



**Development of strategies for maximising the
benefits of the Medicare Benefits Schedule
multidisciplinary care item numbers**

SUMMARY REPORT

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Background

The Medicare Benefit Schedule (MBS) Item Numbers 871 and 872 were introduced under the Australian Better Health Initiative in November 2006 to provide rebates for doctors to participate in or lead a cancer multidisciplinary meeting.

The Western Central Melbourne Integrated Cancer Service (WCMICS) Haematology Tumour Group has identified the MBS Items as a potential opportunity for generating revenue to support participation in, and administrative activities associated with, existing multidisciplinary team (MDT) meetings. Accordingly, this project aimed to clarify the details of the MBS Items and identify opportunities and practical strategies for utilising the Items at Haematology MDT meetings across the WCMICS.

Methodology

Requirements for the billing of the MBS MDC item numbers were clarified using the Medical Benefits Scheme website, information provided by the National Breast Cancer Centre (NBCC), and email communication with Medicare Australia.

In conjunction with the WCMICS 'Strengthening MDT meetings' projects, an audit tool was developed to scope current practices at MDT meetings. This allowed clarification and assessment of current Haematology MDT composition and processes against MBS Item requirements. The audit tool also gathered information on the number of private patients coming through the services, from which an estimate was made of the amount of revenue that could be generated from use of the item numbers.

Meetings were held with relevant stakeholders, including clinicians, administrative coordinators, and finance staff, to determine what current processes exist for MBS billing (if any). Also discussed at these meetings were barriers to implementation, and opportunities to capitalise on current systems.

Key Findings

Clarification of requirements for billing of MBS MDC item numbers

Requirements for MDT meetings to be able to bill using the MBS item numbers 871 & 872 are listed in Appendix 1.

Identification of current MDT meeting practices

A MDT Meeting audit was conducted across the WCMICS Haematology Services to ascertain whether the meetings are currently eligible to bill using the MDC item numbers. The audit identified that no WCMICS Haematology Services are currently meeting the billing requirements.

Table 1: Requirements for MBS billing of MDT meetings: Are WCMICS haematology services meeting them?

MBS Requirements	Audit Results
At least FOUR medical practitioners from DIFFERENT areas of medical practice (which may include general practice) MUST be in attendance.	Not met at 2 of 3 services
At least ONE allied health practitioner MUST be in attendance.	✓
For the item to be billed, the relevant patient must be discussed for at least 10 minutes.	Not met
Participants must be in communication with each other throughout the case conference, either face-to-face, or by telephone or video link.	✓
Practical Requirements	

Documentation of attendance at MDMs	Not met at 2 of 3 services
Identification of Lead Clinician	Not met at 1 of 3 services
Identification at MDMs whether patients are public or private	Not met at 2 of 3 services

Potential revenue

From the results of the MDT Meeting audit, the potential revenue that could be generated through use of the item numbers 871 & 872 has been estimated. Depending on the number of private patients at each hospital, estimated potential revenue ranged from \$2,755 to \$21,130 per annum.

Identification of hospital processes around claiming MBS revenue

Processes around claiming MBS revenue varied between the hospitals. For example:

- At one hospital, consultants seeing private patients generally bulk-bill rather than sending an account. This means that patients are required to sign a Medicare billing form at their appointment, which is then forwarded to the Medical Billing Service for processing.
- At another hospital, haematologists at bill through the Finance Department using fee-for-service billing rather than bulk-billing. The process for this is that the relevant patient details are forwarded to the department by the consultant or their staff, along with the consultant's provider number, and then the patient is sent an invoice by the Finance Department. Revenue goes directly to the hospital cost centre that the consultant comes under, rather than the individual consultant.

Development of strategies for implementation

Hospital 1:

- Private haematology patients are discussed at MDT meetings but are generally not treated at the hospital. Because the current billing process is to bulk-bill patients, consultants would have to ensure patient's consent to their case being discussed at the MDT meeting, track which private patients were discussed at MDT meetings, ensure that when they are next seen in their private rooms they sign the billing form, which then would need to be forwarded to Finance Department for processing.
- Given the complexities of this process, it would be difficult (if not impossible) to implement without provision of additional administration support to coordinate the process. However, given that only a small amount of revenue would be generated from billing using these item numbers at this hospital, the cost of providing administrative support is not justifiable.
- Therefore, implementation of MBS billing for Haematology multidisciplinary meetings is not feasible at this hospital

Hospital 2:

- Billing for Haematology multidisciplinary meetings could potentially be implemented.
- However, due to workforce shortages in pathology and radiology, this hospital is unable meet the billing requirement for four different medical specialists to attend the meeting. Therefore, in practice, implementing billing for MDT meetings is not possible at the moment.
- However, if this were to change, patients could be booked into MDT meetings via a template set up in the Patient Administration System, which would facilitate the billing process for administrative staff.

Hospital 3:

- The hospital's Finance Department indicated that they have the capacity to bill for haematologists attending MDT meetings, and are willing to do so, as long as the relevant information (i.e. patient name and address, provider numbers of meeting attendees) was forwarded to them.
- Discussions are continuing with representatives from the hospital's Oncology Department regarding implementation of billing for MDT meetings.

Conclusion

At the current time, it is not feasible to implement billing for the haematology multidisciplinary meetings using MBS item numbers 871 and 872 at two of the hospitals due to:

- o The small amount of revenue generated being outweighed by the administration costs of the billing process.
- o The billing requirement of having four medical specialties attend the MDT meeting being unable to be met due to pathology and radiology workforce shortages

Should these positions change, there is no reason why billing can not be implemented for haematology services at these WCMICS hospitals.

At one hospital, a viable process for billing has been identified. If implemented, billing for multidisciplinary meetings would be cost effective and the funds generated could be of benefit. Discussions with the relevant managers regarding implementation are continuing.

It is also possible that these item numbers could be used to bill for multidisciplinary team meetings held by other Tumour Groups, particularly if they have an adequate number of specialists attending their meetings, and have sufficient numbers of private patients to make billing worthwhile. Key actions for other Tumour Groups looking at billing for MDT meetings are to:

- o Clarify if MDT meetings are meeting billing requirements
- o Estimate revenue that could be potentially generated
- o Identify current hospital procedures around claiming MBS revenue, and look at where these can be adapted/utilise for billing for the MDC item numbers.
- o Work with hospitals and clinicians so that financial benefit of this billing process can be directed to the relevant service to support the MDT meeting process

There also are indications that the current review of VACS (Victorian Ambulatory Classification and Funding System) will recommend that VACS codes be assigned to multidisciplinary meetings, resulting in the meetings being funded for public patients by DHS.

Appendices

Appendix 1 Clarification of the requirements for billing

List of Abbreviations

DHS	Department of Human Services
MBS	Medicare Benefits Schedule
MDC	Multidisciplinary Care
MDT	Multidisciplinary Team
NBCC	National Breast Cancer Centre
VACS	Victorian Ambulatory Classification and Funding System
WCMICS	Western and Central Melbourne Integrated Cancer Service

Appendix 1

Clarification of Requirements for Claiming of MBS Item Numbers 871 & 872 for Multidisciplinary Care Meetings

General Requirements:

- Each billing practitioner must ensure that his or her patient is informed that a charge will be incurred for the case conference for which a Medicare rebate will be payable.
- Participants must be in communication with each other throughout the case conference, either face-to-face, or by telephone or video link.
- Private patients in public or private hospitals or the community with a malignancy of a solid organ or tissue or a systemic cancer such as a leukaemia or lymphoma are covered, with the exception of patients whose only cancer is a nonmelanoma skin cancer. PUBLIC PATIENTS ARE NOT COVERED by these item numbers.
- Only one practitioner is eligible to claim item 871 for each patient case conference. This should be the doctor who assumes responsibility for leading and coordinating the case conference, ensures that records are kept and that the patient is informed of the outcome of the case conference. In most cases this will be the lead treating doctor.
- The billing medical practitioner may be from any area of medical practice, including surgery, haematology, general practice, etc. Attending allied health providers or support staff are NOT eligible to bill the item.
- The billing medical practitioner must be a treating doctor of the patient discussed at the case conference. A treating doctor should generally have treated or provided a formal diagnosis of the patient's cancer in the past 12 months or expect to do so within the next 12 months. Attending non-treating clinicians are NOT eligible to bill the item.
- At least FOUR medical practitioners from DIFFERENT areas of medical practice (which may include general practice) MUST be in attendance.
- At least ONE allied health practitioner MUST be in attendance.
- Suitable allied health practitioners would generally be from one of the following disciplines: aboriginal health care worker; asthma educator; audiologist; dental therapist; dentist; diabetes educator; dietician; mental health worker; occupational therapist; optometrist; orthoptist; orthotist or prosthetist; pharmacist; physiotherapist; podiatrist; psychologist; registered nurse; social worker; or, speech pathologist.
- For the item to be billed, the relevant patient must be discussed for at least 10 minutes.
- In general, it is expected that no more than two case conferences per patient per year will be billed by a practitioner; and
- Cancer care case conferences are for the purpose of developing a cancer treatment plan in a multidisciplinary team meeting and should not be billed against case conference items for other purposes eg community or discharge case conferences.
- Medicare forms cannot be signed until AFTER the meeting has taken place.