



Changes to Colonoscopy Services – CHANGE TO 1 MARCH 2018 START DATE

Last updated: 02/02/2018

The 1 March 2018 commencement date for new MBS colonoscopy items is changing. Existing MBS items (32090 and 32093) should be used until further notice. This will ensure patients continue to have access to Medicare-funded colonoscopy services.

The changes to colonoscopy services announced in August 2017 recognise that clinical practice and professional standards have shifted over time and the new items were designed to be well supported by the NHMRC *Clinical Guidelines for Surveillance Colonoscopy*. These guidelines are currently being revised and are anticipated to be released in late 2018.

The Government remains committed to an improved suite of colonoscopy items and to ensure as smooth a transition to the new arrangements as possible, the MBS Review Taskforce has been invited to provide further advice.

Stakeholders will be advised in advance of any changes to the MBS items for colonoscopy.

What do the changes involve?

MBS items for colonoscopy 32090 and 32093 will be replaced by 20 new MBS items that better describe the indications for initial colonoscopy and ensure appropriate surveillance intervals of patients at increased risk of developing colorectal cancer. The new items also define the examination of the colon ‘to the caecum’ to ensure that a comprehensive examination is performed.

Claiming restrictions will apply with other colonoscopy services (same day, same patient, same practitioner).

Why is the Government making this change?

These changes are intended to address significant national variation in per capita use of colonoscopy that cannot be explained by clinical or patient demographic factors. These changes are based on recommendations of the Medicare Benefits Schedule Review Taskforce.

Change to item description/fees:

Items to be deleted from the MBS:

32090, 32093

Draft new items on the MBS (final wording of items subject to finalisation and passage of legislation):

32222	<p>Endoscopic examination of the colon to the caecum by COLONOSCOPY with or without biopsy.</p> <ul style="list-style-type: none"> For patient following a positive faecal occult blood test, not being a service associated with a service to which items 32088, 32089 applies (National Bowel Cancer Screening Program participants) and items 32223 to 32240 applies <p>Payable not more than once every 2 years (Anaes.)</p> <p>Fee: \$334.35 Benefit: 75% = \$250.80 85% = \$284.20</p>
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32223	<p>Endoscopic examination of the colon to the caecum by COLONOSCOPY with or without biopsy</p> <ul style="list-style-type: none">• For symptomatic patient or• patient with iron deficiency <p>Not being a service associated with a service to which items 32222, 32224 to 32240 applies (Anaes.)</p> <p>Fee: \$334.35 Benefit: 75% = \$250.80 85% = \$284.20</p>
32224	<p>Endoscopic examination of the colon to the caecum by COLONOSCOPY with or without biopsy</p> <ul style="list-style-type: none">• For patient following surgery for colorectal cancer <p>Not being a service associated with a service to which items 32222, 32223, 32225 to 32240 applies (Anaes.)</p> <p>Fee: \$334.35 Benefit: 75% = \$250.80 85% = \$284.20</p>
32225	<p>Endoscopic examination of the colon to the caecum by COLONOSCOPY with or without biopsy</p> <ul style="list-style-type: none">• For patient with MODERATE risk of colorectal cancer due to family history of colorectal cancer (1 first degree relative < 55yrs at diagnosis OR 2 first degree relatives OR 1 first degree relative and 1 second degree relative on the same side of the family, any age at diagnosis) <p>Not being a service associated with a service to which items 32222 to 32224 and 32226 to 32240 applies (Anaes.)</p> <p>Payable not more than once every 5 years</p> <p>Fee: \$334.35 Benefit: 75% = \$250.80 85% = \$284.20</p>
32226	<p>Endoscopic examination of the colon to the caecum by COLONOSCOPY with or without biopsy</p> <ul style="list-style-type: none">• For patient with HIGH risk of colorectal cancer due to known or suspected familial condition including FAP or Lynch Syndrome <p>Not being a service associated with a service to which items 32222 to 32225 and 32227 to 32240 applies (Anaes.)</p> <p>Payable not more than once every 12 months</p> <p>Fee: \$334.35 Benefit: 75% = \$250.80 85% = \$284.20</p>
32227	<p>Endoscopic examination of the colon to the caecum by COLONOSCOPY with or without biopsy</p> <ul style="list-style-type: none">• For patient with previous history of 1-2 adenomas AND all <10mm, no villous features, no high grade dysplasia; OR• For patient with inflammatory bowel disease, Group 3 (ulcerative colitis without high risk features when two previous colonoscopies are



	<p>macroscopically inactive and histologically negative for dysplasia)</p> <p>Not being a service associated with a service to which items 32222 to 32226 and 32228 to 32240 applies (Anaes.)</p> <p>Payable not more than once every 5 years</p> <p>Fee: \$334.35 Benefit: 75% = \$250.80 85% = \$284.20</p>
32228	<p>Endoscopic examination of the colon to the caecum by COLONOSCOPY with or without biopsy</p> <ul style="list-style-type: none">• For patient with previous history of 3-4 adenomas, sessile serrated OR any adenoma >10mm, villous features, high grade dysplasia; OR• For patient with inflammatory bowel disease, Group 2 (quiescent ulcerative colitis without high risk features) <p>Not being a service associated with a service to which items 32222 to 32227 and 32229 to 32240 applies (Anaes.)</p> <p>Payable not more than once every 3 years</p> <p>Fee: \$334.35 Benefit: 75% = \$250.80 85% = \$284.20</p>
32229	<p>Endoscopic examination of the colon to the caecum by COLONOSCOPY with or without biopsy</p> <p>(i) For patient with previous history of 5-9 adenomas; OR (ii) For patient with inflammatory bowel disease, Group 1 (any high risk feature including:</p> <ul style="list-style-type: none">• Chronically active ulcerative colitis• Primary sclerosing cholangitis• Colorectal cancer in first degree relative at <50y age• Stricture, multiple inflammatory polyps or shortened colon• Previous dysplasia) <p>Not being a service associated with a service to which items 32222 to 32228 and 32230 to 32240 applies (Anaes.)</p> <p>Payable not more than once every 12 months</p> <p>Fee: \$334.35 Benefit: 75% = \$250.80 85% = \$284.20</p>
32230	<p>Endoscopic examination of the colon to the caecum by COLONOSCOPY with or without biopsy</p> <ul style="list-style-type: none">• For patient with previous history of >10 adenomas or incomplete excision of large, sessile adenoma <p>Not being a service associated with a service to which items 32222 to 32229 and 32231 to 32240 applies (Anaes.)</p>



	<p>Payable not more than 4 times per year</p> <p>Fee: \$334.35 Benefit: 75% = \$250.80 85% = \$284.20</p>
32231	<p>Endoscopic examination of the colon to the caecum by COLONOSCOPY with or without biopsy</p> <ul style="list-style-type: none">For failed preparation of the colon <p>Not being a service associated with a service to which items 32222 to 32230 and 32232 to 32240 applies (Anaes.)</p> <p>Fee: \$334.35 Benefit: 75% = \$250.80 85% = \$284.20</p>
32232	<p>Endoscopic examination of the colon to the caecum by COLONOSCOPY for the REMOVAL OF 1 OR MORE POLYPS,</p> <ul style="list-style-type: none">For patient following a positive faecal occult blood test, not in association with items 32088, 32089 for National Bowel Cancer Screening Program participants <p>Not being a service associated with a service to which items 32222 to 32231 and 32233 to 32240 applies (Anaes.)</p> <p>Payable no more than once every 2 years</p> <p>Fee: \$469.20 Benefit: 75% = \$351.90 85% = \$398.85</p>
32233	<p>Endoscopic examination of the colon to the caecum by COLONOSCOPY for the REMOVAL OF 1 OR MORE POLYPS,</p> <ul style="list-style-type: none">For symptomatic patient orpatient with iron deficiency <p>Not being a service associated with a service to which items 32222 to 32232 and 32234 to 32240 applies (Anaes.)</p> <p>Fee: \$469.20 Benefit: 75% = \$351.90 85% = \$398.85</p>
32234	<p>Endoscopic examination of the colon to the caecum by COLONOSCOPY for the REMOVAL OF 1 OR MORE POLYPS,</p> <ul style="list-style-type: none">For patient following surgery for colorectal cancer <p>Not being a service associated with a service to which items 32222 to 32233 and 32235 to 32240 applies (Anaes.)</p> <p>Fee: \$469.20 Benefit: 75% = \$351.90 85% = \$398.85</p>
32235	<p>Endoscopic examination of the colon to the caecum by COLONOSCOPY for the REMOVAL OF 1 OR MORE POLYPS,</p> <ul style="list-style-type: none">For patient with MODERATE risk of colorectal cancer due to family history of colorectal cancer (1 first degree relative <55yrs at diagnosis OR 2 first degree relatives OR 1 first degree relative and 1 second degree relative on the same side of the family, any age at diagnosis) <p>Not being a service associated with a service to which items 32222 to 32234 and</p>



	<p>32236 to 32240 applies (Anaes.)</p> <p>Fee: \$469.20 Benefit: 75% = \$351.90 85% = \$398.85</p>
32236	<p>Endoscopic examination of the colon to the caecum by COLONOSCOPY for the REMOVAL OF 1 OR MORE POLYPS,</p> <ul style="list-style-type: none">• For patient with a HIGH risk of colorectal cancer due to known or suspected familial condition including FAP or Lynch Syndrome <p>Not being a service associated with a service to which items 32222 to 32235 and 32237 to 32240 applies (Anaes.)</p> <p>Fee: \$469.20 Benefit: 75% = \$351.90 85% = \$398.85</p>
32237	<p>Endoscopic examination of the colon to the caecum by COLONOSCOPY for the REMOVAL OF 1 OR MORE POLYPS or LESIONS,</p> <ul style="list-style-type: none">• For patient with previous history of 1-2 adenomas AND all <10mm, no villous features, no high grade dysplasia; OR• For patient with inflammatory bowel disease, Group 3 (ulcerative colitis without high risk features when two previous colonoscopies are macroscopically inactive and histologically negative for dysplasia) <p>Not being a service associated with a service to which items 32222 to 32236 and 32238 to 32240 applies (Anaes.)</p> <p>Fee: \$469.20 Benefit: 75% = \$351.90 85% = \$398.85</p>
32238	<p>Endoscopic examination of the colon to the caecum by COLONOSCOPY for the REMOVAL OF 1 OR MORE POLYPS or LESIONS</p> <ul style="list-style-type: none">• For patient with previous history of 3-4 adenomas or any adenoma >10mm, villous features, high grade dysplasia; sessile serrated OR• For patient with inflammatory bowel disease, Group 2 (quiescent ulcerative colitis without high risk features) <p>Not being a service associated with a service to which items 32222 to 32237 and 32239 to 32240 applies (Anaes.)</p> <p>Fee: \$469.20 Benefit: 75% = \$351.90 85% = \$398.85</p>
32239	<p>Endoscopic examination of the colon to the caecum by COLONOSCOPY for the REMOVAL OF 1 OR MORE POLYPS or LESIONS</p> <p>(i) For patient with previous history of 5-9 adenomas, OR</p> <p>(ii) For patient with inflammatory bowel disease, Group 1 (any high risk feature including:</p> <ul style="list-style-type: none">• Chronically active ulcerative colitis• Primary sclerosing cholangitis• Colorectal cancer in first degree relative at <50y age• Stricture, multiple inflammatory polyps or shortened colon



	<ul style="list-style-type: none"> • Previous dysplasia) <p>Not being a service associated with a service to which items 32222 to 32238 and 32240 applies (Anaes.)</p> <p>Fee: \$469.20 Benefit: 75% = \$351.90 85% = \$398.85</p>
32240	<p>Endoscopic examination of the colon to the caecum by COLONOSCOPY for the REMOVAL OF 1 OR MORE POLYPS,</p> <ul style="list-style-type: none"> • For patient with previous history of >10 adenomas, or incomplete excision of large or sessile adenoma <p>Not being a service associated with a service to which items 32222 to 322239 applies (Anaes.)</p> <p>Fee: \$469.20 Benefit: 75% = \$351.90 85% = \$398.85</p>
32241	<p>Endoscopic examination of the colon by COLONOSCOPY for the treatment of radiation proctitis, angiodysplasia or post-polypectomy bleeding, 1 or more of, not a service association with a service to which item 32212 applies (Anaes.)</p> <p>Fee: \$469.20 Benefit: 75% = \$351.90 85% = \$398.85</p>

Explanatory Note

Gastrointestinal Endoscopic Procedures - (Items 30473 to 30481, 30484 to 30487, 30490 to 30494, 30680 to 32023, 32084 to 32095, 32103, 32104 and 32106, 32222 to 32241)

The following are guidelines for appropriate minimum standards for the performance of GI endoscopy in relation to (a) cleaning, disinfection and sterilisation procedures, and (b) anaesthetic and resuscitation equipment.

These guidelines are based on the advice of the Gastroenterological Society of Australia, the Sections of HPB and Upper GI and of Colon and Rectal Surgery of the Royal Australasian College of Surgeons, and the Colorectal Surgical Society of Australia.

Cleaning, disinfection and sterilisation procedures

Endoscopic procedures should be performed in facilities where endoscope and accessory reprocessing protocols follow procedures outlined in:

1. Infection and Endoscopy (3rd edition), Gastroenterological Society of Australia;
2. Australian Guidelines for the Prevention and Control of Infection in Healthcare (NHMRC, 2010);
3. Australian Standard AS 4187-1994 (and Amendments), Standards Association of Australia.

Anaesthetic and resuscitation equipment

Where the patient is anaesthetised, anaesthetic equipment, administration and monitoring, and post-operative and resuscitation facilities should conform to the standards outlined in 'Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures' (PS09), Australian & New Zealand College of Anaesthetists, Gastroenterological Society of Australia and Royal Australasian College of Surgeons.



Conjoint Committee

For the purposes of Item 32023, the procedure is to be performed by a colorectal surgeon or gastroenterologist with endoscopic training who is recognised by the Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy.

New Colonoscopy Items

MBS items for colonoscopy have been revised to align MBS reimbursement with National Health and Medical Research Council (NHMRC) clinical guidelines:

- NHMRC Clinical Practice Guidelines for the Prevention, Early Detection and Management of Colorectal Cancer
- NHMRC Clinical Practice Guidelines for Surveillance Colonoscopy – in adenoma follow-up; following curative resection of colorectal cancer; and for cancer surveillance in inflammatory bowel disease
- NHMRC Guidelines for the Prevention, Early Detection and Management of Colorectal Cancer: A Guide for General Practitioners

These national guidelines do not support the use of colonoscopy for patients at average or slightly above average risk of colorectal cancer who do not have symptoms or a positive FOBT.

The Cancer Council of Australia, the Gastroenterological Society of Australia and the Colorectal Surgical Society of Australia and New Zealand have endorsed the following algorithms designed to be used in conjunction with the NHMRC approved guidelines:

Colonoscopic Surveillance Intervals – Adenomas. 2013,

Colonoscopic Surveillance Intervals – Following Surgery for Colorectal Cancer. 2013

Colorectal Cancer Screening – Family History. 2013, and

Colonoscopic Surveillance Intervals – Inflammatory Bowel Disease. 2013

For more information see the colorectal cancer pages on the [Cancer Council Australia website](#)

Timing of colonoscopy following polypectomy should conform to the recommended surveillance intervals set out in the endorsed algorithms, taking into account individualised risk assessment. In the absence of reliable clinical history, clinicians should use their best clinical judgement to determine the interval between testing and the item that best suits the condition of the patient.

All patients who require a colonoscopy will receive 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. Practitioners should ensure that their practice conforms to the approved clinical guidelines

Definition of previous history

For items 32227 to 32230 and 32237 to 32240 the most appropriate item to be billed is determined by the previous history of the patient. The previous history for the purpose of these items is defined by number, size and type of adenomas removed during the most recent prior colonoscopy.

Diagnostic colonoscopy Items 32222 to 32231

Diagnostic colonoscopy items 32222, 32225 to 32230 have mandated intervals for repeat surveillance testing as clinically recommended in the approved guidelines and algorithms. These services are payable under Medicare only when provided in accordance with the approved intervals.



For item 32227 to 32230 the patient's previous history is used to determine the appropriate item to bill. In the absence of reliable patient history or evidence the practitioner should be guided by their best clinical judgement (see examples below).

Therapeutic colonoscopy Items 32232 to 32241

Therapeutic colonoscopy items 32233 and 32235 to 32240 do not have mandated intervals for repeat surveillance testing. However, services should conform to the recommended surveillance intervals set out in the endorsed algorithms, taking into account individualised risk assessment. Service patterns by individual practitioners may be subject to audit and peer review assessment.

For item 32237 to 32240 the patient's previous history is used to determine the appropriate item to bill. In the absence of reliable patient history or evidence the practitioner should be guided by their best clinical judgement (see examples below)

Colonoscopy following surgery for colorectal cancer

Items 32224 and 32234 should only be used following surgery for colorectal cancer. Subsequent follow-ups should be billed under the most appropriate item. The guidelines and algorithms recommend that surveillance intervals following surgery for colorectal cancer will differ depending on if the colon was cleared of adenomas and synchronous cancers pre-operatively. If the colon was cleared then colonoscopy should be performed at 1 year post-op. If not, colonoscopy should be performed at 3-6 months post-op. The subsequent colonoscopic interval and items to bill will be dependent on the findings at these follow-ups. If results are normal a 5 yearly repeat is recommended. Where adenomas are found the number of adenomas will determine the interval surveillance in accordance with the guidelines and algorithms. For items 32224 and 32234, service patterns by individual practitioners may be subject to audit and peer review assessment. Follow-up of rectal cancers with examination of the rectum by digital examination, sigmoidoscopy or endorectal ultrasound should be considered independent of colonoscopic surveillance.

Colonoscopy for symptomatic patients

In clinical situations where the practitioner forms and fully documents the opinion that the patient's symptoms dictate that colonoscopy is the most appropriate diagnostic procedure (this excludes screening) then item 32223 or 32233 can be billed. Claims under these items will be subject to increased oversight and review, particularly if larger claims than expected are observed.

How to use the items with new patients who have undergone previous colonoscopy

Patients whose care continues within one practice should have a certain history available to guide decision making regarding surveillance intervals. For new patients, practitioners should make reasonable efforts to establish a patient's previous colonoscopy history. Once these items are established, the patients' MBS claims history for those patients who do not require polypectomy will assist with this. The following case examples are provided to guide practitioners in the appropriate use of these new items.

Example 1 – New patient

A new patient is referred with advice that they had 2 polyps removed at their last colonoscopy but the pathology results and size is unknown. The practitioner may decide that 32227 is the most appropriate item to bill. This means that 1) no polyps were removed at this colonoscopy and 2) the patient can be recalled for a repeat colonoscopy in 5 years. Alternatively the lack of certain history, particularly around the type of polyp removed, may lead the clinician to believe that a shorter interval is appropriate and hence an item that corresponds with a higher risk category could be chosen, for instance item 32228. This establishes the patient's Medicare claims history and is available for other practitioners if the patient moves. If in the future the patient has polyps removed which are adenomas then this will establish a new and possibly



different previous history which may place the patient in a different risk category and item range.

Example 2 – New patient

For the same scenario as above, but where polyps are removed during the current colonoscopy, the practitioner would choose the B item that mirrors 32227 (ie 32237), as the assessment of patient history is the same. However advice to the patient about the appropriate interval for further colonoscopy will depend on the number, size and type of adenomas removed at this colonoscopy. This judgement will usually rely on the outcome of pathology testing and hence will not be available at the time of colonoscopy.

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.

Hierarchy of items

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 FAP or Lynch) and may actually shorten the surveillance intervals (in the case of patient with FDR or SDR with CRC).

Example 1

A patient at high risk of CRC with FAP or Lynch Syndrome has a number of polyps removed at a surveillance colonoscopy. Item 32236 is 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 with a first or second degree family history of CRC has a number of polyps removed at a surveillance colonoscopy. Item 32235 is the appropriate item to bill based on the patient's family history. If the histology result returns 3-4 adenomas then the next surveillance colonoscopy is recommended in 3 years instead of 5 years.

General guidance

"To the caecum" requirements for colonoscopy examinations do not apply to patients who have no caecum following right hemi colectomy or have an obstructed right sided tumour. For these patients the examination should be to the anastomosis or tumour.

Surveillance colonoscopy should be planned based on high-quality endoscopy in a well-prepared colon using most recent and previous procedure information when histology is known. Many patients > 80 years have little to gain from surveillance of adenomas given a 10-20 year lead-time for the progression of adenoma to cancer. The finding of serrated lesions may alter management. Small, pale, distal hyperplastic polyps only do not require follow-up.

General practitioners should ensure colonoscopy referral practices align with applicable NHMRC guidelines and the Royal Australian College of General Practitioners' guidelines for preventive activities in general practice (the red book). When referring patients for a colonoscopy, general practitioners should ensure a complete patient history of any previous colonoscopy with histopathology result is provided to the clinician performing the investigation. In addition, general practitioners are urged to recommend biennial faecal occult blood test (FOBT) screening to age-appropriate patients. The National Bowel Cancer Screening Program (the Program) will be fully rolled out in Australia by 2020 by which time



all 50-74 year old Australian residents will be invited to participate in biennial FOBT screening through the Program.

Failed preparation of the colon (item 32231)

Item 32231 is to be billed where a colonoscopy is unsatisfactory due to a failed preparation of the colon. Under these circumstances a second complete colonoscopy is payable. For example, a patient may be referred for a colonoscopy due to a positive FOBT test. The first colonoscopy examination has failed due to a poorly prepared colon but the caecum has been reached. Item 32231 is payable. The second colonoscopy examination is performed satisfactorily. Item 32222 is payable. If the caecum cannot be reached as this would cause risks to the patient, the most appropriate item to bill is sigmoidoscopy/colonoscopy item 32084.

It should be noted these services cannot be billed together for the same patient, same provider, on the same day during a single episode of sedation/anaesthesia.

Co-claiming restrictions

Colonoscopy services in the item range 32222 to 32231 and 32232 to 32241 cannot be billed together for the same patient, same provider, on the same day during a single episode of sedation/anaesthesia. Colonoscopy services in this item range cannot be billed with Sigmoidoscopy services in the item range 32081 – 32084 for the same patient, same provider, on the same day during a single episode of sedation/anaesthesia. Colonoscopy item 32241 cannot be co-claimed with item 32212 (treatment of radiation proctitis with formalin) same patient, same practitioner, same day during a single episode of sedation/anaesthesia.

Patient eligibility for colonoscopy services

The new structure of the colonoscopy items reflect the current evidence for the use of colonoscopy, including appropriate intervals between colonoscopies used in surveillance of patients who are at increased risk of developing colorectal cancer.

Patients seeking Medicare rebates for colonoscopy services 32222, 32225 to 32231 and 32232 will need to ensure that they are eligible for the service prior to proceeding with the procedure. MBS payments for these services are aligned with approved guidelines and algorithms on the appropriate screening and interval surveillance for colonoscopy.

For further information visit the [Cancer Council Australia website](#).

The Department of Human Services will be able to confirm whether a colonoscopy service has been claimed through Medicare by an individual patient and the date of the service. It will also be able to confirm any restriction on the frequency of the item claimed which would prevent a rebate from being paid if the service was provided again within the restricted period. Patients can seek clarification from the Department of Human Services by calling 132 011.

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.

Further information about these services can be found on the [Department of Human Services website](#).

In the second year of operation (from March 2019) practitioners providing colonoscopy services will be able to call Medicare on a dedicated call line to check the patient's claiming history and ensure time restrictions do not apply to the proposed service. The patient's Medicare card number will be required together with the range of item numbers to be checked. For example, the new item numbers for colonoscopy services are in the range 32222 to 32231 and 32232 to 32241. The operator will interrogate the patient's claiming history and provide advice on any claim paid for a colonoscopy service within the range of



items specified and the date of the service. For new patients who are unsure of past colonoscopy history this advice will assist the practitioner to determine the correct item to bill for the proposed service.

Alternatively, the Health Professionals Online System (HPOS) is a secure way for health professionals and administrators to check if a patient is eligible for a Medicare benefit for a specific item on the date of the proposed service. However, this system will only return advice that the service is payable or not payable on the proposed service date. It will not return full advice on when the last service was provided or when the patient will become eligible for the service again. For example, if the service has a 3 year restriction and the last service was provided in November 2017, the advice will be that the item is not payable if the proposed service date is before November 2020. It will not advise that the last service was provided in November 2017.

Further information about this service can be found on the [Department of Human Services website](#).

All patients who require a colonoscopy will receive 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. Practitioners should ensure that their practice conforms to the approved clinical guidelines.