Report

The effect of the introduction of Commonwealth Medicare Benefit Schedule items 871 and 872 on cancer multidisciplinary teams in NSW

August 2009

Mark Anns, Robyn Thomas and Sue Sinclair

The NSW Government agency dedicated to the control and cure of cancer through prevention, detection, innovation, research and information.

NSW Government

cancer institute NSW

Cancer Institute NSW catalogue number: TBA

National Library of Australia Cataloguing-in-Publication data:

The effect of the introduction of Commonwealth Medicare Benefit Schedule items 871 and 872 on cancer multidisciplinary teams in NSW

State Health Publication Number TBA
ISBN TBA

Keywords: cancer services, multidisciplinary teams, Medicare Benefit Schedule, New South Wales, Australia.

Suggested citation:
Anns, M., Thomas, R. Sinclair, S. *The effect of the introduction of Commonwealth Medicare Benefit Schedule items 871 and 872 on cancer multidisciplinary teams in NSW.* Sydney: Cancer Institute NSW, August 2009.

Published by the Cancer Institute NSW, August 2009.

Australian Technology Park
Biomedical Building
Suite 101
1 Central Avenue
Eveleigh NSW 2015
PO Box 41
Alexandria NSW 1435
Telephone (02) 8374 5600
Facsimile (02) 8374 5700
Email: information@cancerinstitute.org.au
Homepage: www.cancerinstitute.org.au/publications

Contents

1 Executive summary

1.1 Introduction

A multidisciplinary team (MDT) meeting is a regular meeting of all members of the treatment team, including medical practitioners, nurses and allied health personnel, to facilitate best practice management of patients with cancer.

In November 2006, the Commonwealth Government introduced two Medical Benefit Scheme (MBS) items (871 and 872) to encourage and support clinicians participating in cancer case conferences.

MBS item 871 covers attendance by a medical practitioner to lead and coordinate a multidisciplinary case conference on a patient with cancer, to develop a multidisciplinary treatment plan. MBS item 872 covers attendance to participate in such a case conference.

The new process allows private medical practitioners, and those staff specialists with the right of private practice, to claim a rebate from Medicare for services provided under these item numbers. Following its introduction in the period to January 2009, 10,952 services were billed by medical clinicians in Australia for item 871 and 7,782 for item 872 with NSW billing the highest for item 871 and third highest for item 872.

Key messages

- Member attendance at a multidisciplinary team (MDT) meeting was not affected by the availability of Medicare rebates for MBS items 871 and 872.
- The number and type of patients discussed at an MDT meeting was not affected by the availability of Medicare rebates for MBS items 871 and 872.
- Administrative changes to the operation of a MDT meeting were required to allow medical staff MDT members to claim Medicare rebates for MBS items 871 and 872.
- The average annual cost of an MDT meeting ($23,920) exceeded the average collected Medicare rebates for MBS items 871 and 872 per MDT meeting over the same time period ($13,960).
- Thirty-one per cent of MDT members reported other team members claiming MBS items 871 and 872; 10 per cent of members personally made claims; and 20 per cent of these members reported retaining the rebates themselves.

1.2 Methods

Twenty-one NSW cancer MDTs were asked to report on issues related to clinicians billing Medicare Australia for MBS items 871 and 872 using the following methods:

a. MDT meeting administrators were asked to complete an audit tool on the processes and costs of running an MDT.

b. MDT members were surveyed on their attitudes to the Medicare rebates 871 and 872.

c. Staff undertaking the Cancer Institute NSW project on MDTs and use of MBS items 871 and 872 were interviewed.

1.3 Results

Audit of MDTs

Nineteen of 21 MDTs completed the audit tool. The data showed the average annual cost of MDT meetings was $23,920. This increased to $28,769 when two low cost outliers ($200 and $4000) were excluded. The average annual cost of an MDT meeting exceeded the average collected Medicare rebates for 871 and 872 per MDT meeting over the same time period ($13,960). The average cost of collecting Medicare rebates for items 871 and 872 was $5,049 per annum, equating to an average 36 per cent of the rebates collected being expended through the process of collection.

Survey of MDT members

Fifty-nine per cent of MDT members supported the collection of Medicare rebates, with 27 per cent unsure and 14 per cent opposed to collection. The donation of funds collected by clinicians from Medicare rebates to supplement the operational costs of the MDT meeting was occurring for some specialists.

The average number of times item 871 was able to be claimed at a MDT meeting was 7.7 per meeting with the actual average number of claims being 5.2.

The average number of times 872 was claimable among these MDTs was 28 times per meeting (reflecting that multiple clinicians can claim this item for the same patient, compared with item 871). However, the average number of times it was actually claimed was only eight times per meeting. This reflects a reported claiming rate of 29 per cent of the potential claims that could have been made. It is also worth noting that some MDTs provided relatively high figures: for example, one site indicated that item 872 could be claimed an average of 90 times per meeting, although it was claimed only 23 times.

The majority of clinicians did not object to making modifications to administrative procedures to enable collection of Medicare rebates. However, they did not support reducing the time spent planning treatments to maximise Medicare claims.

The availability of Medicare rebates, did not impact on attendance at MDT meetings. Of those respondents claiming for MBS items, 93 per cent stated that the availability of rebates 'makes no difference to my attendance' (the percentage for those not claiming for the MBS items was 96 per cent).

Interviews with staff undertaking the Cancer Institute NSW project on MDTs and use of MBS items 871 and 872

Administrative concerns raised by staff included: excessive time and effort required establishing a system to collect Medicare rebates and directing them back to the MDT meeting; difficulty identifying eligible patients and clinicians; and the collection of the required documentation/signatures. In addition, a philosophical issue was identified related to the expectation that doctors would 'donate' the Medicare rebate to a MDT. Some argued that the Medicare rebate was a payment for the time in attending a meeting and hence was normal income.

1.4 Conclusion

The availability of Medicare rebates for MBS items 871 and 871 was not a strong driver for practitioner attendance at cancer MDT meetings and did not impact upon decision making about whom should be prioritised for discussion at a MDT. Although there was support for the availability of the MBS items, others perceived the low level of rebate as not significant and associated with undue administrative burden.

A number of administrative issues were identified as potential challenges/barriers for the successful collection of the Medicare rebate, including:

- the time involved in setting up the system
- ongoing identification of eligible patients and clinicians
- collation of the required documentation, and follow-up efforts.

In no instance did the Medicare rebates collected meet all the costs of conducting a MDT meeting, but rather, after deducting costs, covered approximately 28 per cent of the average annual cost of running the MDT meetings.

To increase the utilisation of the MBS item numbers by medical personnel attending cancer related MDTs, a number of administrative changes to the scheme have been recommended by those surveyed. These include:

- Obtaining Medicare and Australian Tax Office (ATO) confirmation that a proposed billing approach was acceptable.
- The government providing the rebates retrospectively as a lump sum, perhaps on the basis of audit results per quarter, allowing for smoother administration rather than labour intensive chasing of small fees.
- Taxation implications to be clarified by the ATO, and appropriate solutions communicated, to ensure clinicians do not pay tax on rebates donated to the MDT.
- Administrative conditions to be simplified and processes streamlined, to reduce the administrative workload associated with collecting and/or redirecting rebates.
- Removing the requirement that a patient must be discussed for a minimum of 10 minutes to enable a Medicare claim to be lodged.
- Relaxing the restrictions on which clinicians can bill patients, or the number of clinicians required for billing to occur, particularly within rural settings.
- Increasing the value of the MBS item rebates.

2 Introduction of MBS items 871 and 872

2.1 Introduction

A multidisciplinary team (MDT) meeting is a regular meeting of all members of the treatment team, including medical practitioners, nurses and allied health personnel, to facilitate best practice management of patients with cancer. One of the major outcomes of the multidisciplinary team meeting is the development of a treatment plan, which is discussed with the patient by the lead clinician.

Cancer patients often receive treatment in a variety of settings involving a range of services including screening, diagnosis, treatment (surgery, chemotherapy and radiotherapy), supportive care and palliative care. MDT meetings are considered the primary model to ensure liaison and cooperation of all members of the treatment team.

In November 2006, the Commonwealth Government introduced two Medical Benefit Schedule (MBS) items 871 and 872, to encourage and support clinicians participating in cancer case conferences, including MDT meetings. These item numbers allow private medical practitioners, and those public staff specialists with the right of private practice, to claim a rebate from Medicare for services provided under these item numbers. MBS Item 871 covers attendance by a medical practitioner to lead and coordinate a multidisciplinary case conference on a patient with cancer to develop a multidisciplinary treatment plan. MBS Item 872 covers attendance to participate in such a case conference. The rationale for the introduction was to encourage:

- Attendance at a MDT meeting, as many private specialists and GPs received no income from attending meetings.
- Attendance of a broader range of medical practitioners including GPs at MDT meetings.
- Inclusion of allied health in MDT meetings.
- Development of documented treatment plans.

The creation of MBS item numbers allows appropriate medical practitioners to make a Medicare claim for services provided to an individual private patient. In NSW, the appropriate medical practitioners are public sector 'staff specialists' with a right of private practice, medical staff employed as Visiting Medical Officers (VMOs), private specialists offering cancer related services who may attend a MDT, and General Practitioners (GPs) who may be co-managing the patient.

The criteria for claiming a rebate for MBS items 871 and 872 are as follows;

- Case conference must include at least four medical practitioners from different areas of medical practice and allied health professionals.
- A patient must be discussed for at least 10 minutes.
- A treatment plan must be developed and documented.
- The patient must be a private patient in a public or private hospital or in the community.
- Charges cannot be made for patients with non–melanoma skin cancers.
- Item 871 can only be claimed for by one practitioner for each patient discussed.
- The clinician needs to have seen or be likely to see the patient within a 12 month period.
- The lead practitioner for each patient is responsible for leading and coordinating the case conference, ensuring records are kept and the patient is informed of the outcome of the case conference.
- The patient must be aware the meeting is taking place.
- Records from the case conference must contain: name of patient; date; and sufficient information to enable another practitioner to take over the patient's care.

2.2 Utilisation of MBS item numbers 871 and 872

Information available from Medicare Australia[1] on the utilisation of MBS items 871 and 872 shows that NSW has the highest number of individual claims for MBS items 871 and 872.

During the first seven months of 2008–09, NSW has the highest services per 100,000 head of population for item 871 and South Australia has the highest services per 100,000 for Item 872. NSW is ranked third in the number claims for item 872.

2.3 Objectives of the study

Since 2006, the Cancer Institute NSW has provided over $6 million to support the development of cancer MDT meetings in NSW. In November 2006, concurrent to the initiatives of the Cancer Institute NSW, the Commonwealth introduced Medicare rebates for MBS items 871 and 872 related to attendance at a cancer MDT meeting.

As it was unclear as to the impact that the Commonwealth initiative would have on the other MDT related initiatives of the Cancer Institute NSW, it was agreed to conduct a study to determine the impact of the availability of Medicare rebates for MBS items 871 and 872 on:

- attendance by medical personnel at a cancer MDT meeting
- administrative costs of the collection of Medicare rebates
- administrative changes required to facilitate the collection of Medicare rebates.

Table 1 Medicare items 871 and 872 processed from July 2006 to January 2009

	State								Total
	NSW	VIC	QLD	SA	WA	TAS	ACT	NT	
	Services	Services	Services	Services	Services	Services	Services	Services	Services
871	5,846	2,366	775	1,177	733	17	24	14	10,952
872	3,265	2,736	271	1,006	332	1	162	9	7,782
Total	9,111	5,102	1,046	2,183	1,065	18	186	23	18,734

Table 2 Medicare items 871 and 872 processed from July 2006 to January 2009 services per 100,000

Services per 100,000		State								Total
		NSW	VIC	QLD	SA	WA	TAS	ACT	NT	
871	**2006/2007**	12	5	2	15	4	1	0	0	7
	2007/2008	42	24	8	37	17	1	6	5	26
	YTD 2008/2009	29	16	8	22	14	1	1	1	18
872	**2006/2007**	6	7	2	2	1	0	13	0	5
	2007/2008	25	25	3	31	8	0	19	3	18
	YTD 2008/2009	15	21	2	30	7	0	14	1	14

1. While Medicare Australia takes care in the compilation and provision of the information and data, it does not assume or accept any liability for the accuracy, quality, suitability and currency of the information or data,or for any reliance on the information or data. Medicare Australia recommends that users exercise their own care, skill and diligence with respect to the use and interpretation of the information and data.

3 Methodology

In 2007–08 the Cancer Institute NSW provided $3.4 million across NSW cancer services (including two private cancer facilities) to initiate a MDT development program consisting of seven projects related to the development of MDTs in NSW. One of the projects involved 21 MDTs in NSW who agreed to provide data on how the availability of rebates for Medical Benefit Schedule (MBS) items 871 and 872 were impacting upon MDT meetings. This examination included: the administrative issues of medical staff claiming the benefit within a public health system; whether Medicare rebates were retained by the individual medical staff member or transferred to support the administration of the MDT meeting, and the impact of the Medicare rebate on the number and type of patients discussed at MDT meetings.

Twenty-one NSW cancer MDTs were asked to report on issues related to clinicians billing Medicare Australia for MBS items 871 and 872 using the following methods:

1. MDTs were asked to complete an audit tool on the processes and costs of running an MDT.
2. MDT members were surveyed on their attitudes to the Medicare rebates 871 and 872.
3. Staff undertaking the Cancer Institute NSW project on MDTs and use of Medicare rebates for MBS Items 871 and 872 were interviewed.

3.1 Audit of MDTs

MDTs were requested to identify and supply the following information:

a. Total cost of running the MDT per annum by:
   - recurrent costs – administration, data management, and staffing costs
   - facility costs – Telehealth, room and other costs
   - other costs – transport, accommodation and other.

b. Number of MBS 871 and 872 items that:
   - could have been claimed
   - had been claimed.

c. Total Medicare Rebates received by MDT members.

d. Total administrative cost of submitting and collecting Medicare rebates for items 871 and 872.

3.2 Survey of MDT members

A survey of members of MDTs was conducted

Survey questions.

- Does your MDT bill patients the MBS items 871 and 872?
- To what extent are you satisfied with your MDTs model for collecting Medicare rebates?
- In your opinion, what are the benefits of this model for collecting Medicare rebates?
- In your opinion, in what ways could this model for collecting Medicare rebates be improved?
- Are you aware of how the rebates raised through MBS item numbers are used?

3.3 Interviews of staff undertaking the Cancer Institute NSW project on MDTs and use of MBS items 871 and 872

Interviews were open-ended, aimed at clarifying information in responses to the audit and survey, and to allow an opportunity for further comments.

4 **Results** and discussion

All 21 MDTs involved in the Cancer Institute NSW-funded development program agreed to participate in this project. Overall, 19 audit tool data files were received.[2] Not all components of the audit tool were completed by all 19 sites.

4.1 Costs associated with running an MDT meeting

Eleven MDTs supplied information on the cost of conducting a regular meeting.

The average annual cost of MDT meetings was $23,920. Two of the figures included were, however, comparatively very low ($200 and $4000) and so could be considered outliers; excluding these outliers, the total annual cost of running an MDT increased to $28,769.[3]

The average funds collected via Medicare rebates for items 871 and 872, per MDT, was $13,960 per annum (based on seven MDTs that provided this data), considerably less than the actual costs of meeting.

The average cost of collecting the Medicare rebates for items 871 and 872 was $5,049 per annum, equating to 36 per cent of the rebates collected being expended through the process of collection.

Thus, the Medicare rebates collected (after collection costs are deducted) covered approximately 28 per cent of the average annual cost of running the MDT meeting.[4]

4.2.1 MDT collection methods for Medicare rebates for MBS items 871 and 872

In response to being asked how the model for collecting the Medicare rebates had been formalised by the MDT, two sites indicated that the MDT Coordinator collected the rebates, and another had an arrangement with VMOs that they return 20 per cent of the rebates they receive. Some sites reported that VMOs billed through their private practices and the MDTs were therefore not aware of what was claimed.

One MDT reported that they were still trialing various collection models and that problems were delaying formal resolution of this issue, while another reported that they intended to claim the Medicare rebates and would follow Departmental guidelines. Another MDT had concluded that it was not worth the effort to collect the Medicare rebate.

4.3 MDT member survey

Respondents to the MDT member survey were asked questions regarding the utilisation of Medicare rebates for items 871 and 872 (both actual and hypothetical).

One-hundred and forty-seven responses were received, and are summarised below.

4.3.1 Awareness of extent of claiming for MBS items 871 and 872

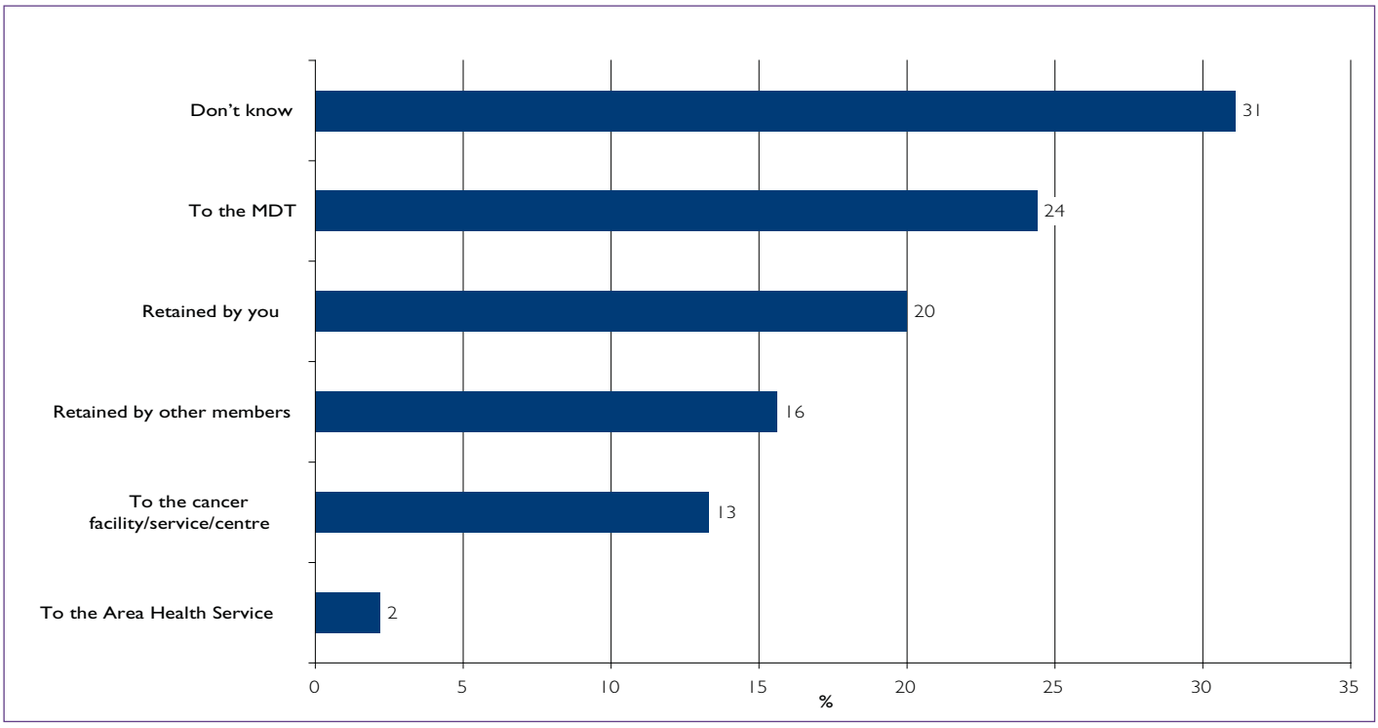
Thirty-one per cent of respondents reported being aware that at least some members of their MDT were currently claiming MBS items 871 or 872, and 10 per cent of the sample reported personally claiming these MBS items.

4.3.2 Destination of Medicare rebates

Figure 1 indicates the destination of the claimed Medicare rebates following collection by individual practitioners attending a MDT. The largest proportion (31 per cent) of respondents were unsure how the Medicare rebates were being distributed. Only 24 per cent reported that rebates collected were provided to the MDT, indicating that, even where the MBS items were being utilised by practitioners, the rebates was not necessarily being directed to the MDT. The next most common response was that rebates were retained by the respondent personally (20%). In addition, 16 per cent reported that some rebates were being billed and retained by other MDT members, and 13 per cent reported that rebates were provided to the cancer facility, service or centre.

2. This reflected that two sites were unable for administrative reasons to provide any data.
3. One site indicated that the primary cost here is that of a billing clerk ($43,500 p.a. or $836.54 p.w.). However, it was not clear that the total salary was attributable to the MDTs only, or how it should be allocated among them.
4. The base for this analysis includes those even sites that provided both income and cost of collection data, as well as data on the total cost of running their MDT.

Figure 1 Destination Medicare rebates claimed by clinicians

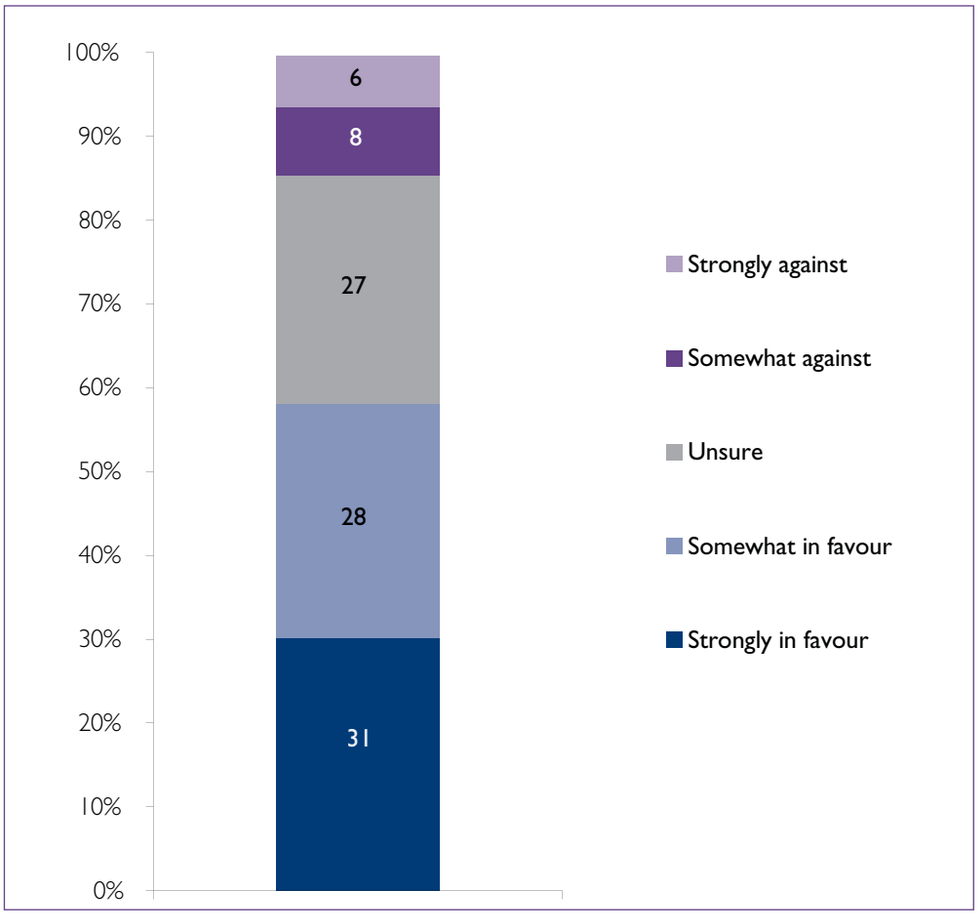


Source: Member survey, Q15: [If aware that at least some MDT members currently collect Medicare rebates]. Once collected, where does this rebates go? (Multiple responses allowed; Base: n=45).

4.3.3 Level of support for claiming MBS Items 871 and 872

More than half (59%) of the MDT members sampled supported the claiming of rebates for MBS items 871 and 872 for the participation of medical practitioners in their MDT meetings (**Figure 2**). However, 27 per cent of respondents were unsure of their stance on this issue, and the remaining 14 per cent opposed the idea.

Figure 2 Support for claiming Medicare rebates

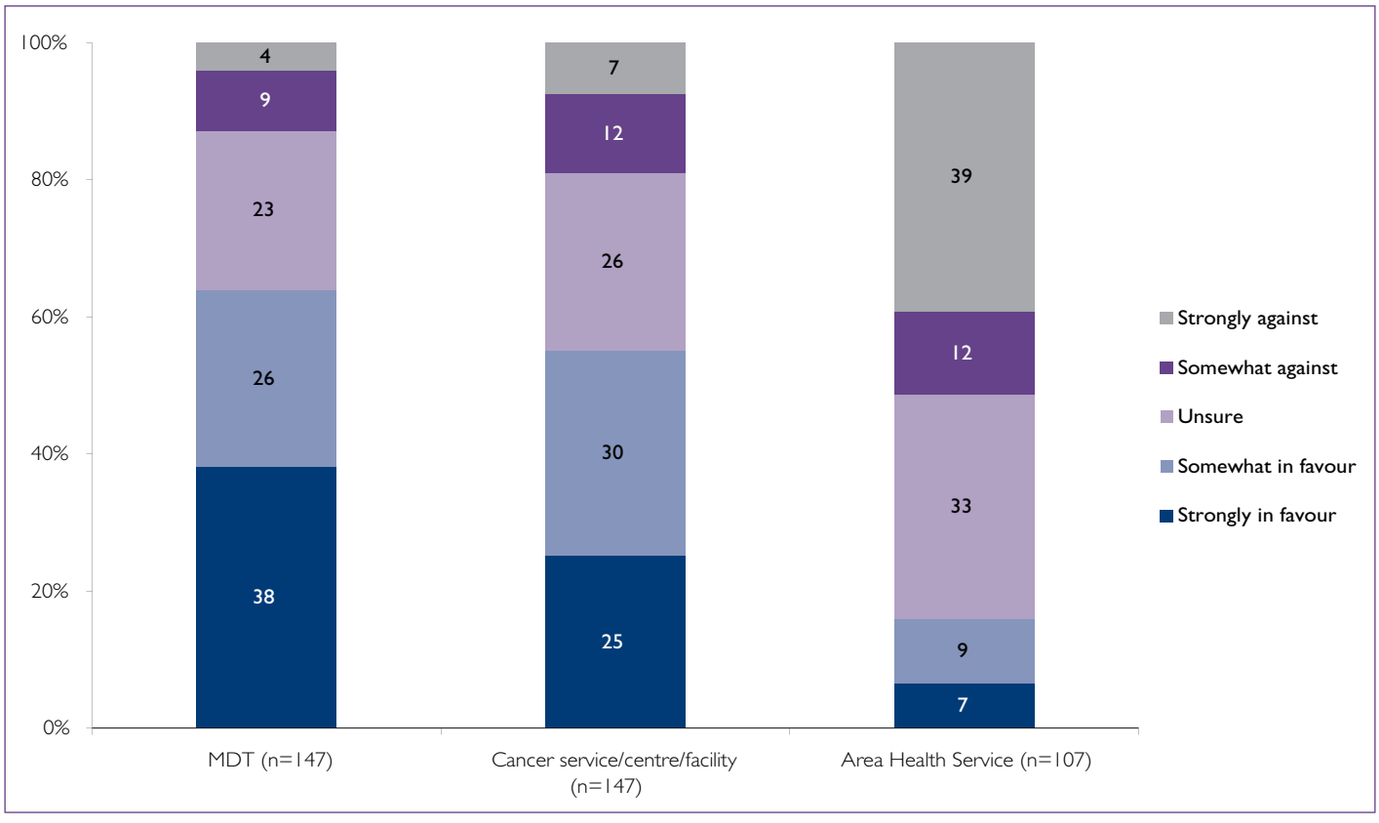


Source: Member survey, Q16: To what extent are you in favour of, or against, collection of Medicare rebates for the participation of medical practitioners in your MDT meetings? (Base: n=147).

4.3.4 *Support for directing Medicare rebates to a MDT*

Support was highest for directing Medicare rebates for MBS items 871 and 872, directly to the MDT meeting (64%) (**Figure 3**). This was followed next by support for providing Medicare rebates to the cancer service, centre or facility (55%). Among those respondents from public facilities, only 16 per cent were in favour of providing Medicare rebates claimed for MBS items 871 and 872 to the Area Health Service. In all situations, a significant proportion of respondents stated that they were unsure (23% to 33%).

Figure 3 Support for destination of collected Medicare rebates



Source: Member survey, Q17: To what extent are you in favour of, or against, MDT members giving claimed Medicare rebates to: (a) your MDT, (b) your cancer service/ centre/facility, and (c) [if public facility] your Area Health Service? (Bases as indicated).

4.3.5 *Impact of availability of Medicare rebates for MBS items 871 and 872 on clinical practice*

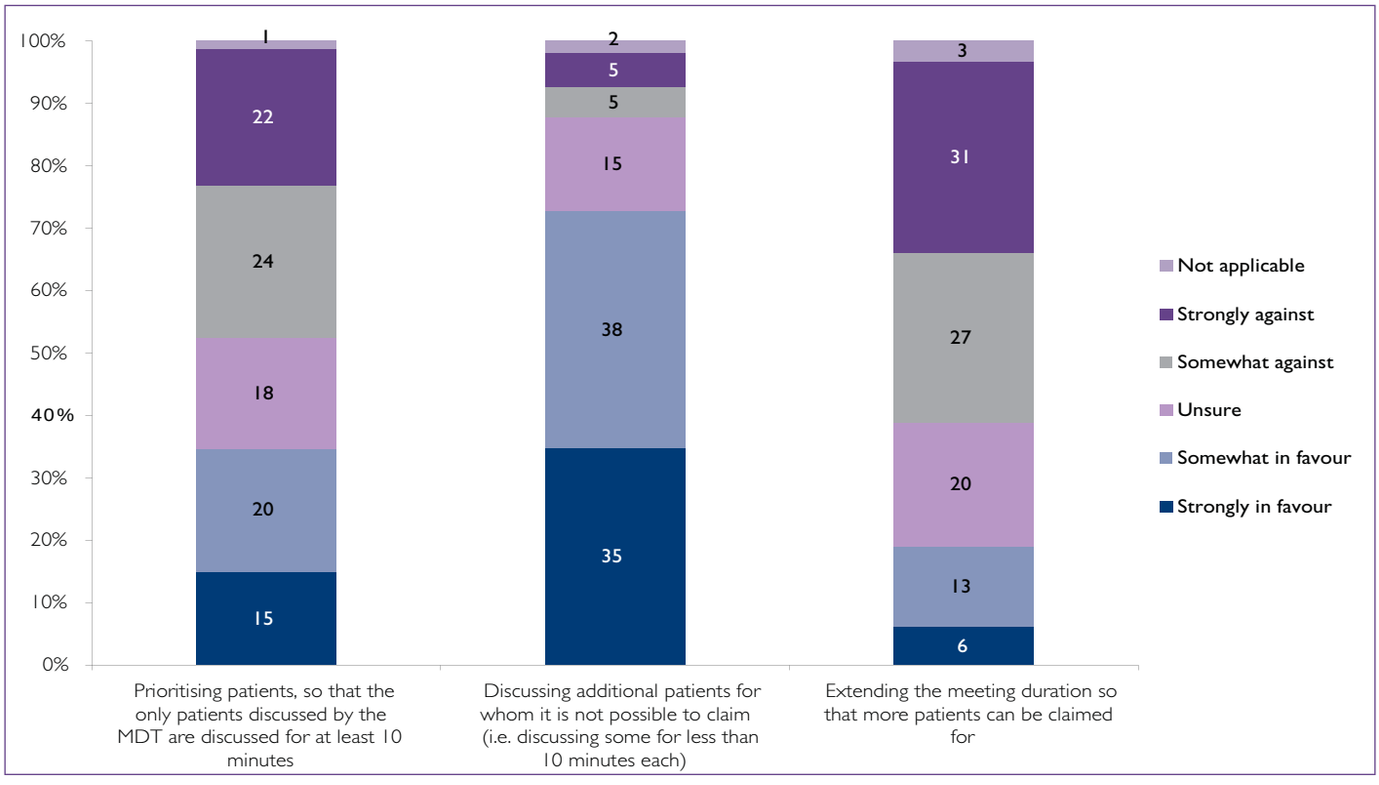
MDT members were presented with three different scenarios related to the criteria that a patient must be discussed for at least ten minutes to enable collection of Medicare rebates (i.e. only six patients can be claimed for every one-hour of MDT meeting time). The results are summarised in **Figure 4**.

Just over a third (35%) of MDT members supported prioritisation of patients so that all patients are discussed for at least 10 minutes. The majority (73%), however, were in favour of discussing additional patients during meetings, even if it meant that no Medicare rebates could be claimed for those patients discussed for less than 10 minutes. A minority (19%) supported extending the duration of the MDT meeting so that claims could be made for more patients. These findings demonstrate that MDT practices are not determined by demand for claiming and MDT practices are unlikely to change to accommodate requirements for claiming the MBS items 871 and 872.

Respondents whose main facility was located in a rural or regional area were more likely to be 'somewhat in favour' of prioritising patients so that the only patients discussed by the MDT are discussed for at least 10 minutes (37%) compared with metropolitan respondents (12%). Metropolitan respondents were more likely to indicate that they were 'strongly against' this scenario (28%) compared with respondents from rural or regional facilities (9%).

There were also differences in support for various scenarios by sector. Respondents from public facilities were more likely than those from private facilities to be 'unsure' about prioritising patients so that all are discussed for at least ten minutes (22% vs 5%), and more likely to be 'unsure' about discussing additional patients for whom it is not possible to claim (19% vs 5%).

Figure 4 Support for scenarios relating to claiming Medicare item number rebates

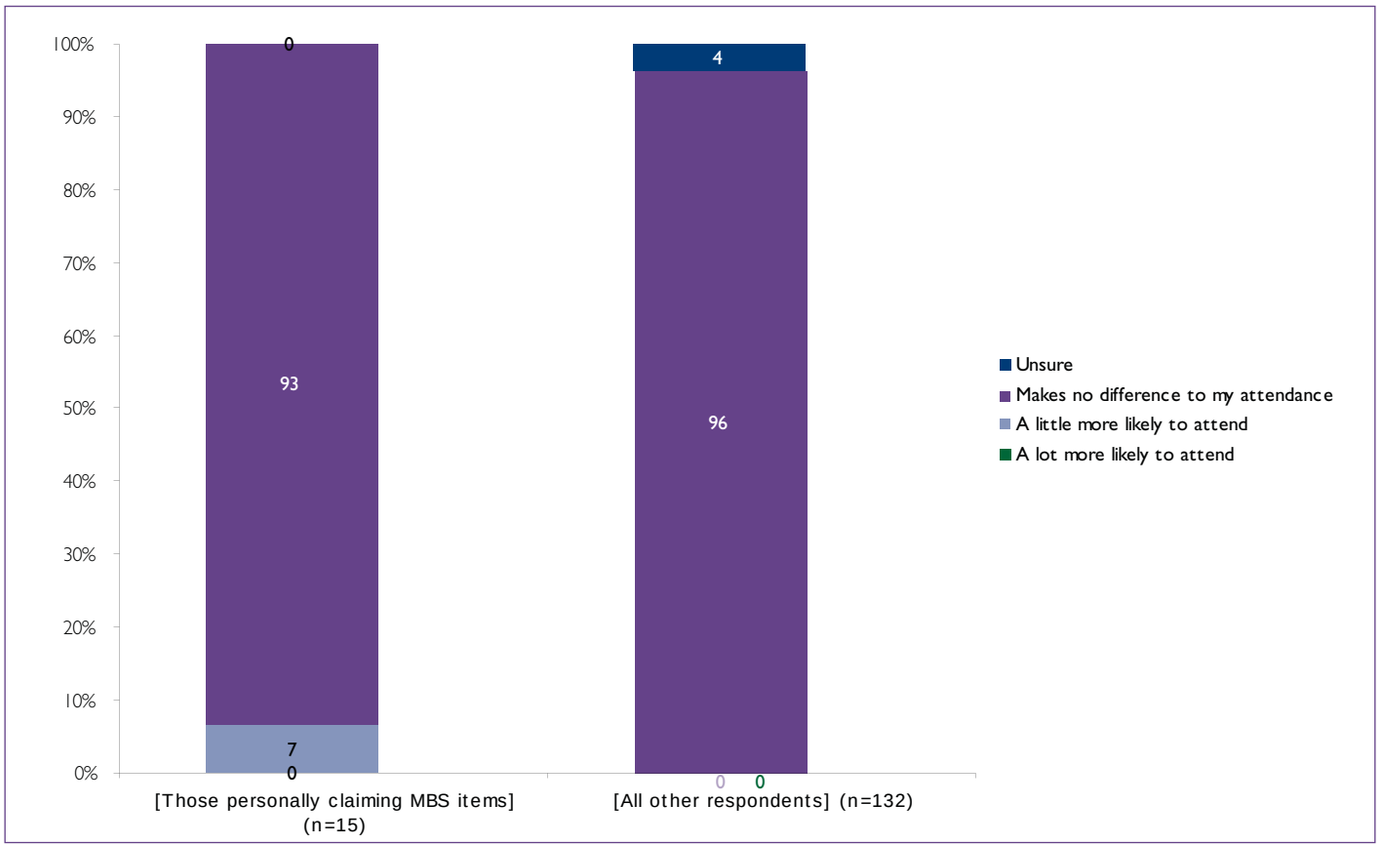


Source: Member survey, Q18: To enable collection of Medicare rebates for a given patient, the patient must be discussed for 10 minutes or more (i.e. a maximum of 6 patients can be claimed for per 1 hour of meeting time). In light of this, to what extent do you support each of the following scenarios… (Base: n=147).

4.3.6 *Impact of Medicare rebates for MBS items 871 and 872 on attendance at a MDT meeting*

The overwhelming majority of respondents reported that the collection of Medicare rebates for MBS items 871 and 872 would make no difference to their attendance at MDT meetings (**Figure 5**). This finding was held among those personally claiming the MBS items (93%), as well as those currently not claiming the MBS items (96%). This suggests that, although part of the rationale for their introduction, MBS items 871 and 872 are not a strong driver for practitioner attendance at MDT meetings.

Figure 5 Influence of Medicare rebates on attendance at MDT meetings by whether or not member personally claims MBS items

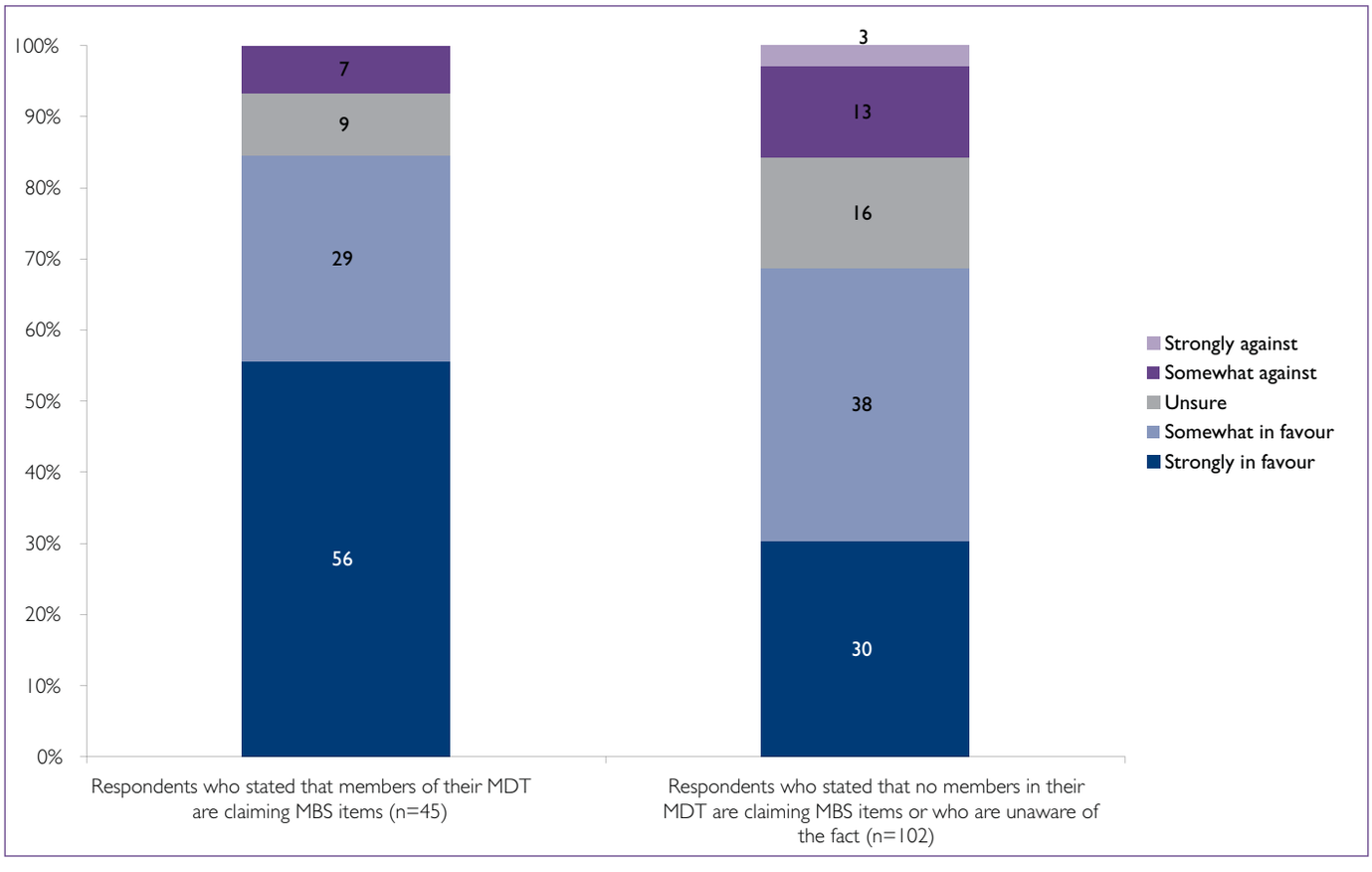


Source: Member survey, Q19(a): [If personally claiming MBS items] To what extent does the possibility of collection of Medicare rebates influence your attendance at these meetings? Q19(b): [If not personally claiming MBS items] To what extent would the possibility of collection of Medicare rebates influence your attendance at these meetings? (Bases as indicated).

4.3.7 Administrative issues and Medicare rebates for MBS items 871 and 872

The majority of MDT members, when asked about their level of support for administrative procedures required to access Medicare rebates MBS items 871 and 872, were not deterred by this administrative burden (**Figure 6**). Willingness to accept administrative procedures was somewhat stronger among those respondents where at least some MDT members were already claiming the Medicare rebates (85%), compared to respondents from other MDTs (68%). This suggests that MDT members' familiar with the claiming processes, and perhaps with administration in place, were more accepting of the need for the changes then those without the experience. In general, support was high across both segments of the sample.

Figure 6 Support for new administrative procedures to enable collection of Medicare rebates



Source: Member survey, Q20: In order for your MDT to collect this Medicare rebates, certain administrative procedures are required (e.g., writing treatment plans, recording attendance, obtaining patient consent and signatures, etc). (a) [If aware of any members claiming] To what extent do you support such procedures in your MDT, to enable collection of Medicare rebates? (b) [If not aware of any members claiming] To what extent would you support such procedures in your MDT, to enable collection of Medicare rebates? (Bases as indicated).

4.3.8 *Perceived benefits of availability of Medicare rebates for MBS items 871 and 872*

For those respondents who were aware of their MDT's examination of the availability of MBS items 871 and 872, the perceived benefits included:

- MBS items as a reward or compensation for MDT members' time and effort
- benefits of MDT meetings for patients
- use of the rebates to support the MDT coordinator position.

The following quotations highlight verbatim responses in support of these findings.

> *"The rebates coming back into the MDT allows the MDT to become stronger and move forward, e.g. involvement of more hospitals, action plans, etc."*

> *"Provides recognition of the work that is done for the patient, that otherwise goes unrewarded."*

Those who viewed the MBS items 871 and 872 as having little or no benefit stated that the available Medicare rebates were not of any significance and were associated with an undue administrative burden. There was a general sense, among those who responded in this way, that the use of relevant MBS items had little bearing on the sustainability of MDTs, involved a trade-off with the number of patients able to be seen, and had only some minor benefits. This viewpoint is illustrated by the following quotations.

> *"Not sure if benefits derived from a maximum of six patients discussed in one hour, with the additional administrative load to the staff of MDT to provide details about the discussions and management plans, would help it to become financially self-sufficient."*

> *"No benefit. It is very cumbersome and time consuming."*

> *"I can't see any real benefit, except encouraging attendance."*

4.3.9 *Respondents views on improving the availability and local administration of Medicare rebates for MBS items 871 and 872*

Most of the respondents' suggestions for improving availability and administration centred on the reduction of the administrative burden. Improvements suggested included:

- greater centralisation
- enabling electronic claiming
- removal of the requirement to obtain a patient signature on the claim form, (given that it often cannot be determined in advanced with certainty whether a patient will be discussed)
- non-administrative improvements related to the wording of the MBS items
- abolishment of the minimum time threshold
- introduction of a mechanism that allows billing 'by the minute'.

The quotations below show a selection of these responses.

> *"Centralised record keeping, for treatment plan and meeting consent."*

> *"Direct billing through Medicare, removing the paperwork for the patients."*

> *"Reduce the time from 10 minutes for each patient, so more cases may be claimed for. Some cases are straightforward and only need a couple of minutes."*

4.4 Interviews with MDT staff undertaking the Cancer Institute NSW project on MDTs and use of MBS items 871 And 872

The staff of the 21 MDTs undertaking the Cancer Institute NSW project on MDTs and use of MBS items 871 and 872 were interviewed as part of the qualitative phase of the evaluation.

4.4.1 Models for claiming MBS items 871 and 872

In developing models to assist clinicians to claim a rebate for MBS items 871 and 872 the following challenges were identified:

- difficulties in establishing the feasibility of claiming Medicare rebates
- difficulties in developing mechanisms of redirecting rebates to the MDT meeting
- difficulties in assessing the formal conditions or inclusion/exclusion criteria for claiming Medicare rebates
- engagement of clinicians
- determining how the eligibility criteria would translate in practice
- a cost analysis comparing potential income against collection costs.

4.4.2 Barriers to effective claiming of Medicare rebates for MBS items 871 and 872

A key problem in developing a system for clinicians to claim Medicare rebates for MBS items 871 and 872 was the significant administrative workload involved, in particular:

- the time involved in setting up the system
- ongoing identification of eligible patients and clinicians
- collation of the required documentation, and follow-up efforts.

An important question identified was who should provide administrative support for a MDT meeting, with common options including:

- hospital or MDT administrative staff
- individual clinicians' own administrative staff
- cancer care coordinators*.

** It was noted that some interviewed stressed responsibility should not fall to cancer care coordinators, as it was not part of their intended role.*

More critical was the issue of whether the administrative effort in establishing a system to facilitate the claiming of Medicare rebates was worthwhile given the limited financial return.

This administrative burden is one of the key reasons why collecting Medicare rebates was considered more challenging for VMOs than staff specialists with the right of private practice, where the former rely on their own practice staff to provide this support. There was a feeling that VMOs would prefer to use their staff for other more critical, or more profitable, tasks that offered a greater 'return on investment' for their staff's time and salary, rather than chasing small individual fees. This sentiment was particularly strong where VMOs were expected to redirect any rebates they collected to support the costs of running the MDT meeting.

It was noted that in NSW regional and rural areas there are a number of additional issues to consider including:

- MDT meetings may be less frequent, and have a lower volume of patients, than metropolitan MDTs and hence there may not be an economy of scale.
- A 'partnership' arrangement between a rural and metropolitan site may disadvantage a rural site.

If a rural site links in with a metropolitan MDT, with the majority of clinicians and patients associated with the metropolitan site, there may be limited opportunity to pool rebates and contribute to the administrative costs of the rural site.

Confusion regarding the details of the eligibility criteria for claiming MBS items 871 and 872 compounded these issues. For instance, clinicians at one site requested confirmation from Medicare and the Australian Tax Office that their proposed collection approach was appropriate, to minimise potential financial risks. A resolution to this matter has not

yet been reached, therefore acting as a key impediment for full implementation of the billing procedures developed by the MDT.

It was noted that MBS item 871 was relatively easier to collect than item 872, and offered greater return per individual clinician, yet this still involved additional effort to 'track patients down' after the meeting to obtain their signature. Some noted that any MDTs seeking patient signatures prior to provision of the service, or not obtaining signatures, would be in breach of the Medicare conditions. As such, greater clarity is required to ensure that practices were rigorous, as ignorance could lead to problems if sites are audited by Medicare. However, some MDTs pointed out that this could be done at the same time as the patient is provided with feedback regarding MDT meeting outcomes.

One site decided to abandon its clinical eligibility notification model, reporting that claiming processes (including identifying eligibility to claim) should be solely the clinician's responsibility, rather than that of the MDT, to avoid the MDT members bearing the risk if claims are made under inappropriate conditions. As a result of this decision, it is expected that having to use their own administrative support will deter some clinicians from claiming and/or redirecting rebates.

Members at one site noted general medico-legal concerns or confusions regarding informed patient consent and privacy, shared decision making, duty of care and the extent of documentation required, as having an impact on their willingness to support the model of MBS rebate collection.

In addition, some MDTs noted that various conditions were particularly difficult to meet and suggested that some conditions be reconsidered. For example, two sites reported that clinicians were keen to ensure that patients did not have any out-of-pocket expenses, and were informed upfront about the process; one site reported that they sometimes failed to meet the requirements of a core forum of four specialities due to clinicians being away; and at one site staff were reluctant to interfere with the free-flowing discussion by imposing time constraints for billing purposes.

4.4.3 Problems or barriers with redirecting Medicare rebates to services

Those MDTs that progressed to the point of exploring options for rebates to be redirected to the MDT encountered further problems. Initially, many concerns related to taxation implications. That is, if the Medicare rebates were considered income by the ATO, even where it was donated to the MDT, clinicians were concerned that they would be expected to pay tax on money they did not receive.

An additional and significant issue arose from the expectation that clinicians would 'donate' money that was seen as 'rightfully theirs' to the MDT. Although opinions were mixed, many had philosophical objections or were unclear why clinicians would be expected to give this particular part of their income to the MDT, and felt that it went against the spirit of the introduction of the MBS items. It was considered 'double-dipping' by many; that is, clinicians were already 'doing hospitals a favour' by donating their time and expertise, and in addition were expected to donate this monetary compensation for their time and expertise.

These arguments were particularly strong in relation to VMOs, whereas the notion of rebates going to the MDT was seen as somewhat more appropriate for staff specialists. One site for instance, reported that only employed clinicians were currently billing, as significant barriers were faced in relation to other clinicians. A number of VMOs or private practitioners were already claiming the MBS items independently through their own practices, and while a very small minority were reportedly willing to donate this income to the MDT, it was considered impossible and inappropriate to force them to do so.

4.4.4 Enablers for effective collection and redistribution of Medicare rebates to MDTs

Factors identified as enabling the effective utilisation of Medicare rebates for MBS items 871 and 872 in support of MDT meetings included:

- lead clinicians, the MDT chair, or head of the department being a 'champion' for the initiative

- MDT members being aware of sustainability issues of their MDT meetings (that is, some clinicians may be more likely to donate the rebates back if the MDT meeting is likely to cease without it)
- meetings are held more frequently with a greater number of patients discussed
- MDT meetings where the patient is more likely to attend or able to sign at the time of the meeting.

Other perceived enablers related to rule changes associated with the MBS items. Most MDTs underestimated the difficulties that would be involved in meeting the requirements for collecting rebates for items 871 and 872, and identified key barriers that could be overcome by the following changes:

- Medicare and ATO confirmation that a proposed billing approach was acceptable.
- Government to provide rebates retrospectively as a lump sum, perhaps on the basis of audit results per quarter, allowing for smoother administration rather than requiring labour intensive chasing of small fees.
- Clarification of taxation implications by the ATO, and provision of solutions to ensure that clinicians do not pay tax on rebates donated to the MDT.
- Simplification of administrative requirements to reduce the workload associated with collecting and/or redirecting rebates.
- Reducing the duration a patient must be discussed.
- Relaxing the restrictions on types of clinicians that can bill patients, or the number of clinicians required for billing to occur.
- Increasing the value of the MBS item rebates.

5 Conclusions

This pilot study provides the first research on the effects of the introduction of two Medical Benefit Scheme (MBS) items 871 and 872 to encourage and support clinicians participating in cancer case conferences. The Cancer Institute NSW, as part of a larger program aimed at developing cancer MDTs in NSW, undertook to examine the effects of these items on clinical practice. Anecdotal reports had indicated that some clinicians able to claim these rebates were transferring the funds to their MDT to support the operation of the meeting.

The availability of MBS items 871 and 872 are not impacting upon the number or type of patients seen at a MDT meeting or the willingness of clinicians to attend MDT meetings. Further, there are significant administrative difficulties in establishing an effective process for claiming the Medicare rebates for MBS items 871 and 872. This partially reflects that cancer services are often provided by both private and public medical specialists.

Anecdotal reports of transfer of funds from private doctors to a MDT to support the operation of the meeting were confirmed. However, the amounts of money transferred have a limited impact upon the overall costs associated with a meeting.

Funds available to medical specialists working in a private capacity belong to the individual claiming. Although some may consider donating these funds it can not be a requirement, and a MDT cannot operate on this income stream alone.

This report has highlighted a number of administrative difficulties associated with the claiming of Medicare rebates for MBS items 871 and 872, and reported on the feedback from clinicians on ways to improved the operation of the rebate process.