



# Medicare Benefits Schedule Review Taskforce

## Taskforce Report from the Specialist and Consultant Physician Consultation Clinical Committee

June 2020

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## IMPORTANT NOTES

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

[Group] Recommendation [#] – Taskforce’s Advice

[The Taskforce’s rationale behind their decision.]



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# 1 Executive summary

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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 to improve health outcomes for patients. The Taskforce will also seek to identify any services that may be unnecessary, outdated, or potentially unsafe.

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

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

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

The Specialist and Consultant Physician Consultation Clinical Committee (the Committee) was established in May 2018 to make recommendations to the Taskforce on MBS items in its area of responsibility, based on rapid evidence review and clinical expertise. The Taskforce asked the Committee to review 143 items related to attendances, along with seven priority issues that are largely structural in nature. The Taskforce referred two further issues to the Committee, as requested by the Minister- referral practices, and incentivising the uptake of My Health Record by clinicians and consumers.

## 1.1 Key recommendations

Detailed recommendations and rationales can be found in Sections 4 to 11, and a complete list of in-scope items and recommendations is provided in Appendix A. A summary of the report's key recommendations is provided below.

### 1.1.1 Standard attendance recommendations

Many of the items for consultant specialist attendances have not been reviewed since their introduction in the 1970s and are based on a rationale that is increasingly dissociated from standard clinical practice. During the course of its discussions, the Committee agreed that the current structure of attendance items does not accurately reflect the contemporary roles of specialists and consultant physicians and the balance of consultative and procedural work across specialties, does not sufficiently support clinicians to invest in consultative care over procedural work; and does not provide consumers with transparency on the cost or the quality of their chosen institution or consultant specialist.

The Committee recommends a new model for attendance items that is greatly simplified (removing over 60 per cent of items), is more equitable, and enables consistent patient rebates for similar services. At the core of the new model is a recommendation to set standard attendance schedule fees based on time. There is consensus within the Committee that using time as a basis for setting schedule fees is applicable within standard clinical practice across all specialties; and can account for distinct activities of varying complexity. A time-based model also strengthens the capacity of consumers to give informed financial consent. The Committee has recommended reviewing the potential impact of time-tiering on distant outreach services.





The Committee has also made recommendations on related attendance items such as telehealth and case conferencing, and the use of data to inform quality care and patient choice. The intention is to increase patient access to these items, and to encourage integrated care and shared decision-making.

The Committee recommends introducing time-tiered attendance items with descriptors including activities to be performed in each time tier. These items replace existing standard attendance items and will be accessed by all consultant specialists.

The Committee also recommends introducing a parallel structure of attendance items that cover acute, urgent, and unplanned attendances occurring outside a consultant specialist's consulting rooms. The Committee recommends a higher schedule fee for these items compared to its equivalent standard time-tiered attendance item, reflective of the disruption and consequently higher inputs of these attendances.

### **1.1.1 Complex plan recommendations**

The Committee recommends removing complex plan items from the MBS for consultant physicians (items 132 and 133), addiction medicine specialists (items 6023 and 6024), and sexual health medicine specialists (items 6057 and 6058). These complex plan services should instead be itemised using the new standard time-tiered attendance items.

Complex plan items were initially created to support the referring practitioner (usually the GP) in managing complex patients. However, evidence suggests that these items are instead being used as a proxy for a long consultation. For example, 41 per cent of patients receiving a complex plan from a consultant physician (item 132) do not see their referring practitioner in the following six months.

The Committee recommends keeping paediatric complex plan items 135 and 137 in the MBS as these items pertain to specific patient population groups (e.g., children with autism spectrum disorder) and are linked to an allied health professional (AHP) pathway. The Committee recommends the changes to these items to ensure they align with best practice and effective treatment. Due to very high complexity and severity of the conditions being assessed and the multidisciplinary domains considered, the schedule fee should be set at equal to or greater than level E.

The Committee also recommends retaining comprehensive geriatric assessment and management plan items 141, 143, 145 and 147 given there are a number of unique, specific requirements.

### **1.1.2 Telehealth recommendations**

#### **Taskforce Note**

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

The Committee has made recommendations on MBS telehealth items to phase out the incentive loading by incrementally reducing the derived fee for the nine telehealth loading items to zero, with annual analysis of its effects to identify potential unintended consequences. This is a recognition that the loading was envisaged to be time limited and its success to date in encouraging telehealth usage.

Further the Committee has recommended new telehealth-specific attendance items (after the nine loading items have been removed) that mirror the standard time-tiered attendance



items, with the same fees, and with item descriptors that describe activities to be performed in each tier.

The Committee recommends all savings from removing the telehealth loading be reinvested to increase:

- Consumer utilisation of and access to telehealth services; and
- Specialist supply of telehealth services.

The Committee recommends consideration of both MBS and non-MBS mechanisms to achieve greater use of telehealth as a recognised and effective tool. This could include developing and sharing the value proposition of telehealth with consumers, including when, where and how to use these services, and their associated health and economic benefits, and educating GPs, PHNs and consultant specialists to identify patient population groups that would most benefit from telehealth and facilitate access to these services.

### **1.1.3 Case conference recommendations**

The Committee recommends a new framework for case conference items consisting of three simplified categories:

- Discharge planning case conferences- a case conference to facilitate better post-discharge care and communication.
- Community case conferences- a case conference held to facilitate the provision of better multidisciplinary care.
- Treatment planning case conferences (new) - a case conference that explores and analyses potential treatment options and their respective benefits.

The Committee has also recommended a series of enhancements to ensure case conferences are effective, covering issues such as who should participate and the need for review of outcomes.

### **1.1.4 Use of data to inform quality care and patient-informed choice and consent recommendations**

The Committee recommends both MBS and non-MBS mechanisms to encourage quality care and patient-informed choice and consent, including:

- Establishing a national minimum data set to inform evidence-based clinical practice and inform patient choice;
- Providing patients with transparency on the cost and outcomes of consultant specialists' services, made publicly available and shared through their GP at the time of referral; and
- Improve patient consent and shared decision-making by specifying in attendance item descriptors what should be discussed when multiple treatment options are available.

The Committee recognises that the integrity and relevance of the data is crucial to this recommendation's success, and its acceptance by the profession, individual clinicians, and consumers. The Committee also recommends that clinicians and consumers be proactively engaged to identify and address potential risks in sharing patient outcome data.

### **1.1.5 My Health Record recommendations**

The Committee supports the principle that electronic health records can enhance information sharing between patients and providers and thereby promote safe practice, support self-management and improve patient care. The Committee recommends the use of



both MBS and non-MBS mechanisms to support the adoption of digital record systems, cognisant of the current limitations of digital readiness among consultant specialists.

The Committee recommends outcomes of case conferences be uploaded to My Health Record. Additionally, the Committee also recommends introducing a single incentive payment to consultant specialists upon their adoption of My Health Record, triggered by achieving a volume of uploads that is proportional to the number of attendances that the provider performs. Other recommendations cover improving the functionality of My Health Record and educating consultant specialists on the benefits of its use.

## **1.2 Consumer engagement**

The Committee includes two consumer members who have provided a consumer perspective on the recommendations in this report. The Committee received over 100 submissions from a variety of stakeholders, including consumer groups.

## **1.3 Consumer impact summary**

Both patients and providers are expected to benefit from these recommendations as they address concerns regarding patient access and quality of care, and they take steps to simplify the MBS and make it easier to use and understand. The Committee also considered each recommendation's impact on provider groups to ensure that any changes were reasonable and fair. Where the Committee identified evidence of potential item misuse or safety concerns, recommendations were made to encourage best practice, in line with the overarching purpose of the MBS Review.



## 2 About the Medicare Benefits Schedule (MBS) Review

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### 2.1 Medicare and the MBS

#### 2.1.1 What is Medicare?

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

Introduced in 1984, Medicare has three components:

- free public hospital services for public patients;
- subsidised drugs covered by the Pharmaceutical Benefits Scheme (PBS); and
- subsidised health professional services listed on the MBS.

#### 2.2 What is the MBS?

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

#### 2.3 What is the MBS Review Taskforce?

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

##### 2.3.1 What are the goals of the Taskforce?

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

- **Affordable and universal access**—the evidence demonstrates that the MBS supports very good access to primary care services for most Australians, particularly in urban Australia. However, despite increases in the specialist workforce over the last decade, access to many specialist services remains problematic, with some rural patients being under-served.
- **Best practice health services**—one of the core objectives of the Review is to modernise the MBS, ensuring that individual items and their descriptors are consistent with contemporary best practice and the evidence base when possible. Although the Medical Services Advisory Committee (MSAC) plays a crucial role in thoroughly evaluating new services, the vast majority of existing MBS items pre-date this process and have never been reviewed.
- **Value for the individual patient**—another core objective of the Review is to have an MBS that supports the delivery of services that are appropriate to the patient's needs, provide real clinical value and do not expose the patient to unnecessary risk or expense.



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

## 2.4 The Taskforce's approach

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

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

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

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

1. Develop an initial fact base for all items under consideration, drawing on the relevant data and literature.
2. Identify items that are obsolete, are of questionable clinical value<sup>1</sup>, are misused<sup>2</sup> and/or pose a risk to patient safety. This step includes prioritising items as "priority 1", "priority 2", or "priority 3", using a prioritisation methodology (described in more detail below).
3. Identify any issues, develop hypotheses for recommendations and create a work plan (including establishing working groups, when required) to arrive at recommendations for each item.
4. Gather further data, clinical guidelines and relevant literature in order to make provisional recommendations and draft accompanying rationales, as per the work plan. This process begins with priority 1 items, continues with priority 2 items and concludes with priority 3 items. This step also involves consultation with relevant stakeholders within the committee, working groups, and relevant colleagues or colleges. For complex cases, full appropriate use criteria were developed for the item's explanatory notes.
5. Review the provisional recommendations and the accompanying rationales, and gather further evidence as required.
6. Finalise the recommendations in preparation for broader stakeholder consultation.

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

<sup>2</sup> 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.

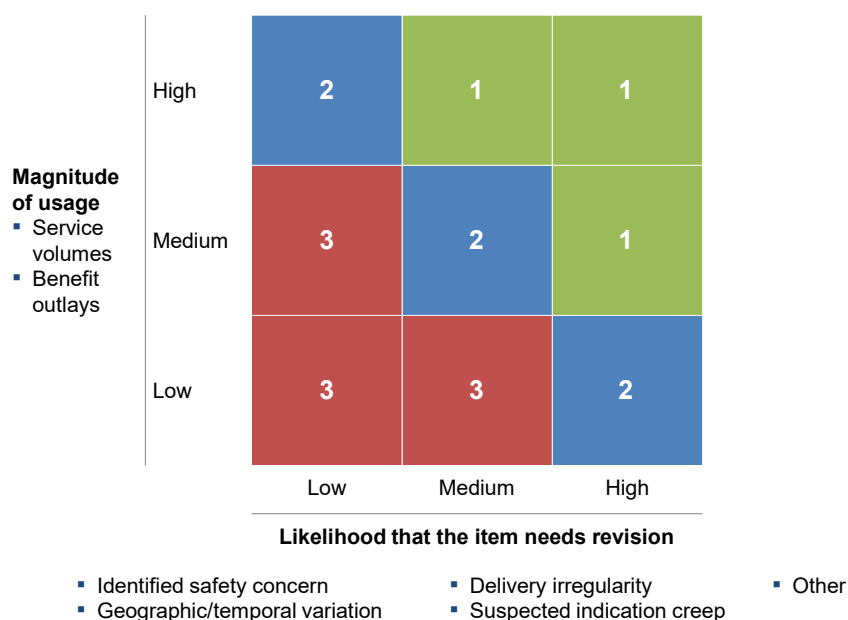


**7. Incorporate feedback gathered during stakeholder consultation and finalise a Clinical Review Report, which provides recommendations for the Taskforce.**

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

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

**Figure 1: Prioritisation matrix**



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



### 3 About the Specialist and Consultant Physician Consultation Clinical Committee

The Specialist and Consultant Physician Consultation Clinical Committee (the Committee) is part of the fifth tranche of clinical committees. It was established in May 2018 to make recommendations to the Taskforce on MBS items in its area of responsibility, based on clinical expertise and rapid evidence review. The Taskforce asked the Committee to review MBS items related to professional attendances, and to consider seven priority issues highlighted by the Taskforce.

#### 3.1 Specialist and Consultant Physician Consultation Clinical Committee members

The Committee consists of 16 members and two ex-officio representatives from the Taskforce. Members' names, positions/organisations and declared conflicts of interest are listed in Table 1.

**Table 1: Specialist and Consultant Physician Consultation Clinical Committee members**

Name	Position/organisation	Declared conflicts of interest
Prof. Anthony Lawler (Co-Chair)	Emergency Physician; Past President of the Australasian College for Emergency Medicine (ACEM); Chief Medical Officer in Tasmania	Board member of ACEM; Jurisdictional employee in Tasmania
Dr Philip Truskett AM (Co-Chair)	General Surgeon at the Prince of Wales Hospital, Sydney	Chair of the Council of Presidents of Medical Colleges; Chair of Day Hospitals Australia
Dr Paul Blackman	Sport and Exercise Physician, Olympic Park Sports Centre Medicine	Board Member of the Australasian College of Sports and Exercise Physicians
Dr Robert Carroll	Nephrologist, University of Adelaide	None
Prof. Derek Chew	Director of Cardiology at Flinders Medical Centre and Academic at Flinders University; Part of the MBS Review for Cardiology	None
Dr Eleanor Chew (Ex-Officio)	GP practising in Brisbane; Member of the MBS Review Principles and Rules Committee (PARC) and GP and Primary Care Clinical Committee	MBS Taskforce; Board Member of the Australian Digital Health Agency; Member of the Professional Services Review Panel; Member of the Australian Health Practitioner Regulation Agency (AHPRA) panel
Dr Stephen De Graaff	Senior Rehabilitation Physician and Director of Pain Services, Epworth HealthCare; Past President, Australasian Faculty of Rehabilitation Medicine, Royal Australian College of Physicians (RACP)	Wife is an allied health professional
Dr Katie Ellard	Gastroenterologist; Private practice in Sydney; Part of the MBS Review for Gastroenterology	None
Prof. Elizabeth Elliott AM	Clinical Academic at the University of Sydney; Consultant Paediatrician Sydney Children's Hospital Network (Westmead); Recent	None



Name	Position/organisation	Declared conflicts of interest
	research focus on fetal alcohol spectrum disorders	
Mr Adam Friederich	Consumer Representative; Works in Australian Public Service; Strong interest in health consumer issues; Served on other committees for the MBS Review	None
Dr Chris Hayes	Director of Hunter Integrated Pain Service based at the John Hunter Hospital; Immediate past Dean, Faculty of Pain Medicine Australian and New Zealand College of Anaesthetists	Member of the Australian Advisory Council on Medicinal Use of Cannabis (AACMC)
Ms Debra Kay	Consumer Member, Medical Services Advisory Committee (MSAC) and Health Technology Assessment Consumer Consultative Committee (CCC); Chair, MBS Review Consumer Panel; Member of the MBS Review Principles and Rules Committee	None
Dr John North	Senior Visiting Orthopaedic Surgeon; Princess Alexandra Hospital, Brisbane; Senior Visiting Orthopaedic Surgeon (Telehealth), Mt Isa Hospital and NWHHS; Chair of the MBS Review Orthopaedic Committee	Panel member for the Australian Health Practitioner Regulation Agency (AHPRA)
Prof. Graeme Samuel	Professional Fellow in Monash University's Business School and School of Public Health and Preventative Medicine; Non-clinician	Member of the sub-committee on Specialist out-of-pocket fees; Chair of South East Melbourne Primary Health Network; Chair of Dementia Australia; Director and Minority Shareholder of Mupharma Pty Ltd; Chair of Lorica Health Pty Ltd.
Prof. David Story	Professor and Chair of Anaesthesia, University of Melbourne; Staff Anaesthetist, Austin Hospital, Melbourne; Part of the MBS Review for Urology	None
Prof. Nick Talley (Ex-Officio)	Senior Specialist Gastroenterologist at the John Hunter	MBS Taskforce; The Medical Journal of Australia (MJA) Editor; Gastroenterological Society of Australia (GESA) Board Member
Dr Julie Thompson	General Practitioner in Victoria	None
Prof. David Watters	Chair of Surgical and Critical Care Programme Safety and Quality Committee; General and Endocrine Surgeon at University Hospital and St John of God Hospital, Geelong; Professor of Surgery, Deakin University	Member of the Clinical Measurement and Reporting Group for the Victorian Agency of Health Information (VAHI); Chair of the General Surgery Clinical Committee (GSCC) for the MBS Review





### 3.2 Conflicts of interest

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

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 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.

### 3.3 Areas of responsibility of the Committee

The Committee was assigned 143 MBS items to review, covering the following:

- A3 specialist attendances
- A4 consultant physician attendances
- A5 prolonged attendances
- A6 group therapy
- A12 occupational physician attendances
- A13 public health physician attendances
- A15 consultant specialist case conferences
- A24 pain and palliative medicine attendances
- A26 neurosurgery attendances
- A28 geriatric medicine
- A29 early intervention, children
- A31 addiction medicine attendances, and
- A32 sexual health attendances.

Attendance items for addiction medicine and sexual health medicine were initially not referred to the Committee as these items were introduced to the MBS in 2016. However, to maintain consistency in the MBS, the Committee believes that many of the recommendations set out in this report should apply to these attendances. For this reason, the Committee subsequently received approval from the Taskforce to make recommendations on these items.

A complete list of the items under review can be found in Appendix A – Index of items.

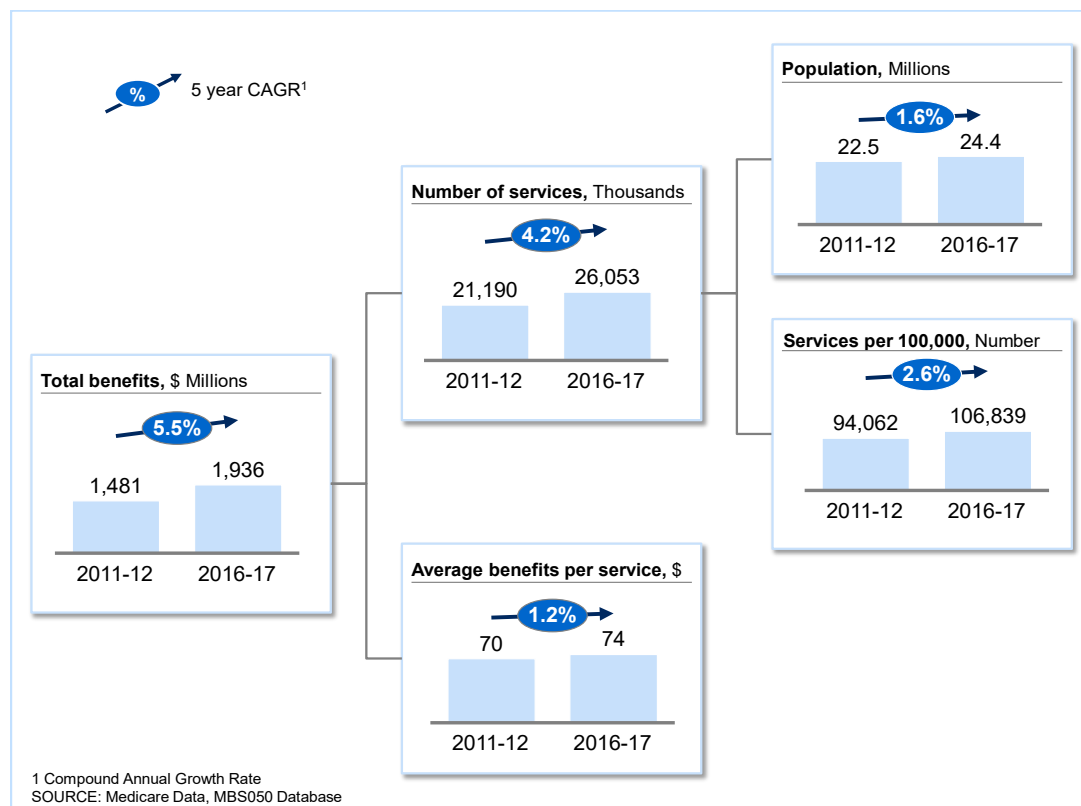
A number of professional attendance items are outside the scope of this review as they are the subject of review by other clinical committees, including specific attendance items for psychiatry, emergency medicine, anaesthetics, intensive care, obstetrics and general practice.

In 2016/17, the attendance items reviewed by the Committee accounted for approximately 26 million services and \$1.9 billion in benefits. Over the past five years, service volumes for these items have grown at 4.2 per cent per year, and the cost of benefits has increased by 5.5 per cent per year (refer to Figure 2). This growth is largely accounted for by a 2.6 per



cent increase in services per head of population, likely as a result of an ageing population and the increased burden of chronic disease.

**Figure 2: Drivers of benefit growth - 2011/12 to 2016/17**



The Committee was also asked to consider seven priority issues identified by the Taskforce. These issues are largely structural in nature, rather than item-specific (refer to Table 2). The Taskforce referred two further issues to the Committee, as requested by the Minister:

- referral practices; and
- incentivising the uptake of My Health Record.



Table 2: Priority issues to address in the committee's review

Issues	Description
1. The structure of the attendance items may not accurately consider resource input	<ul style="list-style-type: none"> <li>There are no requirements with regard to time or activities or assessments that should be provided under the standard attendance, in contrast to the GP attendance items.</li> <li>Fee relativity between initial and subsequent items does not necessarily reflect resource requirement</li> <li>50% loading for telehealth items was to recognise the additional time and increased professional complexity associated with provided telehealth services. This high loading may no longer be appropriate.</li> </ul>
2. The structure of the attendance items may not reflect contemporary roles and profiles of different specialties	<ul style="list-style-type: none"> <li>The assumptions underlying the differentiation between specialist versus consultant physician attendances may no longer hold true due to evolution of medical practices</li> <li>The nature of work performed by consultant physicians has increasingly become 'procedural' as well as 'cognitive' and vice versa for specialists</li> </ul>
3. The complex plan items may not consistently deliver the originally intended benefits to patients	<ul style="list-style-type: none"> <li>These items were introduced to support effective integrated care for consumers with complex and chronic conditions</li> <li><i>(Refer to the rationale and recommendations from the General Practice and Primary Care Clinical Committee)</i></li> </ul>
4. Imbalance between procedures and consultations for some specialties	<ul style="list-style-type: none"> <li>The proportion of consultations undertaken relative to procedures may be suboptimal for patient outcomes</li> </ul>
5. Review and assess multi-disciplinary approach	<ul style="list-style-type: none"> <li>The multi-disciplinary approach could be remodelled and assessed to facilitate better patient outcomes</li> </ul>
6. Review GP referrals to specialists and consultant physicians	<ul style="list-style-type: none"> <li>The Minister requested that the Committee review how referrals operate and whether there should be any changes to referral arrangements to prevent unnecessary GP consultations</li> </ul>
7. Multiple items exist that serve similar purposes	<ul style="list-style-type: none"> <li>Several items fulfil highly similar functions in the current service description, especially for newly added items</li> <li>Different items can be claimed for the same services (e.g. by different provider types)</li> </ul>

Noting significant overlap between some of these issues, the Committee considered:

- How standard attendance items (initial and subsequent attendances with a single consultant specialist) can better reflect resource input (Section 4).
- How complex plan items can better promote integrated care (Section 5).
- Whether telehealth loading items remain the optimal mechanism to promote uptake of telehealth (Section 6).
- How use of case conferences can be increased in the private sector, and how case conferences can involve the right participants to integrate care and improve patient outcomes (Section 7).
- The imbalance between procedures and attendances and the role of data-driven practice and patient consent in improving quality (Section 8).



6. Mechanisms to promote uptake of My Health Record (Section 9).
7. Referral practices, in response to consumer concerns around access and convenience (Section 10).

### 3.4 Summary of the committee's review approach

The Committee completed a review of items in scope across five full Committee meetings and eight working group meetings – supplemented by email correspondence between meetings – to develop the recommendations and rationales contained in this report.

The Committee's review drew on various types of MBS data, including data on utilisation of items (services, benefits, patients, providers and growth rates); service provision (type of provider, geography of service provision); patients (demographics and services per patient); and co-claiming or episodes of services (same-day claiming). The review also drew on data presented in the relevant published literature, all of which is referenced in the report.

#### 3.4.1 Working groups

The Committee formed seven working groups to develop the evidence base and further detail recommendations regarding the following:

1. time-tiered attendances and Telehealth;
2. contemporary roles of medical practitioners;
3. use of data to inform quality care and patient consent;
4. encouraging the use of case conference items;
5. acute attendances;
6. case conference cost-shifting; and
7. fetal alcohol spectrum disorder and other complex neurodevelopmental disorders.

Working group members were selected based on relevant experience and generally included representation of both consumers and clinicians (refer to Appendix C). Each working group met via teleconference to develop draft recommendations. These recommendations were then reviewed and considered by the full Committee at subsequent meetings to reach consensus.

#### 3.4.2 Numbering of proposed items

Where the Committee recommends new items, these are often referred to using letters for ease of reference. If the recommended items are ultimately added to the MBS, the Department of Human Services (DHS) will assign new numbers in the usual format. The Committee is not recommending changes to the MBS numbering system.



## 4 Standard attendance recommendations

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### 4.1 Current standard attendances for consultant specialists

There are 55 MBS items related to standard attendances for consultant specialists. In 2016/17, these items accounted for 24 million services and \$1.6 billion in MBS benefits paid. These include standard attendances from the following Groups in MBS Category 1:

- A3 specialist attendances;
- A4 consultant physician attendances;
- A5 prolonged attendances;
- A12 occupational physician attendances;
- A13 public health physician attendances;
- A24 pain and palliative medicine attendances;
- A26 neurosurgery attendances;
- A31 addiction medicine attendances; and
- A32 sexual health medicine attendances.

Attendance items beyond the scope of the Committee include those for general practice (A1, A2, A15, A18, A22, and A23), obstetrics (T4), anaesthetics (T6), psychiatry (A8), intensive care (T11) and emergency medicine (A21). These items have been reviewed by their respective clinical committees, with both formal and informal consultation and communication occurring between committees where relevant

[See Appendix A.1](#) for a full list of standard attendance items.

### 4.2 Historical context

Many of the items for consultant specialist attendances are long-standing items that have not been reviewed or changed since their introduction in the 1970s. The structure of the items is based on historic roles of specialists and consultant physicians.

Originally, the items were structured to “balance” patient rebate levels between specialists and consultant physicians. Historically, compared to specialists, consultant physicians were deemed to provide more “cognitively complex” attendances and did not conduct as many procedures. The recognition of new specialty groups led to the introduction of new attendance items. In some cases, higher schedule fees were set to address specific issues).

Previous efforts to reform these items, such as the Relative Value Study (RVS) (2), demonstrated the complexity of the task. The RVS conducted extensive analyses in the late 1990s to identify relative value units, practice resources and costs, and suggest appropriate schedule fee levels for individual items. It suggested introducing time-tiered attendance items that would have narrowed the difference in remuneration between specialists and consultant physicians.

#### 4.2.1 The distinction between “specialists” and “consultant physicians”

The MBS and the *Health Insurance Act 1973* makes a distinction between “specialists” and “consultant physicians”. This distinction is based on the traditional roles and training pathways of these groups, with consultant physicians traditionally receiving training through the Royal Australasian College of Physicians (RACP) training pathway, being expected to



perform more “cognitively complex” attendances and performing fewer procedures. By contrast, those groups described as “specialists” receive training through bodies other than the RACP, and traditionally were more procedurally focused. These two broad groups have access to different attendance items (Figure 1).

The following terms are used in this report to distinguish between medical practitioner profiles:

- Specialist: A medical practitioner in a specialty that has access to either A3 specialist attendance items or specialty-specific attendance items.
- Consultant physician: A medical practitioner who is a Fellow of the Royal Australasian College of Physicians (FRACP) and has access to A4 consultant physician items.
- Consultant specialist: An umbrella term for specialists and consultant physicians, used to distinguish from General Practitioners (GPs).

**Table 3: Current specialist and consultant physician access to attendance items**

Specialists with access to A3 items	Consultant Physicians with access to A4 items	Specialists with access to speciality specific attendance items
Anaesthetics	Addiction Medicine	Addiction Medicine
Cardiothoracic Surgery	Cardiology	Anaesthetics
Dermatology	Clinical Genetics	Emergency physicians
Diagnostic Radiology	Clinical Pharmacology	Geriatric Medicine
Diagnostic Ultrasound	Endocrinology	Intensive Care Medicine
Emergency Medicine	Gastroenterology and Hepatology	Obstetrics
General Pathology	General Medicine	Occupational and environmental Medicine
General Surgery	Haematology	Ophthalmology
Gynaecology	Immunology and Allergy	Pain medicine
Immunology	Infectious Diseases	Psychiatry
Intensive Care Medicine	Medical Oncology	Public health Medicine
Medical Oncology	Nephrology	Sexual health Medicine
Microbiology Neurosurgery	Neurology	
Obstetrics and Gynaecology	Nuclear Medicine	
Obstetrics and Gynaecological Ultrasound	Occupational and Environmental Medicine	
Ophthalmology	Respiratory and Sleep Medicine	
Oral and maxillofacial Surgery	Rheumatology	
Orthopaedic Surgery	Neonatal/Perinatal Medicine	
Otolaryngology	Paediatrics (inc. all sub specialities)	
Paediatric Surgery	Palliative Medicine	
Pain medicine	Rehabilitation Medicine	
Pathology		
Plastic and Reconstructive Surgery		
Radiation Oncology		
Reproductive Endocrinology and Infertility		
Sport and Exercise Medicine		
Urogynaecology		
Urology		
Vascular Surgery		



### 4.3 Overview of current standard attendance items

Standard attendance items are defined as either “initial” or “subsequent” attendances with a single provider<sup>3</sup> Initial attendances have schedule fees that are 30 to 50 per cent higher than those for subsequent attendances.

There are parallel items for consultant physicians and specialists (see above for the distinction between professions).

Unique items were created for new specialties that did not exist when the standard attendance items were created, and for specialties that applied to MSAC for access to unique attendance items (most commonly citing longer consultation durations as the rationale for their request). These specialists cannot claim both a standard attendance item and specialty-specific item for the same service.

There are distinct attendance items for certain specialties, including ophthalmology, occupational health, public health, pain medicine, palliative care and neurosurgery. These specialties can also choose to claim via the standard attendance items mentioned above, often with a different schedule fee.

There are also parallel items for attendances that take place either in a consulting room or hospital, or elsewhere.

### 4.4 Issues with current standard attendance items

The distinction between initial and subsequent attendance items does not accurately reflect current clinical practice and there is evidence that they are being inconsistently claimed.

The Committee noted that the distinction between initial and subsequent attendances does not account for cases where a patient’s clinical needs increase in complexity over time. For example, investigations of the patient’s initial problem can lead to a subsequent attendance that requires more time. One result of this issue is the creation of new items for a comprehensive assessment in sexual health medicine and addiction medicine, which can be claimed once in a course of treatment only. These are not restricted to being claimed as an initial consultation in a course of treatment, in recognition that a complex comprehensive assessment may not happen at the first point of contact with the patient.

The Committee noted evidence suggesting inconsistent use of repeat initial attendances. In 2016/17, 229,511 repeat initial attendances occurred between the same patient and provider within nine months of another “initial” attendance. The Committee noted that repeat initial attendances within this timeframe should not commonly occur in clinical practice.

Consumer complaints regarding charges for repeat initial attendances are common and have been referred to the Minister’s Office via the Medical Benefits Division. A sample is provided below:

*“My specialist requires me to get a new referral annually and charges me for an initial consultation fee each time she reviews the same skin cancer... I should be able to go back to the same specialist annually under the original indefinite referral to review the same skin cancer and be charged only for a consultation fee (which is much less than the initial consultation fee). Each year I have to pay for a consultation with my GP for the referral and an initial consultation fee for the specialist.”*

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<sup>3</sup> Items also exist for consultant physicians to claim “minor” subsequent attendances (items 119 and 131).





It can be confusing for both patient and provider.

The distinction between consultant physicians and specialists is increasingly dissociated from modern clinical practice and is unclear to consumers. The distinction is based on a rationale outlined by the 1974 Medicare Tribunal - *“consultant physicians require longer time periods for their consultations. The patients tend to have medical conditions which require study in depth and breadth. By comparison with the specialist group, consultant physicians undertake relatively few procedures and their practice largely consists of time consuming consultations.”*

This distinction has not been updated. Data from modern practice suggest that this distinction is no longer valid for many specialties (Table 5). Changes in technology have resulted in some consultant physicians undertaking many more procedures, as evidenced by the number of new items listed in recent years. For example, transcatheter aortic valve implantation (TAVI), left atrial appendage closure and implantable loop recorder items for cardiologists.

The distinction decreases consumer access to specialists who are highly consultative (i.e. relatively less procedural) and so charge a higher patient contribution (Figure 3). For example, prolonged review consultations for sports and exercise physicians receive a lower schedule fee than consultations with professionals with no specialist medical training (for example, chiropractors).

Standard attendance items have evolved into a complex, disjointed schedule that lacks transparency or clarity for consumers and contains duplicative items for doctors.

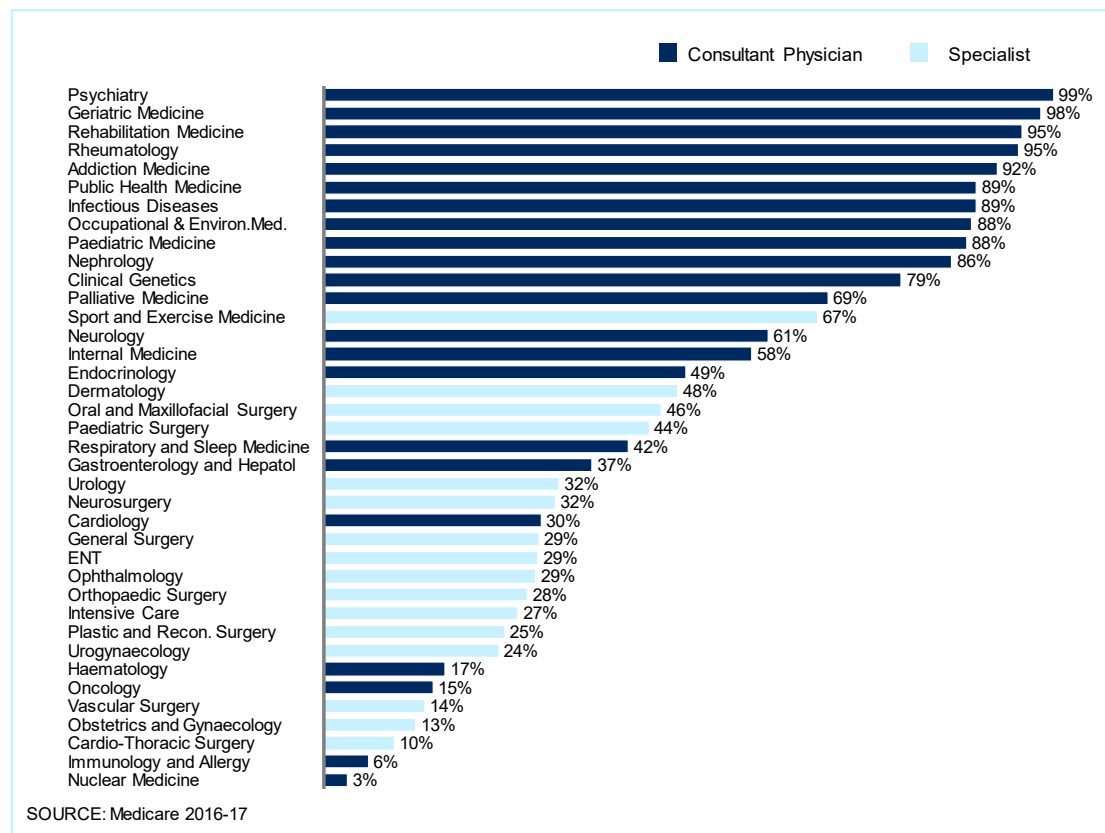
There is a lack of transparency in what consumers are paying for, and there is not a clear rationale to explain to consumers why there are different rebates for services that appear to be the same or similar in nature and value to them (Figure 4).

New items have been generated for certain specialties (for example, pain medicine and palliative medicine attendance items) because legislation prevents specialists from billing Group A4 consultant physician attendance items.

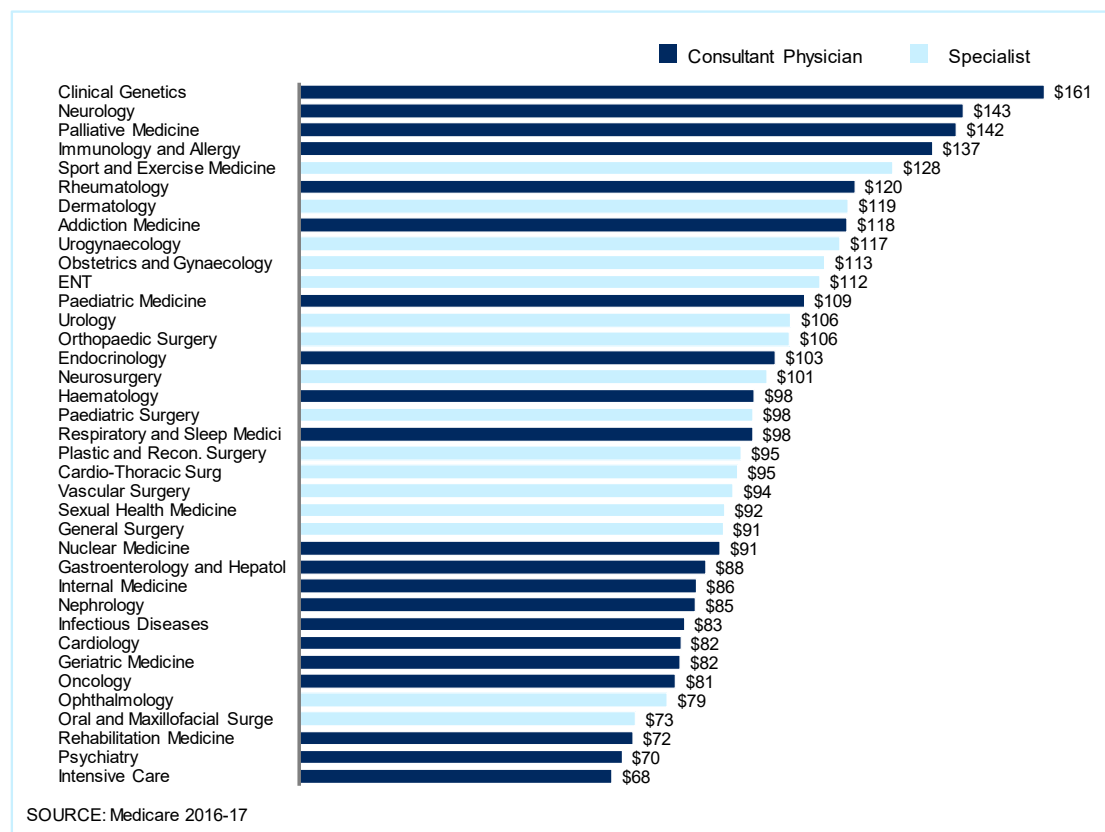
Diagnostics are currently claimed at the same time as attendances, creating a financial incentive to perform more diagnostics as doing so generates additional payment within the same time period.



**Figure 3: Percentage MBS income from standard attendance items, consultant physicians versus specialists (%)**



**Figure 4: Average patient out-of-pocket cost for an initial attendance, consultant physicians versus specialists (\$)**





## 4.5 Guiding principles for standard attendance items in the MBS

To assist the Committee in assessing an improved and best practice approach to standard attendance, the Committee defined the following principles:

1. Attendance schedule fees should be the same per unit of time for all in scope consultant specialists, regardless of specialty.
2. All consultant specialists should have access to the same standard attendance items.
3. Time is a partial indicator for the depth of care delivered in an attendance.
4. Standard attendance item descriptors should reflect both the duration of an attendance and the complexity of that attendance.
5. The complexity of an attendance reflects the specific activities performed and the impact of specific patient interaction factors on the attendance.
6. Total attendance time should be determined based on the amount of time spent by the consultant specialist and should not be delegated to other health professionals.
7. Total attendance time should not include time spent on a procedure or a diagnostic test; these activities should be accounted for separately.
8. Total attendance time should not include non-patient-facing time.
9. The schedule fee structure for attendance items should reflect appropriate clinical practise.
10. The schedule fee structure should implicitly include a set component for non-patient facing time.

The Committee recognises that these principles have the following implications for the structure of standard attendance items in the MBS:

- The removal of the distinction between initial and subsequent attendance items.
- The removal of the distinction between specialists and consultant physicians for standard attendance items.
- The removal of many unique items that have been created for certain consultant specialist groups.

The Committee and the relevant working group/s examined options for standard attendance items. This examination resulted in the recommended framework below. The main alternative option is set out in Section 4.7.1.

## 4.6 Recommendation 1 - Introduce attendance items based on attendance duration and patient complexity factors

The Committee recommends:

- a. introducing time-tiered attendance items to replace most of the current standard attendance items;
- b. removing standard attendance items from Groups A3, A4, A12, A24, A26, A31 and A32;

*Note: See Appendix A.1 for a full list of attendance items that are recommended for removal.*

- c. adding 10 new time-tiered attendance items with the following characteristics (see Table 4):
  - i. item descriptors should specify required attendance time, and standard activities performed (to indicate complexity);



- ii. the duration of the time tiers should be the same as those recommended by the General Practice and Primary Care Clinical Committee (GPPCCC); and
  - iii. parallel items should continue to exist for attendances that occur in a consulting room or hospital, and elsewhere (five items each).
- d. adding explanatory notes for these items that state that:
- i. Specific features of the patient interaction may contribute to the duration of the attendance. This may include communication or comprehension factors that result in more time needed to take a medical history or to take informed consent (e.g., using an interpreter to take a medical history, taking informed consent for an intrusive examination of a child) and mobility factors resulting in more time needed to perform a clinical examination (e.g., the need for an assistant or assistive device to transfer a patient).
  - ii. Non-patient-facing time related to the attendance should not be included in deriving the duration of the attendance as defined in the item descriptors, but is regarded as an integral part of the attendance and should factor in the calculation of the schedule fees.
  - iii. Time spent with other health professionals should not contribute the duration of the attendance.
  - iv. Time spent on a procedure or a diagnostic test should not contribute to the duration of the attendance.
- e. keep Group A5 prolonged attendance items, which have a specific allowance for patients in imminent danger of death (*refer to Recommendation 2*).

**Table 4: Recommended item descriptors for time-tiered attendance items**

Level (item) <sup>1</sup>	Item descriptor	Location	Duration
Level A (XX1A)	Professional attendance of 5 minutes or less by a consultant specialist in the practice of his or her speciality following patient referral for an obvious problem with a straightforward task, including any of the following that are clinically relevant:	Attendance at consulting room or hospital	5 minutes or less
Level A (XX2A)	a) a short patient history and, if required, limited examination and management b) outcomes documented and communicated in writing to the referring practitioner Other than a service to which another Category 1, Group T1, Group T4 or Group T6 professional attendance item applies. Only to be claimed with a Group T8 procedure item: <ul style="list-style-type: none"> <li>I. where the procedure has a schedule fee of less than \$300; or</li> <li>II. where the need for the procedure is identified during the consultation, has not otherwise been scheduled, is performed on the same day as the</li> </ul>	Attendance in a location other than consulting room or hospital	5 minutes or less



Level (item) <sup>1</sup>	Item descriptor	Location	Duration
	attendance, and where the procedure has a schedule fee of \$300 or more.		
Level B (XX1B)	Professional attendance of more than 5 minutes but not more than 20 minutes by a consultant specialist in the practice of his or her speciality following patient referral, including any of the following that are clinically relevant:	Attendance at consulting room or hospital	6–20 minutes
Level B (XX2B)	a) focused patient history and, if required, focused examination and management b) outcomes documented and communicated in writing to the referring practitioner Other than a service to which another Category 1, Group T1, Group T4 or Group T6 professional attendance item applies. Only to be claimed with a Group T8 procedure item: I. where the procedure has a schedule fee of less than \$300; or II. where the need for the procedure is identified during the consultation, has not otherwise been scheduled, is performed on the same day as the attendance, and where the procedure has a schedule fee of \$300 or more.	Attendance in a location other than consulting room or hospital	6–20 minutes
Level C (XX1C)	Professional attendance of more than 20 minutes but not more than 40 minutes by a consultant specialist in the practice of his or her speciality following patient referral, including any of the following that are clinically relevant:	Attendance at consulting room or hospital	21–40 minutes
Level C (XX2C)	a) detailed patient history of a major single or multiple minor conditions b) comprehensive examination of single system OR multi-system focused examination c) single or multiple minor diagnostic problems considered d) a non-complex management plan e) a management plan communicated in writing to the referring practitioner and, if required; f) discussion of multiple treatment options available, including: i. Discussion of treatment options to assess pros and cons of each option given patient characteristics and medical history ii. Consideration and discussion of necessary referrals to other health professionals	Attendance in a location other than consulting room or hospital	21–40 minutes



Level (item) <sup>1</sup>	Item descriptor	Location	Duration
	<p>iii. Written documentation made available for the patient and/or carer that outlines treatment options and information on associated risks and benefits</p> <p>g) outcomes documented and communicated in writing to the referring practitioner</p> <ul style="list-style-type: none"> <li>Other than a service to which another Category 1, Group T1, Group T4 or Group T6 professional attendance item applies.</li> </ul> <p>Only to be claimed with a Group T8 procedure item:</p> <ol style="list-style-type: none"> <li>where the procedure has a schedule fee of less than \$300; or</li> <li>where the need for the procedure is identified during the consultation, has not otherwise been scheduled, is performed on the same day as the attendance, and where the procedure has a schedule fee of \$300 or more.</li> </ol>		
Level D (XX1D)	Professional attendance of more than 40 minutes but not more than 60 minutes by a consultant specialist in the practice of his or her speciality following patient referral, including any of the following that are clinically relevant:	Attendance at consulting room or hospital	41–60 minutes
Level D (XX2D)	<p>a) comprehensive patient history of multiple conditions or a complex single condition</p> <p>b) comprehensive multi-system examination</p> <p>c) multiple diagnostic problems considered</p> <p>d) a comprehensive management plan</p> <p>e) the management plan communicated in writing to the referring practitioner and, if required;</p> <p>f) discussion of multiple treatment options available, including:</p> <ol style="list-style-type: none"> <li>Discussion of treatment options to assess pros and cons of each option given patient characteristics and medical history</li> <li>Consideration and discussion of necessary referrals to other health professionals</li> <li>Written documentation made available for the patient and/or carer that outlines treatment options and information on associated risks and benefits</li> </ol>	Attendance in a location other than consulting room or hospital	41–60 minutes



Level (item) <sup>1</sup>	Item descriptor	Location	Duration
	<p>g) outcomes documented and communicated in writing to the referring practitioner</p> <p>Other than a service to which another Category 1, Group T1, Group T4 or Group T6 professional attendance item applies.</p> <p>Only to be claimed with a Group T8 procedure item:</p> <ol style="list-style-type: none"> <li>I. where the procedure has a schedule fee of less than \$300; or</li> <li>II. where the need for the procedure is identified during the consultation, has not otherwise been scheduled, is performed on the same day as the attendance, and where the procedure has a schedule fee of \$300 or more.</li> </ol>		
Level E (XX1E)	Professional attendance of more than 60 minutes by a consultant specialist in the practice of his or her speciality following patient referral, including any of the following that are clinically relevant:	Attendance at consulting room or hospital	More than 60 minutes
Level E (XX2E)	<p>a) extensive history of multiple complex conditions</p> <p>b) extensive multi-system medical examination</p> <p>c) multiple complex diagnoses considered</p> <p>d) a comprehensive management plan</p> <p>e) the management plan is communicated in writing to the referring practitioner and, if required;</p> <p>f) discussion of multiple treatment options available, including:</p> <ol style="list-style-type: none"> <li>i. Discussion of treatment options to assess pros and cons of each option given patient characteristics and medical history</li> <li>ii. Consideration and discussion of necessary referrals to other health professionals</li> <li>iii. Written documentation made available for the patient and/or carer that outlines treatment options and information on associated risks and benefits</li> </ol> <p>g) outcomes documented and communicated in writing to the referring practitioner</p> <p>Other than a service to which another Category 1, Group T1, Group T4 or Group T6 professional attendance item applies.</p>	Attendance in a location other than consulting room or hospital	More than 60 minutes



Level (item) <sup>1</sup>	Item descriptor	Location	Duration
	<p>Only to be claimed with a Group T8 procedure item:</p> <ul style="list-style-type: none"> <li>I. where the procedure has a schedule fee of less than \$300; or</li> <li>II. where the need for the procedure is identified during the consultation, has not otherwise been scheduled, is performed on the same day as the attendance, and where the procedure has a schedule fee of \$300 or more.</li> </ul>		

## 4.7 Rationale 1

This recommendation focuses on introducing a standard attendance model that is simple, is more equitable, and enables more consistent billing for similar services. It is based on the following:

- The Committee recommends basing attendance schedule fees on time, as the duration of the face-to-face encounter with the patient is indicative of the total amount of work and promotes a more appropriate balance of procedural and consultative work. Time-tiering will enable a simple structure for attendance items that enables more consistent rebates for patients for the same services, transparency for consumers, and clarity on informed financial consent.
- The Committee recommends using time tiers that align with those put forward by the GPPCCC to enable consistency of care for those accessing MBS attendance items. There is consensus within the Committee that these tiers are simple and useable within standard clinical practice, while accommodating the distinct activities of differing complexity levels.
- The Committee has set a duration length of 5 minutes or less as the Committee considers there are attendances that can be completed in this time frame. The Committee also noted that this would not exclude a person understanding the time brackets and asking for the full period of time if a clinician is rushing away or requesting to finish an attendance that they may be aware is drifting into a higher tier.
- In addition, the introduction of time-tiered attendance items aims to:
  - Reflect the work effort required for each attendance item. Evidence suggests that the duration of face-to-face patient attendances is indicative of the total amount of work performed in that attendance.

An Australian study that examined 101,112 GP consultations and the relationship between consultation length, content and GP choice of attendance item demonstrated that GPs use both time and content when choosing item number, rather than relying only on specified time thresholds (3). The study found that the difference in consultation length between Level B and Level C attendances was somewhat marginal, but that GPs were using both time and content appropriately when choosing attendance item numbers.

- Enable consistent, high-quality care by specifying both the attendance duration required and recommended activities for each attendance item.





- Encourage an approach to care that emphasises shared decision-making, including discussion of available treatment options and pathways, costs, likely outcomes and informed consent.
- Incorporate attendance items created for exceptional circumstances—often because the duration of the attendance is longer than for other specialties—into one simplified structure.
- Simplify the attendance item schedule to enable more consistent billing to patients and more equitable MBS reimbursements to patients for the services of consultant specialists.
- Improve access to specialists who are highly consultative but whose patients can currently only access A3 specialist attendance items (for example, sports and exercise medicine, dermatology).
- Reduce the incentive to inconsistently itemise initial attendances by providing rebates to patients of physicians for longer attendances and discussion of available treatment options.
- For example, the Urology Clinical Committee has identified the benefits of longer consultations for patients with prostate cancer to give a full explanation of the treatment options available.
- The Committee recommends keeping prolonged attendance items unchanged (Group A5, items 160-164) as these items are for attendances from one to five hours (longer than the recommended time tiers) and are for specific clinical scenarios.
- The Committee recognises that schedule fees for attendance items take non-patient-facing time into account. This may include making notes, accessing results or contacting peers.
- The methodology for calculating schedule fees is outside the scope of the Committee.
- Non-patient-facing time should not contribute to the duration of the attendance. However, non-patient facing time should be implicitly included in the calculation of schedule fees for attendance items. The Committee notes that this does not account for differences in non-patient-facing time between specialties, and that clinicians do not always explain or discuss with consumers the need for, or cost of, the non-patient-facing component of attendances.

#### 4.7.1 Alternative options to time-tiering

The Committee considered introducing three levels of attendance items, based on the proportion of MBS income derived from attendance items (with Level 1 receiving the lowest schedule fee):

- Level 1: Less than 40 per cent of income derived from attendances.
- Level 2: Between 40 and 65 per cent of income derived from attendances.
- Level 3: More than 65 per cent of income derived from attendances.

The Committee did not endorse this approach for the following reasons:

- Specialist groups would need to be categorised based on MBS income derived from attendance items at a single point in time, meaning that future changes in clinical practice would not be reflected in the model.
- There are large sub-specialty differences in use of attendance items and this approach would not accurately reflect the distinct and variable differences across sub-specialties.



- Such a system is not clear or defensible to consumers, to whom MBS payments are made.

#### 4.8 Recommendation 2 – Introduce new attendance items for acute, urgent and unplanned attendances

The Committee recommends:

- creating four new time-tiered attendance items for acute, urgent, and unplanned attendances;
- specifying that these items are only to be used in specific situations where the attendance is acute, urgent, unplanned, and does not take place in the consultant specialist's consulting rooms or in the emergency department of a public hospital;
- specifying that the duration of these time tiers should be the same as Levels B, C, D, and E used for standard attendance items (*refer to Recommendation 1*);
- a schedule fee for these items that is higher than the schedule fee for standard time-tiered attendances of equivalent duration; and
- that these items should be restricted from being claimed alongside prolonged attendance items 160-164 where the patient is in imminent danger of death.

**Table 5: Acute attendance item descriptors**

Item	Duration	Item descriptor
XY1	5-20 minutes	Professional attendance of more than [X] minutes but not more than [X] minutes by a consultant specialist that is acute, urgent, unplanned, and does not take place in consulting rooms or in the emergency department of a public hospital, and where the patient is: <ol style="list-style-type: none"> <li>at risk of serious morbidity or mortality requiring urgent assessment and resuscitation; or</li> <li>suffering from suspected acute organ or system failure; or</li> <li>suffering from an illness or injury where the viability or function of a body part or organ is acutely threatened; or</li> <li>suffering from a potentially life-threatening complication of an infection (i.e., sepsis)</li> <li>suffering from a drug overdose, toxic substance or toxin effect; or</li> <li>experiencing severe psychiatric disturbance whereby the health of the patient or other people is at immediate risk; or</li> <li>suffering acute severe pain where the viability or function of a body part or organ is suspected to be acutely threatened; or</li> <li>suffering acute significant haemorrhage requiring urgent assessment and treatment</li> </ol> Not to be claimed with prolonged attendance items 160, 161, 162, 163, or 164
XY2	21-40 minutes	
XY3	41-60 minutes	
XY4	More than 60 minutes	

#### 4.9 Rationale 2

This recommendation focuses on reimbursing acute, urgent, and unplanned attendances through the introduction of new attendance items. It is based on the following:

- The Committee notes that acute attendances are different to other standard attendances, in that they:



- are acute, urgent, and unplanned in nature and may result in a consultant specialist postponing or cancelling a previously scheduled procedural list, theatre list or attendances in consulting rooms; and
- often involve multiple face-to-face patient interactions, as well as conversations with multiple other medical professionals (for example, locating results of investigations ordered at the initial touchpoint with the patient) and liaising with carers to access patient information.
- The Committee therefore recommends a schedule fee for these items that is higher than the schedule fee for standard time-tiered attendances of equivalent duration.
- The Committee has attempted to be as comprehensive as possible in drafting a list of clinical scenarios for appropriate use of these items to prevent potential misuse.

#### 4.10 Recommendation 3 - Further considerations when implementing time-tiering

The Committee recommends the Government works closely with peak organisations, clinicians and consumers to refine the detail of implementation, and ensure an effective and sustainable transition. In particular, the following should be considered when moving towards implementation:

- a. collecting data on the duration of attendances across specialties, and the activities performed during these attendances, similar to the data previously collected from GPs through the *Bettering the Evaluation and Care of Health* program (BEACH data);
- b. using the data to accurately model the impact of time-tiering on service volume and benefits;
- c. investing in change management to facilitate the transition to the new items and build understanding of the benefits of the time-tiering model;
- d. making the model clear to provide transparency and consistency for clinicians and consumers;
- e. adding a longer time tier (i.e. Level F) should the need be identified. If introduced, this should accompany an estimate of services claimed through this tier;
- f. ensuring early, active, and regular reviews of attendance items post implementation of time-tiering, including:
  - i. potential impact on out-of-pocket patient costs;
  - ii. potential impact on patient waiting lists, either as a result of longer attendances being performed or as a result of consultant specialists accepting fewer new patients/referrals;
  - iii. potential uncertainty for consumers on the cost of a consultation and ensuring there is robust informed financial consent; and
  - iv. patient-reported experience and outcomes.
- g. making the item descriptors sufficiently detailed to enable auditing through the review of clinical notes, allowing verification that activities of sufficient complexity were performed, as stated in the descriptors;



- h. harmonising all attendance time tiers in the MBS that apply to other consultant specialists (including psychiatry, obstetrics, anaesthesia, intensive care, general practice and emergency medicine); and
- i. setting time-tiers that have the most common attendance times near the middle of each tier, to support fair and reasonable practice.

#### 4.11 Recommendation 4 – Approach to fee setting

The Committee recommends consideration of the following with regard to schedule fees (recognising that fee-setting is out of the Committee's scope):

- a. building support among peak bodies, clinicians and consumers for the principles of time-tiering before introducing schedule fees;
- b. ensuring a linear relationship between attendance time tiers and schedule fees from the outset;
- c. ensuring non-patient facing time is factored into the new fee structure and ensuring that this fact is well communicated; and
- d. recognising that there is a lack of data on the current duration of consultant specialist attendance times and the activities performed in these attendances.

#### 4.12 Rationale 4

This recommendation focuses on assisting the fee setting process to set appropriate fees. It is based on the following:

- The Committee agreed that it was going to be necessary to work closely with providers and consumers in order to achieve effective and sustainable outcomes.
- The Committee recognises that there is no single “optimum attendance time”, given the wide variation that exists both between and within specialties. Attempting to structure schedule fees to incentivise an optimum attendance time is not recommended.
- The Committee notes that significant non-patient-facing time is spent on each attendance, for example, reviewing results prior to seeing patients, writing to the referring doctor, writing management plans.
- The Provider Benefits Integrity Division (PBID) has explained to the Committee that non-patient-facing time is included in the calculation of schedule fees for MBS items, and has recommended that non-patient-facing time is not specified in item descriptors, as this is difficult to audit, and again will vary across different specialist groups.
- The Committee notes that there is a lack of data on the current duration of consultant specialist attendance times and the activities performed in these attendances. This lack of data reduces the ability to accurately set time tiers and schedule fees, and to predict the impact of these recommendations on individual specialties.

#### 4.13 Recommendation 5 – Impact of time-tiering on distant outreach services

The Committee recommends that to address the potential concerns of time-tiering on distant outreach services the following steps will need to be considered:

1. Data will need to be collected on this practice, if possible from MBS data or other sources;
2. If such a problem does exist, a non MBS process will need to be developed to address the issue;



3. Any such process should continue to support patient access to local services where needed; and
4. A community need must be demonstrated in order to justify a non-MBS solution.

#### 4.14 Rationale 5

It has been argued that the viability of some outreach services will suffer if time-tiering replaces fee for service, in so doing removing local access to essential services from patients in rural and remote regions. The existing disparity in rebate of initial vs subsequent consultations may have led to remunerative structures that have a significant dependence on initial consultations to maintain viability

It is accepted that in some rural, regional and remote areas, there is not a critical population mass (or infrastructure) to attract or retain some consultant specialists by relying on the MBS alone. From a strategic perspective it is intended that all Australians have timely and appropriate access to high quality medical and surgical services as needed. This can be best achieved by the development of local service models that may require both MBS and non MBS support.



## 5 Complex plan recommendations

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### 5.1 The complex plan context

The MBS has eight items related to the development of complex plans.<sup>4</sup> These items accounted for 1.7 million services and \$318 million in benefits in 2016/17. The majority of complex plan benefits and services relate to consultant physician items 132 and 133 (93% of benefits, 96% of services).

Complex plan items specify the assessment, diagnosis and development of a comprehensive patient management plan and enable the referring clinician and the patient to better manage everyday health care. The items cover:

- Consultant physician complex plan (items 132 and 133) - attendances of at least 45 minutes and 20 minutes, respectively, for the creation and review of a complex plan.
- Paediatric complex plan (items 135 and 137) - attendances of at least 45 minutes for a child aged under 13 years with autism or another pervasive developmental disorder (item 135) or an eligible disability (item 137).

These items enable assessment of the need and eligibility for a package of allied health professional services including four allied health assessment services and 20 allied health treatment services per eligible child.

- Geriatric complex plan (items 141, 143, 145 and 147) - attendances of more than 60 minutes and 30 minutes, respectively, for the creation and review of a complex plan (two items each for attendances at consulting rooms/hospital or elsewhere).
- Addiction medicine complex plan (items 6023 and 6024) - attendances of at least 45 minutes and 20 minutes, respectively, for the creation and review of a complex plan.
- Sexual health medicine complex plan (items 6057 and 6058) - attendances of at least 45 minutes and 20 minutes, respectively, for the creation and review of a complex plan.

### 5.2 Recommendation 6 - Removing consultant physician, addiction medicine, and sexual health medicine complex plan items

The Committee recommends removing consultant physician, addiction medicine, and sexual health medicine complex plan items from the MBS (items 132, 133, 6023, 6024, 6057, and 6058).

### 5.3 Rationale 6

This recommendation focuses on incorporating the creation of complex plans into standard time-tiered attendances for the following reasons:

- Item 132 was introduced to the MBS in 2007 with the intention of supporting patients with chronic and complex conditions through the creation of a comprehensive management plan by consultant specialists that would enable ongoing management by the referring practitioner (usually the patient's GP).
- In the past five years, there has been rapid growth in use of item 132 (12 per cent compound annual growth rate). Evidence suggests that the item is not being used for the development of a management plan for use by the referring practitioner. While in

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<sup>4</sup> See item level data in Appendix A.2.



2016-17, 41 per cent of patients who received a complex plan did not visit the referring practitioner in the following six months<sup>5</sup>. Feedback received during consultation queried the proportion of consumers that receive treatment from the consultant specialist rather than the GP. In 2017-18, 26 per cent of patients did not visit either the GP or the consultant specialist within six months of receiving a complex plan<sup>7</sup>.

- The Committee considered the option of keeping these items in the MBS with new claiming restrictions (stipulating that it must be requested by the referring practitioner and not initiated by the consultant specialist) and with a recommended schedule fee set relative to one of the longer standard time-tiered attendance items. However, no strong rationale was brought forward as to why these items represented a unique, discrete service that could not be performed under the new time-tiered items.
- The Committee also notes that 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 specialist should build upon a consumer's General Practice Management Plan (where one is in place) and relate directly to the patient's goals.

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<sup>5</sup> Medicare data 2016-17

<sup>7</sup> Medicare data 2017-18



## 5.4 Recommendation 7 - Retain access to paediatric complex plan items with strengthened descriptor

The Committee recommends:

- a. item 289 to be referred to the Psychiatry Clinical Committee;
- b. amend item 135 descriptor for paediatric complex plan (changes in bold) to:

### Item 135

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

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

(other than attendance on a patient for whom payment has previously been made under this item or item 137, 139 or 289)"

- c. amend the explanatory notes to include the following:





### Explanatory Note – Item 135

The item is intended for the initial assessment of patients where by the complexity of the condition is characterised by severe multi-domain cognitive and functional disabilities, delay or impairment”

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

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

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

- a. Stand-alone diagnosis of Attention Deficit Hyperactivity Disorder without other severe neurodevelopmental co-morbidities or co-existing multi-domain disabilities.

- d. that expert bodies are consulted to agree on an appropriate definition of complexity and severity, and which domains of cognitive and functional impairment should be considered.
- e. that the inequity of patient rebates for paediatric complex plans and geriatric complex plans be addressed over time.

## 5.5 Rationale 7

The Committee supports the retention of item 135 given the paediatric complex plan is for a specific patient population groups and are linked to associated allied health professional (AHP) services.

The proposed amendments to the item descriptor and explanatory notes focus on allowing appropriate access to paediatric complex plan items and their associated AHP services for eligible patients, including children with fetal alcohol spectrum disorder (FASD) and other complex neurodevelopmental disorders. It is based on the following:

- The Committee considered a policy paper put forward by the Department on the most appropriate use of MBS items to fund services for FASD. This included input from external stakeholders, including the Royal Australasian College of Physicians (RACP), the Royal Australian and New Zealand College of Psychiatrists (RANZCP), the Australian and New Zealand Association of Paediatric Surgeons (ANZAPS), the Neurodevelopmental



and Behavioural Paediatric Society of Australasia (NBPSA), the Department of Social Services (DSS) and the National Disability Insurance Agency (NDIA).

- A number of approaches were put forward by these stakeholders, including the following:
  - Allow services for FASD to be claimed under existing MBS items.
  - Recognise that existing items use outdated terminology (the term pervasive developmental disorder, or PDD) and update these in line with contemporary clinical practice.
  - Add a new MBS item for FASD as the population is different to what the current items cover.
- Members from the Committee and the Psychiatry Clinical Committee discussed this topic and decided to implement the second approach, updating the terminology in items 135 and 289 so that FASD and other complex neurodevelopmental disorders can be claimed under these items and including the intended specific conditions in the explanatory notes. This option was chosen because it presents an opportunity for outdated terminology to be updated, and for both paediatricians and psychiatrists to have access to MBS items for FASD and other complex neurodevelopmental disorders.
- The Committee agrees that the item is intended to relate to any neurodevelopmental disorders, as defined by severity and complexity rather than by diagnostic labels. The Committee recognises that there are conditions and situations where this item is not appropriate, such as for standalone Attention Deficit Hyperactivity Disorder with no other complex or severe neurodevelopmental co-morbidities where standard consultation assessments are more appropriate.
- The Committee agrees that the requirement to confirm a diagnosis at the initial assessment should be changed to “for the purposes of diagnosis”, as a definitive diagnosis may only be confirmed in subsequent attendances and after all relevant multidisciplinary diagnostic assessments are completed.

## 5.6 Recommendation 8 – Retain the comprehensive geriatric assessment items

The Committee recommends retaining items 141, 143, 145 and 147 and not including under time-tiering.

### 5.7 Rationale 8

The Committee noted the feedback received on the draft report, which originally proposed folding all of the geriatric MBS items into time-tiering. In particular, the Committee noted there are a number of unique, specific requirements for a comprehensive assessment and management plan. These include diagnosis, identification of problems, goal setting and forming a comprehensive management plan for holistic treatment, rehabilitation, support and long-term follow-up. The Committee agreed to retain these items in the MBS to ensure that older Australians can continue to access this high-value care.

The Committee also recommends that the inequity of patient rebates for paediatric complex plans and geriatric complex plans be addressed over time.



## 6 Telehealth recommendations

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### 6.1 Current telehealth framework

The MBS has 17 telehealth attendance items with 67,000 services provided in conjunction with an existing consultation item in FY2016/17.<sup>6</sup> These items include:

- Nine telehealth loading items valued at 50 per cent of the schedule fee for the attendance item with which they are co-claimed, accounting for more than 98 per cent of telehealth service volume and spend.
- Eight items for telehealth attendances under 10 minutes,<sup>7</sup> accounting for just 159 services in 2016/17.

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

There are currently two applications of telehealth in Australia:

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

### 6.2 Benefits of telehealth

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

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

### 6.3 Barriers to telehealth growth

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

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<sup>6</sup> See item-level data for all telehealth attendances in Appendix - A.3.

<sup>7</sup> One item each for specialists, consultant physicians, occupational medicine, pain medicine, palliative care, neurosurgery, addiction medicine and sexual health medicine.



- Patients may not have access to information about when to request telehealth, how to access it, and a clear understanding of its benefits.
- GPs may not be aware of the patient population groups that would benefit most from telehealth, when to recommend it to these patients, and how to integrate it into their practice. Likewise, consumers may be unaware this service option is available.
- Primary care workers may not be aware of existing MBS items for providing clinical support to a patient who is participating in a telehealth attendance.
- Clinicians may be unwilling to change their clinical practice to adopt telehealth and may not be convinced of its effectiveness (4). There may be a lack of understanding of the functionality and security of telehealth.

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

## 6.4 Recommendation 9 – A new framework for telehealth

### Taskforce Note

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

The Committee recommends:

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

**Table 6: Telehealth attendance item descriptors**

Level (item) <sup>8</sup>	Duration	Item descriptor
Level B (THB)	6-20 minutes	Professional attendance of more than 5 minutes but not more than 20 minutes by a consultant specialist in the practice of his or her speciality if: <ol style="list-style-type: none"> <li>the attendance is by video conference; and</li> <li>the patient is not an admitted patient; and</li> <li>the patient:</li> </ol>

<sup>8</sup> Item numbers listed here indicate a structure for the DHS to follow when assigning item numbers.



Level (item) <sup>8</sup>	Duration	Item descriptor
		<ul style="list-style-type: none"> <li>i. is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance--at least 15 km by road from the consultant specialist; or</li> <li>ii. is a care recipient in a residential care service; or</li> <li>iii. is a patient of: (a) an Aboriginal Medical Service; or (b) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the act applies.</li> </ul> <p>An attendance including any of the following that are clinically relevant:</p> <ul style="list-style-type: none"> <li>a) a focused patient history</li> <li>b) implementing a management plan</li> <li>c) outcomes documented and communicated in writing to the referring practitioner</li> </ul>
Level C (THC)	21-40 minutes	<p>Professional attendance of more than 20 minutes but not more than 40 minutes by a consultant specialist in the practice of his or her speciality if:</p> <ul style="list-style-type: none"> <li>a) the attendance is by video conference; and</li> <li>b) the patient is not an admitted patient; and</li> <li>c) the patient: <ul style="list-style-type: none"> <li>i. is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance--at least 15 km by road from the consultant specialist; or</li> <li>ii. is a care recipient in a residential care service; or</li> <li>iii. is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19(2) of the act applies.</li> </ul> </li> </ul> <p>An attendance including any of the following that are clinically relevant:</p> <ul style="list-style-type: none"> <li>a) detailed patient history of a major single or multiple minor conditions</li> <li>b) single or multiple minor diagnostic problems considered</li> <li>c) a non-complex management plan and, if required;</li> <li>d) discussion of multiple treatment options available, including;</li> <li>i. Discussion of treatment options to assess pros and cons of each option given patient characteristics and medical history</li> <li>ii. Consideration and discussion of necessary referrals to other health professionals</li> <li>iii. Written documentation made available for the patient and/or carer that facilitates informed consent, such as treatment options, costs, and information on associated risks and benefits</li> <li>e) outcomes documented and communicated in writing to the referring practitioner</li> </ul>
Level D (THD)	41-60 minutes	<p>Professional attendance of more than 40 minutes but not more than 60 minutes by a consultant specialist in the practice of his or her speciality if:</p> <ul style="list-style-type: none"> <li>d) the attendance is by video conference; and</li> <li>e) the patient is not an admitted patient; and</li> <li>f) the patient: <ul style="list-style-type: none"> <li>i. is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance--at least 15 km by road from the consultant specialist; or</li> <li>ii. is a care recipient in a residential care service; or</li> </ul> </li> </ul>



Level (item) <sup>8</sup>	Duration	Item descriptor
		<p>iii. is a patient of: (a) an Aboriginal Medical Service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19(2) of the act applies.</p> <p>An attendance including any of the following that are clinically relevant:</p> <ul style="list-style-type: none"> <li>a) comprehensive patient history of multiple conditions or a complex single condition</li> <li>b) multiple diagnostic problems considered</li> <li>c) a comprehensive management plan and, if required;</li> <li>d) discussion of multiple treatment options available, including;</li> </ul> <p>i. Discussion of treatment options to assess pros and cons of each option given patient characteristics and medical history</p> <p>ii. Consideration and discussion of necessary referrals to other health professionals</p> <p>iii. Written documentation made available for the patient and/or carer that outlines treatment options and information on associated risks and benefits</p> <p>Outcomes documented and communicated in writing to the referring practitioner</p>
Level E (THE)	More than 60 minutes	<p>Professional attendance of more than 60 minutes by a consultant specialist in the practice of his or her speciality if:</p> <ul style="list-style-type: none"> <li>a) the attendance is by video conference; and</li> <li>b) the patient is not an admitted patient; and</li> <li>c) the patient: <ul style="list-style-type: none"> <li>i. is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance--at least 15 km by road from consultant specialist; or</li> <li>ii. is a care recipient in a residential care service; or</li> <li>iii. is a patient of: (a) an Aboriginal Medical Service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19(2) of the act applies.</li> </ul> </li> </ul> <p>An attendance including any of the following that are clinically relevant:</p> <ul style="list-style-type: none"> <li>a) extensive history of multiple complex conditions</li> <li>b) multiple complex diagnoses considered</li> <li>c) a comprehensive management plan and, if required;</li> <li>d) discussion of multiple treatment options available, including;</li> </ul> <p>i. Discussion of treatment options to assess pros and cons of each option given patient characteristics and medical history</p> <p>ii. Consideration and discussion of necessary referrals to other health professionals</p> <p>iii. Written documentation made available for the patient and/or carer that outlines treatment options and information on associated risks and benefits</p> <ul style="list-style-type: none"> <li>e) Outcomes documented and communicated in writing to the referring practitioner</li> </ul>



## 6.5 Recommendation 10 – Reinvest in telehealth

### Taskforce Note

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

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

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







## 6.6 Rationale 9 & 10

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

- Telehealth is already a cost-effective way of delivering care. A number of systematic reviews have found that telehealth is a cost-effective way of delivering care, and follow-up via telehealth has been shown to have lower associated costs than in-person clinic assessment (4) (5). A study by Marsh et al (6). in 2014 showed that patients followed up after hip surgery via telehealth travelled less (28km versus 104km) and had lower associated costs (\$10 versus \$21), and that attendances took less total time to complete (122 minutes versus 229 minutes).
- The Committee also noted that many countries and health services, including Finland (7), British Columbia and the UK (8), have built successful telehealth services without providing any financial incentive to physicians (Figure 5).

**Figure 5: How are telehealth attendances reimbursed in other geographies?**

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

- Telehealth loading is not the optimal mechanism to incentivise physician uptake. In Australia, growth in utilisation of telehealth for consultations has slowed significantly since the introduction of the loading items in 2011<sup>9</sup>, indicating that they are not incentivising appropriate provider uptake of telehealth. Physicians cite a lack of acceptance of telehealth as the main barrier to uptake.<sup>10</sup>

<sup>9</sup> MBS data 2011/12 to 2016/17

<sup>10</sup> Wade et al. (2014) conducted a qualitative study of 36 Australian telehealth services and concluded that physician acceptance of telehealth was the main driver of low uptake.





- Consumers lack awareness of telehealth services. Bradford et al. (9) conducted a study in rural Queensland in 2015 which showed that 60 per cent of participants were aware of telehealth, but only 13 per cent had used telehealth services. The authors observed that trust is required for telehealth to be an acceptable application for patients, and concluded that greater public awareness and understanding of the potential benefits of telehealth was needed.



## 7 Case conference recommendations

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### 7.1 Current case conferencing framework

The MBS has 55 case conference items. These items accounted for over 350,000 services and almost \$22 million in benefits in 2016/17. The items can be categorised as follows:

- Six consultant physician community case conference items, with durations of 15 to 30 minutes, 30 to 45 minutes and at least 45 minutes, as well as separate items for organisers and participants.
- Six consultant physician discharge case conference items, with durations of 15 to 30 minutes, 30 to 45 minutes and at least 45 minutes, as well as separate items for organisers and participants.
- Two specialist/consultant physician case conference items for patients with cancer, with separate items for organisers and participants.
- Twelve pain medicine case conference items, with durations of 15 to 30 minutes, 30 to 45 minutes and at least 45 minutes, as well as separate items for discharge and community conferences, and for organisers and participants.
- Twelve palliative medicine case conference items, with durations of 15 to 30 minutes, 30 to 45 minutes and at least 45 minutes, as well as separate items for discharge and community conferences, and for organisers and participants.
- One geriatric and rehabilitation medicine case conference item to coordinate a case conference of at least 10 minutes but less than 30 minutes.
- Eight addiction medicine community case conference items, with durations of less than 15 minutes, 15 to 30 minutes, 30 to 45 minutes and at least 45 minutes, as well as separate items for organisers and participants.
- Eight sexual health medicine community case conference items, with durations of less than 15 minutes, 15 to 30 minutes, 30 to 45 minutes and at least 45 minutes, as well as separate items for organisers and participants.

Specific case conference items exist for pain medicine, palliative medicine, addiction medicine and sexual health medicine.

The current system is highly complex and can be difficult to navigate for providers and patients.

### 7.2 Recommendation 11 - Introduce a new framework of case conference items and allow access to all consultant specialists

The Committee recommends:

- a. introducing a new simplified framework of case conference items, featuring three types:
  - i. discharge planning case conferences - a case conference to facilitate better post-discharge care and communication;
  - ii. community case conferences - a case conference to facilitate the provision of better multidisciplinary care; and



- iii. treatment planning case conferences (new) - a case conference that explores and analyses potential treatment options and their respective benefits.
- b. restructuring current case conference items, by:
  - i. Replacing “Cancer planning” conferences with “treatment planning” conferences; broadening use of these items to other conditions that require treatment planning with other members of the treatment team but are not cancer diagnoses.
  - ii. Removing specialty-specific case conference items - with the exception of item 880 for geriatrics and rehabilitation medicine – with consultant specialists instead accessing the three case conference categories listed above.
- c. updating existing discharge and community case conference items (items 820, 822, 823, 825, 826 and 828, and items 830, 832, 834, 835, 837 and 838) descriptors to:
  - i. Allow all consultant specialists to claim these items.
  - ii. Require:
    - 1. mandatory GP (or delegate) participation;
    - OR*
    - 2. mandatory review of outcomes and communication of any proposed changes to the patient and to the case conference organiser.
  - iii. Require mandatory invitation of the patient (or delegate) to participate. Their attendance should be made possible if the patient chooses to do so.
  - iv. Require outcomes to be documented in writing, including agreed, shared decisions and informed consent.
  - v. Stipulate that participants have the option to attend face to face, by videoconference, or over the telephone.
  - vi. Recommend that outcomes be uploaded to My Health Record by the GP (or delegate).
- d. update explanatory notes to:
  - i. include that the GP may not always be the clinician who is the primary care provider for the patient (e.g. complex paediatric patients are sometimes managed by a general or community paediatrician) and that in such cases, there should be mandatory participation of the patient’s primary care provider; and
  - ii. clarify that GP participation or review of outcomes should not be a pre-requisite for the item being claimed by other participants
- e. introduce six new treatment planning case conference items to discuss available treatment options with other members of the treatment team to:
  - i. Require the organiser to send pre-briefing material to participants prior to the conference, and to prepare a written document for the conference that outlines treatment options.



- ii. Encourage GP participation (either face to face, over the phone or by videoconference).
- iii. Stipulate that while final treatment decisions must be made by/with the patient (unless there are exceptional circumstances), patient participation in initial treatment option discussion is not mandatory.
- iv. Recommend that outcomes be uploaded to My Health Record, with the responsibility for uploading resting with the case conference organiser (*refer to Recommendation 18*).
- f. maintain the current distinction between organiser/coordinator and provider participant roles;
- g. introduce a new time tier for less than 15 minutes for each of the three categories; and
- h. stipulate a minimum of 3 attendees of different disciplines at each case conference, which can include consultant specialists, GPs, AHPs, and nurse practitioners (*refer to Recommendation 12*) but should not include patients or carers.

To assist in interpreting this recommendation the Committee has provided new item descriptors in Table 7.

**Table 7: Case conference item descriptors**

Item	Duration	Role	New item descriptor	
82X (new)	<15 minutes	Organise and coordinate	<p>Attendance by a consultant specialist in the practice of his or her specialty to [insert role] a community case conference of at least [X] minutes but less than [X] minutes, requiring:</p> <ul style="list-style-type: none"><li>a) Specialist input to the management of a complex patient in the community; and</li><li>b) Mandatory GP (or delegate) invitation and i) participation, or ii) review of outcomes and communication of any proposed changes to the patient and to the case conference organiser; and</li><li>c) Mandatory patient (or delegate) invitation and to make it possible for them to attend; and</li><li>d) At least two other formal care providers of different disciplines to be present; and</li><li>e) Outcomes to be documented in writing, including shared decisions made and informed consent sought; and</li><li>f) A copy of the case conference outcomes to be uploaded to My Health Record, unless patient consent is withdrawn, and where reasonably achievable.</li></ul> <p>All participants must be in communication with each other throughout the conference, either face-to-face, by telephone or by videoconference, or a combination of these</p>	
820	15–30 minutes			
822	30–45 minutes			
823	> 45 minutes			
82Y (new)	<15 minutes	Participate		
825	15–30 minutes			
826	30–45 minutes			
828	>45 minutes			
83X (new)	<15 minutes	Organise and coordinate		<p>Attendance by a consultant specialist in the practice of his or her specialty to [insert role] a discharge case conference of at least [X] minutes but less than [X] minutes, requiring:</p>
830	15–30 minutes			
832	30–45 minutes			



Item	Duration	Role	New item descriptor
834	> 45 minutes	Participate	<ul style="list-style-type: none"> <li>a) The development and approval of a discharge management plan for transfer of care to the community setting and self-management; and</li> <li>b) Mandatory GP (or delegate) invitation and i) participation, or ii) review of outcomes and communication of any proposed changes to the patient and to the case conference organiser; and</li> <li>c) Mandatory patient (or delegate) invitation and to make it possible for them to attend; and</li> <li>d) At least two other formal care providers of different disciplines; and</li> <li>e) Outcomes to be documented in writing, including shared decisions made and informed consent sought; and</li> <li>f) A copy of the case conference outcomes to be uploaded to My Health Record, unless patient consent is withdrawn, and where reasonably achievable.</li> </ul> <p>All participants must be in communication with each other throughout the conference, either face-to-face, by telephone or by videoconference, or a combination of these</p>
83Y (new)	<15 minutes		
835	15–30 minutes		
837	30–45 minutes		
838	More than 45 minutes		
8TA (new)	<15 minutes	Organise and coordinate	<p>Attendance by a consultant specialist in the practice of his or her specialty to [insert role] a treatment planning case conference of at least [X] minutes but less than [X] minutes, requiring:</p> <ul style="list-style-type: none"> <li>a) Discussion of treatment options, including risks and benefits, for patients who have been diagnosed but not yet received treatment, or where a significant change in ongoing treatment requires MDT input; and</li> <li>b) Written pre-brief materials to be sent prior to the conference that outlines available treatment options; and</li> <li>c) Final treatment decisions to be made together with the patient (unless there are exceptional circumstances); and</li> <li>d) At least 2 other formal care providers of different disciplines to be present; and</li> <li>e) Outcomes to be documented in writing, including shared decisions made and informed consent sought; and</li> <li>f) A copy of the case conference outcomes to be uploaded to My Health Record, unless patient consent is withdrawn, and where reasonably achievable.</li> </ul> <p>All participants must be in communication with each other throughout the conference, either face-to-face, by telephone or by videoconference, or a combination of these</p>
8TB (new)	15–30 minutes		
8TC (new)	30–45 minutes		
8TD (new)	More than 45 minutes		
8TE (new)	<15 minutes	Participate	<ul style="list-style-type: none"> <li>a) Discussion of treatment options, including risks and benefits, for patients who have been diagnosed but not yet received treatment, or where a significant change in ongoing treatment requires MDT input; and</li> <li>b) Written pre-brief materials to be sent prior to the conference that outlines available treatment options; and</li> <li>c) Final treatment decisions to be made together with the patient (unless there are exceptional circumstances); and</li> <li>d) At least 2 other formal care providers of different disciplines to be present; and</li> <li>e) Outcomes to be documented in writing, including shared decisions made and informed consent sought; and</li> <li>f) A copy of the case conference outcomes to be uploaded to My Health Record, unless patient consent is withdrawn, and where reasonably achievable.</li> </ul> <p>All participants must be in communication with each other throughout the conference, either face-to-face, by telephone or by videoconference, or a combination of these</p>
8TF (new)	15–30 minutes		
8TG (new)	30–45 minutes		
8TH (new)	More than 45 minutes		



### 7.3 Rationale 11

This recommendation focuses on better enabling use of multidisciplinary case conferences, encompassing GP participation, and shared decision-making with patients. It is based on the following:

- The Committee believes that case conference items should reflect the full breadth of clinical needs for multidisciplinary care. The item descriptors should clearly specify the requirements for participants and the outputs of a case conference.
- The Committee recommends mandatory GP (or delegate) invitation **and** either participation or review of outcomes for discharge and community case conferences.
  - GPs are critical participants in case conferences, providing contextual knowledge of the patient's overall health care and improving post-multidisciplinary team (MDT) outcomes. Currently only 0.7 per cent of community case conferences include a GP<sup>11</sup>.
  - The Committee acknowledges the logistical challenges of GPs attending all community and discharge case conferences. If a GP (or delegate) cannot attend, the Committee recommends mandatory review of the case conference outcomes by the GP and communication to the GP of any proposed changes to the patient and to the case conference organiser. The Committee notes that GP participation or review of outcomes should not be a pre-requisite for the item being claimed by the consultant specialist.
  - Noting a current mistaken perception that case conferences must be attended in person, the Committee also recommends including reference to attendance over the phone and via videoconferencing in the item descriptor.
- The Committee recommends mandatory invitation of the patient (or delegate) to attend discharge and community case conferences and to make it possible for them to attend if they so choose.
  - Patients should be provided with information on treatment options, costs and the associated risk and benefits. An effective plan starts with the consumer's goals and priorities.
  - Clinicians (either the GP or consultant specialist) should discuss and provide patients with written information on guideline-endorsed treatment options for their condition, along with the clinician's view of what is appropriate in the patient's context. This is critical to ensuring informed consent as patients make critical decisions about their treatment options.
- The Committee recommends new treatment planning case conference items.
  - Multidisciplinary care is a critical component of integrated care. Developing the right treatment plan with patients who have complex care needs related to chronic illnesses and acute care planning has been demonstrated to improve outcomes for patients (10) (11).
  - The Committee recognises that there are many conditions that require a case conference for treatment planning (for example, inflammatory bowel disease) and

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<sup>11</sup> Medicare 2016-17



that access to the benefits of treatment planning case conferences should not be limited to patients with cancer.

- The Committee notes that treatment planning may be more efficient if clinicians initially explore treatment options as a clinical team, recognising that final treatment decisions should always be made together with the patient/delegate. For this reason, the Committee did not recommend mandatory invitation of patients to treatment planning case conferences.
- The Committee recommends keeping item 880 for geriatrics and rehabilitation medicine in the MBS with no change, as this item is used for ongoing subacute care of inpatients and would not fit neatly into the three categories of case conferences (i.e., community, discharge, and treatment planning). This item also has a much lower schedule fee compared to other case conference items and accounted for 33 percent of all case conferences in 2016/17.
- The Committee recommends introducing a new time tier for case conferences of less than 15 minutes duration. Many Committee members noted that case conferences where the treatment plan was straightforward often last just 5-10 minutes. This time tier also already exists for addiction medicine practitioners, who use it much more often than they use any of the longer time tiers.
- The Committee has recommended a minimum number of three attendees of different disciplines for each case conference. The MBS currently states that there must be a minimum of three attendees to claim a participant item and four attendees to claim an organiser/coordinator item. The Committee was of the opinion that changing this to a minimum of three attendees for all items was a simpler approach.

#### **7.4 Recommendation 12 - Introduce case conference items for allied health professionals (AHPs) and nurse practitioners**

The Committee recommends that AHPs who access these items should be limited to those who are eligible to access AHP items under Group M3 of the MBS.<sup>12</sup>

#### **7.5 Rationale 12**

This recommendation focuses on recognising the role of AHPs and nurse practitioners in multidisciplinary patient care. It is based on the following:

- The Committee supports the recommendation put forward by the GPPCCC to create new items for attendance at community and discharge case conferences for both AHPs and nurse practitioners.
- The Committee recognises that AHPs and nurse practitioners often have a central role to play in patient care, particularly in a community setting.

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<sup>12</sup> M3 includes Aboriginal and Torres Strait Islander health practitioners, Aboriginal health workers, audiologists, chiropractors, diabetes educators, dietitians, exercise physiologists, mental health nurses, occupational therapists, osteopaths, physiotherapists, podiatrists, psychologists, social workers and speech pathologists.



## 7.6 Recommendation 13 – Referral for examination of informed financial consent

The Committee recommends that the Principles and Rules Committee examine the issue of informed financial consent for out-of-pocket fees charged with case conference items.

### 7.7 Rationale 13

This recommendation focuses on enabling patients to give informed financial consent for case conference items. It is based on the following:

- Allowing all consultant specialists to access case conference items and introducing new items for AHPs and nurse practitioners will increase usage of case conference items, and may impact on out-of-pocket costs for patients.
- However, the Committee recognises that patients often have no control over (and may not be aware of) who attends their case conference, and therefore do not in practice provide informed financial consent for any associated out-of-pocket costs.
- The Committee also notes that it is not possible to prohibit clinicians from charging out-of-pocket fees for case conferences.





## 8 Use of data to inform quality care and patient informed choice and consent recommendations

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### 8.1 The role of data in patient care

The Committee recognises that using data to inform quality care and improving the patient consent process are mechanisms to support quality consultative care. The Committee does not consider the MBS the primary vehicle for addressing this issue and has therefore made both MBS and non-MBS recommendations.

Clinicians and consumers are partners in health care, at the levels of individual care, service provision and health system governance. At the level of individual care, decisions must be informed by the clinician's expert health knowledge and judgement and the patient's unique knowledge, experience, needs, preferences and priorities. Shared decision-making by clinicians and patients (and carers/legal guardians/substitute decision-makers) is fundamental to informed consent (12). The Committee also acknowledges that it is ultimately the patient who manages their overall health and wellbeing and the consequences of any decisions made about their care, and so it logically follows that patients should participate in decision-making to the degree they are willing and able. It is incumbent on clinicians to support health literacy and engagement by creating care environments where people can actively participate in and agree on health care decisions that affect them.

Evaluating and improving the quality of care provided to patients is crucial in clinical practice. Alongside the requirements for improvement in outcomes and patient experience, there has also been considerable emphasis on informing patient choice and increasing patient involvement in all aspects of care. An important enabler of this is increasing the availability and transparency of data. The Committee has therefore provided recommendations on how data can be used to monitor and improve quality of care, and enable informed consumer choice. The Committee also outlines the principles of informed patient consent.

### 8.2 Recommendation 14 - Establish a national minimum data set to inform evidence-based clinical practice and inform patient choice

The Committee recommends a step-wise approach to establishing a national minimum data set, through:

- a. Creating linkages with the Australian Commission on Safety and Quality in Health Care to support a data-driven picture of variation in clinical practice nationally.
- b. Establishing a national minimum data set to record outcome and process data on topics such as mortality, morbidity, readmissions, quality measures of consultations and patient-reported outcomes. It is recommended the data be used to:
  - i. benchmark internally and with peers (determined by the professional group) to drive quality improvement; and
  - ii. inform patient choice of institution and consultant specialist (see further information in Recommendation 15).
- c. Ensuring complete integrity in the accuracy of the data, the rigour of its analysis, and its appropriate risk-weighting before being used for the purposes of



comparison. This includes, but should not be limited to, addressing the following challenges:

- i. newly qualified consultant specialists;
  - ii. consultant specialists returning from a long leave of absence;
  - iii. the effect of a complication where the incidence of that complication is extremely low;
  - iv. consultant specialists who treat low volume disease of high complexity;
  - v. the introduction of new technologies for a service;
  - vi. the opening of new units (e.g., new hospital developments);
  - vii. consultant specialists whose referral base provides high risk patients; and
  - viii. complication “clusters”.
- d. Progressing the minimum data set into a comprehensive data set, populated by data available from private health insurers and state public health systems.
  - e. Using the collection of homogenous data to inform colleges and peak bodies of trends in clinical practice so that continuing professional development (CPD) and other improvement levers can be more targeted.
  - f. Support clinical audits as a mandatory part of CPD and required attendance of 80 per cent of mortality and morbidity meetings.

### 8.3 Rationale 14

This recommendation focuses on establishing a consistent national minimum data set for the purposes of comparison that will inform evidence-based care and patient choice. It is based on the following:

- Clinical care should be evidence-based and data-driven.
- The provision of timely, relevant and reliable information on patient care to clinicians has been shown to support improvements in health care quality.
- The Committee recognises that the integrity of the data is crucial to this recommendation’s success, and its acceptance by the profession, individual clinicians, and consumers. All challenges identified by clinicians should be addressed prior to using the data for comparison purposes to minimise the possibility of the data set being discredited upon implementation.
- Many health care providers are not aware of how their clinical practice compares to that of their peers. Understanding variation in clinical practice is critical to improving the quality, value and appropriateness of health care.
- Data are fundamental to auditing, benchmarking and monitoring outcomes of care.
- Auditing and benchmarking are important quality assurance and quality improvement tools that can lead to reflection, learning and change in practice.

### 8.4 Recommendation 15 – Provide transparency on the cost and quality of consultant specialist services

The Committee recommends that:

- a. MBS cost data, including data on out-of-pocket fees, is shared at an institutional and individual provider level;



- b. consultant specialist risk-weighted outcome data discussed in Recommendation 14 is shared at an institutional, disease-specific unit level;
- c. cost and outcome data are publicly available to enable discussion with the GP at the time of referral; and
- d. the presentation of cost and outcome data should be co-designed with consumers and include a clear explanation of the data and its limitations.

## 8.5 Rationale 15

This recommendation focuses on providing patients with transparency on cost and outcomes when choosing an institution and seeks to support value-based health care. It is based on the following:

- Increasing the availability and transparency of data on service-level practice will inform choice and improve patient involvement in all aspects of care. It may also improve average standards of quality of care through competition between providers (13).
- Patients must have adequate information conveyed in accessible language to make an informed decision on a preferred consultant specialist.
- Informed patient decision-making will increase competition so that price can reflect quality of care.
- Patients should have transparency on the full financial costs they will bear. A 2017 study by Freed and Allen (14) on out-of-pocket costs for an initial outpatient consultation showed wide variation. For example, there is variation in the mean, median and 10th/90th percentile levels of fees for an initial outpatient consultation between specialties. Mean fees for an initial consultation were less than \$200 (including Medicare benefits and patient contribution) in only three of the 11 specialties.
- There are no data on quality of care in the outpatient setting, and patients do not have access to information on the range of appropriate fees and the value of the service they receive.
- There are global trends towards public reporting on quality and performance, with the objective of improving patient information and choice. In the United Kingdom's (UK) National Health Service (NHS), the NHS Choices website has been established for patients to score providers and add commentary about their experience. In addition surgeon-level, risk-adjusted information on mortality rates, waiting times and volumes of procedures is publicly available. GPs in the UK are legally required to offer patients a choice of consultant specialists for referral, along with the above information, under the "Any qualified provider" policy (15).

## 8.6 Recommendation 16 - Improve informed comprehensive patient consent and shared decision-making practices

The Committee recommends:

- a. including the following in standard attendance item descriptors (refer to Recommendation 1) when multiple treatment options are available:
  - i. discussion of patient treatment options to assess the risks and benefits of each option, given the patient's characteristics, medical history and life circumstance;
  - ii. consideration and discussion of referrals to other health professionals and services; and



- iii. a requirement for written documentation, made available to the patient and/or carer, which outlines treatment options and information on associated risks and benefits.
- b. that provider education on the patient consent process be promoted through:
  - i. colleges, using CPD as a lever; and
  - ii. increased patient awareness of the Australian Commission on Safety and Quality in Health Care's standards, achieved via media campaigns and by informing general practice.
- c. improving the consent process by including in provider education materials, consumer information and other relevant materials the following information:
  - i. the aim of the informed consent discussion is to give a patient the information they need to make a decision about their treatment or procedure (if any) and their overall care
  - ii. the discussion must be tailored to the individual patient and their circumstances
  - iii. informed consent during medical practice—on both treatment options and financial costs—is an essential component of comprehensive medical care. Patient authorisation is “informed” when the physician discloses and the patient understands the diagnosis, the relevant options for treatment (including no treatment) and any respective risks and benefits
  - iv. doctors should give advice in accordance with their scope of practice. There should be no coercion. The patient is always free to accept or reject the advice offered
  - v. clinicians should give information about the risks of any intervention, especially those that are likely to influence the patient's decisions
  - vi. the informed consent process should be documented thoroughly, using an electronic medical record, procedure-specific consent forms, patient education materials and other options whenever possible, and
  - vii. mechanisms should be in place to monitor the quality of the patient consent process, such as peer review and patient reported outcomes.

## 8.7 Rationale 16

This recommendation focuses on improving the patient consent process and encouraging shared decision-making during consultant specialist attendances. It is based on the following:

- The Committee recognises that consent processes may vary in different clinical situations (16), but the basic principle remains the same: the provider must outline any material risk and benefit to the patient (17).
- To protect the rights of patients and guide ethical practice, informed consent is essential, particularly where there is a high rate of interventions associated with potential side effect.
- To support shared decision-making, the Committee believes that the patient's goals should be sought, understood and taken into account, along with the expert medical knowledge of the practitioner.



## 9 My Health Record recommendations

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### 9.1 My Health Record

The Federal Government announced in the 2017 Budget a commitment to continue to expand the My Health Record system. By the end of 2018, every Australian will have a My Health Record unless they choose not to have one. Through the My Health Record system healthcare practitioners have access to timely information about patients such as shared health summaries, discharge summaries, prescription and dispense records, pathology reports and diagnostic imaging reports.

The Committee supports the principle that electronic health records can enhance information sharing between patients and providers and thereby promote safe and efficient practice, support self-management and improve patient care (18).

The Committee has made both MBS and non-MBS recommendations to support the adoption of digital record systems by consultant specialists, cognisant of the current limitations of digital readiness among consultant specialists.

### 9.2 Barriers to uptake of My Health Record by consultant specialists

The Committee notes that adoption of My Health Record is very low among consultant specialists (just 263 providers in September 2017) (19). Barriers to uptake include:

- A fragmented clinical information system provider market, which has led to inter-operability issues;
- Concerns about the usability and utility of the current My Health Record architecture, which acts as document repository (through the uploading of PDFs) with limited search function (20);
- Perceptions regarding the rigour of data privacy; and
- Health care provider and consumer education and engagement (21).

Evaluations of the roll-out of shared electronic health records globally suggest that countries have often quoted time frames of 10 years or more. Such time frames reflect the significant change management required and suggest a need to anticipate and plan for several generations of software (22).

### 9.3 Recommendation 17 – Incentivise adoption of My Health Record

The Committee recommends:

- a. introducing a single incentive payment to consultant specialists upon their adoption of My Health Record, triggered by achieving a volume of uploads that is proportional to the number of attendances that the provider performs; and
- b. reviewing the effectiveness of the incentive payment after a defined period such as two years.

### 9.4 Rationale 17

This recommendation focuses on encouraging use of My Health Record by consultant specialists. It is based on the following:

- Given current barriers to the uptake of My Health Record, the Committee believes that, in the short term, incentivising consultant specialists to adopt My Health Record will be more effective than mandating its use.



## 9.5 Recommendation 18 –Use of My Health Record for case conferences and complex plans

The Committee recommends that:

- a. outcomes of case conferences are uploaded to My Health Record, unless patient consent is withdrawn, and where reasonably achievable, with:
  - i. for treatment planning case conferences, the specialist organising the conference responsible for the upload; and
  - ii. for community and discharge case conferences, the GP participating in the case conference responsible for the upload.
- b. geriatric complex plans and paediatric complex plans be uploaded to My Health Record, with the geriatrician or paediatrician responsible for the upload, unless patient consent is withdrawn, and where reasonably achievable.

*Note: See case conference item descriptors in Section 7 and Recommendation 11e (iv).*

## 9.6 Rationale 18

This recommendation focuses on encouraging the upload of event summaries to My Health Record. It is based on the following:

- Case conferences facilitate consultant specialist input into the management of patient health care, and the upload of case conference outcomes to My Health Record, along with the upload of paediatric and geriatric complex plans, is considered central to support integrated care.
- This will assist patients and their health care professionals through the enhancement of the information available.

## 9.7 Recommendation 19 – Encourage adoption of My Health Record

The Committee recommends:

- a. improving the functionality of My Health Record and educating consultant specialists on the benefits of its use;
- b. continuing to develop and enhance the functionality and ability to search the data of My Health Record, so that it becomes a value-add tool for consumers and clinicians in day-to-day quality patient care;
- c. broadening training for health care providers to include education about using the My Health Record system clinically, and about its benefits for patients and the health system;
  - i. including the development of appropriate scenarios relevant to the full range of health care providers across disciplines and clinical settings.
- d. working with academic institutions to embed digital health competencies into undergraduate and postgraduate training and CPD programmes.

## 9.8 Rationale 19

This recommendation focuses on further enhancing My Health Record to improve health outcomes and improve the efficiency of the overall system. It is based on the following:

- The Committee noted the evidence that electronic health records can enhance information sharing between patients and providers and thereby promote safe practice, support self-management and improve patient care (23).



- The Committee agreed that systems that support professionals in their practice efficiently and effectively are more likely to be adopted and sustainable into the future. The Committee also agreed that use of My Health Record needed to continually move with changes in clinical best practice and reflect the needs of patients and their practitioners.
- The Committee noted that creating awareness was only the first step in encouraging adoption with continuing professional and consumer education necessary to support ongoing use.



## 10 Referral practices recommendations

As part of the review of attendances, the Committee considered the suitability of current referral practices for specialists.

The Committee supports the principles that GPs should remain actively involved in the patient's care when being referred between specialists and recognises that patients require adequate time to visit their referred specialist.

The Committee also acknowledges the importance of allied health services as an integral part of a specialist treatment plan for many common conditions and has made recommendations for specialist-referred AHP services to improve access for patients and streamline access to relevant multidisciplinary treatment.

### 10.1 Recommendation 20 (Not agreed) – Extend the current specialist to specialist referral validity period

#### Taskforce Note

The Taskforce did not agree to this recommendation. The Taskforce noted that this issue had been examined by a number of its clinical committees. The Taskforce supports the critical role of the GP as part of the broader health system and noted that the three-month limit facilitated regular ongoing contact between patient and GP.

The Taskforce therefore recommends retaining the specialist-to-specialist referral validity of three months.

The Committee recommends extending the specialist-to-specialist referral validity from three months to six months. This change does not affect the capacity for GPs to provide referrals to consultant specialists in accordance with the MBS requirements.

### 10.2 Rationale 20

This recommendation focuses on striking a balance between patient convenience and enabling GP oversight of patient care. It is based on the following:

- The Committee noted that specialist-to-specialist referrals are increasingly common in modern clinical practice and recommends increasing their validity from three months to six months to reduce the incidence of expired referrals. For example, episodes of treatment involving preoperative and postoperative chemotherapy and radiation often exceed three months, which can lead to expired referrals before treatment is complete.
- The Committee noted that this topic was also considered by the Principles and Rules Committee and the General Practice and Primary Care Committee, who recommended keeping referral validity to three months to enable GPs to continue to be informed of patient care provided by consultant specialists. However, the Committee believes that extending the specialist to specialist referral validity period will maintain GP involvement and reduce the frequency of need for patients to obtain a re-referral without compromising the quality of care. Appropriate communication with the GP where a specialist to specialist referral occurs should also be strengthened.





### 10.3 Recommendation 21 – Introducing a new AHP pathway

The Committee recommends introducing an AHP pathway for consultant specialists under certain circumstances, but only after a full review of the evidence and the associated costs and benefits of any suggested pathway.

### 10.4 Rationale 21

This recommendation focuses on the increasing importance of the AHP role in consultant specialist care. It is based on the following:

- Consultant specialists increasingly recognise the importance of AHP care in the treatment and pre-treatment of many common conditions. For example, gastroenterologists referring to psychologists to treat irritable bowel syndrome, pain medicine specialists referring to psychologists for somatic symptom disorder, and orthopaedic surgeons referring to physiotherapists before surgical repair of an anterior cruciate ligament injury.
- Consultant specialists can already refer to AHPs, but the patient will not have access to a rebate. This opens up a means-based pathway to patients who can afford to pay for AHP.
- For patients to access a rebate, they must be assessed by their GP for eligibility and development of a GP Management Plan (item 721). If granted, the patient can access up to five AHP visits with a rebate. This is inconvenient for patients, adds an additional cost of visiting their GP, and increases the likelihood of the intervention not taking place.
- The Committee considered a recommendation for consultant specialists to have access to a small number of “AHP bridging referrals” that were eligible for a rebate. However, the Committee agreed this could result in:
  - a very large increase in AHP spend, as there are approximately 25 million consultant specialist attendances per year; and
  - cost-shifting from health funds to the MBS, as many patients currently have AHP visits covered under their health insurance plan.
- The Committee also noted that GPs can only access AHP visits for patient population groups that meet specific chronic disease criteria. The Committee therefore recommended that opening up an AHP pathway for consultant specialists should be considered, while noting that this should only occur after a full review of associated costs and benefits.



## 11 Impact statement

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Both patients and providers are expected to benefit from these recommendations as they address concerns regarding patient access and quality of care, and they take steps to simplify the MBS and make it easier to use and understand. The Committee also considered each recommendation's impact on provider groups to ensure that any changes were reasonable and fair. However, if the Committee identified evidence of potential item misuse or safety concerns, recommendations were made to encourage best practice, in line with the overarching purpose of the MBS Review.

### 11.1 Introductory notes

- The MBS refers to “specialists” and “consultant physicians”. These two roles used to be very different. Now they are similar. In this report, “consultant specialist” means both “specialists and consultant physicians”.
- The MBS uses the term “attendance” for a consultation. This consumer summary will use the term consultation.
- The Committee reviewed 143 MBS items used by consultant specialists to claim for consultations.
- In the financial year 2016-17, these items totalled 26 million services and cost the taxpayer \$1.9 billion – plus out of pocket costs.
- Over the past five years, use of these items has increased by 4.2% per year, and the cost has increased by 5.5% per year.

### 11.2 Standard attendance recommendations

Replace the current consultation items with items based on the length of the consultation (as for GP consultations), and describe key activities for each.

- Consumer points.
  - Consumers can expect GPs and consultant specialists to set their appointments and fees the same way (i.e., by the length of time they spend with you).
  - It will be easier to know and compare the fees (and out of pocket costs) of different consultant specialists.
  - First and subsequent consultations will be charged the same: on the basis of time.

Introduce time-tiered items that mirror the standard consultation structure (above) for acute, urgent, and unplanned consultations and set a higher fee. These items are only used when a patient is at risk of serious harm or death, and the care happens outside the usual consulting rooms.

- Consumer points.
  - The time-tiered item approach is the same as for standard consultations. The higher payment reflects the urgent and unexpected nature of the work.

### 11.3 Complex plan recommendations:

Replace these items with time-tiered items, except for those provided by paediatricians and geriatricians.

- Consumer points.



- These consultations provide the referring doctor (usually the patient's GP) with a detailed management plan, which may include detail on which tests to perform and how often, changes to medications, and when to refer back to the consultant specialist. This item is not, however, always used this way. Changing to time-tiering makes the items simpler without removing any benefit to patients.
- Paediatricians use the existing items for children with certain developmental disorders (e.g., autism) and for children with a disability. These items also provide access to allied health professional visits that are eligible for a MBS rebate. The Committee recommends these items remain with wording changed to reflect modern practice, replacing the outdated term "pervasive neurodevelopment disorder" with "complex neurodevelopmental disorder" to enable paediatricians to use the item for children with fetal alcohol spectrum disorder (FASD).
- Geriatricians use the existing items to provide a comprehensive assessment and management plan for patients who are at least 65 years old and includes evaluation of the medical, physical, psychological and social aspects of the patient's health. The Committee recommends these items remain in the MBS.

#### **11.4 Telehealth recommendations (referred to the Taskforce's Telehealth Working Group for consideration)**

Over time, reduce the loading paid to consultant specialists when they use telehealth and use all the money saved to promote the wider use of telehealth. Monitor this change to make sure it achieves what's intended and does not introduce unwanted consequences. Then introduce telehealth specific items using the time-tiered structure as for standard attendances.

- Consumer points.
  - International evidence shows that once consumers and clinicians understand the benefits of telehealth, they don't need incentives to use it – and it saves everyone time and money.
  - The benefits saved from the loading could be used to educate consumers and clinicians so they use telehealth for everyone's benefit.

#### **11.5 Case conference recommendations**

Case conferences are where a group of health professionals (and their patient) meet to discuss, develop and agree on a care plan.

Change the current case conference items to facilitate shared decision-making and more integrated care with the patient and their GP. Have three types of case conference: (1) discharge planning (2) community care planning, and (3) treatment planning.

- Consumer points.
  - Case conference items are for discussing patient treatment options, risks and benefits; recommending a treatment plan; reaching an agreed decision and obtaining informed patient consent.
  - Consumers must be: invited to community and discharge case conferences, be enabled to participate if they elect to attend, and give informed consent to any treatment care plan.
  - GPs (or their delegate) must participate in both discharge and community care planning case conferences, or review case conference outcomes and communicate any proposed changes to the patient and to the case conference organiser.



- Nurse practitioners and allied health professionals can be included in case conferences. These include Aboriginal and Torres Strait Islander health practitioners, Aboriginal health workers, audiologists, chiropractors, diabetes educators, dietitians, exercise physiologists, mental health nurses, occupational therapists, osteopaths, physiotherapists, podiatrists, psychologists, social workers, and speech pathologists.
- The Committee has recommended that the impact of introducing new case conference items and the potential increase in fees should be closely monitored, including the potential impact on out-of-pocket costs.

## 11.6 Use of data to inform quality care and informed patient choice and consent

Establish a minimum data set for patients and GPs to use together when considering referrals. Include patient outcomes, patient reported outcomes and fees - at the provider and/or service level. Ensure the information is accurate and clearly explained, and co-design the presentation of cost and outcome information with consumers.

- Consumer points.
  - This will provide patients with transparency on the cost and outcomes of consultant specialist services.
  - This will support improved patient consent and shared decision-making processes. MBS item descriptors will include a requirement for multiple treatment options to be discussed when they are available.
  - Consultant specialists will be required to discuss available treatment options with the patient, consider referrals to other consultant specialists, and provide a written document outlining the options and their associated advantages and disadvantages.

## 11.7 My Health Record recommendations

Use MBS and non-MBS mechanisms to support the adoption of digital health record systems.

- MBS mechanism.
  - Outcomes of case conferences are uploaded to My Health Record.
    - For treatment planning case conferences, the consultant specialist organising the conference should be responsible for the upload.
    - For community and discharge case conferences, the GP participating in the case conference should be responsible for the upload.
    - Paediatric complex plans and geriatric complex plans are uploaded to My Health Record, with the paediatrician or geriatrician responsible for the upload.
- Non-MBS mechanisms.
  - Introduce a single incentive payment to consultant specialists upon their adoption of My Health Record, triggered by achieving a volume of uploads proportional to the number of attendances that the provider performs.
  - Improve the functionality of My Health Record and educate consultant specialists on the benefits of its use.



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## 13 Glossary

Term	Description
AHP	Allied Health Professional
CAGR	Compound annual growth rate, or the average annual growth rate over a specified time period.
Carers	Carers provide unpaid care and support to family members and friends who have a disability, mental illness, chronic condition, terminal illness, an alcohol or other drug issue or who are frail aged (Carers Australia, n.d.).
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).
Consumer	<p>Patients and potential patients, carers, and people who use health care services.</p> <p>Collectively, ‘consumers’ and ‘community members’ may be referred to as ‘the public’.</p> <p>The Australian Commission on Safety and Quality in Health Care definition: members of the public who use, or are potential users of health care services - patients, consumers, families, carers and other support people.</p> <p>(National Health &amp; Medical Research Council, 2016)</p>
Consumer-or person- or patient- centred care	<p>Patient or consumer centred care is health care that is respectful of, and responsive to, the preferences, needs and values of patients and consumers and identifies four key principles of patient centred approaches:</p> <p>Treating patients, consumers, carers and families with dignity and respect;</p> <p>Encouraging and supporting participation in decision making by patients, consumers, carers and families;</p> <p>Communicating and sharing information with patients, consumers, carers and families;</p> <p>Fostering collaboration with patients, consumers, carers, families and health professionals in program and policy development, and in health service design, delivery and evaluation (Australian Commission on Safety &amp; Quality in Health Care, 2012).</p>
Consumer representative	<p>Someone who voices consumer perspectives and takes part in the decision-making process on behalf of consumers. This person may be nominated by, and may be accountable to, an organisation of consumers. This consumer representative however may have a narrower view as they are speaking on behalf of their organisation and not necessarily that of the wider community. A consumer representative may be appropriately trained or may undergo training and be supported to advocate for consumer-centred health care (National Health &amp; Medical Research Council, 2016).</p>



Term	Description
CPD	Continuing professional development
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
Discipline	A professional healthcare qualification or role, which contributes a unique domain of knowledge and clinical expertise to a multidisciplinary team, e.g. social worker, cardiologist, physiotherapist etc.
FASD	Fetal alcohol spectrum disorder
FTE	Full-time Equivalent
GP	General practitioner
GPPCCC	General Practice and Primary Care Clinical Committee
Health literacy	Individual health literacy is the knowledge, motivation, skills and capacity of a person to access, understand, appraise and apply information to make effective decisions about health and health care, and make appropriate decisions. The health literacy environment is the infrastructure, policies, processes, materials, people and relationships that have an impact on the way in which people access, understand, appraise and apply health-related information and service. (Australian Commission on Safety & Quality in Health Care, 2012).
High-value care	Services of proven efficacy reflecting current best medical practice, or for which the potential benefit to consumers exceeds the risk and costs.
Inappropriate use / misuse	The use of MBS services for purposes other than those intended. This includes a range of behaviours, from failing to adhere to particular item descriptors or rules through to deliberate fraud.
Low-value care	Services that evidence suggests provide little or no benefit to consumers; or for which the risk of harm exceeds the likely benefit; or, more broadly, where the added costs of services do not provide proportional added benefits.
MBS	Medicare Benefits Schedule
MBS item	An administrative object listed in the MBS and used for the purposes of claiming and paying Medicare benefits, consisting of an item number, service descriptor and supporting information, schedule fee and Medicare benefits.
MBS service	The actual medical consultation, procedure or test to which the relevant MBS item refers.
MDT	Multidisciplinary team





Term	Description
MSAC	Medical Services Advisory Committee
New service	Describes when a new service has been recommended, with a new item number. In most circumstances, new services will need to go through the MSAC. It is worth noting that implementation of the recommendation may result in more or fewer item numbers than specifically stated.
No change or leave unchanged	Describes when the services provided under these items will not be changed or affected by the recommendations. This does not rule out small changes in item descriptors (for example, references to other items, which may have changed as a result of the MBS Review or prior reviews).
Obsolete services / items	Services that should no longer be performed as they do not represent current clinical best practice and have been superseded by superior tests or procedures.
Patient	A person receiving medical services because of a problem or a check-up. (Bronkart, 2016)
PBS	Pharmaceutical Benefits Scheme
PHN	Primary health network
RVS	Relative Value Study was a review of the services and fees in the General Medical Services Table of the Medicare Benefits Schedule (MBS).
SCPPCC	See: The Committee
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 Specialist and Consultant Physician Consultation Clinical Committee of the MBS Review
The Minister	Minister for Health
The Taskforce	The MBS Review Taskforce
Total benefits	Total benefits paid in 2014/15 unless otherwise specified.



## Appendix A Index of items

### A.1. Standard attendance items

Item no.	Item descriptor	Schedule fee	Benefits 2016/17	Services 2016/17	Services 5-year annual avg. growth	Recommended change
104	Professional attendance at consulting rooms or hospital by a specialist in the practice of his or her specialty after referral of the patient to him or her—each attendance, other than a second or subsequent attendance, in a single course of treatment, other than a service to which item 106, 109 or 16401 applies	\$85.55	\$396,169,730	5,278,404	3.4%	Remove from MBS; Replace with time-tiered standard attendances
105	Professional attendance by a specialist in the practice of his or her specialty following referral of the patient to him or her—an attendance after the first in a single course of treatment, if that attendance is at consulting rooms or hospital	\$43.00	\$271,057,335	6,815,886	3.6%	Remove from MBS; Replace with time-tiered standard attendances
106	Professional attendance by a specialist in the practice of his or her specialty of ophthalmology and following referral of the patient to him or her—an attendance (other than a second or subsequent attendance in a single course of treatment) at which the only service provided is refraction testing for the issue of a prescription for spectacles or contact lenses, if that attendance is at consulting rooms or hospital (other than a service to which any of items 104, 109 and 10801 to 10816 applies)	\$71.00	\$48,694	780	-5.5%	Remove from MBS; Replace with time-tiered standard attendances
107	Professional attendance by a specialist in the practice of his or her specialty following referral of the patient to him or her—an attendance (other than a second or subsequent attendance in a single	\$125.50	\$171,899	1,599	5.1%	Remove from MBS; Replace with time-tiered standard attendances



Item no.	Item descriptor	Schedule fee	Benefits 2016/17	Services 2016/17	Services 5-year annual avg. growth	Recommended change
	course of treatment), if that attendance is at a place other than consulting rooms or hospital					
108	Professional attendance by a specialist in the practice of his or her specialty following referral of the patient to him or her—each attendance after the first in a single course of treatment, if that attendance is at a place other than consulting rooms or hospital	\$79.45	\$266,101	3,906	23.6%	Remove from MBS; Replace with time-tiered standard attendances
109	Professional attendance by a specialist in the practice of his or her specialty of ophthalmology following referral of the patient to him or her—an attendance (other than a second or subsequent attendance in a single course of treatment) at which a comprehensive eye examination, including pupil dilation, is performed on: (a) a patient aged 9 years or younger; or (b) a patient aged 14 years or younger with developmental delay;(other than a service to which any of items 104, 106 and 10801 to 10816 applies)	\$192.80	\$6,158,378	36,565	7.1%	Remove from MBS; Replace with time-tiered standard attendances
110	Professional attendance at consulting rooms or hospital, by a consultant physician in the practice of his or her specialty (other than psychiatry) following referral of the patient to him or her by a referring practitioner—initial attendance in a single course of treatment	\$150.90	\$313,540,883	2,451,095	4.0%	Remove from MBS; Replace with time-tiered standard attendances
111	Professional attendance at consulting rooms or in hospital by a specialist in the practice of his or her specialty following referral of the patient to him or her by a referring practitioner—an attendance after the first	\$43.00	New Item	New Item	New Item	Remove from MBS; Replace with time-tiered standard attendances



Item no.	Item descriptor	Schedule fee	Benefits 2016/17	Services 2016/17	Services 5-year annual avg. growth	Recommended change
	attendance in a single course of treatment, if: (a) during the attendance, the specialist determines the need to perform an operation on the patient that had not otherwise been scheduled; and (b) the specialist subsequently performs the operation on the patient, on the same day; and (c) the operation is a service to which an item in Group T8 applies; and (d) the amount specified in the item in Group T8 as the fee for a service to which that item applies is \$300 or more For any particular patient, once only on the same day					
116	Professional attendance at consulting rooms or hospital, by a consultant physician in the practice of his or her specialty (other than psychiatry) following referral of the patient to him or her by a referring practitioner—each attendance (other than a service to which item 119 applies) after the first in a single course of treatment	\$75.50	\$553,213,691	8,751,583	4.8%	Remove from MBS; Replace with time-tiered standard attendances
117	Professional attendance at consulting rooms or in hospital, by a consultant physician in the practice of his or her specialty (other than psychiatry) following referral of the patient to him or her by a referring practitioner—an attendance after the first attendance in a single course of treatment, if: (a) the attendance is not a minor attendance; and (b) during the attendance, the consultant physician determines the need to perform an operation on the patient that had not otherwise been scheduled; and (c) the consultant physician subsequently performs	\$75.50	New Item	New Item	New Item	Remove from MBS; Replace with time-tiered standard attendances



Item no.	Item descriptor	Schedule fee	Benefits 2016/17	Services 2016/17	Services 5-year annual avg. growth	Recommended change
	the operation on the patient, on the same day; and (d) the operation is a service to which an item in Group T8 applies; and (e) the amount specified in the item in Group T8 as the fee for a service to which that item applies is \$300 or more For any particular patient, once only on the same day					
119	Professional attendance at consulting rooms or hospital, by a consultant physician in the practice of his or her specialty (other than psychiatry) following referral of the patient to him or her by a referring practitioner—each minor attendance after the first in a single course of treatment	\$43.00	\$3,260,213	93,852	-1.0%	Remove from MBS; Replace with time-tiered standard attendances
120	Professional attendance at consulting rooms or in hospital by a consultant physician in the practice of his or her specialty (other than psychiatry) following referral of the patient to him or her by a referring practitioner—an attendance after the first attendance in a single course of treatment, if: (a) the attendance is a minor attendance; and (b) during the attendance, the consultant physician determines the need to perform an operation on the patient that had not otherwise been scheduled; and (c) the consultant physician subsequently performs the operation on the patient, on the same day; and (d) the operation is a service to which an item in Group T8 applies; and (e) the amount specified in the item in Group T8 as the fee for a service to which that item applies is \$300 or more For any particular patient, once only on the same day	\$43.00	New Item	New Item	New Item	Remove from MBS; Replace with time-tiered standard attendances
122	Professional attendance at a place other than	\$183.10	\$584,925	3,490	-17.8%	Remove from MBS; Replace



Item no.	Item descriptor	Schedule fee	Benefits 2016/17	Services 2016/17	Services 5-year annual avg. growth	Recommended change
	consulting rooms or hospital, by a consultant physician in the practice of his or her specialty (other than psychiatry) following referral of the patient to him or her by a referring practitioner—initial attendance in a single course of treatment					with time-tiered standard attendances
128	Professional attendance at a place other than consulting rooms or hospital, by a consultant physician in the practice of his or her specialty (other than psychiatry) following referral of the patient to him or her by a referring practitioner—each attendance (other than a service to which item 131 applies) after the first in a single course of treatment	\$110.75	\$1,235,542	12,945	-5.6%	Remove from MBS; Replace with time tiered standard attendances
131	Professional attendance at a place other than consulting rooms or hospital, by a consultant physician in the practice of his or her specialty (other than psychiatry) following referral of the patient to him or her by a referring practitioner—each minor attendance after the first in a single course of treatment	\$79.75	\$99,051	1,400	-4.6%	Remove from MBS; Replace with time-tiered standard attendances
160	Professional attendance for a period of not less than 1 hour but less than 2 hours (other than a service to which another item applies) on a patient in imminent danger of death	\$221.50	\$3,617,787	16,923	16.6%	No change
161	Professional attendance for a period of not less than 2 hours but less than 3 hours (other than a service to which another item applies) on a patient in imminent danger of death	\$369.15	\$910,448	2,730	8.1%	No change
162	Professional attendance for a period of not less than 3 hours but less than 4 hours (other than a service to which another item applies) on	\$516.65	\$495,928	1,112	7.3%	No change



Item no.	Item descriptor	Schedule fee	Benefits 2016/17	Services 2016/17	Services 5-year annual avg. growth	Recommended change
	a patient in imminent danger of death					
163	Professional attendance for a period of not less than 4 hours but less than 5 hours (other than a service to which another item applies) on a patient in imminent danger of death	\$664.55	\$233,428	386	11.3%	No change
164	Professional attendance for a period of 5 hours or more (other than a service to which another item applies) on a patient in imminent danger of death	\$738.40	\$288,216	428	16.2%	No change
385	Professional attendance at consulting rooms or hospital by a consultant occupational physician in the practice of his or her specialty of occupational medicine following referral of the patient to him or her by a referring practitioner--initial attendance in a single course of treatment	\$85.55	\$61,481	809	5.3%	Remove from MBS; Replace with time-tiered standard attendances
386	Professional attendance at consulting rooms or hospital by a consultant occupational physician in the practice of his or her specialty of occupational medicine following referral of the patient to him or her by a referring practitioner--each attendance after the first in a single course of treatment	\$43.00	\$19,948	466	-3.7%	Remove from MBS; Replace with time-tiered standard attendances
387	Professional attendance at a place other than consulting rooms or hospital by a consultant occupational physician in the practice of his or her specialty of occupational medicine following referral of the patient to him or her by a referring practitioner--initial attendance in a single course of treatment	\$125.50	\$1,067	10	-1.2%	Remove from MBS; Replace with time-tiered standard attendances
388	Professional attendance at a place other than consulting rooms or hospital by a consultant occupational physician in the practice of his or her	\$79.45	\$676	10	2.5%	Remove from MBS; Replace with time-tiered standard attendances



Item no.	Item descriptor	Schedule fee	Benefits 2016/17	Services 2016/17	Services 5-year annual avg. growth	Recommended change
	specialty of occupational medicine following referral of the patient to him or her by a referring practitioner--each attendance after the first in a single course of treatment					
410	Professional attendance at consulting rooms by a public health physician in the practice of his or her specialty of public health medicine--attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management.	\$19.55	\$1,382	83	-26.7%	Remove from MBS; Replace with time-tiered standard attendances
411	Professional attendance by a public health physician in the practice of his or her specialty of public health medicine at consulting rooms, 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 one or more health-related issues, with appropriate documentation.	\$42.75	\$327,563	8,968	9.1%	Remove from MBS; Replace with time-tiered standard attendances
412	Professional attendance by a public health physician in the practice of his or her specialty of public health medicine at consulting rooms, 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)	\$82.65	\$187,627	2,661	5.8%	Remove from MBS; Replace with time-tiered standard attendances





Item no.	Item descriptor	Schedule fee	Benefits 2016/17	Services 2016/17	Services 5-year annual avg. growth	Recommended change
	providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation					
413	Professional attendance by a public health physician in the practice of his or her specialty of public health medicine at consulting rooms, 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 one or more health-related issues, with appropriate documentation	\$121.70	\$30,413	294	12.6%	Remove from MBS; Replace with time-tiered standard attendances
414	Professional attendance at other than consulting rooms by a public health physician in the practice of his or her specialty of public health medicine--attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management	Derived Fee	\$-	-		Remove from MBS; Replace with time-tiered standard attendances
415	Professional attendance by a public health physician in the practice of his or her specialty of public health medicine at other than consulting rooms, 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)	Derived Fee	\$50	1		Remove from MBS; Replace with time-tiered standard attendances



Item no.	Item descriptor	Schedule fee	Benefits 2016/17	Services 2016/17	Services 5-year annual avg. growth	Recommended change
	providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation					
416	Professional attendance by a public health physician in the practice of his or her specialty of public health medicine at other than consulting rooms, 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 one or more health-related issues, with appropriate documentation	Derived Fee	\$446	5	1.0%	Remove from MBS; Replace with time-tiered standard attendances
417	Professional attendance by a public health physician in the practice of his or her specialty of public health medicine at other than consulting rooms, 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 one or more health-related issues, with appropriate documentation	Derived Fee	\$-	-		Remove from MBS; Replace with time-tiered standard attendances
2801	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine following referral of the patient to him or her by a referring	\$150.90	\$4,437,672	33,797	17.9%	Remove from MBS; Replace with time-tiered standard attendances



Item no.	Item descriptor	Schedule fee	Benefits 2016/17	Services 2016/17	Services 5-year annual avg. growth	Recommended change
	practitioner--initial attendance in a single course of treatment					
2806	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine following referral of the patient to him or her by a referring practitioner--each attendance (other than a service to which item 2814 applies) after the first in a single course of treatment	\$75.50	\$4,424,902	66,798	17.7%	Remove from MBS; Replace with time-tiered standard attendances
2814	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine following referral of the patient to him or her by a referring practitioner--each minor attendance after the first attendance in a single course of treatment	\$43.00	\$38,597	1,117	3.8%	Remove from MBS; Replace with time-tiered standard attendances
2824	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine following referral of the patient to him or her by a referring practitioner--initial attendance in a single course of treatment	\$183.10	\$1,712	11	62.1%	Remove from MBS; Replace with time-tiered standard attendances
2832	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine following referral of the patient to him or her by a referring practitioner--each attendance (other than a service to which item 2840 applies) after the first in a single course of treatment	\$110.75	\$5,686	53	55.0%	Remove from MBS; Replace with time-tiered standard attendances



Item no.	Item descriptor	Schedule fee	Benefits 2016/17	Services 2016/17	Services 5-year annual avg. growth	Recommended change
2840	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine following referral of the patient to him or her by a referring practitioner--each minor attendance after the first attendance in a single course of treatment	\$79.75	\$-	-	-100.0%	Remove from MBS; Replace with time-tiered standard attendances
3005	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine following referral of the patient to him or her by a referring practitioner--initial attendance in a single course of treatment	\$150.90	\$1,447,287	12,296	10.4%	Remove from MBS; Replace with time-tiered standard attendances
3010	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine following referral of the patient to him or her by a referring practitioner--each attendance (other than a service to which item 3014 applies) after the first in a single course of treatment	\$75.50	\$3,097,277	53,225	10.0%	Remove from MBS; Replace with time-tiered standard attendances
3014	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine following referral of the patient to him or her by a referring practitioner--each minor attendance after the first attendance in a single course of treatment	\$43.00	\$22,274	689	-4.8%	Remove from MBS; Replace with time-tiered standard attendances
3018	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of his or her specialty of palliative	\$183.10	\$333,131	2,136	10.9%	Remove from MBS; Replace with time-tiered standard attendances



Item no.	Item descriptor	Schedule fee	Benefits 2016/17	Services 2016/17	Services 5-year annual avg. growth	Recommended change
	medicine following referral of the patient to him or her by a referring practitioner--initial attendance in a single course of treatment					
3023	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine following referral of the patient to him or her by a referring practitioner--each attendance (other than a service to which item 3028 applies) after the first in a single course of treatment	\$110.75	\$281,552	2,968	13.8%	Remove from MBS; Replace with time-tiered standard attendances
3028	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine following referral of the patient to him or her by a referring practitioner--each minor attendance after the first attendance in a single course of treatment	\$79.75	\$68	1	-62.8%	Remove from MBS; Replace with time-tiered standard attendances
6007	Professional attendance by a specialist in the practice of neurosurgery following referral of the patient to him or her--an attendance (other than a second or subsequent attendance in a single course of treatment) at consulting rooms or hospital	\$129.60	\$10,783,437	91,467	4.0%	Remove from MBS; Replace with time-tiered standard attendances
6009	Professional attendance by a specialist in the practice of neurosurgery following referral of the patient to him or her--a minor attendance after the first in a single course of treatment at consulting rooms or hospital	\$43.00	\$2,129,180	54,283	0.9%	Remove from MBS; Replace with time-tiered standard attendances
6011	Professional attendance by a specialist in the practice of neurosurgery following referral of the	\$85.55	\$5,951,516	77,146	3.9%	Remove from MBS; Replace with time-tiered



Item no.	Item descriptor	Schedule fee	Benefits 2016/17	Services 2016/17	Services 5-year annual avg. growth	Recommended change
	patient to him or her--an attendance after the first in a single course of treatment, involving an extensive and comprehensive examination, arranging any necessary investigations in relation to one or more complex problems and of more than 15 minutes in duration but not more than 30 minutes in duration at consulting rooms or hospital					standard attendances
6013	Professional attendance by a specialist in the practice of neurosurgery following referral of the patient to him or her--an attendance after the first in a single course of treatment, involving a detailed and comprehensive examination, arranging any necessary investigations in relation to one or more complex problems and of more than 30 minutes in duration but not more than 45 minutes in duration at consulting rooms or hospital	\$118.50	\$994,519	9,841	19.6%	Remove from MBS; Replace with time-tiered standard attendances
6015	Professional attendance by a specialist in the practice of neurosurgery following referral of the patient to him or her--an attendance after the first in a single course of treatment, involving an exhaustive and comprehensive examination, arranging any necessary investigations in relation to one or more complex problems and of more than 45 minutes in duration at consulting rooms or hospital	\$150.90	\$226,703	1,785	11.7%	Remove from MBS; Replace with time-tiered standard attendances
6018	Professional attendance by an addiction medicine specialist in the practice of his or her specialty following referral of the patient to him or her by a referring practitioner, if the attendance: (a)	\$150.90	\$93,281	731	N/A	Remove from MBS; Replace with time-tiered standard attendances



Item no.	Item descriptor	Schedule fee	Benefits 2016/17	Services 2016/17	Services 5-year annual avg. growth	Recommended change
	includes a comprehensive assessment; and (b) is the first or only time in a single course of treatment that a comprehensive assessment is provided					
6019	Professional attendance by an addiction medicine specialist in the practice of his or her specialty following referral of the patient to him or her by a referring practitioner, if the attendance is a patient assessment: (a) before or after a comprehensive assessment under item 6018 in a single course of treatment; or (b) that follows an initial assessment under item 6023 in a single course of treatment; or (c) that follows a review under item 6024 in a single course of treatment	\$75.50	\$305,606	4,580	N/A	Remove from MBS; Replace with time-tiered standard attendances
6051	Professional attendance by a sexual health medicine specialist in the practice of his or her specialty following referral of the patient to him or her by a referring practitioner, if the attendance: (a) includes a comprehensive assessment; and (b) is the first or only time in a single course of treatment that a comprehensive assessment is provided	\$150.90	\$172,474	1,324	N/A	Remove from MBS; Replace with time-tiered standard attendances
6052	Professional attendance by a sexual health medicine specialist in the practice of his or her specialty following referral of the patient to him or her by a referring practitioner, if the attendance is a patient assessment: (a) before or after a comprehensive assessment under item 6051 in a single course of treatment; or (b) that follows an initial assessment under item 6057 in a single course of	\$75.50	\$221,276	3,358	N/A	Remove from MBS; Replace with time-tiered standard attendances



Item no.	Item descriptor	Schedule fee	Benefits 2016/17	Services 2016/17	Services 5-year annual avg. growth	Recommended change
	treatment; or (c) that follows a review under item 6058 in a single course of treatment					
6062	Professional attendance at a place other than consulting rooms or a hospital by a sexual health medicine specialist in the practice of his or her specialty following referral of the patient to him or her by a referring practitioner--initial attendance in a single course of treatment	\$183.10	\$246	2	N/A	Remove from MBS; Replace with time-tiered standard attendances
6063	Professional attendance at a place other than consulting rooms or a hospital by a sexual health medicine specialist in the practice of his or her specialty following referral of the patient to him or her by a referring practitioner--each attendance after the attendance under item 6062 in a single course of treatment	\$110.75	\$188	2	N/A	Remove from MBS; Replace with time-tiered standard attendances

## A.2. Complex management plans attendance items

Item no.	Item descriptor	Schedule fee	Benefits 2016/17	Services 2016/17	Services 5-year annual avg. growth	Recommended change
132	Professional attendance by a consultant physician in the practice of his or her specialty (other than psychiatry) of at least 45 minutes in duration for an initial assessment of a patient with at least 2 morbidities (which may include complex congenital, developmental and behavioural disorders) following referral of the patient to him or her by a referring practitioner, if: (a) an assessment is undertaken that covers: (i) a comprehensive history, including psychosocial history and medication review; and (ii) comprehensive multi or detailed single organ system assessment; and (iii) the formulation of differential diagnoses; and (b) a consultant physician treatment and management plan of significant complexity is prepared and provided to the referring practitioner, which involves: (i) an opinion on diagnosis and risk assessment; and (ii) treatment options and decisions; and (iii) medication recommendations; and (c) an attendance on the patient to which item 110, 116 or 119 applies did not take	\$263.90	\$218,143,379	972,726	11.8%	Remove item from MBS; Complex plans to be claimed via standard time-tiered attendances





Item no.	Item descriptor	Schedule fee	Benefits 2016/17	Services 2016/17	Services 5-year annual avg. growth	Recommended change
	place on the same day by the same consultant physician; and (d) this item has not applied to an attendance on the patient in the preceding 12 months by the same consultant physician					
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	\$76,504,490	674,305	12.8%	Remove item from MBS; Complex plans to be claimed via standard time-tiered attendances
135	Professional attendance of at least 45 minutes in duration at consulting rooms or hospital, by a consultant physician in the practice of his or her specialty of paediatrics, following referral of the patient to the consultant by a referring practitioner, for assessment, diagnosis and preparation of a treatment and management plan for a patient aged under 13 years with autism or another pervasive developmental disorder, if the consultant paediatrician does all of the following: (a) undertakes a comprehensive assessment and makes a diagnosis (if appropriate, using information provided by an eligible allied health provider); (b) develops a treatment and management plan, which must include the following: (i) an assessment and diagnosis of the patient's condition; (ii) a risk assessment; (iii) treatment options and decisions; (iv) if necessary—medical recommendations; (c) provides a copy of the treatment and management plan to: (i) the referring	\$263.90	\$2,702,445	11,473	6.8%	Change item descriptor



Item no.	Item descriptor	Schedule fee	Benefits 2016/17	Services 2016/17	Services 5-year annual avg. growth	Recommended change
	practitioner; and (ii) one or more allied health providers, if appropriate, for the treatment of the patient;(other than attendance on a patient for whom payment has previously been made under this item or item 137, 139 or 289)					
137	Specialist or consultant physician, referred consultation for assessment, diagnosis and development of a treatment and management plan for a child with an eligible disability - surgery or hospital professional attendance of at least 45 minutes duration, at consulting rooms or hospital, by a specialist or consultant physician, for assessment, diagnosis and the preparation of a treatment and management plan for a child aged under 13 years, with an eligible disability, who has been referred to the specialist or consultant physician by a referring practitioner, if the specialist or consultant physician does the following:(a) undertakes a comprehensive assessment of the child and forms a diagnosis (using the assistance of one or more allied health providers where appropriate)(b) develops a treatment and management plan which must include the following: (i) the outcomes of the assessment; (ii) the diagnosis or diagnoses; (iii) opinion on risk assessment; (iv) treatment options and decisions; (v) appropriate medication recommendations, where necessary.(c) provides a copy of the treatment and management plan to the: (i) referring practitioner; and (ii) relevant allied health providers (where appropriate).not being an attendance on a child in respect of whom payment has previously been made under this item or items 135, 139 or 289.	\$263.90	\$95,585	422	-15.4%	Change item descriptor
141	Professional attendance of more than 60 minutes in duration at consulting rooms or hospital by a consultant physician or specialist in the practice of his or her specialty of geriatric medicine, if: (a) the patient is at least 65 years old and referred by a medical practitioner practising in general practice (including a general practitioner, but not including a specialist or consultant physician) or a participating nurse practitioner; and (b) the attendance is initiated by the referring practitioner for the provision of a comprehensive assessment and management plan; and (c) during the attendance: (i) the medical, physical, psychological and social aspects of the patient's health are evaluated in detail using appropriately validated assessment tools if indicated (the assessment); and (ii) the patient's various health problems and care needs are identified and prioritised (the formulation); and (iii) a detailed management plan is prepared (the	\$452.65	\$10,917,413	28,433	15.8%	No change



Item no.	Item descriptor	Schedule fee	Benefits 2016/17	Services 2016/17	Services 5-year annual avg. growth	Recommended change
	management plan) setting out: (a) the prioritised list of health problems and care needs; and (b) short and longer term management goals; and (c) recommended actions or intervention strategies to be undertaken by the patient's general practitioner or another relevant health care provider that are likely to improve or maintain health status and are readily available and acceptable to the patient and the patient's family and carers; and (iv) the management plan is explained and discussed with the patient and, if appropriate, the patient's family and any carers; and (v) the management plan is communicated in writing to the referring practitioner; and (d) an attendance to which item 104, 105, 107, 108, 110, 116 or 119 applies has not been provided to the patient on the same day by the same practitioner; and (e) an attendance to which this item or item 145 applies has not been provided to the patient by the same practitioner in the preceding 12 months					
143	Professional attendance of more than 30 minutes in duration at consulting rooms or hospital by a consultant physician or specialist in the practice of his or her specialty of geriatric medicine to review a management plan previously prepared by that consultant physician or specialist under item 141 or 145, if: (a) the review is initiated by the referring medical practitioner practising in general practice or a participating nurse practitioner; and (b) during the attendance: (i) the patient's health status is reassessed; and (ii) a management plan prepared under item 141 or 145 is reviewed and revised; and (iii) the revised management plan is explained to the patient and (if appropriate) the patient's family and any carers and communicated in writing to the referring practitioner; and (c) an attendance to which item 104, 105, 107, 108, 110, 116 or 119 applies was not provided to the patient on the same day by the same practitioner; and (d) an attendance to which item 141 or 145 applies has been provided to the patient by the same practitioner in the preceding 12 months; and (e) an attendance to which this item or item 147 applies has not been provided to the patient in the preceding 12 months, unless there has been a significant change in the patient's clinical condition or care circumstances that requires a further review	\$282.95	\$3,318,319	13,797	13.9%	No change
145	Professional attendance of more than 60 minutes in duration at a place other than consulting rooms or hospital by a consultant physician or specialist in the practice of his or her specialty of geriatric medicine, if: (a)	\$548.85	\$4,938,495	10,526	32.9%	No change



Item no.	Item descriptor	Schedule fee	Benefits 2016/17	Services 2016/17	Services 5-year annual avg. growth	Recommended change
	the patient is at least 65 years old and referred by a medical practitioner practising in general practice (including a general practitioner, but not including a specialist or consultant physician) or a participating nurse practitioner; and (b) the attendance is initiated by the referring practitioner for the provision of a comprehensive assessment and management plan; and(c) during the attendance: (i) the medical, physical, psychological and social aspects of the patient's health are evaluated in detail utilising appropriately validated assessment tools if indicated (the assessment); and (ii) the patient's various health problems and care needs are identified and prioritised (the formulation); and (iii) a detailed management plan is prepared (the management plan) setting out: (a) the prioritised list of health problems and care needs; and (b) short and longer term management goals; and (c) recommended actions or intervention strategies, to be undertaken by the patient's general practitioner or another relevant health care provider that are likely to improve or maintain health status and are readily available and acceptable to the patient, the patient's family and any carers; and (iv) the management plan is explained and discussed with the patient and, if appropriate, the patient's family and any carers; and (v) the management plan is communicated in writing to the referring practitioner; and (d) an attendance to which item 104, 105, 107, 108, 110, 116 or 119 applies has not been provided to the patient on the same day by the same practitioner; and (e) an attendance to which this item or item 141 applies has not been provided to the patient by the same practitioner in the preceding 12 months					
147	Professional attendance of more than 30 minutes in duration at a place other than consulting rooms or hospital by a consultant physician or specialist in the practice of his or her specialty of geriatric medicine to review a management plan previously prepared by that consultant physician or specialist under items 141 or 145, if: (a) the review is initiated by the referring medical practitioner practising in general practice or a participating nurse practitioner; and (b) during the attendance: (i) the patient's health status is reassessed; and (ii) a management plan that was prepared under item 141 or 145 is reviewed and revised; and (iii) the revised management plan is explained to the patient and (if appropriate) the patient's family and any carers and communicated in writing to the referring	\$343.10	\$1,410,833	4,835	37.2%	No change



Item no.	Item descriptor	Schedule fee	Benefits 2016/17	Services 2016/17	Services 5-year annual avg. growth	Recommended change
	practitioner; and (c) an attendance to which item 104, 105, 107, 108, 110, 116 or 119 applies has not been provided to the patient on the same day by the same practitioner; and (d) an attendance to which item 141 or 145 applies has been provided to the patient by the same practitioner in the preceding 12 months; and (e) an attendance to which this item or 143 applies has not been provided by the same practitioner in the preceding 12 months, unless there has been a significant change in the patient's clinical condition or care circumstances that requires a further review					
6023	Professional attendance by an addiction medicine specialist in the practice of his or her specialty of at least 45 minutes for an initial assessment of a patient with at least 2 morbidities, following referral of the patient to him or her by a referring practitioner, if: (a) an assessment is undertaken that covers: (i) a comprehensive history, including psychosocial history and medication review; and (ii) a comprehensive multi or detailed single organ system assessment; and (iii) the formulation of differential diagnoses; and (b) an addiction medicine specialist treatment and management plan of significant complexity that includes the following is prepared and provided to the referring practitioner: (i) an opinion on diagnosis and risk assessment; (ii) treatment options and decisions; (iii) medication recommendations; and (c) an attendance on the patient to which item 104, 105, 110, 116, 119, 132, 133, 6018 or 6019 applies did not take place on the same day by the same addiction medicine specialist; and (d) neither this item nor item 132 has applied to an attendance on the patient in the preceding 12 months by the same addiction medicine specialist	\$263.90	\$130,001	595	N/A	Remove item from MBS; Complex plans to be claimed via standard time-tiered attendances
6024	Professional attendance by an addiction medicine specialist in the practice of his or her specialty of at least 20 minutes, after the first attendance in a single course of treatment, for a review of a patient with at least 2 morbidities if: (a) a review is undertaken that covers: (i) review of initial presenting problems and results of diagnostic investigations; and (ii) review of responses to treatment and medication plans initiated at time of initial consultation; and (iii) comprehensive multi or detailed single organ system assessment; and (iv) review of original and differential diagnoses; and (b) the modified addiction medicine specialist treatment and management plan is provided to the referring practitioner, which involves, if appropriate: (i) a revised opinion on diagnosis and risk assessment;	\$132.10	\$25,065	242	N/A	Remove item from MBS; Complex plans to be claimed via standard time-tiered attendances



Item no.	Item descriptor	Schedule fee	Benefits 2016/17	Services 2016/17	Services 5-year annual avg. growth	Recommended change
	and (ii) treatment options and decisions; and (iii) revised medication recommendations; and (c) an attendance on the patient to which item 104, 105, 110, 116, 119, 132, 133, 6018 or 6019 applies did not take place on the same day by the same addiction medicine specialist; and (d) item 6023 applied to an attendance claimed in the preceding 12 months; and (e) the attendance under this item is claimed by the same addiction medicine specialist who claimed item 6023 or by a locum tenens; and (f) this item has not applied more than twice in any 12 month period					
6057	Professional attendance by a sexual health medicine specialist in the practice of his or her specialty of at least 45 minutes for an initial assessment of a patient with at least 2 morbidities, following referral of the patient to him or her by a referring practitioner, if: (a) an assessment is undertaken that covers: (i) a comprehensive history, including psychosocial history and medication review; and (ii) a comprehensive multi or detailed single organ system assessment; and (iii) the formulation of differential diagnoses; and (b) a sexual health medicine specialist treatment and management plan of significant complexity that includes the following is prepared and provided to the referring practitioner: (i) an opinion on diagnosis and risk assessment; (ii) treatment options and decisions; (iii) medication recommendations; and (c) an attendance on the patient to which item 104, 105, 110, 116, 119, 132, 133, 6051 or 6052 applies did not take place on the same day by the same sexual health medicine specialist; and (d) neither this item nor item 132 has applied to an attendance on the patient in the preceding 12 months by the same sexual health medicine specialist	\$263.90	\$147,985	657	N/A	Remove item from MBS; Complex plans to be claimed via standard time-tiered attendances
6058	Professional attendance by a sexual health medicine specialist in the practice of his or her specialty of at least 20 minutes, after the first attendance in a single course of treatment, for a review of a patient with at least 2 morbidities if: (a) a review is undertaken that covers: (i) review of initial presenting problems and results of diagnostic investigations; and (ii) review of responses to treatment and medication plans initiated at time of initial consultation; and (iii) comprehensive multi or detailed single organ system assessment; and (iv) review of original and differential diagnoses; and (b) the modified sexual health medicine specialist treatment and management plan is provided to the referring practitioner, which involves, if appropriate: (i) a revised opinion on diagnosis and risk assessment;	\$132.10	\$29,857	263	N/A	Remove item from MBS; Complex plans to be claimed via standard time-tiered attendances



Item no.	Item descriptor	Schedule fee	Benefits 2016/17	Services 2016/17	Services 5-year annual avg. growth	Recommended change
	and (ii) treatment options and decisions; and (iii) revised medication recommendations; and (c) an attendance on the patient, being an attendance to which item 104, 105, 110, 116, 119, 132, 133, 6051 or 6052 applies did not take place on the same day by the same sexual health medicine specialist; and (d) item 6057 applied to an attendance claimed in the preceding 12 months; and (e) the attendance under this item is claimed by the same sexual health medicine specialist who claimed item 6057 or by a locum tenens; and (f) this item has not applied more than twice in any 12 month period					



### A.3. Telehealth attendance items (referred to the Taskforce's Telehealth Working Group for consideration)

Item no.	Item descriptor	Schedule fee	Benefits 2016/17	Services 2016/17	Services 5-year annual avg. growth	Recommended change
99	Professional attendance on a patient by a specialist practising in his or her specialty if: (a) the attendance is by video conference; and (b) the attendance is for a service: (i) provided with item 104 lasting more than 10 minutes; or (ii) provided with item 105; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance—at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19(2) of the act applies	Derived Fee	\$726,446	10,137	22.3%	Step-wise reduction in loading followed by introduction of time-tiered telehealth attendance items.
112	Professional attendance on a patient by a consultant physician practising in his or her specialty if: (a) the attendance is by video conference; and (b) the attendance is for a service: (i) provided with item 110 lasting more than 10 minutes; or (ii) provided with item 116, 119, 132 or 133; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance—at least 15 kms by road from the physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19(2) of the act applies	Derived Fee	\$7,954,688	55,445	43.6%	Step-wise reduction in loading followed by introduction of time-tiered telehealth attendance items
113	Initial professional attendance of 10 minutes or less in duration on a patient by a specialist in the practice of his or her speciality if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance—at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19(2) of the act applies; and (d) no other initial consultation has taken place for a single course of treatment	\$64.20	\$1,937	31	N/A	Remove from MBS
114	Initial professional attendance of 10 minutes or less in duration on a patient by a consultant physician practising in his or her specialty if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance—	\$113.20	\$11,032	117	N/A	Remove from MBS





Item no.	Item descriptor	Schedule fee	Benefits 2016/17	Services 2016/17	Services 5-year annual avg. growth	Recommended change
	at least 15 kms by road from the physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19(2) of the act applies; and (d) no other initial consultation has taken place for a single course of treatment					
149	Professional attendance on a patient by a consultant physician or specialist practising in his or her specialty of geriatric medicine if: (a) the attendance is by video conference; and (b) item 141 or 143 applies to the attendance; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance--at least 15 kms by road from the physician or specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service: for which a direction made under subsection 19(2) of the act applies	Derived Fee	\$251,984	462	43.4%	Step-wise reduction in loading followed by introduction of time-tiered telehealth attendance items
384	Initial professional attendance of 10 minutes or less in duration on a patient by a consultant occupational physician practising in his or her specialty of occupational medicine if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance--at least 15 kms by road from the physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19(2) of the act applies; and (d) no other initial consultation has taken place for a single course of treatment	\$64.20	\$164	3	N/A	Remove from MBS
389	Professional attendance on a patient by a consultant occupational physician practising in his or her specialty of occupational medicine if: (a) the attendance is by video conference; and (b) the attendance is for a service: (i) provided with item 385 lasting more than 10 minutes; or (ii) provided with item 386; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance--at least 15 kms by road from the physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for	Derived Fee	\$-	-	-100.0%	Step-wise reduction in loading followed by introduction of time-tiered telehealth attendance items



Item no.	Item descriptor	Schedule fee	Benefits 2016/17	Services 2016/17	Services 5-year annual avg. growth	Recommended change
	which a direction made under subsection 19(2) of the act applies					
2799	Initial professional attendance of 10 minutes or less in duration on a patient by a specialist or consultant physician practising in his or her specialty of pain medicine if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance--at least 15 kms by road from the specialist or physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19(2) of the act applies; and (d) no other initial consultation has taken place for a single course of treatment	\$113.20	\$96	1	N/A	Remove from MBS
2820	Professional attendance on a patient by a specialist or consultant physician practising in his or her specialty of pain medicine if: (a) the attendance is by video conference; and (b) the attendance is for a service: (i) provided with item 2801 lasting more than 10 minutes; or (ii) provided with item 2806 or 2814; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance--at least 15 kms by road from the specialist or physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19(2) of the act applies	Derived Fee	\$47,548	374	44.5%	Step-wise reduction in loading followed by introduction of time-tiered telehealth attendance items
3003	Initial professional attendance of 10 minutes or less in duration on a patient by a specialist or consultant physician practising in his or her specialty of palliative medicine if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance--at least 15 kms by road from the specialist or physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19(2) of the act applies; and (d) no other initial consultation has taken place for a single course of treatment	\$113.20	\$193	2	N/A	Remove from MBS
3015	Professional attendance on a patient by a specialist or consultant physician practising in his or her specialty of palliative medicine if: (a) the attendance is by video conference; and (b) the attendance is for a service: (i) provided with item 3005 lasting more than 10 minutes; or (ii) provided with item 3010 or	Derived Fee	\$20,217	181	121.9%	Step-wise reduction in loading followed by introduction of time-tiered telehealth



Item no.	Item descriptor	Schedule fee	Benefits 2016/17	Services 2016/17	Services 5-year annual avg. growth	Recommended change
	3014; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance--at least 15 kms by road from the specialist or physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19(2) of the act applies					attendance items
6004	Initial professional attendance of 10 minutes or less in duration on a patient by a specialist practising in his or her specialty of neurosurgery if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance--at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19(2) of the act applies; and (d) no other initial consultation has taken place for a single course of treatment	\$97.20	\$413	5	N/A	Remove from MBS
6016	Professional attendance on a patient by a specialist practising in his or her specialty of neurosurgery if: (a) the attendance is by video conference; and (b) the attendance is for a service: (i) provided with item 6007 lasting more than 10 minutes; or (ii) provided with item 6009, 6011, 6013 or 6015; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance--at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19(2) of the act applies	Derived Fee	\$79,387	703	32.8%	Step-wise reduction in loading followed by introduction of time-tiered telehealth attendance items
6025	Initial professional attendance of 10 minutes or less, on a patient by an addiction medicine specialist in the practice of his or her specialty, if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance--at least 15 km by road from the addiction medicine specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19(2) of the act applies; and (d) no	\$113.20	\$3,080	32	N/A	Remove from MBS



Item no.	Item descriptor	Schedule fee	Benefits 2016/17	Services 2016/17	Services 5-year annual avg. growth	Recommended change
	other initial consultation has taken place for a single course of treatment					
6026	Professional attendance on a patient by an addiction medicine specialist in the practice of his or her specialty, if: (a) the attendance is by video conference; and (b) the attendance is for a service: (i) provided with item 6018 or 6019 and lasting more than 10 minutes; or (ii) provided with item 6023 or 6024; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance--at least 15 km by road from the addiction medicine specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19 (2) of the act applies	Derived Fee	\$481	3	N/A	Step-wise reduction in loading followed by introduction of time-tiered telehealth attendance items
6059	Initial professional attendance of 10 minutes or less, on a patient by a sexual health medicine specialist in the practice of his or her specialty, if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance--at least 15 km by road from the sexual health medicine specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19(2) of the act applies; and (d) no other initial consultation has taken place for a single course of treatment	\$113.20	\$1,251	13	N/A	Remove from MBS
6060	Professional attendance on a patient by a sexual health medicine specialist in the practice of his or her specialty if: (a) the attendance is by video conference; and (b) the attendance is for a service: (i) provided with item 6051 or 6052 and lasting more than 10 minutes; or (ii) provided with item 6057 or 6058; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance--at least 15 km by road from the sexual health medicine specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19 (2) of the act applies	Derived Fee	\$96	1	N/A	Step-wise reduction in loading followed by introduction of time-tiered telehealth attendance items



#### A.4. Case conference attendance items

Item no.	Item descriptor	Schedule fee	Benefits 2016/17	Services 2016/17	Services 5-year annual avg. growth	Recommended change
820	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines	\$139.10	\$2,411,730	20,395	18.2%	Change descriptor; Open access to all specialists and consultant physicians
822	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines	\$208.70	\$205,818	1,158	12.8%	Change descriptor; Open access to all specialists and consultant physicians
823	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to organise and coordinate a community case conference of at least 45 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines	\$278.15	\$1,039,317	4,379	3.6%	Change descriptor; Open access to all specialists and consultant physicians
825	Attendance by a consultant physician in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team	\$99.90	\$1,370,265	16,129	27.6%	Change descriptor; Open access to all specialists and consultant physicians
826	Attendance by a consultant physician in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team	\$159.30	\$568,784	4,200	10.6%	Change descriptor; Open access to all specialists and consultant physicians
828	Attendance by a consultant physician in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 45 minutes, with the multidisciplinary case conference team	\$218.75	\$387,502	2,076	-3.7%	Change descriptor; Open access to all specialists and consultant physicians
830	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines	\$139.10	\$2,677,611	25,650	7.6%	Change descriptor; Open access to all specialists and consultant physicians
832	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 30 minutes but less than 45 minutes, with a multidisciplinary team	\$208.70	\$352,998	2,249	4.9%	Change descriptor; Open access to all specialists and



	of at least 3 other formal care providers of different disciplines					consultant physicians
834	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 45 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines	\$278.15	\$827,074	3,959	13.4%	Change descriptor; Open access to all specialists and consultant physicians
835	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines	\$99.90	\$74,442	968	10.7%	Change descriptor; Open access to all specialists and consultant physicians
837	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines	\$159.30	\$10,803	88	15.4%	Change descriptor; Open access to all specialists and consultant physicians
838	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines	\$218.75	\$20,468	123	59.3%	Change descriptor; Open access to all specialists and consultant physicians
871	Attendance by a medical practitioner (including a specialist or consultant physician in the practice of his or her specialty or a general practitioner), as a member of a case conference team, to lead and coordinate a multidisciplinary case conference on a patient with cancer to develop a multidisciplinary treatment plan, if the case conference is of at least 10 minutes, with a multidisciplinary team of at least 3 other medical practitioners from different areas of medical practice (which may include general practice), and, in addition, allied health providers	\$80.30	\$2,853,474	41,923	21.1%	Remove item from MBS; Replace with new treatment planning case conferences
872	Attendance by a medical practitioner (including a specialist or consultant physician in the practice of his or her specialty or a general practitioner), as a member of a case conference team, to participate in a multidisciplinary case conference on a patient with cancer to develop a multidisciplinary treatment plan, if the case conference is of at least 10 minutes, with a multidisciplinary team of at least 4 medical practitioners from different areas of medical practice (which may include general practice), and, in addition, allied health providers	\$37.40	\$3,281,342	103,423	36.7%	Remove item from MBS; Replace with new treatment planning case conferences
880	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of geriatric or rehabilitation medicine, as a member of a case conference team, to coordinate a case conference of at least 10 minutes but less than 30 minutes--for any particular patient, one attendance only in a 7 day period (other than attendance on the same day as an attendance for which item 832, 834, 835, 837 or 838 was applicable in relation to the patient) (H)	\$48.65	\$4,249,249	116,440	11.8%	No change
2946	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a	\$139.10	\$119,742	1,046	1.4%	Remove item from MBS



	community case conference of at least 15 minutes but less than 30 minutes					
2949	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes	\$208.70	\$22,686	128	18.8%	Remove item from MBS
2954	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 45 minutes	\$278.15	\$18,986	81	140.8%	Remove item from MBS
2958	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes	\$99.90	\$77,858	920	59.9%	Remove item from MBS
2972	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes	\$159.30	\$14,493	107	-6.8%	Remove item from MBS
2974	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 45 minutes	\$218.75	\$20,619	111	45.5%	Remove item from MBS
2978	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 15 minutes but less than 30 minutes, before the patient is discharged from a hospital (H)	\$139.10	\$3,548	34	-15.1%	Remove item from MBS
2984	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 30 minutes but less than 45 minutes, before the patient is discharged from a hospital (H)	\$208.70	\$-	-		Remove item from MBS
2988	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 45 minutes, before the patient is discharged from a hospital (H)	\$278.15	\$209	1	0.0%	Remove item from MBS
2992	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, before the patient is discharged from a hospital (H)	\$99.90	\$2,024	27		Remove item from MBS
2996	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain	\$159.30	\$120	1		Remove item from MBS





	medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, before the patient is discharged from a hospital (H)					
3000	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 45 minutes, before the patient is discharged from a hospital (H)	\$218.75	\$-	-		Remove item from MBS
3032	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes	\$139.10	\$314,851	2,771	10.2%	Remove item from MBS
3040	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes	\$208.70	\$33,845	192	93.9%	Remove item from MBS
3044	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 45 minutes	\$278.15	\$19,570	83	69.1%	Remove item from MBS
3051	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes	\$99.90	\$183,835	2,298	15.3%	Remove item from MBS
3055	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines	\$159.30	\$3,362	28	22.9%	Remove item from MBS
3062	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 45 minutes	\$218.75	\$700	4	-4.4%	Remove item from MBS
3069	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 15 minutes but less than 30 minutes, before the patient is discharged from a hospital (H)	\$139.10	\$257,640	2,469	36.7%	Remove item from MBS
3074	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 30 minutes but less than 45	\$208.70	\$16,438	105	29.3%	Remove item from MBS





	minutes, before the patient is discharged from a hospital (H)					
3078	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 45 minutes, before the patient is discharged from a hospital (H)	\$278.15	\$51,537	247	7.6%	Remove item from MBS
3083	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine, as a member of a case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, before the patient is discharged from a hospital (H)	\$99.90	\$53,749	717	111.4%	Remove item from MBS
3088	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, before the patient is discharged from a hospital (H)	\$159.30	\$478	4	-23.2%	Remove item from MBS
3093	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 45 minutes, before the patient is discharged from a hospital (H)	\$218.75	\$1,827	11	-3.3%	Remove item from MBS
6029	Attendance by an addiction medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of less than 15 minutes, with the multidisciplinary case conference team	\$42.70	\$2,088	65	N/A	Remove item from MBS
6031	Attendance by an addiction medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team	\$75.50	0	0	N/A	Remove item from MBS
6032	Attendance by an addiction medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team	\$113.30	0	0	N/A	Remove item from MBS
6034	Attendance by an addiction medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate the multidisciplinary case conference of at least 45 minutes, with the multidisciplinary case conference team	\$150.90	0	0	N/A	Remove item from MBS
6035	Attendance by an addiction medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2	\$34.15	\$8,753	339	N/A	Remove item from MBS



	other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of less than 15 minutes, with the multidisciplinary case conference team					
6037	Attendance by an addiction medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team	\$60.40	0	0	N/A	Remove item from MBS
6038	Attendance by an addiction medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team	\$90.65	\$154	2	N/A	Remove item from MBS
6042	Attendance by an addiction medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 45 minutes, with the multidisciplinary case conference team	\$120.75	\$205	2	N/A	Remove item from MBS
6064	Attendance by a sexual health medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of less than 15 minutes, with the multidisciplinary case conference team	\$42.70	0	0	N/A	Remove item from MBS
6065	Attendance by a sexual health medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team	\$75.50	0	0	N/A	Remove item from MBS
6067	Attendance by a sexual health medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team	\$113.30	\$96	1	N/A	Remove item from MBS
6068	Attendance by a sexual health medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 45 minutes, with the multidisciplinary case conference team	\$150.90	0	0	N/A	Remove item from MBS
6071	Attendance by a sexual health medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other	\$34.15	\$58	2	N/A	Remove item from MBS



	than to organise and coordinate the conference) of less than 15 minutes, with the multidisciplinary case conference team					
6072	Attendance by a sexual health medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team	\$60.40	\$154	3	N/A	Remove item from MBS
6074	Attendance by a sexual health medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team	\$90.65	\$308	4	N/A	Remove item from MBS
6075	Attendance by a sexual health medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 45 minutes, with the multidisciplinary case conference team	\$120.75	\$411	4	N/A	Remove item from MBS

### A.5. Group therapy attendance items

Item no.	Item descriptor	Schedule fee	Benefits FY2016/17	Services FY2016/17	Services 5-year annual avg. growth	Recommended change
170	Professional attendance for the purpose of group therapy of not less than 1 hour in duration given under the direct continuous supervision of a medical practitioner (other than a consultant physician in the practice of his or her specialty of psychiatry) involving members of a family and persons with close personal relationships with that family--each group of 2 patients	\$117.55	\$1,186,406	9,010	2.3%	No change
171	Professional attendance for the purpose of group therapy of not less than 1 hour in duration given under the direct continuous supervision of a medical practitioner (other than a consultant physician in the practice of his or her specialty of psychiatry) involving members of a family and persons with close personal relationships with that family--each group of 3 patients	\$123.85	\$204,109	1,542	-4.9%	No change
172	Professional attendance for the purpose of group therapy of not less than 1 hour in duration given under the direct continuous supervision of a medical practitioner (other than a consultant physician in the practice of his or her specialty of psychiatry) involving	\$150.70	\$70,080	471	1.6%	No change



	members of a family and persons with close personal relationships with that family--each group of 4 or more patients					
6028	Group therapy (including any associated consultation with a patient taking place on the same occasion and relating to the condition for which group therapy is conducted) of not less than 1 hour, given under the continuous direct supervision of an addiction medicine specialist in the practice of his or her specialty for a group of 2 to 9 unrelated patients, or a family group of more than 2 patients, each of whom is referred to the addiction medicine specialist by a referring practitioner--for each patient	\$49.30	\$1,887	51	N/A	No change



## Appendix B List of Recommendations

### Recommendation 1 - Introduce attendance items based on attendance duration and patient complexity factors

The Committee recommends:

- a. introducing time-tiered attendance items to replace most of the current standard attendance items;
- b. removing standard attendance items from Groups A3, A4, A12, A24, A26, A31 and A32;  
*Note: See Appendix A.1 for a full list of attendance items that are recommended for removal.*
- c. adding 10 new time-tiered attendance items with the following characteristics (see Table B.1):
  - i. item descriptors should specify required attendance time, and standard activities performed (to indicate complexity);
  - ii. the duration of the time tiers should be the same as those recommended by the GPPCCC; and
  - iii. parallel items should continue to exist for attendances that occur in a consulting room or hospital, and elsewhere (five items each).
- d. adding explanatory notes for these items that state that:
  - i. Specific features of the patient interaction may contribute to the duration of the attendance. This may include communication or comprehension factors that result in more time needed to take a medical history or to take informed consent (e.g., using an interpreter to take a medical history, taking informed consent for an intrusive examination of a child) and mobility factors resulting in more time needed to perform a clinical examination (e.g., the need for an assistant or assistive device to transfer a patient).
  - ii. Non-patient-facing time related to the attendance should not be included in deriving the duration of the attendance as defined in the item descriptors, but is regarded as an integral part of the attendance and should factor in the calculation of the schedule fees.
  - iii. Time spent with other health professionals should not contribute the duration of the attendance.
  - iv. Time spent on a procedure or a diagnostic test should not contribute to the duration of the attendance.
- e. keep Group A5 prolonged attendance items, which have a specific allowance for patients in imminent danger of death (*refer to Recommendation 2*).

**Table B.1: Recommended item descriptors for time-tiered attendance items**

Level (item) <sup>13</sup>	Item descriptor	Location	Duration
Level A (XX1A)	Professional attendance of 5 minutes or less by a consultant specialist in the practice of his or her speciality following patient referral for an obvious problem with a straightforward task, including any of the following that are clinically relevant:	Attendance at consulting room or hospital	5 minutes or less
Level A (XX2A)	a) a short patient history and, if required, limited examination and management b) outcomes documented and communicated in writing to the referring practitioner Other than a service to which another Category 1, Group T1, Group T4 or Group T6 professional attendance item applies. Only to be claimed with a Group T8 procedure item: <ol style="list-style-type: none"> <li>I. where the procedure has a schedule fee of less than \$300; or</li> <li>II. where the need for the procedure is identified during the consultation, has not otherwise been scheduled, is performed on the same day as the attendance, and where the procedure has a schedule fee of \$300 or more.</li> </ol>	Attendance in a location other than consulting room or hospital	5 minutes or less
Level B (XX1B)	Professional attendance of more than 5 minutes but not more than 20 minutes by a consultant specialist in the practice of his or her speciality following patient referral, including any of the following that are clinically relevant:	Attendance at consulting room or hospital	6–20 minutes
Level B (XX2B)	a) focused patient history and, if required, focused examination and management b) outcomes documented and communicated in writing to the referring practitioner Other than a service to which another Category 1, Group T1, Group T4 or Group T6 professional attendance item applies. Only to be claimed with a Group T8 procedure item: <ol style="list-style-type: none"> <li>I. where the procedure has a schedule fee of less than \$300; or</li> <li>II. where the need for the procedure is identified during the consultation, has not otherwise been scheduled, is performed on the same day as the attendance, and</li> </ol>	Attendance in a location other than consulting room or hospital	6–20 minutes

<sup>13</sup> Item numbers listed here indicate a structure for the DHS to follow when assigning item numbers.



Level (item) <sup>13</sup>	Item descriptor	Location	Duration
	where the procedure has a schedule fee of \$300 or more.		
Level C (XX1C)	Professional attendance of more than 20 minutes but not more than 40 minutes by a consultant specialist in the practice of his or her speciality following patient referral, including any of the following that are clinically relevant:	Attendance at consulting room or hospital	21–40 minutes
Level C (XX2C)	<p>a) detailed patient history of a major single or multiple minor conditions</p> <p>b) comprehensive examination of single system OR multi-system focused examination</p> <p>c) single or multiple minor diagnostic problems considered</p> <p>d) a non-complex management plan</p> <p>e) a management plan communicated in writing to the referring practitioner and, if required;</p> <p>f) discussion of multiple treatment options available, including;</p> <p>i. Discussion of treatment options to assess pros and cons of each option given patient characteristics and medical history</p> <p>ii. Consideration and discussion of necessary referrals to other health professionals</p> <p>iii. Written documentation made available for the patient and/or carer that outlines treatment options and information on associated risks and benefits</p> <p>g) outcomes documented and communicated in writing to the referring practitioner</p> <p>Other than a service to which another Category 1, Group T1, Group T4 or Group T6 professional attendance item applies.</p> <p>Only to be claimed with a Group T8 procedure item:</p> <p>I. where the procedure has a schedule fee of less than \$300; or</p> <p>II. where the need for the procedure is identified during the consultation, has not otherwise been scheduled, is performed on the same day as the attendance, and where the procedure has a schedule fee of \$300 or more.</p>	Attendance in a location other than consulting room or hospital	21–40 minutes
Level D (XX1D)	Professional attendance of more than 40 minutes but not more than 60 minutes by a consultant specialist in the practice of his or her speciality	Attendance at consulting room or hospital	41–60 minutes



Level (item) <sup>13</sup>	Item descriptor	Location	Duration
Level D (XX2D)	<p>following patient referral, including any of the following that are clinically relevant:</p> <ul style="list-style-type: none"> <li>a) comprehensive patient history of multiple conditions or a complex single condition</li> <li>b) comprehensive multi-system examination</li> <li>c) multiple diagnostic problems considered</li> <li>d) a comprehensive management plan</li> <li>e) the management plan communicated in writing to the referring practitioner and, if required;</li> <li>f) discussion of multiple treatment options available, including: <ul style="list-style-type: none"> <li>i. Discussion of treatment options to assess pros and cons of each option given patient characteristics and medical history</li> <li>ii. Consideration and discussion of necessary referrals to other health professionals</li> <li>iii. Written documentation made available for the patient and/or carer that outlines treatment options and information on associated risks and benefits</li> </ul> </li> <li>g) outcomes documented and communicated in writing to the referring practitioner</li> </ul> <p>Other than a service to which another Category 1, Group T1, Group T4 or Group T6 professional attendance item applies.</p> <p>Only to be claimed with a Group T8 procedure item:</p> <ul style="list-style-type: none"> <li>I. where the procedure has a schedule fee of less than \$300; or</li> <li>II. where the need for the procedure is identified during the consultation, has not otherwise been scheduled, is performed on the same day as the attendance, and where the procedure has a schedule fee of \$300 or more.</li> </ul>	Attendance in a location other than consulting room or hospital	41–60 minutes
Level E (XX1E)	Professional attendance of more than 60 minutes by a consultant specialist in the practice of his or her speciality following patient referral, including any of the following that are clinically relevant:	Attendance at consulting room or hospital	More than 60 minutes
Level E (XX2E)	<ul style="list-style-type: none"> <li>a) extensive history of multiple complex conditions</li> <li>b) extensive multi-system medical examination</li> <li>c) multiple complex diagnoses considered</li> <li>d) a comprehensive management plan</li> </ul>	Attendance in a location other than consulting	More than 60 minutes





Level (item) <sup>13</sup>	Item descriptor	Location	Duration
	<p>e) the management plan is communicated in writing to the referring practitioner and, if required;</p> <p>f) discussion of multiple treatment options available, including:</p> <ul style="list-style-type: none"> <li>iv. Discussion of treatment options to assess pros and cons of each option given patient characteristics and medical history</li> <li>v. Consideration and discussion of necessary referrals to other health professionals</li> <li>vi. Written documentation made available for the patient and/or carer that outlines treatment options and information on associated risks and benefits</li> </ul> <p>g) outcomes documented and communicated in writing to the referring practitioner</p> <p>Other than a service to which another Category 1, Group T1, Group T4 or Group T6 professional attendance item applies.</p> <p>Only to be claimed with a Group T8 procedure item:</p> <ul style="list-style-type: none"> <li>I. where the procedure has a schedule fee of less than \$300; or</li> <li>II. where the need for the procedure is identified during the consultation, has not otherwise been scheduled, is performed on the same day as the attendance, and where the procedure has a schedule fee of \$300 or more.</li> </ul>	room or hospital	

## Recommendation 2 – Introduce new attendance items for acute, urgent and unplanned attendances

The Committee recommends:

- a. creating four new time-tiered attendance items for acute, urgent, and unplanned attendances;
- b. specifying that these items are only to be used in specific situations where the attendance is acute, urgent, unplanned, and does not take place in the consultant specialist's consulting rooms or in the emergency department of a public hospital;
- c. specifying that the duration of these time tiers should be the same as Levels B, C, D, and E used for standard attendance items (*refer to Recommendation 1*);
- d. a schedule fee for these items that is higher than the schedule fee for standard time-tiered attendances of equivalent duration; and
- e. that these items should be restricted from being claimed alongside prolonged attendance items 160-164 where the patient is in imminent danger of death.

**Table B.2: Acute attendance item descriptors**

Item	Duration	Item descriptor
XY1	5-20 minutes	Professional attendance of more than [X] minutes but not more than [X] minutes by a consultant specialist that is acute, urgent, unplanned, and does not take place in consulting rooms or in the emergency department of a public hospital, and where the patient is: a) at risk of serious morbidity or mortality requiring urgent assessment and resuscitation; or b) suffering from suspected acute organ or system failure; or c) suffering from an illness or injury where the viability or function of a body part or organ is acutely threatened; or d) suffering from a potentially life-threatening complication of an infection (i.e., sepsis) e) suffering from a drug overdose, toxic substance or toxin effect; or f) experiencing severe psychiatric disturbance whereby the health of the patient or other people is at immediate risk; or g) suffering acute severe pain where the viability or function of a body part or organ is suspected to be acutely threatened; or h) suffering acute significant haemorrhage requiring urgent assessment and treatment Not to be claimed with prolonged attendance items 160, 161, 162, 163, or 164
XY2	21-40 minutes	
XY3	41-60 minutes	
XY4	More than 60 minutes	

**Recommendation 3 - Further considerations when implementing time-tiering**

- a. The Committee recommends the Government works closely with peak organisations, clinicians and consumers to refine the detail of implementation, and ensure an effective and sustainable transition. In particular, the following should be considered when moving towards implementation: Collecting data on the duration of attendances across specialties, and the activities performed during these attendances, similar to the data previously collected from GPs through the *Bettering the Evaluation and Care of Health* program (BEACH data).
- b. Using the data to accurately model the impact of time-tiering on service volume and benefits.
- c. Investing in change management to facilitate the transition to the new items and build understanding of the benefits of the time-tiering model.
- d. Making the model clear to provide transparency and consistency for clinicians and consumers.
- e. Adding a longer time tier (i.e. Level F) should the need be identified. If introduced, this should accompany an estimate of services claimed through this tier.
- f. Ensuring early, active, and regular reviews of attendance items post implementation of time-tiering, including:
  - i. potential impact on out-of-pocket patient costs;
  - ii. potential impact on patient waiting lists, either as a result of longer attendances being performed or as a result of consultant specialists accepting fewer new patients/referrals; and



- iii. patient-reported experience and outcomes.
- g. Making the item descriptors sufficiently detailed to enable auditing through the review of clinical notes, allowing verification that activities of sufficient complexity were performed, as stated in the descriptors.
- h. Harmonising all attendance time tiers in the MBS that apply to other consultant specialists (including psychiatry, obstetrics, anaesthesia, intensive care, general practice and emergency medicine).
- i. Setting time-tiers that have the most common attendance times near the middle of each tier, to support fair and reasonable practice.

#### **Recommendation 4 – Approach to fee setting**

The Committee recommends consideration of the following with regard to schedule fees (recognising that fee-setting is out of the Committee's scope):

- a. building support among peak bodies, clinicians and consumers for the principles of time-tiering before introducing schedule fees;
- b. ensuring a linear relationship between attendance time tiers and schedule fees from the outset;
- c. ensuring non-patient facing time is factored into the new fee structure and ensuring that this fact is well communicated; and
- d. recognising that there is a lack of data on the current duration of consultant specialist attendance times and the activities performed in these attendances.

#### **Recommendation 5 – Impact on time-tiering on distant outreach services**

The Committee recommends that to address the potential concerns of time-tiering on distant outreach services the following steps will need to be considered:

- 1. Data will need to be collected on this practice if possible on the magnitude of this practice from MBS data or other sources;
- 2. If such a problem does exist, a non MBS process will need to be developed to address the issue;
- 3. Any such process should continue to support patient access to local services where needed; and
- 4. A community need must be demonstrated in order to justify a non-MBS solution.

#### **Recommendation 6 - Removing consultant physician, addiction medicine, and sexual health medicine complex plan items**

The Committee recommends removing consultant physician, addiction medicine, and sexual health medicine complex plan items from the MBS (items 132, 133, 6023, 6024, 6057, and 6058).

#### **Recommendation 7 – Retain access to paediatric complex plan items with strengthened descriptor**

The Committee recommends:

- a. item 289 to be referred to the Psychiatry Clinical Committee;
- b. amend item 135 descriptor for paediatric complex plan (changes in bold) to:

**Item 135**

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

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

(other than attendance on a patient for whom payment has previously been made under this item or item 137, 139 or 289)”



- c. amend the explanatory notes to include the following:

**Explanatory Note – Item 135**

The item is intended for the initial assessment of patients where by the complexity of the condition is characterised by severe multi-domain cognitive and functional disabilities, delay or impairment”

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

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

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

- a. Stand-alone diagnosis of Attention Deficit Hyperactivity Disorder without other severe neurodevelopmental co-morbidities or co-existing multi-domain disabilities.

- d. that expert bodies are consulted to agree on an appropriate definition of complexity and severity, and which domains of cognitive and functional impairment should be considered.
- e. that the inequity of patient rebates for paediatric complex plans and geriatric complex plans be addressed over time.

**Recommendation 8 – Retain the geriatrician specific consultation items**

- f. The Committee recommends retaining items 141, 143, 145 and 147 and not including under time-tiering.

**Recommendation 9 – A new framework for telehealth (referred to the Taskforce’s Telehealth Working Group for consideration)**

The Committee recommends:

- a. removing the eight specialty-specific telehealth attendance items (items 113, 114, 384, 2799, 3003, 6004, 6025, and 6059) from the MBS;
- b. incrementally reducing the derived fee for the nine telehealth loading items (items 99, 112, 149, 389, 2820, 3015, 6016, 6026, and 6060) to zero;



- c. undertaking annual analysis of the phase out so to identify potential unintended consequences; and
- d. introducing new telehealth-specific attendance items (after the nine loading items have been removed) that mirror the standard time-tiered attendance items, with the same fees, and with item descriptors that describe recommended activities to be performed in each tier.

**Table B.3: Telehealth attendance item descriptors**

Level (item) <sup>14</sup>	Duration	Item descriptor
Level B (THB)	6-20 minutes	<p>Professional attendance of more than 5 minutes but not more than 20 minutes by a consultant specialist in the practice of his or her speciality if:</p> <ul style="list-style-type: none"> <li>a) the attendance is by video conference; and</li> <li>b) the patient is not an admitted patient; and</li> <li>c) the patient: <ul style="list-style-type: none"> <li>i. is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance--at least 15 km by road from the consultant specialist; or</li> <li>ii. is a care recipient in a residential care service; or</li> <li>iii. is a patient of: (a) an Aboriginal Medical Service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19(2) of the act applies.</li> </ul> </li> </ul> <p>An attendance including any of the following that are clinically relevant:</p> <ul style="list-style-type: none"> <li>d) a focused patient history</li> <li>e) implementing a management plan</li> <li>f) outcomes documented and communicated in writing to the referring practitioner</li> </ul>
Level C (THC)	21-40 minutes	<p>Professional attendance of more than 20 minutes but not more than 40 minutes by a consultant specialist in the practice of his or her speciality if:</p> <ul style="list-style-type: none"> <li>a) the attendance is by video conference; and</li> <li>b) the patient is not an admitted patient; and</li> <li>c) the patient: <ul style="list-style-type: none"> <li>i. is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance--at least 15 km by road from the consultant specialist; or</li> <li>ii. is a care recipient in a residential care service; or</li> <li>iii. is a patient of: (a) an Aboriginal Medical Service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19(2) of the act applies.</li> </ul> </li> </ul> <p>An attendance including any of the following that are clinically relevant:</p>

<sup>14</sup> Item numbers listed here indicate a structure for the DHS to follow when assigning item numbers.



Level (item) <sup>14</sup>	Duration	Item descriptor
		<ul style="list-style-type: none"> <li>a) detailed patient history of a major single or multiple minor conditions</li> <li>b) single or multiple minor diagnostic problems considered</li> <li>c) a non-complex management plan and, if required;</li> <li>d) discussion of multiple treatment options available, including;</li> <li>i. Discussion of treatment options to assess pros and cons of each option given patient characteristics and medical history</li> <li>ii. Consideration and discussion of necessary referrals to other health professionals</li> <li>iii. Written documentation made available for the patient and/or carer that outlines treatment options and information on associated risks and benefits</li> <li>e) outcomes documented and communicated in writing to the referring practitioner</li> </ul>
Level D (THC)	41-60 minutes	<p>Professional attendance of more than 40 minutes but not more than 60 minutes by a consultant specialist in the practice of his or her speciality if:</p> <ul style="list-style-type: none"> <li>a) the attendance is by video conference; and</li> <li>b) the patient is not an admitted patient; and</li> <li>c) the patient: <ul style="list-style-type: none"> <li>i. is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance--at least 15 km by road from the consultant specialist; or</li> <li>ii. is a care recipient in a residential care service; or</li> <li>iii. is a patient of: (a) an Aboriginal Medical Service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19(2) of the act applies.</li> </ul> </li> </ul> <p>An attendance including any of the following that are clinically relevant:</p> <ul style="list-style-type: none"> <li>a) comprehensive patient history of multiple conditions or a complex single condition</li> <li>b) multiple diagnostic problems considered</li> <li>c) a comprehensive management plan and, if required;</li> <li>d) discussion of multiple treatment options available, including;</li> <li>i. Discussion of treatment options to assess pros and cons of each option given patient characteristics and medical history</li> <li>ii. Consideration and discussion of necessary referrals to other health professionals</li> <li>iii. Written documentation made available for the patient and/or carer that outlines treatment options and information on associated risks and benefits</li> </ul>



Level (item) <sup>14</sup>	Duration	Item descriptor
		Outcomes documented and communicated in writing to the referring practitioner
Level E (THE)	More than 60 minutes	<p>Professional attendance of more than 60 minutes by a consultant specialist in the practice of his or her speciality if:</p> <ul style="list-style-type: none"> <li>a) the attendance is by video conference; and</li> <li>b) the patient is not an admitted patient; and</li> <li>c) the patient: <ul style="list-style-type: none"> <li>i. is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance—at least 15 km by road from consultant specialist; or</li> <li>ii. is a care recipient in a residential care service; or</li> <li>iii. is a patient of: (a) an Aboriginal Medical Service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19(2) of the act applies.</li> </ul> </li> </ul> <p>An attendance including any of the following that are clinically relevant:</p> <ul style="list-style-type: none"> <li>a) extensive history of multiple complex conditions</li> <li>b) multiple complex diagnoses considered</li> <li>c) a comprehensive management plan and, if required;</li> <li>d) discussion of multiple treatment options available, including; <ul style="list-style-type: none"> <li>i. Discussion of treatment options to assess pros and cons of each option given patient characteristics and medical history</li> <li>ii. Consideration and discussion of necessary referrals to other health professionals</li> <li>iii. Written documentation made available for the patient and/or carer that outlines treatment options and information on associated risks and benefits</li> </ul> </li> <li>e) Outcomes documented and communicated in writing to the referring practitioner</li> </ul>

**Recommendation 10 – Reinvest in telehealth (referred to the Taskforce’s Telehealth Working Group for consideration)**

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

- a. Increase utilisation of telehealth services among consumers, GPs and PHNs, by:
  - i. developing and sharing the value proposition of telehealth with consumers, including the potential savings in time, travel and other costs;
  - ii. funding PHNs and consumer representatives (community champions) to carry out telehealth education and awareness building in targeted communities (for example, where GPs already provide telehealth);
  - iii. educating GPs and PHNs to identify and promote telehealth with patient population groups that would most benefit from telehealth attendances—





both those held directly with the specialist (for example, follow-up care) and those supported by a health professional (for example, more complex cases or where further support with health literacy is needed);

- iv. investing in education and training of primary care workers, including telehealth training days and the development of training material (for example, online modules); and
  - v. promoting the use of MBS items that already exist for primary care workers to provide clinical support to patients participating in consultant specialist telehealth attendances (Category 8 of the MBS, Groups M12, M13, and M14).
- b. Increasing the supply of telehealth services offered by consultant specialists, by:
- i. developing the value proposition of telehealth for providers and sharing this with provider population groups that are most likely to offer telehealth services;
  - ii. educating consultant specialists to identify and promote telehealth with patient population groups that would most benefit from telehealth attendances;
  - iii. developing materials on how to set up and run telehealth services;
  - iv. coordinating with Colleges to promote telehealth education and training, including awarding CPD points for telehealth training;
  - v. encouraging Colleges to educate consultant specialists on the benefits of telehealth, how to set it up, and when it should be used; and
  - vi. developing guidelines and tools to determine and resolve any clinical governance issues and concerns.

**Recommendation 11 - Introduce a new framework of case conference items and allow access to all consultant specialists**

The Committee recommends:

- a. introducing a new simplified framework of case conference items, featuring three types:
  - i. discharge planning case conferences - a case conference to facilitate better post-discharge care and communication;
  - ii. community case conferences - a case conference to facilitate the provision of better multidisciplinary care; and
  - iii. treatment planning case conferences (new) - a case conference that explores and analyses potential treatment options and their respective benefits.
- b. restructuring current case conference items, by:
  - i. Replacing “Cancer planning” conferences with “treatment planning” conferences, broadening use of these items to other conditions that require treatment planning with other members of the treatment team but are not cancer diagnoses.



- ii. Removing specialty-specific case conference items - with the exception of item 880 for geriatrics and rehabilitation medicine – with consultant specialists instead accessing the three case conference categories listed above.
- c. updating existing discharge and community case conference items (items 820, 822, 823, 825, 826 and 828, and items 830, 832, 834, 835, 837 and 838) descriptors to:
  - i. Allow all consultant specialists to claim these items.
  - ii. Require:
    - 1. mandatory GP (or delegate) participation
    - OR
    - 2. mandatory review of outcomes and communication of any proposed changes to the patient and to the case conference organiser
  - iii. Require mandatory invitation of the patient (or delegate) to participate. Their attendance should be made possible if the patient chooses to do so.
  - iv. Require outcomes to be documented in writing, including agreed, shared decisions and informed consent.
  - v. Stipulate that participants have the option to attend face to face, by videoconference, or over the telephone.
  - vi. Recommend that outcomes be uploaded to My Health Record by the GP (or delegate).
- d. update explanatory notes to:
  - i. include that the GP may not always be the clinician who is the primary care provider for the patient (e.g. complex paediatric patients are sometimes managed by a general or community paediatrician) and that in such cases, there should be mandatory participation of the patient's primary care provider; and
  - ii. clarify that GP participation or review of outcomes should not be a pre-requisite for the item being claimed by other participants.
- e. introduce six new treatment planning case conference items to discuss available treatment options with peer medical practitioners, to:
  - i. Require the organiser to send pre-briefing material to participants prior to the conference, and to prepare a written document for the conference that outlines treatment options.
  - ii. Encourage GP participation (either face to face, over the phone or by videoconference).
  - iii. Stipulate that while final treatment decisions must be made together with the patient (unless there are exceptional circumstances), patient participation in initial treatment option discussion is not mandatory.
  - iv. Recommend that outcomes be uploaded to My Health Record, with the responsibility for uploading resting with the case conference organiser (refer to *Recommendation 18*).



- f. maintain the current distinction between organiser/coordinator and participant roles;
- g. introduce a new time tier for less than 15 minutes for each of the three categories; and
- h. stipulate a minimum of 3 attendees of different disciplines at each case conference, which can include consultant specialists, GPs, AHPs, and nurse practitioners (*refer to Recommendation 12*) but should not include patients or carers.

To assist in interpreting this recommendation the Committee has provided new item descriptors in Table B.4.

**Table B.4: Case conference item descriptors**

Item	Duration	Role	New item descriptor
82X (new)	<15 minutes	Organise and coordinate	<p>Attendance by a consultant specialist in the practice of his or her specialty to [insert role] a community case conference of at least [X] minutes but less than [X] minutes, requiring:</p> <ul style="list-style-type: none"> <li>g) Specialist input to the management of a complex patient in the community; and</li> <li>h) Mandatory GP (or delegate) invitation and</li> <li>i) participation, or ii) review of outcomes and communication of any proposed changes to the patient and to the case conference organiser; and</li> <li>i) Mandatory patient (or delegate) invitation and to make it possible for them to attend; and</li> <li>j) At least two other formal care providers of different disciplines to be present; and</li> <li>k) Outcomes to be documented in writing, including shared decisions made and informed consent sought; and</li> <li>l) A copy of the case conference outcomes to be uploaded to My Health Record, unless patient consent is withdrawn, and where reasonably achievable. <p>All participants must be in communication with each other throughout the conference, either face-to-face, by telephone or by videoconference, or a combination of these</p> </li></ul>
820	15–30 minutes		
822	30–45 minutes		
823	> 45 minutes		
82Y (new)	<15 minutes	Participate	
825	15–30 minutes		
826	30–45 minutes		
828	>45 minutes		
83X (new)	<15 minutes	Organise and coordinate	<p>Attendance by a consultant specialist in the practice of his or her specialty to [insert role] a discharge case conference of at least [X] minutes but less than [X] minutes, requiring:</p> <ul style="list-style-type: none"> <li>g) The development and approval of a discharge management plan for transfer</li> </ul>
830	15–30 minutes		
832	30–45 minutes		
834	> 45 minutes		
83Y (new)	<15 minutes	Participate	



Item	Duration	Role	New item descriptor
835	15–30 minutes		<p>of care to the community setting and self-management; and</p> <p>h) Mandatory GP (or delegate) invitation and</p> <p>i) participation, or ii) review of outcomes and communication of any proposed changes to the patient and to the case conference organiser; and</p> <p>i) Mandatory patient (or delegate) invitation and to make it possible for them to attend; and</p> <p>j) At least two other formal care providers of different disciplines; and</p> <p>k) Outcomes to be documented in writing, including shared decisions made and informed consent sought; and</p> <p>l) A copy of the case conference outcomes to be uploaded to My Health Record, unless patient consent is withdrawn, and where reasonably achievable.</p> <p>All participants must be in communication with each other throughout the conference, either face-to-face, by telephone or by videoconference, or a combination of these</p>
837	30–45 minutes		
838	More than 45 minutes		
8TA (new)	<15 minutes	Organise and coordinate	<p>Attendance by a consultant specialist in the practice of his or her specialty to [insert role] a treatment planning case conference of at least [X] minutes but less than [X] minutes, requiring:</p> <p>g) Discussion of treatment options, including risks and benefits, for patients who have been diagnosed but not yet received treatment, or where a significant change in ongoing treatment requires MDT input; and</p>
8TB (new)	15–30 minute		
8TC (new)	30–45 minutes		
8TD (new)	More than 45 minutes		
8TE (new)	<15 minutes	Participate	<p>h) Written pre-brief materials to be sent prior to the conference that outlines available treatment options; and</p> <p>i) Final treatment decisions to be made together with the patient (unless there are exceptional circumstances); and</p> <p>j) At least 2 other formal care providers of different disciplines to be present; and</p> <p>k) Outcomes to be documented in writing, including shared decisions made and informed consent sought; and</p> <p>l) A copy of the case conference outcomes to be uploaded to My Health Record, unless patient consent is withdrawn, and where reasonably achievable.</p>
8TF (new)	15–30 minutes		
8TG (new)	30–45 minutes		
8TH (new)	More than 45 minutes		



Item	Duration	Role	New item descriptor
			All participants must be in communication with each other throughout the conference, either face-to-face, by telephone or by videoconference, or a combination of these

### **Recommendation 12 - Introduce case conference items for allied health professionals (AHPs) and nurse practitioners**

The Committee recommends that AHPs who access these items should be limited to those who are eligible to access AHP items under Group M3 of the MBS, including:

- i. Aboriginal and Torres Strait Islander health practitioners, Aboriginal health workers, audiologists, chiropractors, diabetes educators, dietitians, exercise physiologists, mental health nurses, occupational therapists, osteopaths, physiotherapists, podiatrists, psychologists, social workers, and speech pathologists.

*Note: Full descriptors for these items can be viewed in the final GPPCCC report.*

### **Recommendation 13 – Referral for examination of informed financial consent**

The Committee recommends that the Principles and Rules Committee examine the issue of informed financial consent for out-of-pocket fees charged with case conference items.

### **Recommendation 14 - Establish a minimum data set to inform evidence-based clinical practice and inform patient choice**

The Committee recommends a step-wise approach to establishing a national minimum data set, through:

- a. Creating linkages with the Australian Commission on Safety and Quality in Health Care to support a data-driven picture of variation in clinical practice nationally.
- b. Establishing a minimum data set to record outcome and process data on topics such as mortality, morbidity, readmissions, quality measures of consultations and patient-reported outcomes. It is recommended the data be used to:
  - i. benchmark internally and with peers (determined by the professional group) to drive quality improvement; and
  - ii. inform patient choice of institution and consultant specialist (see further information in Recommendation 15).
- c. Ensuring complete integrity in the accuracy of the data, the rigour of its analysis, and its appropriate risk-weighting before being used for the purposes of comparison. This includes, but should not be limited to, addressing the following challenges:
  - i. newly qualified consultant specialists;
  - ii. consultant specialists returning from a long leave of absence;
  - iii. the effect of a complication where the incidence of that complication is extremely low;
  - iv. consultant specialists who treat low volume disease of high complexity;
  - v. the introduction of new technologies for a service;
  - vi. the opening of new units (e.g., new hospital developments);
  - vii. consultant specialists whose referral base provides high risk patients; and
  - viii. complication “clusters”.
- d. Progressing the minimum data set into a comprehensive data set, populated by data available from private health insurers and state public health systems.



- e. Using the collection of homogenous data to inform colleges and peak bodies of trends in clinical practice so that CPD and other improvement levers can be more targeted.
- f. Support clinical audits as a mandatory part of CPD and required attendance of 80 per cent of mortality and morbidity meetings.

**Recommendation 15 – Provide transparency on the cost and quality of consultant specialist services**

The Committee recommends that:

- a. MBS cost data, including data on out-of-pocket fees, is shared at an institutional and individual provider level;
- b. consultant specialist risk-weighted outcome data discussed in Recommendation 14 is shared at an institutional, disease-specific level;
- c. cost and outcome data are publicly available to enable discussion with the GP at the time of referral; and
- d. the presentation of cost and outcome data should be co-designed with consumers and include a clear explanation of the data and its limitations.

**Recommendation 16 - Improve informed comprehensive patient consent and shared decision-making practices**

The Committee recommends:

- a. Including the following in standard attendance item descriptors (refer to Recommendation 1) when multiple treatment options are available:
  - i. discussion of patient treatment options to assess the risks and benefits of each option, given the patient's characteristics, medical history and life circumstance;
  - ii. consideration and discussion of referrals to other health professionals and services; and
  - iii. a requirement for written documentation, made available to the patient and/or carer, which outlines treatment options and information on associated risks and benefits.
- b. That provider education on the patient consent process be promoted through:
  - i. colleges, using CPD as a lever; and
  - ii. increased patient awareness of the Australian Commission on Safety and Quality in Health Care's clinical standards, achieved via media campaigns and by informing general practice.
- c. Improving the consent process by including in provider education materials, consumer information and other relevant materials the following information:
  - i. the aim of the informed consent discussion is to give a patient the information they need to make a decision about their treatment or procedure (if any) and their overall care;
  - ii. the discussion must be tailored to the individual patient and their circumstances;
  - iii. informed consent during medical practice—on both treatment options and financial costs—is an essential component of comprehensive medical care. Patient authorisation is “informed” when the physician discloses and the patient understands the diagnosis, the relevant options for treatment (including no treatment) and any respective risks and benefits;
  - iv. doctors should give advice in accordance with their scope of practice. There should be no coercion. The patient is always free to accept or reject the advice offered;



- v. clinicians should give information about the risks of any intervention, especially those that are likely to influence the patient's decisions;
- vi. the informed consent process should be documented thoroughly, using an electronic medical record, procedure-specific consent forms, patient education materials and other options whenever possible; and
- vii. mechanisms should be in place to monitor the quality of the patient consent process, such as peer review and patient reported outcomes.

#### **Recommendation 17 – Incentivise adoption of My Health Record**

The Committee recommends:

- a. introducing a single incentive payment to consultant specialists upon their adoption of My Health Record, triggered by achieving a volume of uploads that is proportional to the number of attendances that the provider performs; and
- b. reviewing the effectiveness of the incentive payment after a defined period such as two years.

#### **Recommendation 18 – Use of My Health Record for case conferences and complex plans**

The Committee recommends that:

- a. outcomes of case conferences are uploaded to My Health Record, unless patient consent is withdrawn, and where reasonably achievable, with:
  - i. for treatment planning case conferences, the specialist organising the conference responsible for the upload; and
  - ii. for community and discharge case conferences, the GP participating in the case conference responsible for the upload.
- b. geriatric complex plans and paediatric complex plans be uploaded to My Health Record, with the geriatrician or paediatrician responsible for the upload, unless patient consent is withdrawn, and where reasonably achievable.

#### **Recommendation 19 – Encourage adoption of My Health Record**

The Committee recommends:

- a. improving the functionality of My Health Record and educating consultant specialists on the benefits of its use;
- b. continuing to develop and enhance the functionality and ability to search the data of My Health Record, so that it becomes a value-add tool for consumers and clinicians in day-to-day quality patient care;
- c. broadening training for health care providers to include education about using the My Health Record system clinically, and about its benefits for patients and the health system;
  - i. including the development of appropriate scenarios relevant to the full range of health care providers across disciplines and clinical settings; and
- d. working with academic institutions to embed digital health competencies into undergraduate and postgraduate training and CPD programmes.

#### **Recommendation 20 (Not agreed) – Extend the specialist to specialist referral validity period**

The Taskforce did not agree to the Committee's recommendation to extend the specialist to specialist referral validity period from three months to six months. The Taskforce recommends maintaining the current arrangements to enable regular GP oversight of patient care by consultant specialists.

**Recommendation 21 – Introducing a new AHP pathway**

The Committee recommends the consideration introducing an AHP pathway for consultant specialists under certain circumstances, but only after a full review of the evidence and the associated costs and benefits of any suggested pathway.





## Appendix C Working group membership

**Table C.1: Time-tiered attendances**

Member	Position/organisation	Declared conflicts of interest
Dr Robert Carroll	Nephrologist, University of Adelaide	None
Dr Eleanor Chew (Ex-Officio)	GP practising in Brisbane; Member of the MBS Review Principles and Rules Committee (PARC) and the GP and Primary Care Clinical Committee	MBS Taskforce; Board Member of the Australian Digital Health Agency Member of Professional Services Review Panel; Member of the Australian Health Practitioner Regulation Agency (AHPRA) panel
Ms Debra Kay	Consumer Representative	Member of the Consumer Issues Panel and the Principles and Rules Committee
Dr Julie Thompson	General Practitioner	None
Dr Philip Truskett AM (Co-Chair)	General Surgeon at Prince of Wales Hospital, Sydney	None

**Table C.2: Telehealth**

Member	Position/organisation	Declared conflicts of interest
Mr Adam Friederich	Consumer Representative; Works in the Australian public service; Strong interest in health consumer issues; Served on other committees for the MBS Review	None
Dr John North	Senior Visiting Orthopaedic Surgeon, Princess Alexandra Hospital, Brisbane; Senior Visiting Orthopaedic Surgeon (Telehealth), Mt Isa Hospital and NWHHS; Chair of the MBS Review Orthopaedic Committee	Panel member of the Australian Health Practitioner Regulation Agency (AHPRA)
Dr Julie Thompson	General Practitioner in Victoria	None
Dr Philip Truskett AM (Co-Chair)	General Surgeon at the Prince of Wales Hospital, Sydney	None

**Table C.3: Contemporary roles of medical practitioners**

Member	Position/organisation	Declared conflicts of interest
Dr Paul Blackman	Sport and Exercise Physician, Olympic Park Sports Centre Medicine	Board Member of the Australasian College of Sports and Exercise Physicians
Ms Debra Kay PSM	Consumer Member, Medical Services Advisory Committee (MSAC) and Health Technology Assessment Consumer Consultative	None



Member	Position/organisation	Declared conflicts of interest
	Committee (CCC); Chair, MBS Review Consumer Panel; Member of the MBS Review Principles and Rules Committee	
Prof. David Story	Professor and Chair of Anaesthesia, University of Melbourne; Staff Anaesthetist, Austin Hospital, Melbourne; Part of the MBS Review for Urology	None
Prof. David Watters OBE	Chair of the Surgical and Critical Care Programme Safety and Quality Committee; General and Endocrine Surgeon at University Hospital and St John of God Hospital, Geelong; Professor of Surgery, Deakin University	Member of the Clinical Measurement and Reporting Group for the Victorian Agency of Health Information (VAHI)

**Table C.4: Use of data to inform quality care and patient choice**

Member	Position/organisation	Declared conflicts of interest
Dr Eleanor Chew (Ex-Officio)	GP practising in Brisbane; Member of the MBS Review Principles and Rules Committee (PARC) and GP and Primary Care Clinical Committee	MBS Taskforce; Board Member of the Australian Digital Health Agency; Member of the Professional Services Review Panel; Member of the AHPRA panel
Dr John North	Senior Visiting Orthopaedic Surgeon, Princess Alexandra Hospital, Brisbane; Senior Visiting Orthopaedic Surgeon (Telehealth), Mt Isa Hospital and NWHHS; Chair of the MBS Review Orthopaedic Committee	Panel member for AHPRA
Prof. Graeme Samuel AC	Non-clinician; Professional Fellow in Monash University's Business School and School of Public Health and Preventative Medicine	Member of the Sub-Committee on Specialist Out of Pocket Fees; Chair of South East Melbourne Primary Health Network; Chair of Dementia Australia; Director and Minority Shareholder of Mupharma Pty Ltd; Chair of Lorica Health Pty Ltd.

**Table C.5: Encouraging use of case conference items**

Member	Position/organisation	Declared conflicts of interest
Prof. Derek Chew	Director of Cardiology, Flinders Medical Centre and Academic at Flinders University; Committee Member of the Cardiac Services Clinical Committee	None
Dr Steve De Graaf, Chair	Senior Rehabilitation Physician and Director of Pain Services, Epworth HealthCare; Past President, Australasian Faculty of Rehabilitation Medicine (RACP)	Wife is an allied health professional
Mr Adam Friederich	Consumer Representative; Works in the Australian public service; Strong interest in health consumer issues; Served on other committees for the MBS Review	None
Dr Julie Thompson	General Practitioner in Victoria	None

**Table C.6: Acute attendances**

Member	Position/organisation	Declared conflicts of interest
Prof. Derek Chew	Director of Cardiology, Flinders Medical Centre and Academic at Flinders University; Committee Member of the Cardiac Services Clinical Committee	None
Dr Robert Carroll	Nephrologist, University of Adelaide	None
Prof. David Watters OBE	Chair of Surgical and Critical Care Programme Safety and Quality Committee; General and Endocrine Surgeon at University Hospital and St John of God Hospital, Geelong; Professor of Surgery, Deakin University	Member of the Clinical Measurement and Reporting Group for the Victorian Agency of Health Information (VAHI)

**Table C.7: Case conference cost-shifting**

Member	Position/organisation	Declared conflicts of interest
Dr Steve De Graaf, Chair	Senior Rehabilitation Physician and Director of Pain Services, Epworth HealthCare; Past President, Australasian Faculty of Rehabilitation Medicine (RACP)	Wife is an allied health professional
Dr Philip Truskett AM (Co-chair)	General Surgeon at the Prince of Wales Hospital, Sydney	None
Dr Andrew Singer	Principle Medical Adviser in the Department of Health; Adjunct Associate Professor in the Australian National University Medical School; Emergency Medicine Physician	Department of Health Employee

**Table C.8: Fetal alcohol spectrum disorder and other complex neurodevelopmental disorders**

Member	Position/organisation	Declared conflicts of interest
Prof. Anthony Lawler (Co-Chair)	Emergency Physician; Past President of the Australasian College for Emergency Medicine (ACEM); Chief Medical Officer in Tasmania	Board member of ACEM; Jurisdictional employee in Tasmania
Dr Philip Truskett AM (Co-Chair)	General Surgeon at the Prince of Wales Hospital, Sydney	None
Prof. Malcolm Hopwood (Chair of Psychiatry Clinical Committee)	Professor of Psychiatry, Ramsay Health Care; Member of the Board of the Sumner Foundation; Member of the Board of Phoenix Australia	None
Prof. Elizabeth Elliott	Clinical Academic at the University of Sydney; Consultant Paediatrician Sydney Children's Hospital Network (Westmead); Recent research focus on fetal alcohol spectrum disorders	None
Dr James Oldham (Member of Psychiatry Clinical Committee)	Senior Staff Specialist Psychiatrist, Child and Mental Health Services, Adolescent Inpatient Service & Adolescent Day Unit, Shellharbour Hospital	None



Member	Position/organisation	Declared conflicts of interest
A/Professor Beth Kotze (Member of Psychiatry Clinical Committee)	Executive Director Mental Health, Western Sydney Local Health District	None
Dr Peter Jenkins (Member of Psychiatry Clinical Committee)	Psychiatrist	Board Director of RANZCP; Chair of the MBS Review Working Group of RANZCP



## Appendix D Summary for consumers

This table describes the medical service, the recommendation(s) of the Committee and why the recommendation(s) has been made.

**Table D.1. Standard attendance items**

Item	What it does	Committee recommendation	What would be different	Why
104	Professional attendance at consulting rooms or hospital by a specialist in the practice of his or her specialty after referral of the patient to him or her—each attendance, other than a second or subsequent attendance, in a single course of treatment, other than a service to which item 106, 109 or 16401 applies	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance item	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services
105	Professional attendance by a specialist in the practice of his or her specialty following referral of the patient to him or her—an attendance after the first in a single course of treatment, if that attendance is at consulting rooms or hospital	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance item	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services
106	Professional attendance by a specialist in the practice of his or her specialty of ophthalmology and following referral of the patient to him or her—an attendance (other than a second or subsequent attendance in a single course of treatment) at which the only service provided is refraction testing for the issue of a prescription for spectacles or contact lenses, if that attendance is at consulting rooms or hospital (other than a service to which any of items 104, 109 and 10801 to 10816 applies)	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance item	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services
107	Professional attendance by a specialist in the practice of his or her specialty following referral of the patient to him or her—an attendance (other than a second or subsequent attendance in a single course of treatment), if that attendance is at a place other than consulting rooms or hospital	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance item	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services
108	Professional attendance by a specialist in the practice of his or her specialty following referral of the patient to him or her—each attendance after the first in a single course of treatment, if that attendance is at a place other than consulting rooms or hospital	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance item	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services
109	Professional attendance by a specialist in the practice of his or her specialty of ophthalmology following referral of the patient to him or her—an attendance (other than a second or subsequent attendance in a	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the	Makes the standard attendance model more



Item	What it does	Committee recommendation	What would be different	Why
	single course of treatment) at which a comprehensive eye examination, including pupil dilation, is performed on: (a) a patient aged 9 years or younger; or (b) a patient aged 14 years or younger with developmental delay;(other than a service to which any of items 104, 106 and 10801 to 10816 applies)		current standard attendance item	simple, equitable, and enables more consistent billing for similar services
110	Professional attendance at consulting rooms or hospital, by a consultant physician in the practice of his or her specialty (other than psychiatry) following referral of the patient to him or her by a referring practitioner—initial attendance in a single course of treatment	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance item	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services
111	Professional attendance at consulting rooms or in hospital by a specialist in the practice of his or her specialty following referral of the patient to him or her by a referring practitioner—an attendance after the first attendance in a single course of treatment, if: (a) during the attendance, the specialist determines the need to perform an operation on the patient that had not otherwise been scheduled; and (b) the specialist subsequently performs the operation on the patient, on the same day; and (c) the operation is a service to which an item in Group T8 applies; and (d) the amount specified in the item in Group T8 as the fee for a service to which that item applies is \$300 or more For any particular patient, once only on the same day	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance item	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services
116	Professional attendance at consulting rooms or hospital, by a consultant physician in the practice of his or her specialty (other than psychiatry) following referral of the patient to him or her by a referring practitioner—each attendance (other than a service to which item 119 applies) after the first in a single course of treatment	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance item	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services
117	Professional attendance at consulting rooms or in hospital, by a consultant physician in the practice of his or her specialty (other than psychiatry) following referral of the patient to him or her by a referring practitioner—an attendance after the first attendance in a single course of treatment, if: (a) the attendance is not a minor attendance; and (b) during the attendance, the consultant physician determines the need to perform an operation on the patient that had not otherwise been scheduled; and (c) the consultant physician subsequently performs the operation on the patient, on the same day; and (d) the operation is a service to which an item in Group T8 applies; and (e) the amount specified in the item in Group T8 as the fee for a service to which that item applies is \$300 or more For any particular patient, once only on the same day	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance item	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services
119	Professional attendance at consulting rooms or hospital, by a consultant physician in the practice of his or her specialty (other than psychiatry) following referral of the patient to him or her by a referring	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the	Makes the standard attendance model more



Item	What it does	Committee recommendation	What would be different	Why
	practitioner—each minor attendance after the first in a single course of treatment		current standard attendance item	simple, equitable, and enables more consistent billing for similar services
120	Professional attendance at consulting rooms or in hospital by a consultant physician in the practice of his or her specialty (other than psychiatry) following referral of the patient to him or her by a referring practitioner—an attendance after the first attendance in a single course of treatment, if: (a) the attendance is a minor attendance; and (b) during the attendance, the consultant physician determines the need to perform an operation on the patient that had not otherwise been scheduled; and (c) the consultant physician subsequently performs the operation on the patient, on the same day; and (d) the operation is a service to which an item in Group T8 applies; and (e) the amount specified in the item in Group T8 as the fee for a service to which that item applies is \$300 or more For any particular patient, once only on the same day	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance item	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services
122	Professional attendance at a place other than consulting rooms or hospital, by a consultant physician in the practice of his or her specialty (other than psychiatry) following referral of the patient to him or her by a referring practitioner—initial attendance in a single course of treatment	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance item	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services
128	Professional attendance at a place other than consulting rooms or hospital, by a consultant physician in the practice of his or her specialty (other than psychiatry) following referral of the patient to him or her by a referring practitioner—each attendance (other than a service to which item 131 applies) after the first in a single course of treatment	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance item	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services
131	Professional attendance at a place other than consulting rooms or hospital, by a consultant physician in the practice of his or her specialty (other than psychiatry) following referral of the patient to him or her by a referring practitioner—each minor attendance after the first in a single course of treatment	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance item	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services
160	Professional attendance for a period of not less than 1 hour but less than 2 hours (other than a service to which another item applies) on a patient in imminent danger of death	No change	-	-
161	Professional attendance for a period of not less than 2 hours but less than 3 hours (other than a service to which another item applies) on a patient in imminent danger of death	No change	-	-



Item	What it does	Committee recommendation	What would be different	Why
162	Professional attendance for a period of not less than 3 hours but less than 4 hours (other than a service to which another item applies) on a patient in imminent danger of death	No change	-	-
163	Professional attendance for a period of not less than 4 hours but less than 5 hours (other than a service to which another item applies) on a patient in imminent danger of death	No change	-	-
164	Professional attendance for a period of 5 hours or more (other than a service to which another item applies) on a patient in imminent danger of death	No change	-	-
385	Professional attendance at consulting rooms or hospital by a consultant occupational physician in the practice of his or her specialty of occupational medicine following referral of the patient to him or her by a referring practitioner--initial attendance in a single course of treatment	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance item	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services
386	Professional attendance at consulting rooms or hospital by a consultant occupational physician in the practice of his or her specialty of occupational medicine following referral of the patient to him or her by a referring practitioner--each attendance after the first in a single course of treatment	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance item	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services
387	Professional attendance at a place other than consulting rooms or hospital by a consultant occupational physician in the practice of his or her specialty of occupational medicine following referral of the patient to him or her by a referring practitioner--initial attendance in a single course of treatment	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance item	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services
388	Professional attendance at a place other than consulting rooms or hospital by a consultant occupational physician in the practice of his or her specialty of occupational medicine following referral of the patient to him or her by a referring practitioner--each attendance after the first in a single course of treatment	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance item	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services
410	Professional attendance at consulting rooms by a public health physician in the practice of his or her specialty of public health medicine--attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management.	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance item	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services





Item	What it does	Committee recommendation	What would be different	Why
411	Professional attendance by a public health physician in the practice of his or her specialty of public health medicine at consulting rooms, 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 one or more health-related issues, with appropriate documentation.	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance item	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services
412	Professional attendance by a public health physician in the practice of his or her specialty of public health medicine at consulting rooms, 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 one or more health-related issues, with appropriate documentation	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance item	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services
413	Professional attendance by a public health physician in the practice of his or her specialty of public health medicine at consulting rooms, 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 one or more health-related issues, with appropriate documentation	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance item	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services
414	Professional attendance at other than consulting rooms by a public health physician in the practice of his or her specialty of public health medicine-- attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance item	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services
415	Professional attendance by a public health physician in the practice of his or her specialty of public health medicine at other than consulting rooms, 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 one or more health-related issues, with appropriate documentation	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance item	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services
416	Professional attendance by a public health physician in the practice of his or her specialty of public health medicine at other than consulting rooms, 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 one or more health-related issues, with appropriate documentation	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance item	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services



Item	What it does	Committee recommendation	What would be different	Why
417	Professional attendance by a public health physician in the practice of his or her specialty of public health medicine at other than consulting rooms, 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 one or more health-related issues, with appropriate documentation	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance item	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services
2801	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine following referral of the patient to him or her by a referring practitioner--initial attendance in a single course of treatment	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance item	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services
2806	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine following referral of the patient to him or her by a referring practitioner--each attendance (other than a service to which item 2814 applies) after the first in a single course of treatment	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance item	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services
2814	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine following referral of the patient to him or her by a referring practitioner--each minor attendance after the first attendance in a single course of treatment	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance item	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services
2824	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine following referral of the patient to him or her by a referring practitioner--initial attendance in a single course of treatment	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance item	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services
2832	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine following referral of the patient to him or her by a referring practitioner--each attendance (other than a service to which item 2840 applies) after the first in a single course of treatment	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance item	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services



Item	What it does	Committee recommendation	What would be different	Why
2840	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine following referral of the patient to him or her by a referring practitioner--each minor attendance after the first attendance in a single course of treatment	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance item	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services
3005	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine following referral of the patient to him or her by a referring practitioner--initial attendance in a single course of treatment	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance item	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services
3010	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine following referral of the patient to him or her by a referring practitioner--each attendance (other than a service to which item 3014 applies) after the first in a single course of treatment	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance item	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services
3014	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine following referral of the patient to him or her by a referring practitioner--each minor attendance after the first attendance in a single course of treatment	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance item	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services
3018	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine following referral of the patient to him or her by a referring practitioner--initial attendance in a single course of treatment	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance item	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services
3023	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine following referral of the patient to him or her by a referring practitioner--each attendance (other than a service to which item 3028 applies) after the first in a single course of treatment	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance item	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services
3028	Professional attendance at a place other than consulting rooms or hospital by a specialist, or	Remove from MBS; replace with time-	Time-tiered attendance items	Makes the standard



Item	What it does	Committee recommendation	What would be different	Why
	consultant physician, in the practice of his or her specialty of palliative medicine following referral of the patient to him or her by a referring practitioner--each minor attendance after the first attendance in a single course of treatment	tiered standard attendances	would replace the current standard attendance item	attendance model more simple, equitable, and enables more consistent billing for similar services
6007	Professional attendance by a specialist in the practice of neurosurgery following referral of the patient to him or her--an attendance (other than a second or subsequent attendance in a single course of treatment) at consulting rooms or hospital	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance item	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services
6009	Professional attendance by a specialist in the practice of neurosurgery following referral of the patient to him or her--a minor attendance after the first in a single course of treatment at consulting rooms or hospital	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance item	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services
6011	Professional attendance by a specialist in the practice of neurosurgery following referral of the patient to him or her--an attendance after the first in a single course of treatment, involving an extensive and comprehensive examination, arranging any necessary investigations in relation to one or more complex problems and of more than 15 minutes in duration but not more than 30 minutes in duration at consulting rooms or hospital	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance item	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services
6013	Professional attendance by a specialist in the practice of neurosurgery following referral of the patient to him or her--an attendance after the first in a single course of treatment, involving a detailed and comprehensive examination, arranging any necessary investigations in relation to one or more complex problems and of more than 30 minutes in duration but not more than 45 minutes in duration at consulting rooms or hospital	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance item	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services
6015	Professional attendance by a specialist in the practice of neurosurgery following referral of the patient to him or her--an attendance after the first in a single course of treatment, involving an exhaustive and comprehensive examination, arranging any necessary investigations in relation to one or more complex problems and of more than 45 minutes in duration at consulting rooms or hospital	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance item	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services
6018	Professional attendance by an addiction medicine specialist in the practice of his or her specialty following referral of the patient to him or her by a referring practitioner, if the attendance: (a) includes a	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the	Makes the standard attendance model more



Item	What it does	Committee recommendation	What would be different	Why
	comprehensive assessment; and (b) is the first or only time in a single course of treatment that a comprehensive assessment is provided		current standard attendance item	simple, equitable, and enables more consistent billing for similar services
6019	Professional attendance by an addiction medicine specialist in the practice of his or her specialty following referral of the patient to him or her by a referring practitioner, if the attendance is a patient assessment: (a) before or after a comprehensive assessment under item 6018 in a single course of treatment; or (b) that follows an initial assessment under item 6023 in a single course of treatment; or (c) that follows a review under item 6024 in a single course of treatment	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance item	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services
6051	Professional attendance by a sexual health medicine specialist in the practice of his or her specialty following referral of the patient to him or her by a referring practitioner, if the attendance: (a) includes a comprehensive assessment; and (b) is the first or only time in a single course of treatment that a comprehensive assessment is provided	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance item	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services
6052	Professional attendance by a sexual health medicine specialist in the practice of his or her specialty following referral of the patient to him or her by a referring practitioner, if the attendance is a patient assessment: (a) before or after a comprehensive assessment under item 6051 in a single course of treatment; or (b) that follows an initial assessment under item 6057 in a single course of treatment; or (c) that follows a review under item 6058 in a single course of treatment	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance item	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services
6062	Professional attendance at a place other than consulting rooms or a hospital by a sexual health medicine specialist in the practice of his or her specialty following referral of the patient to him or her by a referring practitioner--initial attendance in a single course of treatment	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance item	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services
6063	Professional attendance at a place other than consulting rooms or a hospital by a sexual health medicine specialist in the practice of his or her specialty following referral of the patient to him or her by a referring practitioner--each attendance after the attendance under item 6062 in a single course of treatment	Remove from MBS; replace with time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance item	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services
Recommendation 2	Introduce new attendance items for acute, urgent and unplanned attendances	Introduce the new items	There would be four new time-tiered attendance items which could only be used in specific situations where the	To reimburse acute, urgent and unplanned attendances at a fee higher than the



Item	What it does	Committee recommendation	What would be different	Why
			attendance is acute, urgent, unplanned, and does not take place in consulting rooms or in the ED of a public hospital	schedule fee for standard time-tiered attendances of an equivalent duration, recognising that they may result in a consultant specialist postponing or cancelling a previously scheduled procedural risk, and that these attendances often involve multiple face-to-face patient interactions, conversations with other medical professionals and liaising with carers to access patient information
Recommendation 3	Consider further issues when implementing time-tiering	Consider: (a) collecting data on the duration of attendances across specialties, and activities performed; (b) using this data to model the impact of time-tiering on service volume and benefits; (c) investing in change management; (d) making the model clear; (e) adding a longer time tier should the need be identified; (f) regular reviews of items post-implementation; (g) making descriptors detailed to enable auditing; (h) harmonising time-tiers in the MBS that apply to other consultant specialists; and (i) setting time-tiers that have the most	Ensures that time-tiering is effective in achieving its goals	To ensure that relevant considerations are addressed when time-tiering is implemented



Item	What it does	Committee recommendation	What would be different	Why
		common attendance times near the middle of each tier, to support fair and reasonable practice		
Recommendation 4	Approach to fee-setting	Consider the approach to fee-setting, including building support for the principles of time-tiering before introducing schedule fees; ensuring a linear relationship between attendance time tiers and schedule fees from the outset; recognising the non-face-to-face time spent on each attendance; and recognising the lack of current data	Ensure that fees are supported and appropriately reflect the new workload for clinicians	To assist the fee setting process to set appropriate fees
Recommendation 5	Impact of time-tiering on distant outreach services	To address the potential concerns of time-tiering on distant outreach services: data will need to be collected; if such a problem exists a non-MBS process will need to be identified; any such process should continue to support patient access; and a community need demonstrated.	Ensure time-tiering is effective in achieving its goals	To ensure that relevant considerations are addressed when time-tiering is implemented

**Table D.2. Complex management plans attendance items**

Item	What it does	Committee recommendation	What would be different	Why
132	Professional attendance by a consultant physician in the practice of his or her specialty (other than psychiatry) of at least 45 minutes in duration for an initial assessment of a patient with at least 2 morbidities (which may include complex congenital, developmental and behavioural disorders) following referral of the patient to him or her by a referring practitioner, if: (a) an assessment is undertaken that covers: (i) a comprehensive history, including psychosocial history and medication review; and (ii) comprehensive multi or detailed single organ system assessment; and (iii) the	Remove from MBS; Complex plans to be claimed via standard time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance items and complex management plans attendance items	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services



Item	What it does	Committee recommendation	What would be different	Why
	formulation of differential diagnoses; and (b) a consultant physician treatment and management plan of significant complexity is prepared and provided to the referring practitioner, which involves: (i) an opinion on diagnosis and risk assessment; and (ii) treatment options and decisions; and (iii) medication recommendations; and (c) an attendance on the patient to which item 110, 116 or 119 applies did not take place on the same day by the same consultant physician; and (d) this item has not applied to an attendance on the patient in the preceding 12 months by the same consultant physician			
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.	Remove from MBS; Complex plans to be claimed via standard time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance items and complex management plans attendance items	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services
135	Professional attendance of at least 45 minutes in duration at consulting rooms or hospital, by a consultant physician in the practice of his or her specialty of paediatrics, following referral of the patient to the consultant by a referring practitioner, for assessment, diagnosis and preparation of a treatment and management plan for a patient aged under 13 years with autism or another pervasive developmental disorder, if the consultant paediatrician does all of the following: (a) undertakes a comprehensive assessment and makes a diagnosis (if appropriate, using information provided by an eligible allied health provider); (b) develops a treatment and management plan, which must include the following: (i) an assessment and diagnosis of the patient's condition; (ii) a risk assessment; (iii) treatment options and decisions; (iv) if necessary—	Change item descriptor to ensure paediatric complex plans are performed by a consultant paediatrician including an assessment ' <i>for the purposes of making a diagnosis</i> ' of the patient's condition	The item for paediatric complex plans remains in place with a strengthened descriptor	To allow appropriate access to paediatric complex plan items and their associated AHP services for appropriate patients, including children with fetal alcohol spectrum disorder and other complex neurodevelopmental disorders





Item	What it does	Committee recommendation	What would be different	Why
	medical recommendations; (c) provides a copy of the treatment and management plan to: (i) the referring practitioner; and (ii) one or more allied health providers, if appropriate, for the treatment of the patient;(other than attendance on a patient for whom payment has previously been made under this item or item 137, 139 or 289)			
137	Specialist or consultant physician, referred consultation for assessment, diagnosis and development of a treatment and management plan for a child with an eligible disability - surgery or hospital professional attendance of at least 45 minutes duration, at consulting rooms or hospital, by a specialist or consultant physician, for assessment, diagnosis and the preparation of a treatment and management plan for a child aged under 13 years, with an eligible disability, who has been referred to the specialist or consultant physician by a referring practitioner, if the specialist or consultant physician does the following:(a) undertakes a comprehensive assessment of the child and forms a diagnosis (using the assistance of one or more allied health providers where appropriate)(b) develops a treatment and management plan which must include the following: (i) the outcomes of the assessment; (ii) the diagnosis or diagnoses; (iii) opinion on risk assessment; (iv) treatment options and decisions; (v) appropriate medication recommendations, where necessary.(c) provides a copy of the treatment and management plan to the: (i) referring practitioner; and (ii) relevant allied health providers (where appropriate).not being an attendance on a child in respect of whom payment has previously been made under this item or items 135, 139 or 289.	Change item descriptor to ensure paediatric complex plans are performed by a consultant paediatrician including an assessment ' <i>for the purposes of making a diagnosis</i> ' of the patient's condition	The item for paediatric complex plans remains in place with a strengthened descriptor	To allow appropriate access to paediatric complex plan items and their associated AHP services for appropriate patients, including children with fetal alcohol spectrum disorder and other complex neurodevelopmental disorders
141	Professional attendance of more than 60 minutes in duration at consulting rooms or hospital by a consultant physician or specialist in the practice of his or her specialty of geriatric medicine, if: (a) the patient is at least 65 years old and referred by a medical practitioner practising in general practice (including a general practitioner, but not including a specialist or consultant physician) or a participating nurse practitioner; and (b) the attendance is initiated by the referring practitioner for the provision of a comprehensive assessment and management plan; and (c) during the attendance: (i) the medical, physical, psychological and social aspects of the patient's health are evaluated in detail using appropriately validated assessment tools if indicated (the assessment); and (ii) the patient's various health problems and care needs are identified and prioritised (the formulation); and (iii) a detailed management plan is prepared (the management plan) setting out: (a) the prioritised list of health problems and care needs; and (b) short and longer term	No change as per Recommendation 8	No change	The Committee agreed to retain these items



Item	What it does	Committee recommendation	What would be different	Why
	management goals; and (c) recommended actions or intervention strategies to be undertaken by the patient's general practitioner or another relevant health care provider that are likely to improve or maintain health status and are readily available and acceptable to the patient and the patient's family and carers; and (iv) the management plan is explained and discussed with the patient and, if appropriate, the patient's family and any carers; and (v) the management plan is communicated in writing to the referring practitioner; and (d) an attendance to which item 104, 105, 107, 108, 110, 116 or 119 applies has not been provided to the patient on the same day by the same practitioner; and (e) an attendance to which this item or item 145 applies has not been provided to the patient by the same practitioner in the preceding 12 months			
143	Professional attendance of more than 30 minutes in duration at consulting rooms or hospital by a consultant physician or specialist in the practice of his or her specialty of geriatric medicine to review a management plan previously prepared by that consultant physician or specialist under item 141 or 145, if: (a) the review is initiated by the referring medical practitioner practising in general practice or a participating nurse practitioner; and (b) during the attendance: (i) the patient's health status is reassessed; and (ii) a management plan prepared under item 141 or 145 is reviewed and revised; and (iii) the revised management plan is explained to the patient and (if appropriate) the patient's family and any carers and communicated in writing to the referring practitioner; and (c) an attendance to which item 104, 105, 107, 108, 110, 116 or 119 applies was not provided to the patient on the same day by the same practitioner; and (d) an attendance to which item 141 or 145 applies has been provided to the patient by the same practitioner in the preceding 12 months; and (e) an attendance to which this item or item 147 applies has not been provided to the patient in the preceding 12 months, unless there has been a significant change in the patient's clinical condition or care circumstances that requires a further review	No change as per Recommendation 8	No change	The Committee agreed to retain these items
145	Professional attendance of more than 60 minutes in duration at a place other than consulting rooms or hospital by a consultant physician or specialist in the practice of his or her specialty of geriatric medicine, if: (a) the patient is at least 65 years old and referred by a medical practitioner practising in general practice (including a general practitioner, but not including a specialist or consultant physician) or a participating nurse practitioner; and (b) the attendance is initiated by the referring practitioner for the provision of a comprehensive assessment and management plan; and (c) during the attendance: (i) the	No change as per Recommendation 8	No change	The Committee agreed to retain these items



Item	What it does	Committee recommendation	What would be different	Why
	<p>medical, physical, psychological and social aspects of the patient's health are evaluated in detail utilising appropriately validated assessment tools if indicated (the assessment); and (ii) the patient's various health problems and care needs are identified and prioritised (the formulation); and (iii) a detailed management plan is prepared (the management plan) setting out: (a) the prioritised list of health problems and care needs; and (b) short and longer term management goals; and (c) recommended actions or intervention strategies, to be undertaken by the patient's general practitioner or another relevant health care provider that are likely to improve or maintain health status and are readily available and acceptable to the patient, the patient's family and any carers; and (iv) the management plan is explained and discussed with the patient and, if appropriate, the patient's family and any carers; and (v) the management plan is communicated in writing to the referring practitioner; and (d) an attendance to which item 104, 105, 107, 108, 110, 116 or 119 applies has not been provided to the patient on the same day by the same practitioner; and (e) an attendance to which this item or item 141 applies has not been provided to the patient by the same practitioner in the preceding 12 months</p>			
147	<p>Professional attendance of more than 30 minutes in duration at a place other than consulting rooms or hospital by a consultant physician or specialist in the practice of his or her specialty of geriatric medicine to review a management plan previously prepared by that consultant physician or specialist under items 141 or 145, if: (a) the review is initiated by the referring medical practitioner practising in general practice or a participating nurse practitioner; and (b) during the attendance: (i) the patient's health status is reassessed; and (ii) a management plan that was prepared under item 141 or 145 is reviewed and revised; and (iii) the revised management plan is explained to the patient and (if appropriate) the patient's family and any carers and communicated in writing to the referring practitioner; and (c) an attendance to which item 104, 105, 107, 108, 110, 116 or 119 applies has not been provided to the patient on the same day by the same practitioner; and (d) an attendance to which item 141 or 145 applies has been provided to the patient by the same practitioner in the preceding 12 months; and (e) an attendance to which this item or 143 applies has not been provided by the same practitioner in the preceding 12 months, unless there has been a significant change in the patient's clinical condition or care circumstances that requires a further review</p>	No change as per Recommendation 8	No change	The Committee agreed to retain these items
6023	Professional attendance by an addiction medicine specialist in the practice of his or her	Remove from MBS; Complex plans to	Time-tiered attendance items would replace the	Makes the standard attendance model



Item	What it does	Committee recommendation	What would be different	Why
	specialty of at least 45 minutes for an initial assessment of a patient with at least 2 morbidities, following referral of the patient to him or her by a referring practitioner, if: (a) an assessment is undertaken that covers: (i) a comprehensive history, including psychosocial history and medication review; and (ii) a comprehensive multi or detailed single organ system assessment; and (iii) the formulation of differential diagnoses; and (b) an addiction medicine specialist treatment and management plan of significant complexity that includes the following is prepared and provided to the referring practitioner: (i) an opinion on diagnosis and risk assessment; (ii) treatment options and decisions; (iii) medication recommendations; and (c) an attendance on the patient to which item 104, 105, 110, 116, 119, 132, 133, 6018 or 6019 applies did not take place on the same day by the same addiction medicine specialist; and (d) neither this item nor item 132 has applied to an attendance on the patient in the preceding 12 months by the same addiction medicine specialist	be claimed via standard time-tiered standard attendances	current standard attendance items and complex management plans attendance items	more simple, equitable, and enables more consistent billing for similar services
6024	Professional attendance by an addiction medicine specialist in the practice of his or her specialty of at least 20 minutes, after the first attendance in a single course of treatment, for a review of a patient with at least 2 morbidities if: (a) a review is undertaken that covers: (i) review of initial presenting problems and results of diagnostic investigations; and (ii) review of responses to treatment and medication plans initiated at time of initial consultation; and (iii) comprehensive multi or detailed single organ system assessment; and (iv) review of original and differential diagnoses; and (b) the modified addiction medicine specialist treatment and management plan is provided to the referring practitioner, which involves, if appropriate: (i) a revised opinion on diagnosis and risk assessment; and (ii) treatment options and decisions; and (iii) revised medication recommendations; and (c) an attendance on the patient to which item 104, 105, 110, 116, 119, 132, 133, 6018 or 6019 applies did not take place on the same day by the same addiction medicine specialist; and (d) item 6023 applied to an attendance claimed in the preceding 12 months; and (e) the attendance under this item is claimed by the same addiction medicine specialist who claimed item 6023 or by a locum tenens; and (f) this item has not applied more than twice in any 12 month period	Remove from MBS; Complex plans to be claimed via standard time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance items and complex management plans attendance items	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services
6057	Professional attendance by a sexual health medicine specialist in the practice of his or her specialty of at least 45 minutes for an initial assessment of a patient with at least 2 morbidities, following referral of the patient to him or her by a referring practitioner, if: (a) an assessment is undertaken that covers: (i) a	Remove from MBS; Complex plans to be claimed via standard time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance items and complex management plans attendance items	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services



Item	What it does	Committee recommendation	What would be different	Why
	comprehensive history, including psychosocial history and medication review; and (ii) a comprehensive multi or detailed single organ system assessment; and (iii) the formulation of differential diagnoses; and (b) a sexual health medicine specialist treatment and management plan of significant complexity that includes the following is prepared and provided to the referring practitioner: (i) an opinion on diagnosis and risk assessment; (ii) treatment options and decisions; (iii) medication recommendations; and (c) an attendance on the patient to which item 104, 105, 110, 116, 119, 132, 133, 6051 or 6052 applies did not take place on the same day by the same sexual health medicine specialist; and (d) neither this item nor item 132 has applied to an attendance on the patient in the preceding 12 months by the same sexual health medicine specialist			
6058	Professional attendance by a sexual health medicine specialist in the practice of his or her specialty of at least 20 minutes, after the first attendance in a single course of treatment, for a review of a patient with at least 2 morbidities if: (a) a review is undertaken that covers: (i) review of initial presenting problems and results of diagnostic investigations; and (ii) review of responses to treatment and medication plans initiated at time of initial consultation; and (iii) comprehensive multi or detailed single organ system assessment; and (iv) review of original and differential diagnoses; and (b) the modified sexual health medicine specialist treatment and management plan is provided to the referring practitioner, which involves, if appropriate: (i) a revised opinion on diagnosis and risk assessment; and (ii) treatment options and decisions; and (iii) revised medication recommendations; and (c) an attendance on the patient, being an attendance to which item 104, 105, 110, 116, 119, 132, 133, 6051 or 6052 applies did not take place on the same day by the same sexual health medicine specialist; and (d) item 6057 applied to an attendance claimed in the preceding 12 months; and (e) the attendance under this item is claimed by the same sexual health medicine specialist who claimed item 6057 or by a locum tenens; and (f) this item has not applied more than twice in any 12 month period	Remove from MBS; Complex plans to be claimed via standard time-tiered standard attendances	Time-tiered attendance items would replace the current standard attendance items and complex management plans attendance items	Makes the standard attendance model more simple, equitable, and enables more consistent billing for similar services

**Table D.3. Telehealth attendance items (referred to the Taskforce's Telehealth Working Group for consideration)**

Item	What it does	Committee recommendation	What would be different	Why
99	Professional attendance on a patient by a specialist practising in his or her specialty if: (a) the attendance is by video conference; and (b) the attendance is for a	Step-wise reduction in loading followed by introduction of time-tiered telehealth attendance items	The derived fee on loading items would be incrementally reduced to zero and new telehealth-specific attendance items would be	Removes a MBS telehealth loading that is no longer effective and reinvesting this



Item	What it does	Committee recommendation	What would be different	Why
	service: (i) provided with item 104 lasting more than 10 minutes; or (ii) provided with item 105; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance—at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19(2) of the act applies		introduced that mirror the standard time-tiered attendance items	saving to increase uptake of telehealth services
112	Professional attendance on a patient by a consultant physician practising in his or her specialty if: (a) the attendance is by video conference; and (b) the attendance is for a service: (i) provided with item 110 lasting more than 10 minutes; or (ii) provided with item 116, 119, 132 or 133; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance—at least 15 kms by road from the physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19(2) of the act applies	Step-wise reduction in loading followed by introduction of time-tiered telehealth attendance items	The derived fee on loading items would be incrementally reduced to zero and new telehealth-specific attendance items would be introduced that mirror the standard time-tiered attendance items	Removes a MBS telehealth loading that is no longer effective and reinvesting this saving to increase uptake of telehealth services
113	Initial professional attendance of 10 minutes or less in duration on a patient by a specialist in the practice of his or her specialty if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance—at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19(2) of the act applies; and (d) no other initial consultation has taken place for a single course of treatment	Remove from MBS	The specialty-specific telehealth items would be removed from the MBS, and new telehealth-specific attendance items would be introduced to mirror the standard time-tiered attendance items	Removes a MBS telehealth loading that is no longer effective and reinvesting this saving to increase uptake of telehealth services



Item	What it does	Committee recommendation	What would be different	Why
114	Initial professional attendance of 10 minutes or less in duration on a patient by a consultant physician practising in his or her specialty if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance—at least 15 kms by road from the physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19(2) of the act applies; and (d) no other initial consultation has taken place for a single course of treatment	Remove from MBS	The specialty-specific telehealth items would be removed from the MBS, and new telehealth-specific attendance items would be introduced to mirror the standard time-tiered attendance items	Removes a MBS telehealth loading that is no longer effective and reinvesting this saving to increase uptake of telehealth services
149	Professional attendance on a patient by a consultant physician or specialist practising in his or her specialty of geriatric medicine if: (a) the attendance is by video conference; and (b) item 141 or 143 applies to the attendance; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance—at least 15 kms by road from the physician or specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19(2) of the act applies	Step-wise reduction in loading followed by introduction of time-tiered telehealth attendance items	The derived fee on loading items would be incrementally reduced to zero and new telehealth-specific attendance items would be introduced that mirror the standard time-tiered attendance items	Removes a MBS telehealth loading that is no longer effective and reinvesting this saving to increase uptake of telehealth services
384	Initial professional attendance of 10 minutes or less in duration on a patient by a consultant occupational physician practising in his or her specialty of occupational medicine if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance—at least 15 kms by road from the physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19(2) of the act applies; and (d) no other initial	Remove from MBS	The specialty-specific telehealth items would be removed from the MBS, and new telehealth-specific attendance items would be introduced to mirror the standard time-tiered attendance items	Removes a MBS telehealth loading that is no longer effective and reinvesting this saving to increase uptake of telehealth services



Item	What it does	Committee recommendation	What would be different	Why
	consultation has taken place for a single course of treatment			
389	Professional attendance on a patient by a consultant occupational physician practising in his or her specialty of occupational medicine if: (a) the attendance is by video conference; and (b) the attendance is for a service: (i) provided with item 385 lasting more than 10 minutes; or (ii) provided with item 386; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance--at least 15 kms by road from the physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19(2) of the act applies	Step-wise reduction in loading followed by introduction of time-tiered telehealth attendance items	The derived fee on loading items would be incrementally reduced to zero and new telehealth-specific attendance items would be introduced that mirror the standard time-tiered attendance items	Removes a MBS telehealth loading that is no longer effective and reinvesting this saving to increase uptake of telehealth services
2799	Initial professional attendance of 10 minutes or less in duration on a patient by a specialist or consultant physician practising in his or her specialty of pain medicine if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance--at least 15 kms by road from the specialist or physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19(2) of the act applies; and (d) no other initial consultation has taken place for a single course of treatment	Remove from MBS	The specialty-specific telehealth items would be removed from the MBS, and new telehealth-specific attendance items would be introduced to mirror the standard time-tiered attendance items	Removes a MBS telehealth loading that is no longer effective and reinvesting this saving to increase uptake of telehealth services
2820	Professional attendance on a patient by a specialist or consultant physician practising in his or her specialty of pain medicine if: (a) the attendance is by video conference; and (b) the attendance is for a service: (i) provided with item 2801 lasting more than 10 minutes; or (ii) provided with item 2806 or 2814; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (a) within a telehealth eligible area;	Step-wise reduction in loading followed by introduction of time-tiered telehealth attendance items	The derived fee on loading items would be incrementally reduced to zero and new telehealth-specific attendance items would be introduced that mirror the standard time-tiered attendance items	Removes a MBS telehealth loading that is no longer effective and reinvesting this saving to increase uptake of telehealth services





Item	What it does	Committee recommendation	What would be different	Why
	and (b) at the time of the attendance--at least 15 kms by road from the specialist or physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19(2) of the act applies			
3003	Initial professional attendance of 10 minutes or less in duration on a patient by a specialist or consultant physician practising in his or her specialty of palliative medicine if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance--at least 15 kms by road from the specialist or physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19(2) of the act applies; and (d) no other initial consultation has taken place for a single course of treatment	Remove from MBS	The specialty-specific telehealth items would be removed from the MBS, and new telehealth-specific attendance items would be introduced to mirror the standard time-tiered attendance items	Removes a MBS telehealth loading that is no longer effective and reinvesting this saving to increase uptake of telehealth services
3015	Professional attendance on a patient by a specialist or consultant physician practising in his or her specialty of palliative medicine if: (a) the attendance is by video conference; and (b) the attendance is for a service: (i) provided with item 3005 lasting more than 10 minutes; or (ii) provided with item 3010 or 3014; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance--at least 15 kms by road from the specialist or physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19(2) of the act applies	Step-wise reduction in loading followed by introduction of time-tiered telehealth attendance items	The derived fee on loading items would be incrementally reduced to zero and new telehealth-specific attendance items would be introduced that mirror the standard time-tiered attendance items	Removes a MBS telehealth loading that is no longer effective and reinvesting this saving to increase uptake of telehealth services
6004	Initial professional attendance of 10 minutes or less in duration on a patient by a specialist practising in	Remove from MBS	The specialty-specific telehealth items would be removed from the MBS, and	Removes a MBS telehealth loading that is no longer



Item	What it does	Committee recommendation	What would be different	Why
	his or her specialty of neurosurgery if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance--at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19(2) of the act applies; and (d) no other initial consultation has taken place for a single course of treatment		new telehealth-specific attendance items would be introduced to mirror the standard time-tiered attendance items	effective and reinvesting this saving to increase uptake of telehealth services
6016	Professional attendance on a patient by a specialist practising in his or her specialty of neurosurgery if: (a) the attendance is by video conference; and (b) the attendance is for a service: (i) provided with item 6007 lasting more than 10 minutes; or (ii) provided with item 6009, 6011, 6013 or 6015; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance--at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19(2) of the act applies	Step-wise reduction in loading followed by introduction of time-tiered telehealth attendance items	The derived fee on loading items would be incrementally reduced to zero and new telehealth-specific attendance items would be introduced that mirror the standard time-tiered attendance items	Removes a MBS telehealth loading that is no longer effective and reinvesting this saving to increase uptake of telehealth services
6025	Initial professional attendance of 10 minutes or less, on a patient by an addiction medicine specialist in the practice of his or her specialty, if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance--at least 15 km by road from the addiction medicine specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19(2) of the act applies; and (d) no other initial	Remove from MBS	The specialty-specific telehealth items would be removed from the MBS, and new telehealth-specific attendance items would be introduced to mirror the standard time-tiered attendance items	Removes a MBS telehealth loading that is no longer effective and reinvesting this saving to increase uptake of telehealth services



Item	What it does	Committee recommendation	What would be different	Why
	consultation has taken place for a single course of treatment			
6026	Professional attendance on a patient by an addiction medicine specialist in the practice of his or her specialty, if: (a) the attendance is by video conference; and (b) the attendance is for a service: (i) provided with item 6018 or 6019 and lasting more than 10 minutes; or (ii) provided with item 6023 or 6024; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance--at least 15 km by road from the addiction medicine specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19 (2) of the act applies	Step-wise reduction in loading followed by introduction of time-tiered telehealth attendance items	The derived fee on loading items would be incrementally reduced to zero and new telehealth-specific attendance items would be introduced that mirror the standard time-tiered attendance items	Removes a MBS telehealth loading that is no longer effective and reinvesting this saving to increase uptake of telehealth services
6059	Initial professional attendance of 10 minutes or less, on a patient by a sexual health medicine specialist in the practice of his or her specialty, if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (a) within a telehealth eligible area; and (b) at the time of the attendance--at least 15 km by road from the sexual health medicine specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19(2) of the act applies; and (d) no other initial consultation has taken place for a single course of treatment	Remove from MBS	The specialty-specific telehealth items would be removed from the MBS, and new telehealth-specific attendance items would be introduced to mirror the standard time-tiered attendance items	Removes a MBS telehealth loading that is no longer effective and reinvesting this saving to increase uptake of telehealth services
6060	Professional attendance on a patient by a sexual health medicine specialist in the practice of his or her specialty if: (a) the attendance is by video conference; and (b) the attendance is for a service: (i) provided with item 6051 or 6052 and lasting more than 10 minutes; or (ii) provided with item 6057 or 6058; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (a) within a telehealth eligible area;	Step-wise reduction in loading followed by introduction of time-tiered telehealth attendance items	The derived fee on loading items would be incrementally reduced to zero and new telehealth-specific attendance items would be introduced that mirror the standard time-tiered attendance items	Removes a MBS telehealth loading that is no longer effective and reinvesting this saving to increase uptake of telehealth services



Item	What it does	Committee recommendation	What would be different	Why
	and (b) at the time of the attendance--at least 15 km by road from the sexual health medicine specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (a) an aboriginal medical service; or (b) an aboriginal community controlled health service; for which a direction made under subsection 19 (2) of the act applies			
Recommendation 10	Reinvest in telehealth	Reinvesting all savings from removing the telehealth loading towards non-MBS mechanisms that increase uptake of telehealth services in Australia	There would be increased investment in MBS or non-MBS mechanisms to increase the uptake of telehealth	Focuses on increasing uptake of telehealth services using the optimal mechanisms to incentivise physician uptake

**Table D.4. Case conference attendance items**

Item	What it does	Committee recommendation	What would be different	Why
820	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines	Introduce a new framework of case conference items; open access to all specialists and consultant physicians	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients
822	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines	Introduce a new framework of case conference items; open access to all specialists and consultant physicians	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients



Item	What it does	Committee recommendation	What would be different	Why
			organiser; and outcomes must be documented in writing including agreed decisions and informed consent	
823	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to organise and coordinate a community case conference of at least 45 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines	Introduce a new framework of case conference items; open access to all specialists and consultant physicians	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients
825	Attendance by a consultant physician in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team	Introduce a new framework of case conference items; open access to all specialists and consultant physicians	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients
826	Attendance by a consultant physician in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team	Introduce a new framework of case conference items; open access to all specialists and consultant physicians	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients



Item	What it does	Committee recommendation	What would be different	Why
			organiser; and outcomes must be documented in writing including agreed decisions and informed consent	
828	Attendance by a consultant physician in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 45 minutes, with the multidisciplinary case conference team	Introduce a new framework of case conference items; open access to all specialists and consultant physicians	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients
830	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines	Introduce a new framework of case conference items; open access to all specialists and consultant physicians	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients
832	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines	Introduce a new framework of case conference items; open access to all specialists and consultant physicians	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients



Item	What it does	Committee recommendation	What would be different	Why
			organiser; and outcomes must be documented in writing including agreed decisions and informed consent	
834	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 45 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines	Introduce a new framework of case conference items; open access to all specialists and consultant physicians	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients
835	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines	Introduce a new framework of case conference items; open access to all specialists and consultant physicians	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients
837	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines	Introduce a new framework of case conference items; open access to all specialists and consultant physicians	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients



Item	What it does	Committee recommendation	What would be different	Why
			organiser; and outcomes must be documented in writing including agreed decisions and informed consent	
838	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines	Introduce a new framework of case conference items; open access to all specialists and consultant physicians	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients
871	Attendance by a medical practitioner (including a specialist or consultant physician in the practice of his or her specialty or a general practitioner), as a member of a case conference team, to lead and coordinate a multidisciplinary case conference on a patient with cancer to develop a multidisciplinary treatment plan, if the case conference is of at least 10 minutes, with a multidisciplinary team of at least 3 other medical practitioners from different areas of medical practice (which may include general practice), and, in addition, allied health providers	Remove item from MBS; replace with new treatment planning case conferences	There will be six new treatment planning case conference items to discuss available treatment options with other members of the treatment team	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients
872	Attendance by a medical practitioner (including a specialist or consultant physician in the practice of his or her specialty or a general practitioner), as a member of a case conference team, to participate in a multidisciplinary case conference on a patient with cancer to develop a multidisciplinary treatment plan, if the case conference is of at least 10 minutes, with a multidisciplinary team of at least 4 medical practitioners from different areas of medical practice (which may include general practice), and, in addition, allied health providers	Remove item from MBS; replace with new treatment planning case conferences	There will be six new treatment planning case conference items to discuss available treatment options with other members of the treatment team	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients
880	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of geriatric or rehabilitation medicine, as a member of a case conference team,	No change	-	-





Item	What it does	Committee recommendation	What would be different	Why
	to coordinate a case conference of at least 10 minutes but less than 30 minutes--for any particular patient, one attendance only in a 7 day period (other than attendance on the same day as an attendance for which item 832, 834, 835, 837 or 838 was applicable in relation to the patient) (H)			
2946	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes	Remove item from MBS	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients
2949	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes	Remove item from MBS	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients
2954	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 45 minutes	Remove item from MBS	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients



Item	What it does	Committee recommendation	What would be different	Why
			phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	
2958	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes	Remove item from MBS	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients
2972	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes	Remove item from MBS	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients
2974	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 45 minutes	Remove item from MBS	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients



Item	What it does	Committee recommendation	What would be different	Why
			phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	
2978	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 15 minutes but less than 30 minutes, before the patient is discharged from a hospital (H)	Remove item from MBS	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients
2984	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 30 minutes but less than 45 minutes, before the patient is discharged from a hospital (H)	Remove item from MBS	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients
2988	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 45 minutes, before the patient is discharged from a hospital (H)	Remove item from MBS	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients



Item	What it does	Committee recommendation	What would be different	Why
			phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	
2992	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, before the patient is discharged from a hospital (H)	Remove item from MBS	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients
2996	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, before the patient is discharged from a hospital (H)	Remove item from MBS	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients
3000	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 45 minutes, before the patient is discharged from a hospital (H)	Remove item from MBS	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients



Item	What it does	Committee recommendation	What would be different	Why
			phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	
3032	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes	Remove item from MBS	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients
3040	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes	Remove item from MBS	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients
3044	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 45 minutes	Remove item from MBS	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients



Item	What it does	Committee recommendation	What would be different	Why
			phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	
3051	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes	Remove item from MBS	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients
3055	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines	Remove item from MBS	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients
3062	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 45 minutes	Remove item from MBS	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients



Item	What it does	Committee recommendation	What would be different	Why
			phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	
3069	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 15 minutes but less than 30 minutes, before the patient is discharged from a hospital (H)	Remove item from MBS	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients
3074	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 30 minutes but less than 45 minutes, before the patient is discharged from a hospital (H)	Remove item from MBS	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients
3078	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 45 minutes, before the patient is discharged from a hospital (H)	Remove item from MBS	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients



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			phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	
3083	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine, as a member of a case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, before the patient is discharged from a hospital (H)	Remove item from MBS	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients
3088	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, before the patient is discharged from a hospital (H)	Remove item from MBS	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients
3093	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 45 minutes, before the patient is discharged from a hospital (H)	Remove item from MBS	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients





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			phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	
6029	Attendance by an addiction medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of less than 15 minutes, with the multidisciplinary case conference team	Remove item from MBS	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients
6031	Attendance by an addiction medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team	Remove item from MBS	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients
6032	Attendance by an addiction medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team	Remove item from MBS	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients



Item	What it does	Committee recommendation	What would be different	Why
			phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	
6034	Attendance by an addiction medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate the multidisciplinary case conference of at least 45 minutes, with the multidisciplinary case conference team	Remove item from MBS	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients
6035	Attendance by an addiction medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of less than 15 minutes, with the multidisciplinary case conference team	Remove item from MBS	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients
6037	Attendance by an addiction medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30	Remove item from MBS	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients



Item	What it does	Committee recommendation	What would be different	Why
	minutes, with the multidisciplinary case conference team		phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	
6038	Attendance by an addiction medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team	Remove item from MBS	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients
6042	Attendance by an addiction medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 45 minutes, with the multidisciplinary case conference team	Remove item from MBS	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients
6064	Attendance by a sexual health medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of less than 15 minutes, with the multidisciplinary case conference team	Remove item from MBS	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients



Item	What it does	Committee recommendation	What would be different	Why
			phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	
6065	Attendance by a sexual health medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team	Remove item from MBS	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients
6067	Attendance by a sexual health medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team	Remove item from MBS	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients
6068	Attendance by a sexual health medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 45 minutes, with the multidisciplinary case conference team	Remove item from MBS	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients



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			phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	
6071	Attendance by a sexual health medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of less than 15 minutes, with the multidisciplinary case conference team	Remove item from MBS	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients
6072	Attendance by a sexual health medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team	Remove item from MBS	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients
6074	Attendance by a sexual health medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45	Remove item from MBS	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients



Item	What it does	Committee recommendation	What would be different	Why
	minutes, with the multidisciplinary case conference team		phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	
6075	Attendance by a sexual health medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 45 minutes, with the multidisciplinary case conference team	Remove item from MBS	There will be a new simplified framework featuring three types of case conference items: (1) discharge planning case conferences; (2) community case conferences; (3) treatment planning case conferences. All consultant specialists will be able to claim these items; the patient must be invited to participate including face-to-face, by videoconference or over the phone; the patient's GP (or delegate) must participate or there must be a mandatory communication of outcomes and changes to the patient and the organiser; and outcomes must be documented in writing including agreed decisions and informed consent	To encourage increased use of multidisciplinary case conferences, GP participation, and shared decision-making with patients
Recommendation 12	Introduce case conference items for allied health professionals and nurse practitioners	AHPs who can access AHP items under Group M3 of the MBS, and nurse practitioners, should have MBS items to claim for attending case conferences	AHPs and nurse practitioners would be reimbursed for participating in case conferences	AHPs and nurse practitioners often have a central role to play in patient care
Recommendation 13	Referral for examination of informed financial consent	The Principles and Rules Committee should examine the issue of informed financial consent for out-of-pocket fees charged with case conference items	Consideration would be given to informed financial consent by patients for case conference items	The Committee's recommendations will increase usage of case conference items, which may impact out-of-pocket costs, and patients may not have control over or be aware of who attends their case conference or what out-of-pocket costs are charged

**Table D.5. Group therapy attendance items**

Item	What it does	Committee recommendation	What would be different	Why
170	Professional attendance for the purpose of group therapy of not less than 1 hour in duration given under the direct continuous supervision of a medical practitioner (other than a consultant physician in the practice of his or her specialty of psychiatry) involving members of a family and persons with close personal relationships with that family--each group of 2 patients	No change	-	-
171	Professional attendance for the purpose of group therapy of not less than 1 hour in duration given under the direct continuous supervision of a medical practitioner (other than a consultant physician in the practice of his or her specialty of psychiatry) involving members of a family and persons with close personal relationships with that family--each group of 3 patients	No change	-	-
172	Professional attendance for the purpose of group therapy of not less than 1 hour in duration given under the direct continuous supervision of a medical practitioner (other than a consultant physician in the practice of his or her specialty of psychiatry) involving members of a family and persons with close personal relationships with that family--each group of 4 or more patients	No change	-	-
6028	Group therapy (including any associated consultation with a patient taking place on the same occasion and relating to the condition for which group therapy is conducted) of not less than 1 hour, given under the continuous direct supervision of an addiction medicine specialist in the practice of his or her specialty for a group of 2 to 9 unrelated patients, or a family group of more than 2 patients, each of whom is referred to the addiction medicine specialist by a referring practitioner--for each patient	No change	-	-

**Table D.6. Other Recommendations**

Item	What it does	Committee recommendation	What would be different	Why
Recommendation 14	Establish a minimum data set to inform evidence-based clinical practice and inform patient choice	Step-wise approach to establishing a minimum data set for the purposes of comparison	There would be a consistent minimum data set which can be used to inform evidence-based care and patient choice	To inform evidence-based care and patient choice



Item	What it does	Committee recommendation	What would be different	Why
Recommendation 15	Provide transparency on the cost and quality of consultant specialist services	MBS cost data, including data on out-of-pocket fees should be shared at an institutional and individual provider level, and consultant-specialist risk-weighted outcome data should be shared at an institutional, disease-specific level; Cost and outcome data should be shared with the patient through their GP at the time of referral; and the presentation of this data should be co-designed with consumers.	Patients would be better informed about the cost and quality of consultant specialist services, and data would exist to support value-based health care	To provide patients with transparency on cost and outcomes when choosing an institution or consultant specialist, and to support value-based health care
Recommendation 16	Improve informed patient consent and shared decision-making processes	Change descriptors where multiple treatment options available to include requirements around discussion of options and information on risks and benefits; improve provider education on patient consent; and improve the consent process by including additional information in provider education materials	There would be more emphasis on shared decision-making and informed patient consent	To improve patient consent process and encourage shared decision-making during consultant specialist attendances
Recommendation 17	Incentivise adoption of My Health Record	A single incentive payment to consultant specialists should be introduced upon their adoption of My Health Record, triggered by achieving a volume of uploads proportional to the number of attendances a provider performed (to be reviewed after XX period)	Consultant specialists would have an incentive to use My Health Record for the majority of their patients	To incentivise use of My Health Record by consultant specialists
Recommendation 18	Use of My Health Record for case conference outcomes, geriatric complex plans and paediatric complex plans	The outcomes of case conferences, as well as geriatric and paediatric complex plans, should be uploaded to My Health Record	Case conference outcomes, and geriatric and paediatric complex plans, would be uploaded to My Health Record	To encourage the upload of event summaries and plans to My Health Record
Recommendation 19	Encourage adoption of My Health Record	Improve the functionality of My Health Record and educate consultant specialists on its benefits; enhance the functionality so it becomes a value-add tool for consumers and clinicians; broaden training for health care providers to include education about using MHR clinically, and work with academic institutions to embed digital health competencies into degrees	Measures would be in place to ensure clinicians are well equipped to use MHR, and see it as beneficial	To enhance MHR to improve health outcomes and improve the efficiency of the overall system
Recommendation 20	Extend the specialist-to-specialist referral validity from three months to six months <i>Note: The Taskforce did not agree to</i>	Extend the specialist-to-specialist referral validity to six months ( <i>not agreed by the Taskforce</i> )	Patients would have more time to see the referred practitioner before the referral expires ( <i>not agreed</i> )	To strike a balance between patient convenience and GP oversight of patient care





Item	What it does	Committee recommendation	What would be different	Why
	<i>this recommendation but recommends maintaining the current arrangements to enable regular GP oversight of patient care by consultant specialists.</i>			
Recommendation 21	Introduce a new AHP pathway	Introduce an AHP pathway for consultant specialists under certain circumstances, but only after a full review of the evidence and associated costs	There would be consideration of options for an AHP pathway, assessed against the evidence and associated costs	To recognise the increasing importance of the AHP role in consultant specialist care