



Colonoscopy services FAQs

Last updated: 9 December 2019

- This change is effective from 1 November 2019.
- A factsheet summarising what the change is, why the change has been made, how it will affect stakeholders and what they need to do is available on [MBS Online](#).
- More information about the change is provided below, in response to frequently asked questions. If you cannot find the information you need, please contact the Department of Health at askMBS@health.gov.au.
- Information is also available in the quick reference guide and claiming examples sheet.
- To subscribe to future MBS Online updates, visit www.mbsonline.gov.au and click 'Subscribe'.

Why are the changes being made?

Changes to the Medicare Benefits Schedule (MBS) colonoscopy item numbers are part of a suite of Department of Health guided initiatives to improve the appropriate use of colonoscopy and keep Australians safe while reducing the burden of gastrointestinal disease, particularly bowel cancer, the second most common cancer in Australia.

- By 2020 the [National Bowel Cancer Screening Program](#) will invite every Australian between the ages of 50-74 to participate by sending a free Faecal Occult Blood Test (FOBT) test kit in the mail. Around 95-98% of the population are at near-average risk and should be screened via an FOBT.
- In 2018, the [Colonoscopy Clinical Care Standard](#), which provides a framework to ensure [clinicians provide](#) and [consumers receive](#), a high quality colonoscopy, was endorsed by government and incorporated into the standards for accreditation of all hospitals and day facilities.
- In 2017 and 2019 the [NHMRC endorsed guidelines](#) for bowel cancer screening and for surveillance of higher risk populations.
- From 1 November 2019, there will be a revised structure for items for colonoscopy services to better guide diagnostic, screening and surveillance decisions.

How did the changes come about?

Changes to the MBS items for colonoscopy services were recommended following a comprehensive review by clinicians, health system experts and consumers.

The changes to the MBS have been developed to support the provision of evidence-based colonoscopy services and reduce low-value care to patients. This means patients will receive Medicare rebates for colonoscopy services that are clinically appropriate and reflect modern best-practice.



These changes are a result of a review by the MBS Review Taskforce (the Taskforce), which was informed by the Gastroenterology Clinical Committee (GCC). The review also included extensive consultation with the sector. More information about the Taskforce and associated Committees is available on the [Medicare Benefits Schedule Review](#) page in the consumer section of the [Department of Health website](#).

How have these changes been communicated to stakeholders?

Key stakeholders were notified of the upcoming changes in early September 2019 and were encouraged to inform their members. Prior to the 1 November 2019 listings, the Department presented the changes at forums, circulated communication material to relevant professional groups, and encouraged dissemination of these materials. Information was also made available through the [MBS website](#).

Claiming new MBS colonoscopy services items

It is not the intention of the MBS review to limit access to appropriate care. The clinician always has to make a judgement as to the most appropriate care for an individual patient, based on the available evidence. It is recommended that you use clinical judgement and document the rationale for your decision.

How do I know what item to bill on the new MBS colonoscopy schedule?

Each item has an item descriptor that outlines the service requirements which must be met before the item can be billed. Additional information and guidance is provided in the form of explanatory notes. Explanatory notes explain the service requirements in more detail and outline the range of treatments and/or assessments you need to provide to meet the requirements for billing the service. Explanatory note TN.8.152 is the main explanatory note for the new MBS items for colonoscopy.

In addition to this FAQ sheet, other communication material has been developed to help you navigate the new schedule. The [Quick Reference Guide](#) outlines the new item numbers and descriptors, and includes additional explanatory information on item use. If you are using a downloaded PDF version of the MBS, an index of services is provided within each category to assist you in locating the appropriate item number for the service provided.

All new colonoscopy services items are located within subgroup 17 (colonoscopy services) of group T8 (surgical operations) on the MBS (items 32222–32229). These services cannot be billed with any other service from group T8 when performed for the purpose of colonoscopy services.

Will I be able to bill against colonoscopy MBS items 32088, 32089, 32090 and 32093 for a procedure performed on or after 1 November 2019?

No. On recommendation from the Taskforce, MBS items 32088, 32089, 32090 and 32093 will be removed from the MBS on 1 November and replaced with the eight new items for colonoscopy services (MBS items 32222–32229). Providers will not be able to bill against MBS items 32088, 32089, 32090, or 32093 after 1 November 2019. MBS funded services are processed according to day of service therefore services delivered prior to 1 November 2019 and billed against 32088, 32089, 32090 or 32093 will remain valid and will be processed, even if they are processed by Medicare after implementation of the new items.



Will the new items be implemented retrospectively or prospectively?

The new MBS colonoscopy items were implemented prospectively from 1 November 2019. Clinicians should continue to provide colonoscopies according to best practice using the item number that best describes the indication for the procedure. Any applicable time restrictions of the new items will be calculated from the last time a colonoscopy item was billed *after* 1 November 2019. To be clear, the time intervals will not be calculated from a service billed against any of the deleted items i.e. any service delivered prior to 1 November 2019.

Can patients that booked a colonoscopy before 1 November 2019 to be delivered after 1 November 2019 still receive the service?

Yes. Providers should make every effort to familiarise themselves with the new MBS colonoscopy items and should use their best clinical judgement to determine the new item that best suits the condition of the patient and use that item. To ensure no patients are disadvantaged by the introduction of the new items, one of the new items (item 32228) allows patients to have a one off colonoscopy regardless of eligibility. Item 32228 can also be used if a provider is unable to access sufficient patient information to enable a colonoscopy to be performed under items 32222-32226, but in their clinical opinion believe that there is a clinical need for a colonoscopy. Item 32228 is available once per patient per lifetime so it is important that this item is used judiciously.

It is important to note that a FOBT continues to be the safest and most effective screening tool for bowel cancer for asymptomatic, low risk patients. FOBT is used to screen for bleeding from the gut/intestine, which may be an indicator of bowel cancer. This test can be completed at home by anyone from the age of 50 to 74 as part of the Australian Government's [National Bowel Cancer Screening Program](#). A FOBT can also be requested by a GP. The test is eligible for a Medicare benefit.

Why is there a new explanatory note for Colonoscopy items (items 32222-32229)?

The new MBS items for colonoscopy will be accompanied by a new explanatory note (TN.8.152) that is designed to provide additional guidance for the use of the new items. Much of the content of the explanatory note is also included in other supporting communication material such as this FAQ sheet and the Quick Reference Guide. This includes clarification on the definitions and criteria of 'previous history' and 'moderate risk due to family history'.

Is there additional guidance for General Practitioners referring patients for a colonoscopy?

General practitioners should ensure colonoscopy referral practices align with applicable [NHMRC guidelines](#), the [Royal Australian College of General Practitioners' guidelines for preventive activities in general practice](#) (the red book) and provide sufficient information in the referral to enable the colonoscopist to recommend appropriately timed colonoscopy if indicated. In addition, general practitioners are urged to recommend biennial FOBT screening to all near-average risk patients from age 50 to 74 or above as clinically indicated. Around 95-98% of the population are at near-average risk and should be screened via an FOBT.

How do I use the items with new patients who have undergone previous colonoscopy?

All clinicians are expected to make reasonable efforts to obtain and review patients' relevant past history including colonoscopy and histopathology results. The [Colonoscopy Clinical Care Standard](#) outlines the required standard for colonoscopy in Australia. This includes that all patients and their GPs receive a letter from their colonoscopist providing information on the indication for colonoscopy, the findings including pathology and management as well as advice on timing of any followup procedure. The [Colonoscopy Clinical Care Standard](#), mandates that all facilities



responsible for providing colonoscopy services provide a copy of this report to patients and their GPs. This important step will substantially increase the likelihood of GP referrals and the MyHealth Record providing this information and reduce the need for colonoscopists to contact the previous GP, facility where the last procedure took place or the Department of Human Services (DHS).

Clinicians should use the item number that best describes the indication for the procedure. For patients with symptoms or signs of colonic disease as described in item 32222 there is no time restriction. When a patient presents for a second or subsequent screening or surveillance colonoscopy after 1 November 2019 the timing of the previous screening or surveillance colonoscopy will be relevant and will determine eligibility for patients who are having a screening or surveillance colonoscopy.

Patients whose care continues within one practice should have a relevant history available to guide decision making. For new patients, practitioners should make reasonable efforts to establish a patient's previous colonoscopy history by the mechanisms described above. The patients' MBS claims history for colonoscopy services will also assist with this.

For audit purposes it is important to record the most appropriate item. In accordance with good practice, clinicians are required to maintain records that include pathology results which can be made available to the patient or other practitioners as required.

What if I don't have access to, or cannot determine, a patient's history?

Providers should use their best clinical judgement to determine the most appropriate care of the patient. They should use the sources available and described above to locate the patient's last colonoscopy to inform that decision. If a provider is unable to access sufficient patient information to enable a colonoscopy to be performed under items 32222-32226, but in their clinical opinion believe that there is a clinical need for a colonoscopy, then item 32228 can be used. This item is available once per patient per lifetime.

Can I confirm patient eligibility for MBS funded colonoscopy services?

All patients who require a colonoscopy will be eligible for a service. However, MBS rebates will not be payable for services which do not meet the clinical indications and the item requirements for a colonoscopy or a repeat colonoscopy where the interval is specified in the item.

Providers can call the DHS on 13 21 50 (Medicare Provider Enquiries Option 2 - Provider registrations, claiming, payment and general enquiries) to get advice on whether a patient is eligible for a particular service on a particular date. To access this advice, the caller (a provider or a nominated person e.g. practice manager) will need to give a provider number, the MBS item number and the proposed date of service, as well as the patient's Medicare number, name and date of birth. Answers to security questions may also be required. DHS will not be able to give detailed information about the patient's history, e.g. the date of the last service or which provider they saw.

Alternatively, providers can check a patient's eligibility via the Health Professionals Online System (HPOS). From 1 November 2019, HPOS will be able to return advice on whether a service is payable or not payable.

A patient (or a provider if the patient is present and able to provide consent) can access more detailed information on their claiming history by calling the Medicare General Enquiries line on 132 011. The patient will need to provide their Medicare number, name and date of birth. Patients can also access their own claiming history with a My Health Record, or by establishing a Medicare online account through myGov or the Express Plus Medicare mobile app.



The DHS enquiry lines are available 24 hours a day, seven days a week. Further information about these services can be found on the Department of Human Services website.

What should I do if a polypectomy needs to be deferred or referred after finding polyps at the time of surveillance colonoscopy?

It is understood that in some cases a polypectomy may be deferred e.g. patient is on anticoagulation or antiplatelet therapy, or referred to an interventional colonoscopist e.g. removal of very large lesion that requires specific expertise in advanced endoscopy.

Initially, apply the appropriate item number for the procedure that was indicated at the time. (i.e. 32222, 32223 etc). If you remove other polyps then you also apply item 32229.

When a patient is brought back for a deferred polypectomy, it will be appropriate to use item 32225 plus item 32229 as the polyp has not been able to be completely removed.

The same items would be used for referred polypectomies. The advanced endoscopist should apply item 32225 plus item 32229 as the appropriate items for the indicated procedure.

What is meant by Time intervals (Items 32223, 32224, 32225 and 32226)?

Items 32223, 32224, 32225 and 32226 have time intervals for repeat colonoscopy which align with best practice and guidelines. These services are payable under Medicare only when provided in accordance with the approved intervals.

Patients may fit several categories and the most appropriate fit is a matter for clinician judgement with the highest risk indicating what subsequent colonoscopy intervals are appropriate. The examples provided below show that the result of the histopathology will not lengthen the surveillance intervals (in the case of patient with familial adenomatous polyposis (FAP) or Lynch) and may actually shorten the surveillance intervals.

Example 1

A patient at high risk of colorectal cancer with FAP or Lynch Syndrome has a number of polyps removed at a surveillance colonoscopy. Item 32226 and 32229 are the appropriate item to bill. If the histology result returns 1-2 adenomas for patients at low to moderate risk then the next surveillance colonoscopy is recommended in 5 years. However, the patient's familial condition means that a shorter interval (12 months) is recommended and payable.

Example 2

A patient at moderate risk of colorectal cancer because of family history has a number of polyps removed at a surveillance colonoscopy. Item 32223 and 32229 are the appropriate items to bill based on the patient's family history. If the histology testing returns showing a adenoma with high-risk histological features then the next surveillance colonoscopy is recommended in 3 years instead of 5 years.



The item descriptors include 'up to the caecum'. Can I still bill against an item if I do not, or cannot, perform a colonoscopy 'up to the caecum'?

No. Items 32222-32228 specify that there is endoscopic examination to the caecum. However, the 'to the caecum' requirements for colonoscopy examinations do not apply to patients who have no caecum following right hemi colectomy. For these patients the examination should be to the anastomosis for a colonoscopy to be billed. Item 32084 should be billed if preparation is inadequate to allow visualisation to the caecum or right hemicolectomy anastomosis.

Item 32227 is for endoscopic examination by colonoscopy 'to the caecum' for the treatment of bleeding, or colonic stricture with balloon dilation. Use item 32087 for endoscopic examination by colonoscopy (or sigmoidoscopy) up to the hepatic flexure for the removal of polyps or the treatment of radiation proctitis, angiodysplasia or post-polypectomy bleeding by argon plasma coagulation.

What item number should be used if the caecum is reached but the bowel prep was regarded as inadequate.

You should use the colonoscopy item number according to the indication for the procedure e.g. 32222, 32223, 32224 etc. If you abort the procedure and don't get to the caecum then use item 32084.

You should bring the patient back with an enhanced bowel prep, and use item number 32222 the next time. Note that item 32222 can be used without a time interval applying if it is for an appropriate indication.

What is an advanced serrated adenoma?

An advanced serrated adenoma is a serrated adenoma or polyp with high-grade dysplasia, or adenocarcinoma.

What is the definition of a serrated polyposis syndrome? Who determines this?

Clinicians should be familiar with the National Health and Medical Research Council endorsed [Clinical Practice Guidelines for prevention, early detection and management of colorectal cancer \(2017\)](#) and the [Clinical Practice Guidelines for Surveillance –in adenoma follow-up, following curative resection and cancer surveillance in inflammatory bowel disease \(2019\)](#) that include information on familial syndromes and a definition for serrated polyposis syndrome. The clinician needs to determine if, in their judgement, the patient fulfils a definition of a familial syndrome and, if so, perform appropriate surveillance. Apply item number 32226 for each procedure.

Can a consultation be charged with a colonoscopy?

During the course of a single attendance by a medical practitioner where both an attendance and another medical service are rendered, Medicare benefits are generally payable for both the attendance and the other service subject to certain exceptions. Exceptions include (for specialists and consultant physicians only) Group T8 (surgical operations) items that have a schedule fee of equal to or greater than \$304.80 claimed with subsequent attendance items 105, 116, 119, 386 2806, 2814, 3010, 3014, 6019, 6052, and 16404. Medicare Benefits Schedule (MBS) items for colonoscopy services are part of the Group T8 (surgical operations) of the MBS, and the minimum schedule fee for the new colonoscopy items is \$339.70 which is above the Group T8 and consult co-claim cut off of \$304.80 (item 32229 is \$274.00 but this is always co-claimed with a colonoscopy item). As such, in most cases, providers cannot co-



claim a consult on the same day as a colonoscopy. More detailed information on co-claiming MBS attendance items with MBS procedural items can be found in MBS explanatory note AN.3.1. at MBS Online.

How will use of the new items be monitored?

The clinician is responsible for appropriate care of the patient and for billing items that best suit the needs of the patient. It is recommended that clinicians do their best to adhere to the appropriate item number for the indicated procedure. When appropriate, clinicians should photodocument the size of a lesion by endophotographs at the time of resection using an open snare as a reference.

The department will continue to monitor and review the use of the new colonoscopy items during and post implementation. This is an important part of the implementation process. The aim of the monitoring is to not only assess compliance but also to identify areas that can be refined and may need adjustment.

While the department will closely monitor the use of the new items and assess compliance, it is understood that a patient may satisfy the criteria for more than one item, and that clinicians may, at times, unintentionally bill against an item that is less compatible with a patient's clinical profile. Compliance will look for atypical claiming patterns that suggest a clinician is repeatedly billing incorrect items. An audit may be undertaken in such cases.

We encourage you to report any suspected MBS fraud. This will help ensure that our health system remains equitable. You do not need to leave your name to report suspected fraud. More information can be found on the [Department of Health website](#).

Please note that the information provided is a general guide only. It is ultimately the responsibility of treating practitioners to use their professional judgment to determine the most clinically appropriate services to provide, and then to ensure that any services billed to Medicare fully meet the eligibility requirements outlined in the legislation.

This sheet is current as of the Last updated date shown above, and does not account for MBS changes since that date.