiving care in a residential aged care service (other than a professional attendance at a self-contained unit); or b) at consulting rooms situated within such a complex where the patient is a resident of the aged care service (excluding accommodation in a self-contained unit) and who is participating in a video consultation with a specialist or Consultant Physician, on 1 occasion - each patient.	\$0.00	2	\$139	-
2126	Level B - Telehealth attendance at consulting rooms. Professional attendance at consulting rooms of less than 20 minutes in duration (whether or not continuous) by a Medical Practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or Consultant Physician; and (b) is not an admitted patient; and (c) either: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance—at least 15 kms by road from the specialist or physician mentioned in paragraph (a); or (ii) is a patient of: (a) an Aboriginal medical service; or (b) an	\$49.95	14,161	\$707,590	-

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
	Aboriginal community controlled health service for which a direction made under subsection 19 (2) of the Act applies.				
2137	Level B - Telehealth attendance other than at consulting rooms. Professional attendance not in consulting rooms of less than 20 minutes in duration (whether or not continuous) by a Medical Practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or Consultant Physician; and (b) is not an admitted patient; and (c) is not a care recipient in a residential care service; and (d) is located both: (i) within a telehealth eligible area; and (ii) at the time of the attendance—at least 15 kms by road from the specialist or physician mentioned in paragraph (a); for an attendance on one or more patients at one place on one occasion—each patient.	\$0.00	65	\$5,173	-
2138	Level B - telehealth attendance at residential aged care facility. Professional attendance of less than 20 minutes in duration (whether or not continuous) by a Medical Practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or Consultant Physician; and (b) is a care recipient in a residential care service; and (c) is not a resident of a self-contained unit; for an attendance on one or more patients at one place on one occasion—each patient.	\$0.00	86	\$5,942	-
2143	Level C - Telehealth attendance at consulting rooms. Professional attendance at consulting rooms of at least 20 minutes in duration (whether or not continuous) by a Medical Practitioner who provides clinical support to a patient who: is participating in a video conferencing consultation with a specialist or Consultant Physician; and is not an admitted patient; and either: is located both: within a telehealth eligible area; and at the time of the attendance at least 15 kms by road from the specialist or physician mentioned in paragraph (a); or is a patient of: an Aboriginal medical service; or an Aboriginal community controlled health service for which a direction made under subsection 19 (2) of the act applies.	\$96.85	12,844	\$1,244,213	-
2147	Level C - Telehealth attendance other than at consulting rooms. Professional attendance not in consulting rooms of at least 20 minutes in duration (whether or not continuous) by a Medical Practitioner providing clinical support to a patient who: is participating in a video conferencing consultation with a specialist or Consultant Physician; and is not an admitted patient; and is not a care recipient in a residential care service; and is located both: within a telehealth eligible area; and at the time of	\$0.00	174	\$21,409	-

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
	the attendance at least 15 kms by road from the specialist or physician mentioned in paragraph (a); for an attendance on one or more patients at one place on one occasion each patient.				
2179	Level C - a professional attendance by a Medical Practitioner (not being a service to which any other items applies) lasting at least 20 minutes (whether or not continuous) that requires the provision of clinical support to a patient who is (a) a care recipient receiving care in a residential aged care service (other than a professional attendance at a self-contained unit) or b) at consulting rooms situated within such a complex where the patient is a resident of the aged care service (excluding accommodation in a self-contained unit) and who is participating in a video consultation with a specialist or Consultant Physician, on 1 occasion - each patient.	\$0.00	70	\$9,299	-
2195	Level D - Telehealth attendance at consulting rooms. Professional attendance at consulting rooms of at least 40 minutes in duration (whether or not continuous) by a Medical Practitioner providing clinical support to a patient who: is participating in a video conferencing consultation; and is not an admitted patient; and either: is located both: within a telehealth eligible area; and at the time of the attendance at least 15 kms by road from the specialist or Consultant Physician mentioned in paragraph (a); or is a patient of: an Aboriginal medical service; or an Aboriginal community controlled health service for which a direction made under subsection 19 (2) of the act applies.	\$142.50	5,770	\$822,256	-
2199	Level D - Telehealth attendance other than at consulting rooms. Professional attendance not in consulting rooms of at least 40 minutes in duration (whether or not continuous) by a Medical Practitioner providing clinical support to a patient who: is participating in a video conferencing consultation with a specialist or Consultant Physician; and is not an admitted patient; and is not a care recipient in a residential care service; and is located both: within a telehealth eligible area; and at the time of the attendance at least 15 kms by road from the specialist or physician mentioned in paragraph (a); for an attendance on one or more patients at one place on one occasion each patient.	\$0.00	76	\$12,778	-
2220	Level D - telehealth attendance at residential aged care facility. A professional attendance by a Medical Practitioner (not being a service to which any other item applies) lasting at least 40 minutes (whether or not continuous) that requires	\$0.00	61	\$11,012	-

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
	the provision of clinical support to a patient who is: a) a care recipient receiving care in a residential aged care service (other than a professional attendance at a self-contained unit); or b) at consulting rooms situated within such a complex where the patient is a resident of the aged care service (excluding accommodation in a self-contained unit); and who is participating in a video consultation with a specialist or Consultant Physician, on 1 occasion - each patient.				

Unpublished data, extract based on date of service (Department of Health).

Request 6

- △ The Committee requests that the Allied Health Clinical Committee considers whether the MBS should include patient-end clinical support services provided by Allied Health Practitioners for telehealth consultations with Specialists or Consultant Physicians.

Rationale

This request focuses on ensuring that access to medical care is available to all Australians, regardless of the consumer's place of residence.

- △ Patient-end clinical support telehealth services are underutilised in rural and remote areas, and for frail elderly and persons with disability (wherever they reside). (The Committee believes that service volumes are lower than would be expected with optimal use.)
- △ Poor access to services is primarily due to logistical challenges in scheduling a mutually agreeable time between consumers, the patient-end clinical support clinician and the Specialist/Consultant Physician.
- △ Introducing access to patient-end clinical support by other members of the primary care team may afford the flexibility required to improve consumer access to Specialist and Consultant Physician care in rural and remote areas, and to frail elderly and persons with disability (wherever they reside).
 - Nurse Practitioners, Aboriginal Health Workers, Midwives and Optometrists can currently provide patient-end clinical support for telehealth services under alternative MBS items (10983–4, 82150–2, 82220–5 and 10945–8). However, items do not exist for other Allied Health Practitioners.
 - There are specific clinical scenarios where involvement of an Allied Health Practitioner may be preferable (e.g., the presence of a Physiotherapist on behalf of the GP following orthopaedic surgery).

Recommendation 11

- △ Consider introducing items for GP direct-to-patient teleconferencing for the purposes of providing consulting services to patients in rural and remote areas, and to frail elderly and persons with disability (wherever they reside).

Rationale

- △ Rural and remote consumer access to GPs could be improved by creating alternative methods of communication for these consumers.

- △ Current telehealth items for GP use are restrictive in terms of the types of consumers that can use these services, the location settings they can be used in, and the clinicians that can offer the service. However, there is a risk that creating telehealth items in innovative areas might increase potentially low-value care. Special emphasis should be placed on improving access for rural and remote residents.

The Committee considered the merits and consequences of expanding telehealth to other areas, taking into account both the consumer's situation (i.e., consumers who have difficulty accessing medical practices) and the clinical situation (e.g., delivering results). However, the Committee acknowledged that this was outside the remit of the review.

4.7 Request directed to the Ophthalmology Clinical Committee regarding the removal of a foreign body from the eye (items 30061 and 42644)

The MBS currently has the following items for foreign body removal:

- △ Two items for foreign body removal from the eye by a Medical Practitioner (items 30061 and 42644).
 - The higher fee item (42644) covers the complete removal of an *embedded* foreign body from the cornea or sclera, while item 30061 covers the removal of a *superficial* foreign body from any location (including the cornea or sclera).
- △ One item for foreign body removal from the eye by an Optometrist (item 10944).
- △ Five items for foreign body removal from other areas of the body (items 30064, 30068, 41500, 41503 and 41659).

The explanatory notes define “superficial” as “affecting skin and subcutaneous tissue including fat” and “deeper tissue” as “all tissues deep to but not including subcutaneous tissue such as fascia and muscle.”

The Committee considered only the two items relating to foreign body removal from the eye by a Medical Practitioner: items 30061 and 42644.

Table 8: Item introduction table for items 30061 and 42644

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
30061	Superficial foreign body, removal of, (including from cornea or sclera) as an independent procedure (Anaes.)	\$23.50	51,401	\$1,013,794	-0.2%
42644	Cornea or sclera, complete removal of embedded foreign body from - not more than once on the same day by the same practitioner (excluding aftercare) (Anaes.)	\$72.15	23,954	\$1,470,008	-3.1%

Unpublished data, extract based on date of service (Department of Health).

Request 7

- △ The Committee requests that the Ophthalmology Clinical Committee considers the following recommendations:
 - Revise item 42644 for the removal of an embedded foreign body from the eye to clarify that “embedded” is defined as foreign bodies that are “not easily removed by irrigation or with use of a cotton bud.”

- Revise the items to differentiate between centrally embedded (corneal) foreign bodies, where the risk of corneal scarring is of clinical significance, and peripherally embedded (scleral) foreign bodies.
- Stipulate within the explanatory notes that appropriate follow-up and after-care must be provided, including the use of fluorescein to confirm removal of the foreign body.
- Within the explanatory notes for item 42644, include language similar to that in the explanatory notes for the Optometrist service (item 10944) to guide the clinician regarding the circumstances in which he/she should consider referral to an Ophthalmologist.

Rationale

This request focuses on making it easier for GPs to claim the most appropriate item for the service they provide.

- △ These items relate to services that are safe and effective. However, item descriptors could be more clearly written, including specifying how to differentiate between the different levels of skill, equipment and time required, and the relevant remuneration received.
 - In particular, it is unclear whether an “embedded” (i.e., sub-epithelial or intraepithelial) foreign body refers to a foreign body that is entirely embedded, or whether the foreign body may be protruding above the epithelium.
 - It is also unclear whether the term “superficial” covers some of these circumstances.
- △ The RenWG believes that the following factors should be reflected in different MBS items:
 - Tools required in removal: If a foreign body can be removed using simple measures (such as with a cotton bud or by irrigation), the time, skill and equipment required is considerably less than if other tools (i.e., slit-lamp, needle) are required.
 - Centrality of the foreign body: Centrally placed corneal foreign bodies carry a high risk of vision loss and should be removed with care and caution, using higher levels of skill and equipment to achieve magnification.

4.8 Request directed to the Vascular Surgery and Interventional Radiology Clinical Committee regarding ankle/wrist: brachial indices (items 11610 and 11611)

The MBS currently has two items that cover Medical Practitioners providing diagnostic testing for peripheral vascular disease by performing pressure indices on the limbs. Both items require pressure index calculations, waveform assessment, examination and a hard copy of the wave trace and report. These two items are differentiated by the location of the investigation, specifically whether it is performed on the upper or lower limb.

Table 9: Item introduction table for items 11610 and 11611

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
11610	Measurement of ankle — brachial indices and arterial waveform analysis, measurement of posterior tibial and dorsalis pedis (or toe) and brachial arterial pressures bilaterally using doppler or plethysmographic techniques, the calculation of ankle (or toe) brachial systolic pressure indices and assessment	\$63.75	93,517	\$5,074,699	12.2%

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
	of arterial waveforms for the evaluation of lower extremity arterial disease — examination, hard copy trace and report				
11611	Measurement of wrist — brachial indices and arterial waveform analysis, measurement of radial and ulnar (or finger) and brachial arterial pressures bilaterally using doppler or plethysmographic techniques, the calculation of the wrist (or finger) brachial systolic pressure indices and assessment of arterial waveforms for the evaluation of upper extremity arterial disease — examination, hardcopy trace and report	\$63.75	4,268	\$231,424	36.8%

Unpublished data, extract based on date of service (Department of Health).

Request 8

△ The Committee requests that the Vascular Surgery and Interventional Radiology Clinical Committee considers the following recommendations:

- Revise the item descriptor to stipulate that MBS benefits are payable only where the service is “for the evaluation of a symptomatic patient, or for monitoring in the context of an established diagnosis of peripheral vascular disease.”
- Revise the item descriptor to permit electronic copies of the trace and report, rather than just hard copies.
- Revise the explanatory notes to explicitly state that an MBS benefit for this item is not payable for use in screening asymptomatic patients.

The proposed item descriptor and explanatory notes are provided below.

Item 11610:

MEASUREMENT OF ANKLE: BRACHIAL INDICES AND ARTERIAL WAVEFORM ANALYSIS

Assessment of suspected or established lower extremity arterial disease for the evaluation of a symptomatic patient, or for monitoring in the context of an established diagnosis of peripheral arterial disease, by:

- Measurement of bilateral posterior tibial and dorsalis pedis (or toe) and brachial arterial pressures using doppler or plethysmographic techniques;
- Calculation of ankle (or toe) brachial systolic pressure indices; and
- Assessment of arterial waveforms — through examination of and provision of a copy of the trace and report (hard copy or electronic).

Item 11611:

MEASUREMENT OF WRIST: BRACHIAL INDICES AND ARTERIAL WAVEFORM ANALYSIS

Assessment of suspected or established upper extremity arterial disease for the evaluation of a symptomatic patient, or for monitoring in the context of an established diagnosis of peripheral arterial disease, by:

- Measurement of bilateral radial and ulnar (or finger) and brachial arterial pressures bilaterally using doppler or plethysmographic techniques;
- Calculation of wrist (or finger) brachial systolic pressure indices; and

(c) Assessment of arterial waveforms — through examination of and provision of a copy of the trace and report (hard copy or electronic).

Rationale

This request focuses on preventing misuse of these items for screening asymptomatic consumers for peripheral vascular disease.

- △ Current clinical guidelines indicate that there is no evidence for the use of ankle/wrist: brachial indices for screening asymptomatic consumers. (7) Despite this, Committee members are aware that the item is being used for this purpose.
- △ This is an appropriate first-line investigation tool for the evaluation of the symptomatic population (i.e., for referral to a Surgeon), and for monitoring consumers known to have peripheral vascular disease. The test is a simple and non-invasive first-line choice, either used alone or as an adjunct to Doppler ultrasound.
- △ Hard-copy printouts of a waveform record are not clinically necessary (only calculation and recording of the ratio is required). However, hard copies of the waveform are currently required in order for an MBS benefit to be payable. The Committee suspects that the need to purchase equipment in order to print waveforms results in overuse of Ankle/Wrist : Branchial Indices in clinics that have made this investment and underuse in clinics that have not.

4.9 Request directed to the Vascular Surgery and Interventional Radiology Clinical Committee regarding sclerosant injection for varicose veins (32500 and 32501)

The MBS currently has two items that cover Medical Practitioners therapeutically injecting sclerosant into varicose veins. These items are differentiated by the number of services provided in a given 12-month period:

- Item 32500 covers a maximum of six treatments in a 12-month period.
- Item 32501 covers a seventh or subsequent treatment in a 12-month period, where certain clinical requirements are met and an application is approved by the Medicare Claims Review Panel (MCRP).

Table 10: Item introduction for items 32500 and 32501

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
32500	Varicose veins where varicosity measures 2.5mm or greater in diameter, multiple injections of sclerosant using continuous compression techniques, including associated consultation - 1 or both legs - not being a service associated with any other varicose vein operation on the same leg (excluding aftercare) - to a maximum of 6 treatments in a 12 month period (Anaes.)	\$109.80	50,496	\$6,299,797	-3.4%
32501	Varicose veins where varicosity measures 2.5mm or greater in diameter, multiple injections of sclerosant using continuous compression techniques, including associated consultation - 1 or both legs - not being a service associated with any other varicose vein operation on the same	\$109.80	2	\$352	-7.8%

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
	leg, (excluding after-care) where it can be demonstrated that truncal reflux in the long or short saphenous veins has been excluded by duplex examination - and that a 7th or subsequent treatment (including any treatments to which item 32500 applies) is indicated in a 12-month period.				

Unpublished data, extract based on date of service (Department of Health).

Request 9

- △ The Committee requests that the Vascular Surgery and Interventional Radiology Clinical Committee considers introducing a frequency restriction (i.e., specifying the minimum time between services) to prevent potential item misuse by clinicians who unnecessarily separate service provision across multiple episodes.

Rationale

This request focuses on improving value for consumers and the community and ensuring that consumers receive appropriate and convenient care. It is based on the following observations.

- △ Varicose veins can be painful and can have a significant impact on quality of life. In such circumstances, they should be treated.
- △ Injection of sclerosant is a safe and effective treatment for varicose veins, including in the primary care setting.
- △ The current items allow separate benefits to be paid for multiple attendances on separate days, even when the treatment may be safely and more conveniently provided within one attendance. Revising the item descriptors to preclude this will protect the value of this service for consumers and the community.

4.10 Recommendation and request directed to the Nurse Practitioners Clinical Committee regarding bladder catheterisation (item 36800)

The MBS currently has one item that covers Medical Practitioners inserting an indwelling bladder catheter.⁹

Table 11: Item introduction table for item 36800

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
36800	Bladder, catheterisation of, where no other procedure is performed (Anaes.)	\$27.60	16,809	\$394,706	3.7%

Unpublished data, extract based on date of service (Department of Health).

Request 10

- △ The Committee requests that the Urology Clinical Committee considers the following recommendation:

⁹ There are separate items for the creation of suprapubic cystostomy or vesicostomy (items 37008, 37026 and 37011).

- Split this item into two separate items, differentiated by levels of complexity, in order to create a higher complexity item for services (a) performed on a male and (b) requiring the use of a guidewire and local anaesthetic.

The proposed item descriptors are provided below.

Item 3680X

BLADDER CATHETERISATION – HIGH COMPLEXITY

Catheterisation of the urinary bladder, catheterisation of, performed on a male and requiring the use of a guidewire and local anaesthetic. This procedure cannot be claimed when other procedures are performed. (Anaes.)

Item 3680Y

BLADDER CATHETERISATION – LOW COMPLEXITY

Catheterisation of the urinary bladder, where item 3580X does not apply and where no other procedure is performed (Anaes.).

Rationale

This request focuses on ensuring that item descriptors (and the associated MBS benefits available to consumers) accurately reflect the different levels of professional involvement required. It is based on the following observations.

- △ The complexity of inserting male and female catheters varies markedly and should be reflected in the item structure.
 - In particular, male catheters requiring guidewire use necessitate a lengthier, more complex and more skill-dependent procedure.
- △ Although MBS data shows that a higher volume of services is provided for older males, this may be explained by the fact that a large number of female catheterisation services are performed by nursing staff and do not attract an MBS benefit.

Request 11

The Committee would like the Nurse Practitioners Clinical Committee to consider whether bladder catheterisation items should be included as services provided by Nurse Practitioners, either through an amendment to the existing items or by replicating these items in the part of the MBS that covers services provided by Nurse Practitioners.

Rationale

- △ Nurse Practitioners currently perform bladder catheterisation in primary health care settings and are appropriately qualified to provide high-quality care.
- △ The lack of access to Medicare rebates for these services potentially disadvantages consumers who seek services from a Nurse Practitioner, particularly in circumstances where a Nurse Practitioner is the only suitably qualified health professional who is readily accessible to deliver those services (e.g., in rural and remote locations).

5. Referred services request directed to the Consultation Services Clinical Committee

5.1 Referred Services Working Group membership

The Committee formed a Working Group to consider referred services. The RefWG included the members listed in Table 12.

Table 12. Referred Services Working Group members

Name	Position/Organisation
Mr Gary Smith (Chair)	Practice Manager Past National and New South Wales State President, Australian Association of Practice Management Ltd (AAPM) Advisor to the Commonwealth Government on the management of health reform Member of various advisory groups on behalf of the AAPM Holds Board positions with: <ul style="list-style-type: none"> • Australian General Practice Accreditation Ltd (AGPAL; provides accreditation to general practices in Australia) • Quality in Practice, Chair (QIP; provides quality accreditation programs consistent with international standards to all sectors of business, both in Australia and internationally) • Nepean Blue Mountains Local Health District (LHD; appointed by the New South Wales Government to provide strategic oversight and monitor the LHD financial and operational performance under the state-wide performance framework, against the identified performance measures) • General Practice Workforce Tasmania (GPW; facilitates the recruitment and retention of General Practitioners and Allied Health in rural and remote areas in the state of Tasmania) Surveyor with AGPAL and an International Surveyor with the International Society of Quality Health (ISQua)
Ms Thy Cao	President of the New South Wales Branch of the Australian Physiotherapy Association Current Chair of the University of Technology Sydney Physiotherapy Industry Advisory Board Member, State Insurance Regulatory Authority (SIRA) Allied 2014–16 Member, Allied Health Practitioner Management Framework Review Working Party
Mr Peter Gooley	Alzheimer's and Dementia Coach Lead of a diabetes support group in the Hawkesbury area Member, Community Board of Advice at the St John of God Hawkesbury Hospital, Part of the Nepean Blue Mountains PHN (NBMPHN) Working Group, Hawkesbury Member of the Community Advisory Committee, NBMPHN Administrator, Memory People President of local community centre management committee Vice President, not-for-profit group encouraging and purchasing defibrillators, Hawkesbury local government area
Prof Claire Jackson	National President of the Royal Australian College of General Practitioners (RACGP) since October 2010 (current) Member of Queensland's General Practice Advisory Council (current) Immediate past Chair of the RACGP (Qld Faculty) Chair of the RACGP's national College Council (past)
Prof Lyn Littlefield	Executive Director, Australian Psychological Society Professor of Psychology, La Trobe University Chair, Allied Health Professions Australia Chair, Mental Health Professions Australia
Prof Tim Usherwood (Committee Chair)	Head of the Department of General Practice, Sydney Medical School Westmead, University of Sydney Visiting Professorial Fellow, the George Institute for Global Health Clinical Academic, Westmead Hospital

Name	Position/Organisation
	GP, Sydney West Aboriginal Health Service

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

The RefWG developed the following recommendations, which were unanimously endorsed by the Committee.

5.2 Complex Consultant Physician management plan items (132 and 133)

The MBS currently has two items that cover an extended attendance by a Consultant Physician for a consumer with complex medical needs in order to develop a comprehensive management plan and communicate it to the referring Medical Practitioner. Item 132 attracts benefits for an initial attendance of at least 45 minutes, and item 133 attracts benefits for attendances of at least 20 minutes, subsequent to the first attendance. Item 132 can only be claimed once per consumer per clinician per year. Item 133 can be claimed twice per consumer per clinician per year.

These items are differentiated from the standard Consultant Physician attendance items (110 and 116) by the following:

- △ Consumer profile: Consumers must have at least two “morbidity,” which can include complex congenital, development and behavioural disorders.
- △ A requirement for a comprehensive management plan (as outlined within the explanatory notes): This must be communicated to the referring Medical Practitioner within a reasonable time frame.

Table 13: Item introduction table for items 132 and 133

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
132	Professional attendance of at least 45 minutes duration for an initial assessment of a patient with at least two morbidities (this can include complex congenital, developmental and behavioural disorders), where the patient is referred by a referring practitioner, and where a) assessment is undertaken that covers: a comprehensive history, including psychosocial history and medication review; comprehensive multi or detailed single organ system assessment; the formulation of differential diagnoses; and b) a Consultant Physician treatment and management plan of significant complexity is developed and provided to the referring practitioner that involves: an opinion on diagnosis and risk assessment treatment options and decisions medication recommendations not being an attendance on a patient in respect of whom, an attendance under items 110, 116 and 119 has been received on the same day by the same Consultant Physician not being an attendance on the patient in respect of whom, in the preceding 12 months, payment has been made under this item for attendance by the same Consultant Physician.	\$263.90	790,316	\$177,936,772	12.7%

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
133	Professional attendance of at least 20 minutes duration subsequent to the first attendance in a single course of treatment for a review of a patient with at least two morbidities (this can include complex congenital, developmental and behavioural disorders), where a) a review is undertaken that covers:- review of initial presenting problem/s and results of diagnostic investigations - review of responses to treatment and medication plans initiated at time of initial consultation comprehensive multi or detailed single organ system assessment - review of original and differential diagnoses; and b) a modified Consultant Physician treatment and management plan is provided to the referring practitioner that involves, where appropriate:- a revised opinion on the diagnosis and risk assessment - treatment options and decisions - revised medication recommendations not being an attendance on a patient in respect of whom, an attendance under item 110, 116 and 119 has been received on the same day by the same Consultant Physician or locum tenens. Being an attendance on a patient in respect of whom, in the preceding 12 months, payment has been made under item 132. Item 133 can be provided by either the same Consultant Physician or a locum tenens. Payable no more than twice in any 12 month period.	\$132.10	524,559	\$59,853,964	13.5%

Unpublished data, extract based on date of service (Department of Health).

Request 12

△ The Committee requests that the Consultation Services Clinical Committee considers the following recommendations:

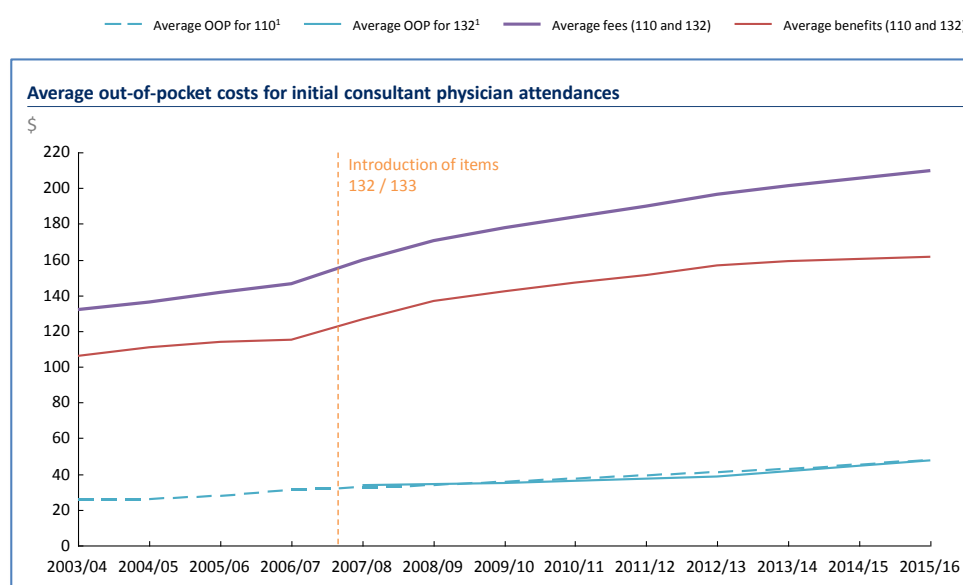
- Remove reference to “single organ system” assessments (retaining reference to multi-organ system assessment).
- Add the term “comprehensive” to describe the treatment and management plans provided.
- Require the treatment and management plan to be provided to the consumer’s nominated GP (regardless of whether the referrer was a GP).
- Stipulate that benefits are only payable under item 132 once per 12-month period per consumer, except where there are exceptional circumstances relating to a significant change in the consumer’s clinical condition or care requirements that necessitate the performance of the service for the consumer.
- Move the requirements for treatment and management plans from the explanatory notes to the item descriptor.
- Stipulate that benefits are only payable under item 132 if the referring practitioner makes a specific referral for that service (e.g., the referring practitioner requests a “comprehensive management plan equivalent to that outlined for item 132”).

Rationale

This request focuses on strengthening the impact of items 132 and 133 in terms of supporting effective integrated care for consumers with complex and chronic conditions. It is based on the following observations.

- △ Ensuring best-practice and high-value referrals requires consideration of the service in the clinical context of the consumer's journey. The majority of referrals for Specialist consultations are made by GPs. GPs therefore play an important role in helping consumers navigate their journey, and as responsible stewards of the health system.
- △ Items 132 and 133 were introduced to the MBS in 2007 in order to support consumers with chronic and complex conditions. The items provide higher MBS benefits for long and comprehensive consultations by Consultant Physicians. They are intended to make Consultant Physician services more affordable, and to lead to effective ongoing management with the primary care clinician.
 - Consultant Physician review of consumers in order to provide complex, comprehensive treatment and management plans is a valuable service that supports the integration of care (if the consumer's GP remains engaged and the review does not cause fragmentation of care due to multiple single-issue/single-organ plans being created by multiple Specialists).
- △ However, it is currently unclear what extra benefit items 132 and 133 provide as the resultant treatment and management plans are inconsistently provided to the consumer's GP.
 - This is in the context of high growth in service volume (8–16 per cent growth year on year for the past six years), with no apparent corresponding decline in out-of-pocket costs to consumers for initial Consultant Physician attendances (item 110) since the introduction of the higher-fee item (132).

Figure 4: Average out-of-pocket costs for items 110 and 132 since the introduction of item 132/133 (FY2003/04 – FY2015/16)



¹ Calculated by using total benefits, fees and services for "out of hospital" patients only, due to private health insurance benefits obscuring the "gap" seen for in-hospital patient data. Out of hospital services made up the majority - 76% (item 110) and 88% (item 132) - of services in 2015/16.

Average out-of-pocket costs calculated using total fees, benefits and services. This method includes inpatients and outpatients, as well as bulk-billed and billed consumers. Complex Consultant Physician management plan items include items 132 and 133. Extract based on date of service (Department of Health).

- △ Including the requirements for the management plan in the item descriptors may make expectations clearer and requirements more enforceable. It may also improve the consistency with which high-quality plans are provided to the referring practitioner.
 - Receiving information back from the Consultant Physician is a large part of the benefit of the service provided under this item. This channel of communication could be aided by moving the current outline of an example treatment and management plan from the explanatory notes to the descriptor.
 - Management plans should be additive and synergistic, building on the initial plan that was created, rather than being separately created and existing as a stand-alone entity. Specifically, it was noted that the Consultant Physician should build upon a consumer's General Practice Management Plan (where one is in place) when performing the service under item 132.
 - The Committee noted that information regarding the structure of the plan and the speed with which it is provided to the referring Medical Practitioner/GP is important and could be moved to the descriptor. (A detailed description is currently provided only as guidance in the explanatory notes.)
- △ Currently, referrers are not required to stipulate whether a complex treatment and management plan is requested under item 132, or whether a service under item 110 is requested instead.
- △ The Committee noted that it stipulated one comprehensive management plan per consumer per year in order to prevent different clinicians (both Specialists and GPs) from generating multiple management plans, with the aim of limiting fragmentation of care.

6. Requests directed to the Diagnostic Medicine Clinical Committee regarding diagnostic imaging

6.1 Diagnostic Imaging Working Group membership

The Committee formed a Working Group to consider diagnostic imaging services. The DIWG included the members listed in Table 14.

Table 14: Diagnostic Imaging Working Group members

Name	Position/Organisation
Dr Ewen McPhee (Chair)	President of the Rural Doctors Association of Australia (RDAA)
Ms Thy Cao	President of the New South Wales Branch of the Australian Physiotherapy Association Current Chair of the University of Technology Sydney Physiotherapy Industry Advisory Board Member, State Insurance Regulatory Authority (SIRA) Allied 2014–2016 Member, Allied Health Practitioner Management Framework Review Working Party
Prof Steve Jan	Head of the Health Economics and Process Evaluation Program, the George Institute for Global Health Professor, Sydney Medical School Associate, Menzies Centre for Health Policy and the Poche Centre for Indigenous Health Chief Investigator, National Health and Medical Research Council (NHMRC) Australian Partnership Prevention Centre
Dr Elizabeth Marles	Director, Hornsby-Brooklyn GP Unit Past President, Royal Australian College of General Practitioners (RACGP) Member, Pharmaceutical Benefits Advisory Committee Director, Therapeutic Guidelines
A/Prof Kathryn Panaretto	Research Fellow, Centre for Chronic Disease, The University of Queensland School of Medicine, Royal Brisbane & Women's Hospital
Prof Tim Usherwood (Committee Chair)	Head, Department of General Practice, Sydney Medical School, University of Sydney Visiting Professorial Fellow, the George Institute for Global Health Clinical Academic, Westmead Hospital GP, Sydney West Aboriginal Health Service

The DIWG developed the requests outlined in the following sections, which were then unanimously endorsed by the Committee. The requests relate to MBS items that represent high-volume and/or high-benefit services that are predominately requested by GPs. In making these requests, the Committee noted the following:

- △ The MBS Review Taskforce's goals are to ensure that the MBS funds "affordable and universal access" to "best practice health services" that represent both "value for the individual patient" and "value for the community."
- △ Ensuring best-practice and high-value diagnostic services, such as diagnostic imaging, requires consideration of the service in the clinical context of the consumer's journey. The requesting clinician should consider the relative merits of a request for diagnostic imaging (and whether such imaging would change management decisions and consumer outcomes) versus the benefits of clinical examination and judgement, watchful waiting and presumptive treatment. If imaging is warranted, the clinician should consider which investigation is most appropriate.
- △ GPs make the majority of diagnostic imaging requests. As a result, GPs play an important role in helping consumers navigate their journey, and as responsible stewards of the health system.

6.2 Imaging for lower back pain (items 56223–56238 and 63151–65237)

MBS items that cover lower back imaging are differentiated by:

- △ Modality (e.g., CT or MRI)
- △ The number of anatomical regions imaged
- △ Clinical indication (for MRI items only)
- △ Capital sensitivity status of the item (K or NK items)

Table 15: Item introduction table for items 56223–56238 and 63151–63237

Item	Abbreviated descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
58106	XR Lumbosacral region	\$77.00	317,829	\$22,806,224	-0.4%
58109	XR Sacrococcygeal region	\$47.00	27,554	\$1,167,067	13.0%
58112	XR 2 regions	\$97.25	137,717	\$12,554,170	1.4%
58115	XR 3 regions	\$110.00	25,383	\$2,615,812	-24.5%
58121	XR 3 regions	\$110.00	103,225	\$10,759,150	5.4%
58120	XR 4 regions	\$110.00	17,948	\$1,872,104	22.9%
58108	XR 4 regions	\$110.00	2,783	\$288,020	-19.3%
59700	Discography	\$96.55	1,505	\$115,811	-6.1%
59724	Myelography	\$226.45	440	\$77,973	-5.8%
56223	CT Lumbosacral region without contrast	\$240.00	334,590	\$75,445,414	4.8%
56226	CT Lumbosacral region with contrast (including pre-contrast scans)	\$351.40	1,834	\$594,926	6.4%
56233	CT Two spinal regions, without contrast	\$240.00	26,549	\$5,934,104	6.7%
56234	CT Two spinal regions, with contrast (including pre-contrast scans)	\$351.40	503	\$160,207	1.4%
56237	CT Three spinal regions, without contrast	\$240.00	2,264	\$494,910	19.2%
56238	CT Three spinal regions, with contrast (including pre-contrast scans)	\$351.40	81	\$25,300	23.7%
63151*	MRI for spinal infection - One region or two contiguous regions of the spine (Contrast) (Anaes.)	\$358.40	3,389	\$1,129,584	10.4%
63154*	MRI for spinal infection - Three contiguous regions or two non-contiguous regions of the spine	\$358.40	6,949	\$2,375,009	5.3%
63161*	MRI for spinal malignancy/tumour - One region or two contiguous regions of the spine (Contrast) (Anaes.)	\$358.40	6,717	\$2,304,343	11.2%
63164*	MRI for spinal malignancy/tumour - Three contiguous regions or two non-contiguous regions of the spine (R) (Contrast) (Anaes.)	\$358.40	867	\$302,632	-0.1%
63167*	MRI for cauda equina - One region or two contiguous regions of the spine (Contrast) (Anaes.)	\$358.40	8,032	\$2,802,412	2.8%
63176*	MRI for cauda equina - Three contiguous regions or two non-contiguous regions of the spine (R) (Contrast) (Anaes.)	\$358.40	53,146	\$18,374,178	4.7%
63179*	MRI for sciatica - One region or two contiguous regions of the spine (Contrast) (Anaes.)	\$358.40	19,071	\$6,643,760	5.1%

Item	Abbreviated descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
63201*	MRI for sciatica - Three contiguous regions or two non-contiguous regions of the spine (R) (Contrast) (Anaes.)	\$448.00	1,190	\$483,502	9.6%
63204*	MRI for spinal canal stenosis - One region or two contiguous regions of the spine (Contrast) (Anaes.)	\$448.00	7,239	\$3,081,221	6.1%
63222*	MRI for spinal canal stenosis - Three contiguous regions or two non-contiguous regions of the spine (R) (Contrast) (Anaes.)	\$448.00	1,987	\$870,451	5.4%
63225*	MRI for myelopathy - One region or two contiguous regions of the spine (Contrast) (Anaes.)	\$448.00	3,175	\$1,372,665	3.3%
63234*	MRI for myelopathy - Three contiguous regions or two non-contiguous regions of the spine (R) (Contrast) (Anaes.)	\$448.00	2,667	\$1,141,312	11.0%
63237*	MRI for spinal infection - One region or two contiguous regions of the spine (Contrast) (Anaes.)	\$448.00	3,943	\$1,677,907	8.7%

Unpublished data, extract based on date of service (Department of Health). NB: corresponding "NK" items not shown.

*NOTE: MRI items included in this table are included for reference. They cannot currently be requested by GPs.

Request 13

- △ The Committee requests that the DMCC considers the following recommendation:
- Revise lower back diagnostic imaging items (including plain film X-rays, CT and MRI) to prevent early imaging for non-specific lower back pain unless red flag indications exist. (A desire for consumer reassurance is not a red flag.) (21)

Rationale

This request focuses on improving the value of MBS-funded services for the consumer and the community. It is based on the following observations.

- △ The Diagnostic Imaging Clinical Committee (DICC) has previously developed recommendations on lower back pain. Two recommendations were particularly relevant to GPs:
 - Introduce items for GP-requested MRI of the lumbosacral spine for defined indications.
 - Limit GP-requested CT of the lumbosacral spine to situations where this modality is superior, or where MRI is unavailable or contraindicated.
- △ The Committee noted that the broader and more significant issue is imaging for lower back pain in general, and that creating an MRI item for GPs to use with the indication of lower back pain would merely transfer the issue of inappropriate over-imaging of the population.
- △ Early imaging for non-specific lower back pain does not improve clinical outcomes, (22) and delayed imaging has been found to be a low-risk approach. In such circumstances:
 - Imaging risks over-diagnosis (23) by detecting clinically insignificant anomalies. As a result, it may exacerbate consumer anxiety, rather than provide reassurance.
 - Imaging may carry associated risks of harm from radiation (23) (e.g., where the imaging modality is CT) and incurs a cost to the consumer and the community.

- Alternatives to imaging are available. Thorough clinical assessment, referral to Allied Health Practitioners and medical management often constitute an appropriate first-line approach.
- Requestor and consumer education offer important opportunities to ensure appropriate requesting. Both have already been used to address the challenge of over-prescribing antibiotics.

6.3 Abdominal imaging (items 55036–55039 and 56401–45412)

MBS abdominal imaging items are differentiated by:

- △ Modality (e.g., CT with contrast, CT without contrast or ultrasound)
- △ Anatomical region (e.g., abdomen, pelvis, urinary tract, or a combination of these)
- △ Referral status (referred or unreferred)
- △ Capital sensitivity status of the item (K or NK item).

Table 16: Item introduction table for items 55036–55039 and 56401–56412

Item	Abbreviated descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
55036	Ultrasound scan of the abdomen (including scan of urinary tract when performed), where ...the service is not solely a transrectal ultrasonic examination of the prostate gland, bladder base and urethra, or any of those organs; and within 24 hours of the service, a service mentioned in item 55017, 55038, 55067 or 55065 is not performed on the same patient by the providing practitioner (R) (K)	\$111.30	799,956	\$82,915,298	6.2%
55037	Ultrasound scan of the abdomen (including scan of urinary tract when performed)... (NR) (K)	\$37.85	4,903	\$172,023	11.4%
55065	Ultrasound scan of the pelvis, by any or all approaches, where ... the service is not solely a transrectal ultrasonic examination of the prostate gland, bladder base and urethra, or any of those organs; and within 24 hours of the service, a service mentioned in item 55014, 55017, 55036 or 55038 is not performed on the same patient by the providing practitioner (R) (K)	\$98.25	842,022	\$77,155,407	5.5%
55068	Ultrasound scan of the pelvis (NR) (K)	\$35.00	102,956	\$3,498,353	-1.6%
55038	Ultrasound scan of urinary tract... if the service is not solely a transrectal ultrasonic examination of the prostate gland, bladder base and urethra, or any of those organs; and within 24 hours of the service, a service mentioned in item 55017, 55036, 55067 or 55065 is not performed on the same patient by the providing practitioner (R) (K)	\$109.10	483,167	\$49,227,970	7.0%
55039	Ultrasound scan of urinary tract... (NR)	\$37.85	14,940	\$512,410	3.7%
56401	CT scan of upper abdomen only (diaphragm to iliac crest) without IV contrast medium, not being a service to which item 56301, 56501, 56801 or 57001 applies (R) (K)	\$250.00	8,280	\$1,893,698	1.2%
56407	CT scan of upper abdomen only with IV contrast medium and with any scans of upper abdomen prior to IV contrast injection, not being a service to which item 56307, 56507, 56807 or 57007 applies (R) (K)	\$360.00	11,346	\$3,753,473	-0.5%

Item	Abbreviated descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
56501	CT scan of upper abdomen and pelvis without IV contrast, not for the purposes of virtual colonoscopy, not being a service to which item 56801 or 57001 applies (R) (K)	\$385.00	129,442	\$45,683,921	6.7%
56507	CT scan of upper abdomen and pelvis with IV contrast and with any scans of upper abdomen and pelvis prior to IV contrast injection, when undertaken, not for the purposes of virtual colonoscopy, not being a service to which item 56807 or 57007 applies (R) (K)	\$480.05	368,240	\$162,325,928	5.2%
56409	CT scan of pelvis only (iliac crest to pubic symphysis) without IV contrast not being a service associated with a service to which item 56401 applies (R) (K)	\$250.00	22,678	\$5,161,531	8.4%
56412	Computed tomography scan of pelvis only, with IV contrast and with any scans of pelvis prior to IV contrast injection, when undertaken, not being a service to which item 56407 applies (R) (K)	\$360.00	8,771	\$2,883,343	17.9%

Unpublished data, extract based on date of service (Department of Health).

Request 14

△ The Committee requests that the DMCC considers the following recommendation:

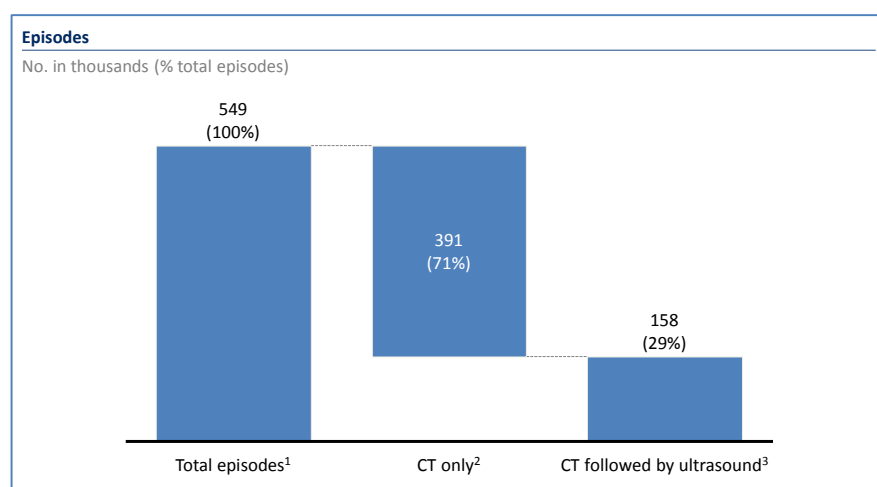
- Review items for ultrasound and CT imaging of the abdominal region, and consider developing appropriate use criteria (for CT imaging of this region in particular).

Rationale

This request focuses on improving the safety and value of MBS-funded services for the consumer and the community. It is based on the following observations.

- △ Ultrasound and CT imaging of the abdomen are two of the largest diagnostic imaging item groups by MBS benefits (accounting for approximately \$220 million in benefits for ultrasound of this region and approximately \$224 million in benefits for CT of this region).
- △ BEACH data shows that between 2002–05 and 2009–12, there was a significant increase in the imaging order rate for abdominal pain presentations, from 35.5 to 41.5 imaging tests requested per 100 consumers presenting with abdominal pain. (24)
- △ There is an unusual pattern of use, with a clear preference for “whole of region” imaging when CT is the chosen modality. Ninety-four per cent of CT imaging of this region is of the entire upper abdomen and pelvis, rather than a more specific area of focus.
- △ There is also a high degree of variation between states/territories in terms of both the total volume of imaging of this region and the chosen imaging modality.
- △ Twenty-nine per cent of CT imaging studies of this region are followed by an ultrasound of the same region (abdomen, pelvis or urinary tract) within 12 months. In part, the high rate of follow-up testing may be due to inappropriate modality selection for the original test. It may also be partly due to a need to further investigate incidental findings.

Figure 5: Annual sequential claiming rates of abdominal/pelvic ultrasound scans, following CT abdomen



¹ Trigger items (initial CT item) include 56401, 56407 (Upper Abdomen); 56501, 56507 (Upper Abdomen and pelvis); 56409, 56412 (Pelvis)
² Counts all patient episodes where CT of the items in footnote 1, is claimed without an USS scan (abdomen, pelvis and urinary tract) within 12 months
³ Counts all patient episodes where a CT scan is claimed, followed by an USS scan (Ultrasound Abdomen +/- urinary tract - 55036, 55037; Ultrasound Pelvis - 55065 and 55068; Ultrasound urinary tract - 55038 and 55039) within 12 months
 Note: data included excludes those patients that have more than 2 combination episodes within 12 months (i.e. USS>USS>CT or USS>CT>USS)

Episode: items claimed for the same patient, within the same facility, on the same day. Extract based on service volumes retrieved for June, July and August 2015, extrapolated to 12 months.

- △ The Committee is not informed about the clinical indications for which this imaging is used, but it believes that these items warrant review by the DMCC (in particular, integrating the perspective of Radiologists, who may be familiar with common indications that result in imaging requests, as well as both Generalist and Specialist clinicians).

6.4 Head imaging (items 56001–56036)

MBS items for abdominal imaging are differentiated by:

- △ Modality (e.g., CT with contrast, CT without contrast or ultrasound)
- △ Anatomical region (e.g., abdomen, pelvis, urinary tract, or a combination of these)
- △ Referral status (referred or unreferred)
- △ Capital sensitivity status of the item (K or NK items).

Table 17: Item introduction table for items 56001–56036

Item	Abbreviated descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
56001	CT scan of brain without IV contrast (R) (K)	\$195.05	300,171	\$52,797,971	1.6%
56007	CT scan of brain with IV contrast and with any scans of the brain prior to IV contrast injection, when undertaken (R) (K)	\$250.00	77,777	\$17,900,478	-0.5%
56010	CT scan of pituitary fossa with or without IV contrast and with or without brain scan when undertaken (R) (K)	\$252.10	1,914	\$455,561	-9.6%
56013	CT scan of orbits with or without IV contrast and with or without brain scan when undertaken (R) (K)	\$250.00	7,986	\$1,870,597	-4.5%

Item	Abbreviated descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
56016	CT scan of petrous bones in axial and coronal planes in 1 mm or 2 mm sections, with or without IV contrast, with or without scan of brain (R) (K)	\$290.00	43,866	\$11,966,286	2.3%
56030	CT scan of facial bones, paranasal sinuses or both, with scan of brain, without IV contrast (R) (K)	\$225.00	25,950	\$5,428,457	2.5%
56036	CT scan of facial bones, paranasal sinuses or both, with scan of brain, with IV contrast, where: (a) a scan without IV contrast has been undertaken; and (b) the service is required because the result of the scan mentioned in paragraph (a) is abnormal (R) (K)	\$336.80	3,845	\$1,207,007	-1.0%
63507	Referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of head for a patient under 16 years for: unexplained seizure(s); or unexplained headache where significant pathology is suspected; or paranasal sinus pathology which has not responded to conservative therapy	\$403.20	8,459	\$3,385,843	-
63551	Referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of head for a patient 16 years or older for unexplained seizure(s), or unexplained chronic headache with suspected intracranial pathology	\$403.20	78,695	\$31,314,558	-

Unpublished data, extract based on date of service (Department of Health). NB: NK items not shown.

Request 15

△ The Committee requests that the DMCC considers the following recommendations:

- Revise head CT imaging items to minimise residual use in children.

In particular, the Committee would like the DMCC to consider the clinical indications that warrant the use of CT instead of MRI in children.

- If there are too many indications to list, it is suggested that exclusions (inappropriate clinical indications) are listed for head CT imaging within the descriptor.
- If the number of indications is limited, it is suggested that item descriptors be revised to restrict head CT imaging in children to only the listed indications within the descriptor.
- If no appropriate indications exist, head CT imaging items could be revised to restrict use in children.

For all the scenarios listed above, it is suggested that an exception should be put in place for head CT use where head MRI is not available in a clinically appropriate time frame (e.g., in rural areas), or where there is a contraindication to MRI (e.g., claustrophobia, ferromagnetic implants, inability to remain still for the required time).

For all scenarios listed above, a corresponding amendment to the GP-requested MRI item (63507) descriptor should be made to ensure that MBS benefits are payable for clinical indications where MRI should be provided instead of CT.

- Revise the item descriptor for GP-requested adult MRI (item 63551) to focus use on indications where imaging is likely to result in a change in management.
 - The current terminology of “unexplained chronic headaches with suspected intracranial pathology” lacks specificity, prompting concern that the item may be used to

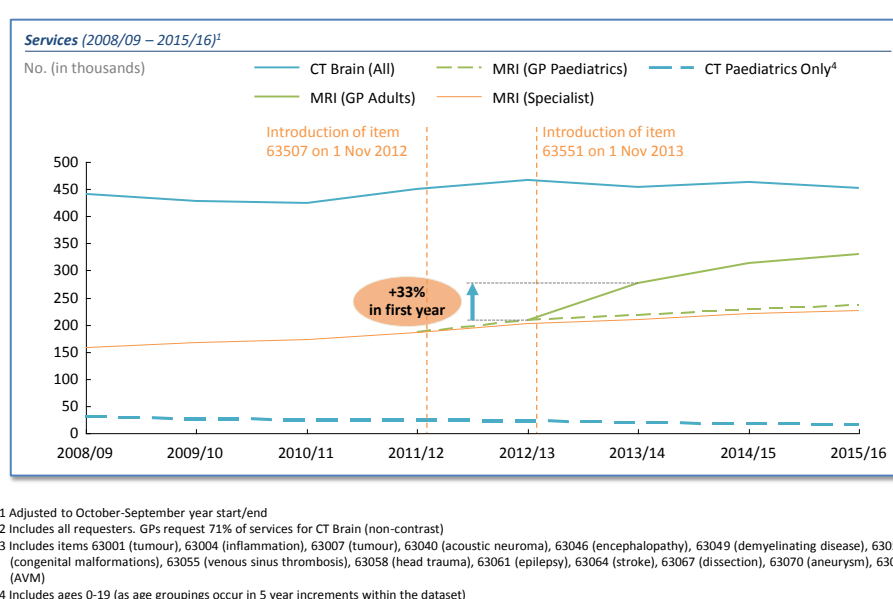
investigate common chronic headache presentations. As a suggested example, this clinical indication could be revised to include a requirement for abnormal neurological signs or other red flags. The wording of such an amendment may require the input of both Radiologists and requestor specialties (such as Neurology and/or Neurosurgery) to ensure appropriately specific clinical indications that do not inadvertently exclude appropriate uses or make this issue worse.

Rationale

This request focuses on improving the safety and value of MBS-funded services for the consumer and the community. It is based on the following observations.

- △ GP-requested MRI brain items (item 63507 for consumers less than 16 years old and item 63551 for consumers 16 years and older) were introduced to improve access to MRI services for consumers managed by GPs who would otherwise need to be referred to a Specialist or Consultant Physician in order to receive MRI services (increasing the cost for both the consumer and the health system, and adding delays). The items were also introduced to encourage MRI use and avoid exposure to unnecessary radiation (particularly for children) from CT imaging.
- △ The introduction of GP-requested paediatric MRI item 63507 coincided with a modest gradual decline in brain CTs requested for the paediatric population. In contrast, there has only been a small reduction in the growth of brain CTs requested for the adult population since the introduction of the GP-requested adult MRI item (63551).
- △ Following the introduction of the GP-requested adult MRI brain item, there was a 33 per cent increase in total MRI brain services (both Specialist and non-Specialist) within the first 12 months, without a corresponding reduction in CT brain services. The Committee is therefore concerned that there may be low-value use of brain MRIs in the adult population, and it may be necessary to consider clearer appropriate use criteria.

Figure 6: Service volumes for head CT and MRI items FY2008/09 to FY2015/16



- △ MRI is expensive and carries risks of over-diagnosis (a safety issue). Use should therefore be limited to cases where the benefit of affording increased access to consumers in primary care outweighs the concern of over-diagnosis (and low-value use). (25)

6.5 Shoulder imaging (items 55808–55811)

The MBS currently has eight shoulder imaging items:

- △ Four items cover ultrasound of the shoulder or upper arm, differentiated by referral status (referred or not referred) and the capital sensitivity status of the item (K or NK items).
- △ Four items cover x-ray of the shoulder or scapula, differentiated by referral status (referred or not referred) and the capital sensitivity status of the item (K or NK items).

Table 18: Item introduction table for items 55800–55803

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
55808	<p>Ultrasound scan of shoulder or upper arm (1 or both sides), where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member, and where the service is provided, for the assessment of one or more of the following conditions or suspected conditions:</p> <ul style="list-style-type: none"> ▪ evaluation of injury to tendon, muscle or muscle/tendon junction; or ▪ rotator cuff tear/calcification/tendinosis (biceps, subscapular, supraspinatus, infraspinatus); or ▪ biceps subluxation; or ▪ capsulitis and bursitis; or ▪ evaluation of mass including ganglion; or ▪ occult fracture; or ▪ acromioclavicular joint pathology (R) 	\$109.10	461,480	\$46,925,207	8.6%
55809	<p>Ultrasound scan of shoulder or upper arm (1 or both sides) (R) (NK)</p> <p><i>Note: Benefits are only payable when referred based on the clinical indicators outlined in the item descriptions. Benefits are not payable when referred for non-specific shoulder pain alone.</i></p>	\$54.55	4	\$148	-
55810	<p>SHOULDER OR UPPER ARM, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner, and where the service is provided, for the assessment of one or more of the following conditions or suspected conditions:</p> <ul style="list-style-type: none"> ▪ evaluation of injury to tendon, muscle or muscle/tendon junction; or ▪ rotator cuff tear/calcification/tendinosis (biceps, subscapular, supraspinatus, infraspinatus); or ▪ biceps subluxation; or 	\$37.85	4,409	\$155,931	24.9%

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
	<ul style="list-style-type: none"> capsulitis and bursitis; or evaluation of mass including ganglion; or occult fracture; or acromioclavicular joint pathology (R) 				
55811	Ultrasound scan of shoulder or upper arm (1 or both sides) (NR) (NK) <i>Note: Benefits are only payable when referred based on the clinical indicators outlined in the item descriptions. Benefits are not payable when referred for non-specific shoulder pain alone.</i>	\$18.95	44	\$787	-
57700	Shoulder or scapula (NR)	\$40.50	8,211	\$299,041	0.1%
57702	Shoulder or scapula (NR) (NK)	\$20.25	9	\$140	-
57703	Shoulder or scapula (R)	\$54.00	431,544	\$20,588,827	5.5%
57705	Shoulder or scapula (R) (NK)	\$27.00	129	\$3,109	-

Unpublished data, extract based on date of service (Department of Health).

Request 16

△ The Committee requests that the DMCC considers the following recommendations:

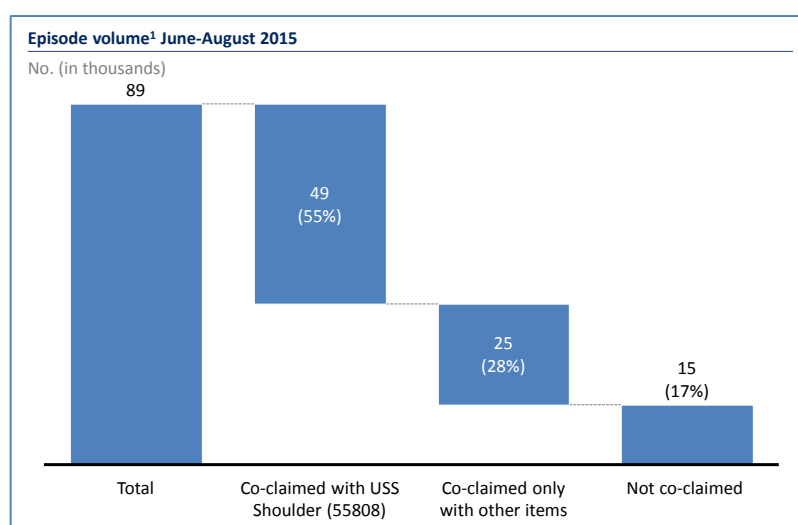
- Review mechanisms that support better requesting—for example, use of decision support, requestor education and/or targeted feedback from Radiologists (including incidence/prevalence information within comments that infer the meaning of an abnormal finding, specifically for shoulder ultrasound items).
- Restrict co-claiming of x-ray with ultrasound of the shoulder, except for specified clinical indications to be included in the descriptor or explanatory notes.

Rationale

This request focuses on improving the value of MBS-funded services for the consumer and the community. It is based on the following observations.

- △ BEACH data shows that between 2002–05 and 2009–12, there was a 37 per cent increase (from 32.5 to 44.5 imaging orders per 100 shoulder problems) in the imaging order rate for all shoulder problems. This suggests a tendency to order an increasing number of images for the management of a consumer who presents with a shoulder complaint or syndrome. The same data shows that the increase stems mostly from a significant increase in the rate of ultrasound orders, from 17.6 to 28.9 per 100 shoulder problems. (26)
- △ A large number of shoulder x-rays (55 per cent) occur on the same day as a shoulder ultrasound, on the same consumer. There is a concern that this reflects clinical uncertainty and a lack of confidence, and that x-rays are not being used as a specific and targeted diagnostic test to look for a specific result that can inform management.

Figure 7: Co-claiming rates of x-ray and ultrasound shoulder



¹ Note that this includes the main item (by service volume) for both US and XR shoulder ("R"), and excludes the remaining 3 items ("NR", "NK")

Co-claiming: MBS services claimed within an episode. Episode: items claimed for the same consumer, within the same facility, on the same day. Extract based on episode volumes for June-August inclusive.

- △ There is also a concern that unnecessary imaging, particularly in the case of shoulder ultrasound, is resulting in over-diagnosis of asymptomatic rotator cuff tears.

6.6 Ultrasound of the hand or wrist (items 55800–55803)

The MBS currently has four items relating to ultrasound of the hand or wrist, differentiated by referral status (referred or not referred) and the capital sensitivity status of the item (K or NK items).

Table 19: Item introduction table for items 55800–55803

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
55800	Hand or wrist, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in subgroup 2 or 3 applies; and (b) the patient is referred by a medical practitioner; and (c) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R)	\$109.10	166,224	\$16,945,993	17.1%
55801	Hand or wrist, 1 or both sides, ultrasound scan of, where: (b) the service is not associated with a service to which an item in subgroup 2 or 3 applies; and (c) the patient is referred by a medical practitioner; and (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK)	\$54.55	1	\$19	-
55802	Hand or wrist, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a	\$37.85	2,378	\$84,748	48.3%

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
	service to which an item in subgroup 2 or 3 applies; and (b) the patient is not referred by a medical practitioner (NR)				
55803	Hand or wrist, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and (b) the patient is not referred by a medical practitioner (NR) (NK)	\$18.95	68	\$1,259	-

Unpublished data, extract based on date of service (Department of Health).

Request 17

- △ The Committee requests that the DMCC considers the following recommendation:
- Revise items for ultrasound of the hand/wrist (55800–55803) to include appropriate use criteria, particularly to prevent imaging for diagnosis of certain tendon and ligament conditions.

Rationale

This request focuses on improving the value of MBS-funded services for the consumer and the community. It is based on the following observations.

- △ Certain tendon and ligament conditions (such as carpal tunnel syndrome, tenosynovitis such as trigger finger, or rupture/avulsion injuries such as mallet finger) are diagnosed by clinical examination, and ultrasound results do not change the management of these conditions. However, there are some tendon and ligament conditions where an ultrasound may be helpful, and it is suggested that the DMCC obtains further input from Specialists to develop specific appropriate use criteria.
- The age and gender distribution of services—with a peak in females aged 34–70 (unmatched in males)—suggests that a significant number of ultrasounds are performed for carpal tunnel syndrome. Conditions such as carpal tunnel syndrome are better assessed by clinical examination and, if necessary, through nerve conduction studies.
- △ There are other appropriate indications for ultrasound of the hand or wrist, including ‘lumps, bumps and foreign bodies’ (e.g., ganglion, subungual haemangioma and lipoma). In these instances, ultrasound provides both diagnostic reassurance and helps to guide decisions regarding surgical removal (whether for cosmetic, functional or pain purposes).

6.7 Ultrasound of the neck (items 55011–55033)

The MBS currently has four items relating to ultrasound of the neck, differentiated by referral status (referred or not referred) and the capital sensitivity status of the item (K or NK items).

Table 20: Item introduction table for items 55011–55033

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
55011	Neck, 1 or more structures of, ultrasound scan of, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a	\$54.55	3	\$150	-

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
	service associated with a service to which an item in subgroups 2 or 3 of this group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK)				
55013	Neck, 1 or more structures of, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in subgroups 2 or 3 of this group applies (NR) (NK)	\$18.95	44	\$713	-
55032	Neck, 1 or more structures of, ultrasound scan of, if: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroup 2 or 3 applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R)	\$109.10	293,275	\$29,932,360	9.8%
55033	Neck, 1 or more structures of, ultrasound scan of, if the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroup 2 or 3 applies (NR)	\$37.85	11,758	\$414,462	4.7%

Unpublished data, extract based on date of service (Department of Health).

Request 18

△ The Committee requests that the DMCC considers the following recommendation:

- Revise items for ultrasound of the neck to prevent imaging in the absence of clinically palpable thyroid abnormalities, except where clinical examination is impossible due to documented anatomical barriers (e.g., obesity, torticollis)

Rationale

This request focuses on improving the value of MBS-funded services for the consumer and the community. It is based on the following observations.

- △ Ultrasound of the thyroid in the absence of clinically palpable abnormalities will rarely change management decisions (including in the presence of abnormal thyroid function test results).
- △ Imaging may risk detection of ‘incidentalomas,’ resulting in over-diagnosis/overtreatment.

6.8 Ultrasound of the hip and groin (items 55816–55819)

The MBS currently has four items relating to ultrasound of the hip and groin, differentiated by referral status (referred or not referred) and the capital sensitivity status of the item (K or NK items).

Table 21: Item introduction table for items 55816–55819

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
55816	Hip or groin, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in subgroups 2 or 3 of	\$109.10	227,068	\$23,055,948	15.1%

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
	this group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R)				
55817	Hip or groin, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK)	\$54.55	5	\$487	-
55818	Hip or groin, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and (b) the patient is not referred by a medical practitioner (NR)	\$37.85	1,553	\$57,699	24.4%
55819	Hip or groin, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and (b) the patient is not referred by a medical practitioner (NR) (NK)	\$18.95	50	\$779	-

Unpublished data, extract based on date of service (Department of Health).

Request 19

- △ The Committee requests that the DMCC considers the following recommendation:
- Revise items for ultrasound of the hip/groin to prevent imaging in clinically evident hernia.

Rationale

This request focuses on improving the value of MBS-funded services for the consumer and the community. It is based on the following observations.

- △ Only cases of obscure pain and/or doubtful swelling in the groin require further diagnostic investigation.
- △ Hernia surgery is indicated on the basis of clinical assessment. (27) However, MBS data indicates that approximately 30 per cent of hernia surgeries are associated with a groin ultrasound in the preceding 12 months.

6.9 Paediatric hip ultrasound (items 55820–55823)

The MBS currently has four items relating to paediatric hip ultrasound for dysplasia, differentiated by referral status (referred or not referred) and the capital sensitivity status of the item (K or NK items).

Table 22: Item introduction table for items 55820–55823

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
55820	Paediatric hip examination for dysplasia, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies;	\$109.10	53,059	\$5,756,028	11.6%

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
	and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R)				
55821	Paediatric hip examination for dysplasia, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK)	\$54.55	2	\$231	-
55822	Paediatric hip examination for dysplasia, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and (b) the patient is not referred by a medical practitioner (NR)	\$37.85	278	\$10,977	-2.8%
55823	Paediatric hip examination for dysplasia, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and (b) the patient is not referred by a medical practitioner (NR) (NK)	\$18.95	2	\$16	-

Unpublished data, extract based on date of service (Department of Health).

Request 20

- △ The Committee requests that the DMCC considers the following recommendation:
- Revise items for paediatric hip examination by ultrasound to specify appropriate clinical indications for use.

Rationale

This request focuses on improving the value of MBS-funded services for the consumer and the community. It is based on the following observations.

- △ Universal ultrasound screening for developmental dysplasia of the hip is not recommended. (28)
- △ High testing volumes indicate that some requestors may be using ultrasound examination for screening purposes. Epidemiological data indicates that for the number of live births in Australia, approximately 1,500 ultrasounds could be positive. Approximately 53,000 ultrasounds were performed under the MBS in FY2014/15 and there were approximately 310,000 live births, with a 5 in 1,000 incidence of true dislocation in newborn infants. (29,30)

6.10 Ultrasound of the ankle/hind foot (items 55836–55839)

The MBS currently has four items relating to ankle/hind foot ultrasound, differentiated by referral status (referred or not referred) and the capital sensitivity status of the item (K or NK items).

Table 23: Item introduction table for items 55836–55839

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
55836	Ankle or hind foot, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R)	\$109.10	150,897	\$15,338,369	17.0%
55837	Ankle or hind foot, 1 or both sides, ultrasound scan of, where: (a) the services is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK)	\$54.55	3	\$120	-
55838	Ankle or hind foot, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR)	\$37.85	2,335	\$81,974	26.6%
55839	Ankle or hind foot, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and (b) the patient is not referred by a medical practitioner (NR) (NK)	\$18.95	19	\$319	-

Unpublished data, extract based on date of service (Department of Health).

Request 21

- △ The Committee requests that the DMCC considers the following recommendation:
- Revise items 55836–55839 to specifically exclude the use of ultrasound for assessment of reduced bone mineral density and plantar fasciitis, and restrict co-claiming (on the same consumer within the same day) of both x-ray and ultrasound of the ankle.

Rationale

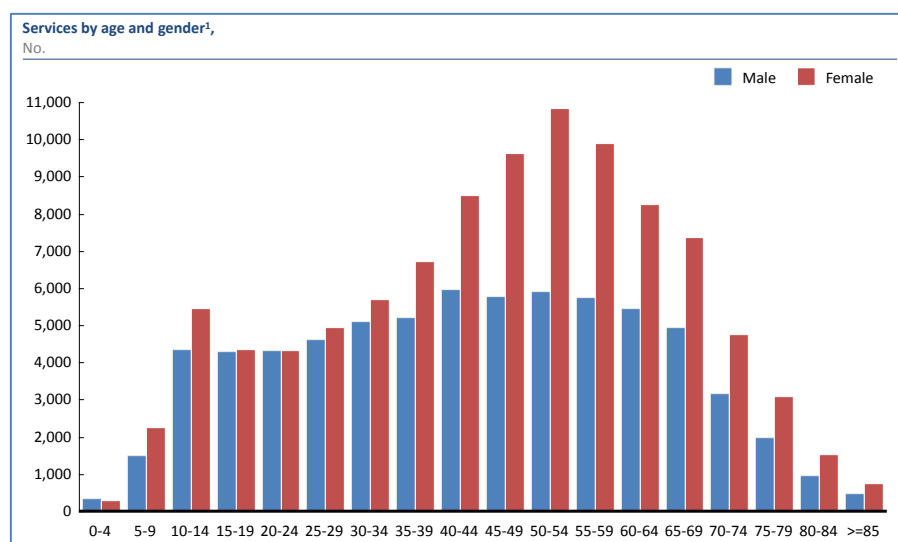
This request focuses on improving the value of MBS-funded services for the consumer and the community. It is based on the following observations.

- △ Use of ultrasound for ankle/hind foot injuries has been growing rapidly, with an 18 per cent annual growth in benefits, driven primarily by 16 per cent annual growth in services per capita.
- △ Most clinically significant acute ankle injuries can be diagnosed based on consumer history, examination and selective use of plain radiography. Deciding whether to perform imaging for acute ankle trauma can be safely guided by the Ottawa Ankle Rules.⁷
- △ Based on anecdotal evidence, there are concerns that the high level of ultrasound use is due to the following:
 - Indiscriminate imaging: A large proportion (40 per cent) of ankle/hind foot ultrasounds occur on the same day as an ankle x-ray on the same consumer. There is a concern that this reflects clinical uncertainty and lack of confidence, and that imaging is not being used as a

specific and targeted diagnostic test to look for a specific result that can inform management.

- Use as an alternative to dual-energy x-ray absorptiometry (DEXA) imaging: Use of ultrasound of the ankle/hind foot is growing and appears to be concentrated among females aged 40–69 (diverging from the pattern of use seen in the male population).

Figure 8: Service volume for ultrasound of the ankle/hind foot (item 55836), by age and gender



¹ All requester types, includes items 55836 (of which, GPs request 87% of services) and 55838 (not referred)

Extract based on date of service (Department of Health).

- There is a concern that ultrasound of the ankle/hind foot is being used as an alternative to DEXA imaging to detect reduced bone mineral density, where the consumer is not eligible for DEXA. (Indications included in current DEXA MBS items are for minimal trauma fracture, specified glucocorticoid and hormonal disturbances, in consumers aged 70 or older). Use of ultrasound for the measurement of bone mineral density (and assessment of fracture risk) is not evidence-based. There is no agreed definition of osteoporosis using quantitative ultrasound, and it cannot be used to assess the response to osteoporosis treatment. In addition, intervention trials have predominantly been based on cases identified through DEXA assessment, so their results cannot readily be applied to individuals identified by other means. (7)
- Use in assessing for plantar fasciitis: Instead, this condition should be assessed based on consumer history and examination findings.

7. Requests directed to the Diagnostic Medicine Clinical Committee regarding Pathology

7.1 Pathology Working Group membership

The Committee formed a Working Group to consider Pathology services. The PWG included the members listed in Table 24.

Table 24: Pathology Working Group members

Name	Position/Organisation
Dr Noel Hayman (Chair)	GP and Clinic Director, Inala Indigenous Health Service Associate Professor, University of Queensland School of Medicine
Mr Peter Gooley	Alzheimer's and Dementia Coach Lead of a diabetes support group in the Hawkesbury area Member, Community Board of Advice at the St John of God Hawkesbury Hospital, Part of the Nepean Blue Mountains PHN (NBMPHN) Working Group, Hawkesbury Member of the Community Advisory Committee, NBMPHN Administrator, Memory People President of local community centre management committee Vice President, not-for-profit group encouraging and purchasing defibrillators, Hawkesbury local government area
A/Prof Caroline Laurence	Associate Professor and Head of the School of Public Health, University of Adelaide Health Services Researcher
Dr Mark Morgan	Associate Professor, Bond University, Queensland Associate GP, Eastbrooke Family Clinic, Burleigh Waters, Queensland Member of the RACGP Expert Committee for Quality Care Member of the MBS Review DMCC and After Hours Working Group Member of the Health Care Homes Implementation Advisory Committee Member of the Digital Patient Safety Expert Advisory Group
Mr Tim Perry	Consultant Pharmacist Member of the Western Sydney PHN Clinical Council
Mr Gary Smith	Practice Manager Past National and New South Wales State President, Australian Association of Practice Management Ltd (AAPM) Advisor to the Commonwealth Government on the management of health reform Member of various advisory groups on behalf of the AAPM Holds Board positions with: <ul style="list-style-type: none"> • Australian General Practice Accreditation Ltd (AGPAL; provides accreditation to general practices in Australia) • Quality in Practice, Chair (QIP; provides quality accreditation programs consistent with international standards to all sectors of business, both in Australia and internationally) • Nepean Blue Mountains Local Health District (LHD; appointed by the New South Wales Government to provide strategic oversight and monitor the LHD financial and operational performance based on the state-wide performance framework, using the identified performance measures) • General Practice Workforce Tasmania (GPW; facilitates the recruitment and retention of General Practitioners and Allied Health in rural and remote areas in the state of Tasmania) Surveyor with AGPAL and an International Surveyor with the International Society of Quality Health (ISQua)
Prof Tim Usherwood (Committee Chair)	Head of the Department of General Practice, Sydney Medical School Westmead, University of Sydney Visiting Professorial Fellow, the George Institute for Global Health Clinical Academic, Westmead Hospital GP, Sydney West Aboriginal Health Service

The PWG developed the requests outlined in the following sections, which were then unanimously endorsed by the Committee. The requests relate to MBS items that represent high-volume and/or high-benefit services that are predominately requested by GPs.

In making these requests, the Committee noted the following:

- △ The MBS Review Taskforce's goals are to ensure that the MBS funds "affordable and universal access" to "best practice health services" that represent both "value for the individual patient" and "value for the community."
- △ Ensuring best-practice and high-value diagnostic services, such as Pathology, requires consideration of the service in the clinical context of the consumer's journey, particularly consideration of the relative merits of a request for Pathology testing (and whether testing would change both management decisions and consumer outcomes) within the context of the overall consumer journey and diagnostic/therapeutic pathway.
- △ GPs make the majority of Pathology requests. As a result, GPs play an important role in helping consumers navigate their journey, and as responsible stewards of the health system.

7.2 Iron studies (items 66593 and 66596)

The MBS currently has two items related to iron testing: one covers a full panel of iron studies (item 66596) and one covers a ferritin test only (item 66593).

Table 25: Item introduction table for items 66593 and 66596

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
66593	Ferritin - quantitation, except if requested as part of iron studies	\$18.00	532,506	\$8,172,531	8.2%
66596	Iron studies, consisting of quantitation of: (a) serum iron; and (b) transferrin or iron binding capacity; and (c) ferritin	\$32.55	4,895,249	\$135,887,248	9.3%

Unpublished data, extract based on date of service (Department of Health).

Request 22

- △ The Committee requests that the DMCC considers the following recommendations:
 - Revise items 66593 and 66596 to stipulate the following when testing for iron deficiency (noting that the Pathologist should assume that the request is for iron deficiency if no indication is recorded):
 - A ferritin test is performed first, followed by a Pathologist-determined test for full iron studies if ferritin levels are either normal or raised (noting that there is no need to perform iron studies if the ferritin result is low, as this confirms iron deficiency), regardless of whether the request is for a ferritin test or iron studies.
 - Restrict follow-up testing (either of ferritin or iron studies) to four times a year.
 - Consider the merits of setting a frequency per year (as above) rather than set duration (e.g., a three-month lock-out) to ensure that repeat testing is not performed unnecessarily (for instance, within a week).

Rationale

This request focuses on improving the value of MBS-funded services for the consumer and the community. It is based on the following observations.

- △ The Committee believes that iron studies are overused in instances where a ferritin test would be adequate, despite the latter being an appropriate first-line test.
- △ Guidelines recommend a ferritin test for the detection of iron-deficiency anaemia, due to its high sensitivity and specificity. (31)
- △ The majority of studies performed are full iron studies, rather than the more targeted ferritin test (4.9 million and 0.53 million, respectively, in FY2014/15). Specialists request a greater proportion of ferritin-specific studies than non-specialists (they are 1.5 times more likely to request these studies.) However, this may be due to Specialists managing conditions such as haemochromatosis. Iron studies represent a significant cost to the MBS and service volumes are growing rapidly (with a compound annual growth rate of approximately 9 per cent).
- △ There are concerns about a lack of understanding among GPs regarding the appropriate choice of test (e.g., some GPs may want only a ferritin test but for various reasons may request “iron studies”). For this reason, clarity in item descriptors may be beneficial.
- △ The Committee noted patterns of high-volume testing on younger women and was concerned that this may reflect a full-panel approach to test ordering, rather than more directed testing.
- △ There are some instances where iron studies may be indicated, and these can be considered (e.g., in haemochromatosis).
- △ There is no need for repeat testing within three months, and allowing time for an adequate trial of oral therapy is recommended. However, in FY2014/15, approximately 254,000 consumers (6.7 per cent of all consumers receiving an iron study) underwent at least one repeat iron study within three months of the initial test. (31)

7.3 Coagulation studies (items 65120–65129)

The MBS currently has four items related to coagulation testing, differentiated by the number of specific tests provided.

Table 26: Item introduction table for items 65120–65129

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
65120	Prothrombin time (including INR where appropriate), activated partial thromboplastin time, thrombin time (including test for the presence of heparin), test for factor XIII deficiency (qualitative), Echis test, Stypven test, reptilase time, fibrinogen, or 1 of fibrinogen degradation products, fibrin monomer or D-dimer - 1 test	\$13.70	3,133,509	\$36,083,723	-3.8%
65123	2 tests described in item 65120	\$20.35	386,449	\$6,192,744	3.2%
65126	3 tests described in item 65120	\$27.85	270,598	\$6,000,910	8.5%
65129	4 or more tests described in item 65120	\$35.50	337,168	\$9,717,214	11.7%

Unpublished data, extract based on date of service (Department of Health).

Request 23

- △ The Committee requests that the DMCC considers the following recommendations:

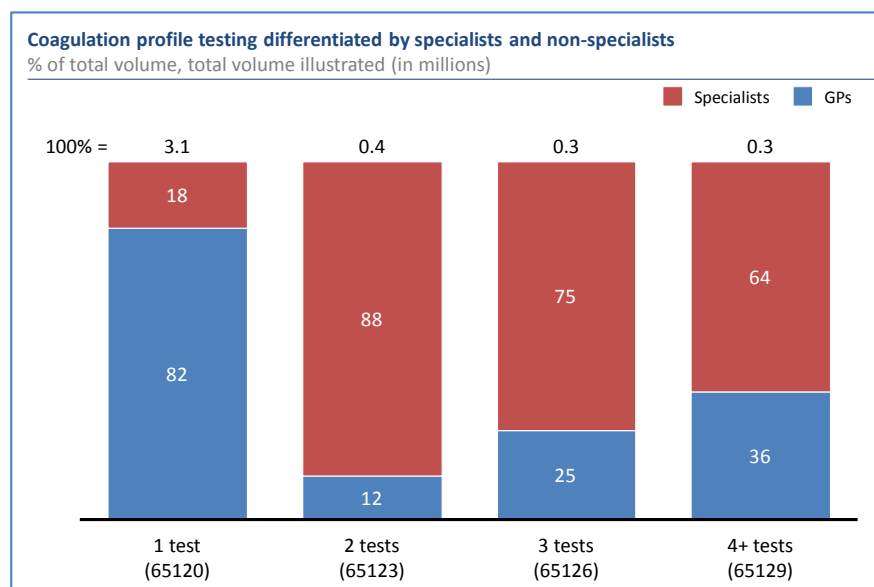
- Separate items for D-Dimer and INR (commonly indicated single tests).
- Revise items to stipulate the clinical indications where four or more tests are done (the full panel), or consider deleting items 65126 and 65129 (for three or more tests and four or more tests) and retain items 65120 and 65123 (for one test and two tests).
 - Specifically, consider stipulating situations where testing for bleeding disorders is not warranted (for example, menorrhagia, where testing is unlikely to be informative unless there is other evidence of a bleeding disorder).
- Revise items to stipulate indications for repeat testing and how often this should occur for each item.

Rationale

This request focuses on improving the value of MBS-funded services for the consumer and the community. It is based on the following observations.

- △ The Committee believes that full-panel coagulation tests (item 65129) are overused and that more directed testing may be all that is clinically required.
- △ The Committee noted an unusual distribution of test counts requested by clinician type: GPs request either a single test or many tests (“coag studies”).

Figure 9: Coagulation profile requesting by specialists versus non-specialists



Extract based on date of processing (Department of Health), FY2014/15.

- △ Although the increased volume of single tests can be explained by repeated INR testing, the increased proportion of four or more tests (relative to two tests and three tests) cannot be explained.
- △ There is considerable variation across states and territories in terms of the distribution of the number of tests (full panel versus targeted). This does not seem to be an access issue as the relative proportions of the tests within this group of items do not differ much by rurality.

- △ There is also an unusual distribution of service volumes across age and gender, with younger female consumers more commonly undergoing two, three and four or more test items, compared to male consumers. This trend that is not reflected in the one-test item.
- △ Large volumes of repeat testing are being performed within seven days of the initial test. This is not necessarily supported by clinical indications and is contrary to what one would expect epidemiologically.
- △ Approximately 20,000 consumers (8.5 per cent of consumers receiving testing involving four or more tests within a year) received further testing involving four or more tests within seven days of the initial tests.

7.4 Urine examination (items 69300 and 69333)

The MBS currently has two items that can potentially be used for microbiological examination of urine: one item relates specifically to urine examination and requires both microscopy and culture, amongst other service components (item 69333); and one item relates to any wet film material other than blood and does not require culture (item 69300).

Table 27: Item introduction table for items 69300 and 69333

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
69300	Microscopy of wet film material other than blood, from 1 or more sites, obtained directly from a patient (not cultures) including: (a) differential cell count (if performed); or (b) examination for dermatophytes; or (c) dark ground illumination; or (d) stained preparation or preparations using any relevant stain or stains; 1 or more tests	\$12.50	24,336	\$249,783	9.7%
69333	Urine examination (including serial examination) by any means other than simple culture by dip slide, including: (a) cell count; and (b) culture; and (c) colony count; and (d) (if performed) stained preparations; and (e) (if performed) identification of cultured pathogens; and (f) (if performed) antibiotic susceptibility testing; and (g) (if performed) examination for PH, specific gravity, blood, protein, urobilinogen, sugar, acetone or bile salts	\$20.55	4,373,183	\$76,065,703	4.8%

Unpublished data, extract based on date of service (Department of Health).

Request 24

- △ The Committee requests that the DMCC considers the following recommendations:
 - Revise items 69300 and 69333 to apply appropriate use criteria and prevent testing in consumers without symptoms of urinary tract infection, except in children, during pregnancy or prior to instrumentation of the urinary tract. Consider education programs to support appropriate use.
 - Revise item 69300 to stipulate that culture is only performed if microscopy is positive, except in children, during pregnancy or prior to instrumentation of the urinary tract.

Rationale

This request focuses on improving the value of MBS-funded services for the consumer and the community. It is based on the following observations.

- △ The Committee is concerned that current items encourage overuse of culture and sensitivity testing without positive microscopy findings.
- △ Under the MBS, the urine examination (culture) item is used 29 times more frequently than the microscopy item alone, and its usage is growing. Use of the microscopy-only item is declining.
- △ There is considerable variation in services per population across jurisdictions (e.g., some jurisdictions provide six or seven times more services per population than others).
- △ There are also high rates of testing among elderly consumers (30 per cent of services are for people aged 70 years and older), with 90,000 tests performed in residential aged care.
- △ Screening for asymptomatic bacteriuria is not appropriate, especially in terms of antibiotic stewardship. (32,33) Anecdotally, asymptomatic consumers with type 2 diabetes may be screened in General Practice, and staff in residential aged care facilities dipstick clients' urines and request microscopy and culture in those with dipstick abnormalities.
- △ Approximately 93,000 consumers (3.4 per cent of all consumers receiving this test within one year) received at least one repeat test within seven days of the first test.

7.5 Vitamin B12 and B12 marker testing (items 66838 and 66839)

The MBS currently has two items relating to B12 testing: one item covers testing of serum vitamin B12 levels, and the other item covers testing of vitamin B12 markers such as holoTranscobalamin.

Table 28: Item introduction table for items 66838 and 66839

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
66838	Serum vitamin B12 test (Item is subject to Rule 25)	\$23.60	943,666	\$18,976,899	-
66839	Quantification of vitamin B12 markers such as holoTranscobalamin or methylmalonic acid, where initial serum vitamin B12 result is low or equivocal	\$42.95	690,892	\$25,403,862	-

Unpublished data, extract based on date of service (Department of Health).

Request 25

- △ The Committee requests that the DMCC considers the following recommendations:
 - Revise the B12 marker item (66839) so that it has the same 12-month frequency restriction (Rule 25) as the vitamin B12 item (66838).
 - Consider what constitutes “low” and “equivocal” levels of vitamin B12, as there is currently no agreed cut-off point.

Rationale

This request focuses on improving the value of MBS-funded services for the consumer and the community. It is based on the following observations.

- △ Rule 25 is in place for vitamin B12 testing (item 66838), but the same restriction does not apply to B12 marker testing (e.g., holoTranscobalamin; item 66839). As a result, inappropriately frequent testing of vitamin B12 has been replaced by inappropriately frequent testing of vitamin B12 markers.

- Large numbers of repeat vitamin B12 marker tests are performed within a year: approximately 25 per cent of consumers undergoing testing for vitamin B12 markers have a repeat vitamin B12 marker test within the same year.
- There is no obvious merit in repeating vitamin B12 measurements during replacement (unless lack of compliance is suspected or anaemia recurs). If it is necessary to monitor the consumer's response to treatment, a full blood count is recommended. (34)

7.6 High-density lipoprotein (HDL) testing (item 66536)

The MBS currently has one item that covers HDL testing and a set of five items that covers a group of tests including testing for other lipid components such as total cholesterol, low-density lipoprotein (LDL) and triglycerides. Items within this set are differentiated by the number of tests performed.

Table 29: Item introduction table for items 66838 and 66839

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
66536	Quantitation of HDL cholesterol	\$11.05	1,635,937	\$15,351,898	-2.7%
66500	Quantitation in serum, plasma, urine or other body fluid (except amniotic fluid), by any method except reagent tablet or reagent strip (with or without reflectance meter) of: acid phosphatase, alanine aminotransferase, albumin, alkaline phosphatase, ammonia, amylase, aspartate aminotransferase, bicarbonate, bilirubin (total), bilirubin (any fractions), c-reactive protein, calcium (total or corrected for albumin), chloride, creatine kinase, creatinine, gamma glutamyl transferase, globulin, glucose, lactate dehydrogenase, lipase, magnesium, phosphate, potassium, sodium, total protein, total cholesterol, triglycerides, urate or urea - 1 test	\$9.70	772,934	\$6,308,791	2.3%
66503	2 tests described in item 66500	\$11.65	419,796	\$4,139,177	-1.2%
66506	3 tests described in item 66500	\$13.65	261,074	\$3,024,453	-6.2%
66509	4 tests described in item 66500	\$15.65	73,901	\$968,997	-0.9%
66512	5 or more tests described in item 66500	\$17.70	14,457,644	\$213,306,873	4.1%

Unpublished data, extract based on date of service (Department of Health).

Request 26

△ The Committee requests that the DMCC considers the following recommendation:

- Restrict frequency of testing within the item descriptor to:
 - No more than once in every 11 months for screening.
 - No more than twice in every 11 months for monitoring when consumers are on lipid-lowering therapy (including dietary intervention).

The Working Group that looked at this item noted that the Pathology Clinical Committee was considering combining HDL, cholesterol, triglycerides and LDL in a new “complete lipid panel” item. The Working Group is supportive of such a move from a clinical point of view, providing the costs of such a change are neutral.

Rationale

This request focuses on improving the value of MBS-funded services for the consumer and the community. It is based on the following observations.

- △ Current guidelines suggest that repeat testing has limited benefits.
 - At most, screening is recommended annually in high-risk populations, such as those with diabetes, cardiac disease, stroke, hypertension or kidney disease (RACGP guidelines). For low-risk adults, RACGP guidelines suggest that blood lipids should be assessed every five years, starting at 45 years of age (35 for Aboriginal and Torres Strait Islander peoples). (35)
 - Monitoring is recommended after three months of lipid-lowering therapy for both primary and secondary prevention (National Institute for Health and Care Excellence [NICE] guidelines). (36)
- △ Service volumes and patterns of repeat testing do not align with these guidelines. For example, at least 50,000 consumers received repeat testing within one to three months in FY2014/15.
- △ Evolving evidence suggests that there is no clinical indication for rechecking cholesterol levels¹⁰ soon after a consumer has been started on statin treatment. (37)(38) On a practical level, this means that consumers should be placed on the highest tolerated statin dose for the long term, rather than targeting a specific HDL level.

7.7 Prostate-specific antigen testing (items 66655–66660)

The MBS currently has four items for prostate-specific antigen (PSA) testing: one item for initial (screening) testing; one item for monitoring consumers with previously diagnosed prostatic disease; and two items for measuring two or more fractions when initial PSA testing gives a result either above the median but below the upper limit of normal, or above the upper limit of normal.

Table 30: Item introduction table for items 66655–66660

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
66655	Prostate specific antigen - quantitation - 1 of this item in a 12 month period (Item is subject to rule 25)	\$20.15	667,184	\$11,448,366	-3.2%
66656	Prostate specific antigen - quantitation in the monitoring of previously diagnosed prostatic disease (including a test described in item 66655)	\$20.15	788,283	\$13,541,716	2.1%
66659	Prostate specific antigen - quantitation of 2 or more fractions of PSA and any derived index including (if performed) a test described in item 66656, in the follow up of a PSA result that lies at or above the age related median but below the age related, method specific 97.5% reference limit - 1 of this item in a 12 month period (item is subject to rule 25)	\$37.30	106,339	\$3,386,164	4.4%
66660	Prostate specific antigen – quantitation of 2 or more fractions of PSA and any derived index including (if performed) a test described in item	\$37.30	54,372	\$1,729,572	1.3%

¹⁰ LDL specifically

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
	66656, in the follow up of a PSA result that lies at or above the age related, method specific 97.5% reference limit, but below a value of 10 ug/l – 4 of this item in a 12 month period (item is subject to rule 25)				

Unpublished data, extract based on date of service (Department of Health).

Request 27

- △ The Committee requests that the DMCC considers the following recommendations:
- Revise item 66655 to restrict the frequency of testing for PSA screening to once every 23 months.
 - Alter the explanatory notes to:
 - Reference the NHMRC guidelines on PSA testing, noting that there may be reason to test above the recommended age group if the consumer has prolonged life expectancy.
 - Remind clinicians that PSA may be elevated as a result non-malignant conditions (e.g., benign prostatic hypertrophy).
 - Encourage health practitioners to talk to men about the potential benefits and harms of PSA testing before screening a healthy man.

Rationale

This request focuses on ensuring that MBS services reflect best-practice and high-value care, in line with clinical guidelines. It is based on the following observations.

- △ NHMRC guidelines recommend that asymptomatic men should only be screened for prostate cancer by testing PSA once every two years up to the age of 69, and that testing should only be performed after health practitioners talk to men about the potential benefits and harms of PSA testing. (39)
- △ RACGP guidelines recommend that asymptomatic men at low risk of prostate cancer should not be screened by testing PSA, and that this testing should only be performed on demand after the consumer has been informed about the potential benefits and harms. (35)
- △ The Committee recognises that a blanket restriction on screening for asymptomatic men or men above the age of 69 would inappropriately limit access among consumers who may benefit from PSA testing. However, the Committee's Pathology Working Group noted that current guidelines may lead to the screening of some asymptomatic men where the harms of overdiagnosis and overtreatment outweigh the benefits.
- △ The Committee does not recommend any amendment to item 66656 (which provides for repeat testing), given the diverse reasons for requiring repeat PSA testing (including follow-up of men with prostate cancer).

7.8 Folate testing (item 66840)

The MBS currently has one item for measuring folate levels, introduced in November 2014 to replace previous items that allowed testing for folate and B12 together.

Table 31: Item introduction table for items 66840

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
66840	Serum folate test and, if required, red cell folate test for a patient at risk of folate deficiency, including patients with malabsorption conditions, macrocytic anaemia or coeliac disease	\$23.60	480,634	\$9,585,968	-

Unpublished data, extract based on date of service (Department of Health).

Request 28

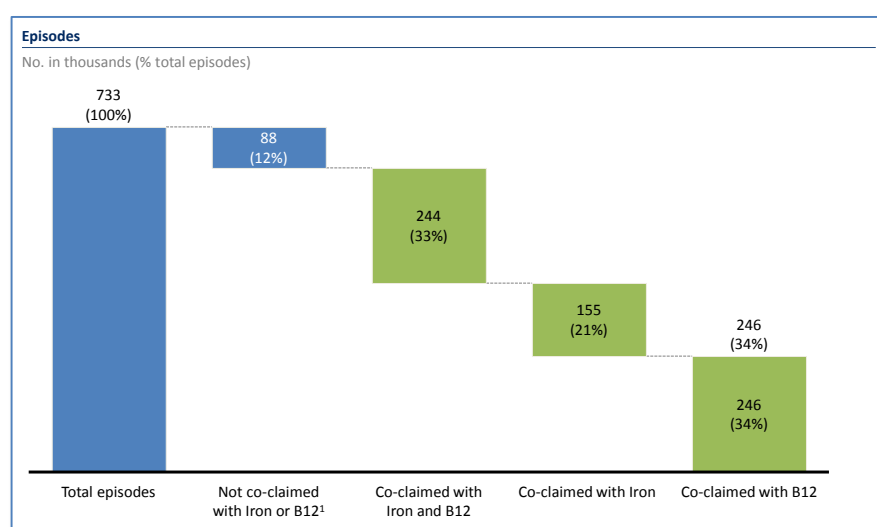
- △ The Committee requests that the DMCC considers the following recommendations:
- Restrict the frequency of folate testing to once every 11 months.
 - Develop appropriate use criteria for the clinical indications for quantification of folate, and stipulate that these be detailed within the request.
 - If it is more appropriate to list exclusions, these could be included in the descriptor.
 - If it is more appropriate to list inclusions, these could be included in the explanatory notes.

Rationale

This request focuses on ensuring that MBS services reflect best-practice and high-value care, in line with clinical guidelines. It is based on the following observations.

- △ In Australia, the prevalence of folate deficiency is low and does not warrant the current volume of testing. In part, this is because folate levels in the general population have increased since fortification of wheat flour was introduced in 2009. (40) The very low levels of folate deficiency in Australia have prompted concern that folate testing currently represents low-value care.
- △ There is no need for repeating folate quantification once treatment has started unless the consumer remains symptomatic or if anaemia reoccurs. (41)
- △ A large number of folate tests (approximately 399,000, or 54 per cent of total folate testing) are performed with ferritin or iron studies (either alone or within a panel of B12 quantification), despite folate deficiency causing a macrocytic anaemia and iron deficiency causing a microcytic anaemia.

Figure 10: Co-claiming of folate testing and iron studies/ferritin testing



¹ "Iron" includes items for ferritin (66593) and iron studies (66596); B12 includes items for B12 (66838) and B12 markers (66839)

Episode: items claimed for the same consumer, within the same facility, on the same day. Co-claiming: MBS services claimed within an episode. Extract taken using episode volumes for FY2015/16.

- △ The Committee noted that the Chemical Working Group of the Pathology Clinical Committee is reviewing this item and is currently collating evidence about the proportion of abnormal tests in a community setting. This work may inform the DMCC's deliberations about the overall value of this test.

7.9 Vitamin D testing (items 66833–66837)

The MBS currently has three items that attract benefits for vitamin D quantification. These were introduced in November 2014 (replacing previous items) in an attempt to increase the discriminate nature of vitamin D quantification, in the context of rapidly rising service volumes and high volume testing.

Table 32: Item introduction table for items 66833–66837

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
66833	25-hydroxyvitamin d, quantification in serum, for the investigation of a patient who: (a) has signs or symptoms of osteoporosis or osteomalacia; or (b) has increased alkaline phosphatase and otherwise normal liver function tests; or (c) has hyperparathyroidism, hypo- or hypercalcaemia, or hypophosphataemia; or (d) is suffering from malabsorption (for example, because the patient has cystic fibrosis, short bowel syndrome, inflammatory bowel disease or untreated coeliac disease, or has had bariatric surgery); or (e) has deeply pigmented skin, or chronic and severe lack of sun exposure for cultural, medical, occupational or residential reasons; or (f) is taking medication known to decrease 25oh-d levels (for example,	\$30.05	1,955,531	\$50,067,746	-

Item	Descriptor	Schedule fee	Volume of services FY2014/15	Total benefits FY2014/15	Services 5-year-average annual growth
	anticonvulsants); or (g) has chronic renal failure or is a renal transplant recipient; or (h) is less than 16 years of age and has signs or symptoms of rickets; or (i) is an infant whose mother has established vitamin d deficiency; or (j) is a exclusively breastfed baby and has at least one other risk factor mentioned in a paragraph in this item; or (k) has a sibling who is less than 16 years of age and has vitamin d deficiency				
66834	A test described in item 66833 if rendered by a receiving APP (Item is subject to Rule 18)	\$30.05	1,089	\$27,569	-
66835	1, 25-dihydroxyvitamin D - quantification in serum, if the request for the test is made by, or on advice of, the specialist or consultant physician managing the treatment of the patient	\$39.05	7,501	\$249,184	-
66836	1, 25-dihydroxyvitamin d—quantification in serum, if: (a) the patient has hypercalcaemia; and (b) the request for the test is made by a general practitioner managing the treatment of the patient	\$39.05	74	\$2,381	-
66837	A test described in item 66835 or 66836 if rendered by a receiving APP (Item is subject to Rule 18)	\$39.05	1,120	\$37,061	-

Unpublished data, extract based on date of service (Department of Health).

Request 29:

△ The Committee requests that the DMCC considers the following recommendation:

- Perform an evidence review to inform deliberations about:
 - Restricting testing to once every one to two years, unless specific clinical circumstances apply.
 - Updating the current appropriate use criteria within item 66833 to reflect changes in clinical evidence and guidelines.

Rationale

There is a concern that despite the introduction of new items in November 2014 (which included more specific appropriate-use criteria), vitamin D testing reflects overutilisation of healthcare resources and low-value care. This is based on the following observations.

- △ Although testing volumes initially declined following the introduction of new items for vitamin D testing in November 2014 (which included specific appropriate-use criteria), testing volumes have begun to stabilise and have even increased in recent months (compared to the previous year's equivalent month).
 - In part, this is because clinical indications in the descriptor for item 66833 are broad (e.g., “chronic and severe lack of sun exposure for cultural, medical, occupational or residential reasons”).
 - There are also higher volumes of testing among females, particularly women aged 25 to 39 with no clinically apparent need for testing.

- △ The clinical benefit of vitamin D supplementation appears to be limited, with the current literature base supporting supplementation only in at-risk patients. (42)(42) Even in this subpopulation, there is no clear guidance that suggests that a set vitamin D level should be targeted by supplementation. (43) Consequently, vitamin D testing should not be altering treatment decisions.
- △ Repeat testing should not be performed unless there has been a change in the consumer's risk factor profile. Despite this, at least 490,000 consumers received at least one repeat test within 6–12 months of an initial test in FY2014/15.
 - In 2013, the Royal College of Pathologists of Australasia (RCPA) recommended repeating vitamin D quantification after three months of treatment. If the previously diagnosed deficiency had been corrected, no further testing was required.

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Appendix A – Glossary

Term	Description
ACRRM	Australian College of Rural and Remote Medicine
BEACH	Bettering the Evaluation and Care of Health
CAGR	Compound annual growth rate, or the average annual growth rate over a specified time period.
Change	When referring to an item, 'change' describes when the item and/or its services will be affected by the recommendations. This could result from a range of recommendations, such as: (i) specific recommendations that affect the services provided by changing item descriptors or explanatory notes; (ii) the consolidation of item numbers; and (iii) splitting item numbers (for example, splitting the current services provided across two or more items).
Co-claiming	MBS services claimed within an episode (same day, same facility, same patient)
CT	Computed tomography
Delete	Describes when an item is recommended for removal from the MBS and its services will no longer be provided under the MBS.
Department, The	Australian Government Department of Health
DHS	Australian Government Department of Human Services
DICC	Diagnostic Imaging Clinical Committee
DIWG	Diagnostic Imaging Working Group
DMCC	Diagnostic Medicine Clinical Committee
ED	Emergency Department
Episode	Same consumer, same facility, same day
FB	Foreign body
FY	Financial year
GP	General Practitioner
GPPCCC	General Practice and Primary Care Clinical Committee
High-value care	Services of proven efficacy reflecting current best medical practice, or for which the potential benefit to consumers exceeds the risk and costs.
Inappropriate use / misuse	The use of MBS services for purposes other than those intended. This includes a range of behaviours, from failing to adhere to particular item descriptors or rules through to deliberate fraud.
LBP	Lower back pain
LHN	Local Hospital Networks
Low-value care	Services that evidence suggests confer no or very little benefit to consumers; or for which the risk of harm exceeds the likely benefit; or, more broadly, where the added costs of services do not provide proportional added benefits.
MBS	Medicare Benefits Schedule

MBS item, item	An administrative object listed in the MBS and used for the purposes of claiming and paying Medicare benefits, consisting of an item number, service descriptor and supporting information, schedule fee and Medicare benefits.
MBS service	The actual medical consultation, procedure or test to which the relevant MBS item refers.
Misuse (of MBS item)	The use of MBS services for purposes other than those intended. This includes a range of behaviours, from failing to adhere to particular item descriptors or rules through to deliberate fraud.
MRCP	Medicare Claims Review Panel
MRI	Magnetic resonance imaging
MSAC	Medical Services Advisory Committee
New service	Describes when a new service has been recommended, along with a new item number. In most circumstances, new services will need to go through the MSAC. It is worth noting that implementation of the recommendation may result in more or fewer item numbers than specifically stated.
NHMRC	National Health and Medical Research Council
NICE	National Institute for Health and Care Excellence
“NK” items and “K” items	The letters used to denote “Capital sensitive items,” where a reduced schedule fee applies to the imaging service provided on equipment that is 10 or more years old. This equipment must have been first installed in Australia 10 or more years ago, or in the case of imported pre-used equipment, must have been first manufactured 10 or more years ago. The one exception to this rule is where equipment is located in a remote area, when items with the letter “K” will apply.
No change or leave unchanged	Describes when the services provided under these items will not be changed or affected by the recommendations. This does not rule out small changes in item descriptors (for example, references to other items, which may have changed as a result of the MBS Review or prior reviews).
Non-VRGP	Non-Vocationally Registered General Practitioner
NPS	National Prescribing Service
PARC	Principles and Rules Committee, a Committee within the MBS Review that looks at legislative and regulatory framework changes underpinning the MBS, and that considers broader questions about principles, objectives and boundaries shaping the approach of the review.
PBS	Pharmaceutical Benefits Scheme
PCC	Pathology Clinical Committee
PHN	Primary Health Network
PIP	Practice Incentives Program
PWG	Pathology Working Group
RACGP	Royal Australian College of General Practitioners
RACMA	Royal Australian College of Medical Administrators
RCPA	Royal College of Pathologists of Australasia

Sequential claiming	MBS services claimed for the same consumer, on different (sequential) occasions
Services average annual growth	The average growth per year, over five years to 2014/15, in utilisation of services. Also known as the compound annual growth rate (CAGR).
The Committee	The General Practice and Primary Care Clinical Committee of the MBS Review
The Taskforce	The MBS Review Taskforce
Total benefits	Total benefits paid in 2014/15 unless otherwise specified.
VRGP	Vocationally Registered General Practitioner
XR	X-ray