Co-claiming limitations of subsequent attendance items with certain Group T8 surgical operations

Last updated: 3 February 2024

- From 1 November 2017, the co-claiming of subsequent attendance items were restricted when co-claimed with any surgical operation in Group T8, if the surgical operation has a Schedule Fee equal to or greater than a set threshold amount, if the same practitioner provides the operation on the same day.
- **The set threshold amount for the surgical operation in Group T8 is subject to indexation and the current threshold amount can be found at MBS Online by searching explanatory note AN.0.70 – limitation of items – certain attendances by specialists and consultant physicians and AN.3.1 – subsequent attendance items.**
- This change recognised surgical procedures are generally planned and discussed in advance of the procedure and will ensure patients receive the same MBS benefit for the same service.
- From 1 March 2024, subsequent telehealth services will be added to the existing 2017 co-claiming restriction.

What are the changes?

From 1 November 2017, the co-claiming of subsequent attendance MBS items 105, 116, 119, 386, 2806, 2814, 3010, 3014, 6019, 6052 and 16404 were blocked when co-claimed with any surgical operation in Group T8, if the procedure had a Schedule Fee equal to or greater than the set threshold amount (as stipulated in explanatory note AN.0.70 – limitation of items – certain attendances by specialist and consultant physicians). The threshold amount is subject to indexation and practitioners should review this amount following indexation.

From 1 March 2021, subsequent attendance MBS items 6009-6015 were included to correct an inadvertent omission.

From 1 March 2024, subsequent telehealth services 91823, 91825, 91826, 91833, 91836, 92611, 92612, 92613 and 92618 will be added to the co-claiming restriction.

Why are the changes being made?

The original co-claiming restriction changes are a result of a review by the MBS Review Taskforce (the Taskforce). The review was informed by the Principles and Rules Clinical Committee. More information about the Taskforce and associated Committees

is available in Medicare Benefits Schedule Review in the consumer section of the Department of Health and Aged Care website.

A full copy of the Principles and Rules Clinical Committee's final report can be found in the Principles and Rules Committee section of the Department of Health and Aged Care website.

The co-claiming restriction has been reviewed to include new subsequent attendance items that are performed by telehealth.

What does this mean for providers?

Medical Practitioners will not be able to claim MBS benefits for subsequent attendance items 105, 116, 119, 386, 2806, 2814, 3010, 3014, 6009 to 6015, 6019, 6052, 16404, 91823, 91825, 91826, 91833, 91836, 92611, 92612, 92613 and 92618 if they are claiming any Group T8 item with a Schedule Fee of equal to or greater than the set threshold amount on the same day.

Medical practitioners who are not claiming subsequent attendance items with Group T8 items will not be affected.

Four previously introduced attendance items provide for exceptional circumstances and allow a practitioner to bill a subsequent attendance in conjunction with a Group T8 item where this rule applies (MBS items 111, 115, 117, and 120).

Items 111,117 and 120 can be claimed on the same day as a surgical operation in Group T8 with a Schedule Fee of equal to or greater than the set threshold amount, if the procedure is urgent and not able to be predicted prior to the commencement of the attendance.

Item 115 allows for co-claiming of a consultation item, if the nature of the consultation could not be predicted prior to the Group T8 procedure with an MBS Fee higher than the set threshold amount and it is considered a clinical risk to defer the attendance to a later day.

These items are not intended for routine use and it is expected that their use would be uncommon. Clinical records should clearly indicate the reasons why the consultation and procedure are necessary including the clinical risk for the patient to defer.

How will these changes affect patients?

Patients should no longer receive different Medicare benefits for the same operation.

Who was consulted on the changes?

The Principles and Rules Committee was established in 2015 by the Taskforce to provide broad clinician and consumer expertise. The MBS Review included a public consultation process on the proposed changes from 9 September 2015 for 4 weeks. Feedback was received from a broad range of stakeholders and was considered by the Principles and Rules Committee prior to making its final recommendations to the Taskforce.

How will the changes be monitored and reviewed?

This co-claiming restriction will be subject to MBS compliance processes and activities, including audits, which may require a provider to submit evidence about the services, claimed.

The co-claiming restriction was reviewed in December 2022 where it was determined that new subsequent attendance items performed by telehealth (i.e. MBS items 91823, 91825, 91826, 91833, 91836, 92611, 92612, 92613 and 92618) should also be included in the restriction.

Where can I find more information?

The full item descriptor(s) and information on other changes to the MBS can be found on the MBS Online website at www.mbsonline.gov.au. You can also subscribe to future MBS updates by visiting MBS Online and clicking 'Subscribe'.

The Department of Health and Aged Care provides an email advice service for providers seeking advice on interpretation of the MBS items and rules and the *Health Insurance Act 1973* and associated regulations. If you have a query relating exclusively to interpretation of the Schedule, you should email askMBS@health.gov.au.

Private health insurance information on the product tier arrangements is available at www.privatehealth.gov.au. Detailed information on the MBS item listing within clinical categories is available on the Department's website. Private health insurance minimum accommodation benefits information, including MBS item accommodation classification, is available in the latest version of the *Private Health Insurance (Benefit Requirements) Rules 2011* found on the Federal Register of Legislation. If you have a query in relation to private health insurance, you should email PHI@health.gov.au.

Subscribe to 'News for Health Professionals' on the Services Australia website and you will receive regular news highlights.

If you are seeking advice in relation to Medicare billing, claiming, payments, or obtaining a provider number, please go to the Health Professionals page on the Services Australia website or contact the Services Australia on the Provider Enquiry Line – 13 21 50.

The data file for software vendors when available can be accessed via the Downloads page.

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