The Royal Australian and New Zealand College of Radiologists®

The Faculty of Clinical Radiology

Multiple Services Rules
Position paper

The multiple services rules, first introduced in November 1996, discount Medicare schedule fees when an imaging service is provided on the same day as other imaging, consultation or procedural services.

They were implemented with the intention to bring diagnostic imaging in line with other areas of the Medicare Benefits Schedule (MBS), where fees are discounted to better reflect the resources used, and efficiencies gained, in providing more than one service during the same episode of patient care.
Unless there are clinical reasons for not doing so, they should be provided to the patient at the one attendance and the efficiencies from doing so reflected in the overall fee charged. Any decision to have a patient return on a different day to complete a multi-area diagnostic imaging service should only be made on the basis of clinical necessity.

The multiple services rules are complex to follow and are poorly articulated in the schedule. The substantially reduced rebates produced by application of the rules are unrealistic with regard to the minor efficiencies gained in providing multiple diagnostic imaging services on the same day. The rules promote inefficient delivery of services and a variety of behaviours designed to work around them (e.g. splitting services over more than one day)—see examples below.

Current Multiple Services Rules

The Health Insurance (HI) Act (Section 4AB) contains regulations in the Diagnostic Imaging Services Table to provide for a reduction in the fee applicable to a diagnostic imaging service, where that service and at least one other medical service, which may be a service other than a diagnostic imaging service, are provided to the same patient.

A range of multiple services rules have been introduced into the DIST regulations:

Rules applicable to all Diagnostic Imaging Services

There are three multiple services rules applicable to all diagnostic imaging, with the exception of services rendered in remote locations. The rules are:

Rule A. When a medical practitioner renders two or more diagnostic imaging services to a patient on the same day, then:

- the diagnostic imaging service with the highest schedule fee has an unchanged Schedule fee; and
- the Schedule fee for each additional diagnostic imaging service is reduced by $5.

Rule B. When a medical practitioner renders at least one R-type diagnostic imaging service and at least one consultation to a patient on the same day, there is a deduction to the Schedule fee for the diagnostic imaging service with the highest Schedule fee as follows:

- if the Schedule fee for the consultation is $40 or more—by $35; or
- if the Schedule fee for the consultation is less than $40 but more than $15—by $15; or
- if the Schedule fee for the consultation is less than $15—by the amount of that fee.

The deduction under Rule B is only made once. If there is more than one consultation, the consultation with the highest Schedule fee determines the deduction amount. There is no further deduction for additional consultations.

A ‘consultation’ is a service rendered under an item from Category 1 of the Medicare Benefits Schedule (MBS), that is, items 1 to 10816 inclusive.

Rule C. When a medical practitioner renders an R-type diagnostic imaging service and at least one non-consultation service to the same patient on the same day, the Schedule fee for the diagnostic imaging service with the highest Schedule fee is reduced by $5.

The deduction under Rule C is only made once. There is no further deduction for any additional medical services.

For Rule C, a 'non-consultation' is defined as any following item from the MBS:

- Category 2, items 11000 to 12533;
- Category 3, items 13020 to 51318;
- Category 4, items 51700 to 53460;
- Cleft Lip and Palate services, items 75001 to 75854 (as specified in the "Medicare Benefits for the treatment of cleft lip and cleft palate conditions" book).

Pathology services are not included in Rule C.

When both Rules B and C apply, the sum of the deductions in the Schedule fee for the diagnostic imaging service with the highest Schedule fee is not to exceed that Schedule fee.

Modality Specific Multiple Service Rules

Other Multiple Service Rules are applicable specifically to Vascular Ultrasound, General Ultrasound, O & G Ultrasound, Musculoskeletal MRI and Interventional services.

Rules applicable to all vascular ultrasound services claimed on the same day of service (i.e. whether performed at the same attendance by the same practitioner or at different attendances)

Where more than one vascular ultrasound service is provided to the same patient by the same practitioner on the same date of service, the following formula applies to the Schedule fee for each service:

- 100% for the item with the greatest Schedule fee
- plus 60% for the item with the next greatest Schedule fee
- plus 50% for each other item.

When the Schedule fee for some of the items are the same, the reduction is calculated in the following order:

- 100% for the item with the greatest Schedule fee and the lowest item number
- plus 60% for the item with the greatest Schedule fee and the second lowest item number
- plus 50% for each other item.

That is, if 2 or more Schedule fees are equally the highest, the one with the lowest item number is taken to have the higher fee.

When calculating the benefit, it should be noted, that despite the reduction, the collective items are treated as one service for the application of Rule A of the general diagnostic imaging multiple services rules and the patient gap.

Other rules applicable to vascular ultrasound services

Medicare benefits are only payable for a maximum of two vascular ultrasound studies in a seven-day period. A vascular ultrasound study may include one or more items. Additionally where a patient is referred for a bilateral study of both arms or both legs, the account should indicate "bilateral" or "left" or "right" to enable benefits to be paid.

Rules applicable to other ultrasound services

According to the explanatory notes in the DIST, as a rule benefits are payable once only for ultrasonic examination at the one attendance, irrespective of the areas involved. There does not seem to be any legislative support for this rule.

The notes go on to say that in general, attendance means that there is a clear separation between one service and the next. If there is a short time between one ultrasound and the next, benefits will be payable for one service only. As a guide, the Department of Human Services looks to a separation of three hours between services and this must be stated on accounts issued for more than one service on the one day.

Where more than one ultrasound service is rendered on the one occasion and the service relates to a non-contiguous body area, and they are “clinically relevant”, (i.e. the service is generally accepted in the medical profession as being necessary for the appropriate treatment or management of the patient to whom it is rendered), benefits greater than the single rate may be payable. Accounts should be marked “non-contiguous body areas”.

Benefits for two contiguous areas may be payable where it is generally accepted that there are different preparation requirements for the patient and a clear difference in set-up time and scanning.
Accounts should be endorsed “contiguous body area with different set-up requirements”.

There are several ultrasound items in the schedule subject to specific multiple services restrictions.
For example, the MBS precludes a rebate for ultrasound examination of the pelvis (55065), if performed on the same patient within 24 hours of abdominal ultrasound examination (55036 or 55014) or urinary tract ultrasound (55038 or 55017).

Medicare benefits are not payable for more than three NR-type O & G ultrasound services that are performed on the same patient in any one pregnancy.

Rules applicable to Cone Beam CT (CBCT) services

Claims for more than one CBCT per day are not permitted; claiming for two-dimensional imaging in the same attendance (OPG items 57959 to 57969) and with CT in the same attendance (items 56001 to 57361) are also excluded.

Rules applicable to Magnetic Resonance Imaging (MRI) – Musculoskeletal

If a medical practitioner performs 2 or more scans from MRI subgroup 12 and 13 for the same patient on the same day, the fees specified for items that apply to the service are affected as follows:

(a) the item with the highest schedule fee retains 100% of the schedule fee; and

(b) any other fee, except the highest is reduced by 50%.

If 2 or more Schedule fees are equally the highest, the one with the lowest item number is taken to have the highest fee.

In addition, the modifying item for contrast can only be claimed once for a group of services subject to this rule.

If a medical practitioner provides

(a) 2 or more MRI services from subgroups 12 and 13 for the same patient on the same day; and

(b) 1 or more other diagnostic imaging services for that patient on that day

The amount of the fees payable for the MRI services is taken, for the purposes of this rule, to be an amount payable for 1 diagnostic imaging service in applying Rule A of the general diagnostic imaging multiple services rules.

Interventional Imaging

There are specific rules relating to the following Ultrasound and CT interventional items:

55054 ULTRASONIC CROSS-SECTIONAL ECHOGRAPHY, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which any other item in this Group applies (R)

57341 COMPUTED TOMOGRAPHY, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which another item in this table applies (R) (K) (Anaes.)

57345 COMPUTED TOMOGRAPHY, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which another item in this table applies (R) (NK) (Anaes.)

Other Items

These individual items all require consideration as each has a multiple service rule included in the indicator.

Item 56233 COMPUTED TOMOGRAPHY - scan of spine, two examinations of the kind referred to in items 56220, 56221 and 56223 without intravenous contrast medium payable once only, whether 1 or more attendances are required to complete the service

Item 56619 COMPUTED TOMOGRAPHY - scan of extremities, 1 or more regions without intravenous contrast medium, payable once only whether 1 or more attendances are required to complete the service

Item 57350 COMPUTED TOMOGRAPHY - spiral angiography with intravenous contrast medium, including any scans performed before intravenous contrast injection - 1 or more spiral data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy recording of multiple projections, where:

(a) the service is not a service to which another item in this group applies; and

(b) the service is performed for the exclusion of arterial stenosis, occlusion, aneurysm or embolism; and

(c) the service has not been performed on the same patient within the previous 12 months; and

(d) the service is not a study performed to image the coronary arteries

Item 60503 FLUOROSCOPY, without general anaesthesia (not being a service associated with a radiographic examination)

Issues for consideration

As is evident from the summary of the rules, the multiple services rules are complex, poorly articulated and there are even some questions about their actual legislative support.

Examples of the implications and issues associated with the various multiple services rules as they relate to diagnostic imaging services are set out below:

- Clinical radiologists rarely provide MBS Category 1 consultations or Category 2, 3 or 4 services.
  Hence, Rules B and C are seldom applicable in diagnostic imaging. The $5 discount applied to additional diagnostic imaging services rendered on the same day by implementation of Rule A is a reasonable figure and roughly reflects the efficiencies associated with image acquisition and reporting of multiple region or multiple modality studies.

- The fee discount for additional vascular ultrasound services rendered on the same day is intended to reflect the time saved in scanning two or more regions in a single patient, compared to a single region in two or more patients. Although the sonographer scanning time and clinical radiologist reporting time for additional region is similar, there are some efficiencies gained in reduced patient processing, changing and set-up times. However, the discounts applied for additional items are high and overestimate the efficiencies gained in providing multiple vascular ultrasound services on the same day.
- Female patients with abdominal or pelvic symptoms are frequently referred for ultrasound examination of the abdomen and pelvis. The examination of both regions is time consuming, particularly as transvaginal sonography of the pelvis is required for most patients. The current MBS fee is inadequate given the additional setup time required for a transvaginal examination. The patient must empty her bladder and a dedicated transvaginal transducer must be prepared with a microbial barrier in order to prevent contamination. For intimate examinations regardless of the gender of practitioner or patient it is best practice for the examination to be chaperoned. The sonographer or clinical radiologist performing the examination, must find a chaperone to assist in caring for the patient during the examination. The transvaginal component of the examination typically adds an additional 20 minutes to the length of the ultrasound study.

  In view of the above, referring medical practitioners are typically "coached" to request a single examination region on each request form. The patient is then scheduled to have the abdominal examination one day, and the transvaginal pelvis examination the next, resulting in inconvenience for the patient.
- In the case of CBCT, data provided to MSAC showed that there was a high level of claiming of CBCT items with other panoramic radiography services and additional CBCT scan/s during a single episode of care. Concern about radiation dose was cited as MSAC when disallowing panoramic radiography (OPG) on the same day as CBCT. In fact, it is likely to have the opposite effect. Most CBCT units allow varying field of view so that it is possible to limit the scan to one dental arch or even a part of one arch. It is common for orthodontists to request OPG for an overview of all dentition, and CBCT targeted to one or more un-erupted impacted teeth (typically upper canines) which requires three-dimensional imaging. This is the appropriate way to image. The rule encourages referrers to ask for a large volume CBCT of the entire maxillofacial region, which is not appropriate for routine orthodontic assessment (but only for selected patients where orthognathic surgery is planned). This will lead to over servicing and increased radiation doses in these (usually paediatric) patients.

- Magnetic Resonance Imaging (MRI) is a diagnostic technique with high capital and operating costs. The cost of an MRI examination is largely determined by the time the patient is in the MRI scanner, radiographer staff costs and clinical radiologist reporting costs.

  Each MRI examination is targeted to an anatomical region and involves precise positioning of the region of interest within a dedicated receiver coil and a period of image acquisition lasting approximately 15 to 30 minutes for each region. The receiver coils are designed to closely match the anatomy of a region (e.g. shoulder, wrist, hip, knee, ankle etc). Scanning an additional region usually involves getting the patient off the scanner and repositioning the additional region of interest in a new receiver coil, or for bilateral studies, moving the coil to the other side of the table prior to re-positioning the patient.

  The period of image acquisition is approximately the same for each musculoskeletal region imaged. Unlike some other imaging modalities, there are no significant efficiency gains in MR imaging of multiple regions on the same day. Scanning two musculoskeletal regions takes almost twice the set up and scanning time as a single region and it takes twice as long for the clinical radiologist to generate a report of two regions compared with a single region as there is twice the number of images to analyse and interpret. There are only very small time saving to be made in safety

screening and administrative tasks. In view of this, the 50% discount applied to the second and subsequent regions is clearly inappropriate and does not reflect the true cost of providing the service.

The current MBS rebates for MRI are already below the cost of delivering a quality service and it not possible for most providers to absorb a 50% discount for the second or subsequent region of a bilateral or multiple region examination.

The multiple services rule for musculoskeletal MRI provides a substantial disincentive to efficient service provision. The impact of the musculoskeletal MRI multiple services rule is that—

- Bilateral or multiple region musculoskeletal MRI services performed on the same day are rarely bulk-billed. In some cases referring medical practitioners are "coached" to avoid requesting more than one MRI region examination on a request form. This is inefficient and inconvenient for patients as it involves twice the travel time and expense and is a particularly severe impost for rural patients where there may be additional accommodation costs incurred. These costs are, in part, transferred to the State Government via Patient Assistance Travel Schemes.
- The second and subsequent regions of a bilateral or multi-region MRI study performed on the same day are charged, where possible, to the patient at same rate as the first scan, resulting in a high out-of-pocket "gap" payment for the second or subsequent region scan.

- Rules regarding interventional ultrasound performed on the same day as a diagnostic ultrasound study cause inefficient scheduling and substantial inconvenience for patients. This is most often observed in the area of breast ultrasound. A patient presenting with a breast lump typically undergoes routine diagnostic mammography and ultrasound examination. The ultrasound examination is frequently performed by a skilled breast sonographer. The mammogram and ultrasound images are reviewed by a breast clinical radiologist and there is often communication with the referring medical practitioner regarding the results and a discussion regarding the need for biopsy.

  If a breast biopsy is to be performed, Medicare will not pay for an ultrasound-guided FNA/biopsy unless there is a 3 hour time separation between the breast ultrasound and the FNA/biopsy.
  This not only causes distress to the patient, it is poor clinical practice and poor patient service.
  The patient may either wait 3 hours prior to undergoing an ultrasound-guided biopsy in order for the examination to be eligible for a Medicare rebate or may agree to pay a large out-of-pocket fee to have the examination conducted quickly and efficiently. An ultrasound-guided biopsy is a time consuming and poorly remunerated procedure. It is not possible for most practices to forego the fee for the preceding diagnostic ultrasound examination.

  This causes scheduling difficulty and inefficient use of resources. It discourages breast ultrasound examinations performed after 1.30pm as there is insufficient time to permit a 3 hours window prior to an ultrasound guided biopsy if the patient does not wish to pay a large out-of-pocket fee for a Medicare ineligible service. Patients are frequently scheduled to return the following day to undergo the biopsy, resulting in added anxiety and inconvenience for patients as it involves twice the travel time, lost productivity and expense. This is a particularly severe impost for rural patients where there may be additional accommodation costs incurred.

  The rule regarding imaging services performed on the same day as a CT interventional procedure also causes inefficient use of resources and considerable patient inconvenience and cost. A typical example of the rule would be a young patient with a recently discovered rapidly growing aggressive cancer (e.g. lymphoma, sarcoma). These patients typically undergo multiple imaging studies including conventional radiography and diagnostic CT of the mass, staging MRI of the mass and staging CT of the chest, abdomen and pelvis to assess for metastatic disease. The patient also

undergoes an expeditious CT-guided biopsy of the mass. The current MBS CT intervention rule precludes a rebate for ANY imaging examination rendered on the same day as an interventional CT.

For most practices, it is not possible to absorb the cost of the conventional radiography, diagnostic and staging CTs and staging MRI examinations. Patients with a newly diagnosed malignancy are usually anxious and keen for all diagnostic imaging studies to be performed as soon as possible, in order that treatment can be planned and instituted in a timely fashion. Patients can pay large out-of-pocket expenses to have an efficient service with all imaging, including a CT-guided biopsy, performed on a same day. If the patient does not wish to pay a large out-of-pocket fee for a Medicare ineligible service, they are scheduled to return the following day to undergo the CT-guided biopsy, resulting in added anxiety, sick leave and financial losses, delayed diagnosis, increased travel time and expense. This is a particularly severe impost for rural patients where there may be additional accommodation costs incurred.

- Other examples of Multiple Services Rules that require revision:
    - Item 56233: CT of multiple spine regions. These are all paid at the same benefit as a single spine region even if scanned on separate occasions.
    - Item 56619: CT scan of extremities: These are all paid at the same benefit as a single region even if scanned on separate occasions.
    - Item 57350 CT angiography: No other CT allowed with this item.
    - Item 60503 Fluoroscopy: no radiograph allowed with this item.

Recommendation

RANZCR recommends at least the following changes be made to the current rules to address issues of patient inconvenience and additional costs as well as the unrealistic and disproportionate rebate reductions relative to the minor efficiencies that might be gained by providing multiple diagnostic imaging services on the same day:

1. Reduce the discount for multiple vascular ultrasound examinations performed on a single day.
2. Remove the 50% multiple services discount rule for musculoskeletal MRI.
3. Allow rebates to be payable for transvaginal ultrasound performed on the same day as an abdominal ultrasound examination in view of the additional time and setup required.
4. Remove the 3hr separation rule for interventional US.
5. Permit rebates for interventional CT procedures on the same day as other diagnostic imaging services.