

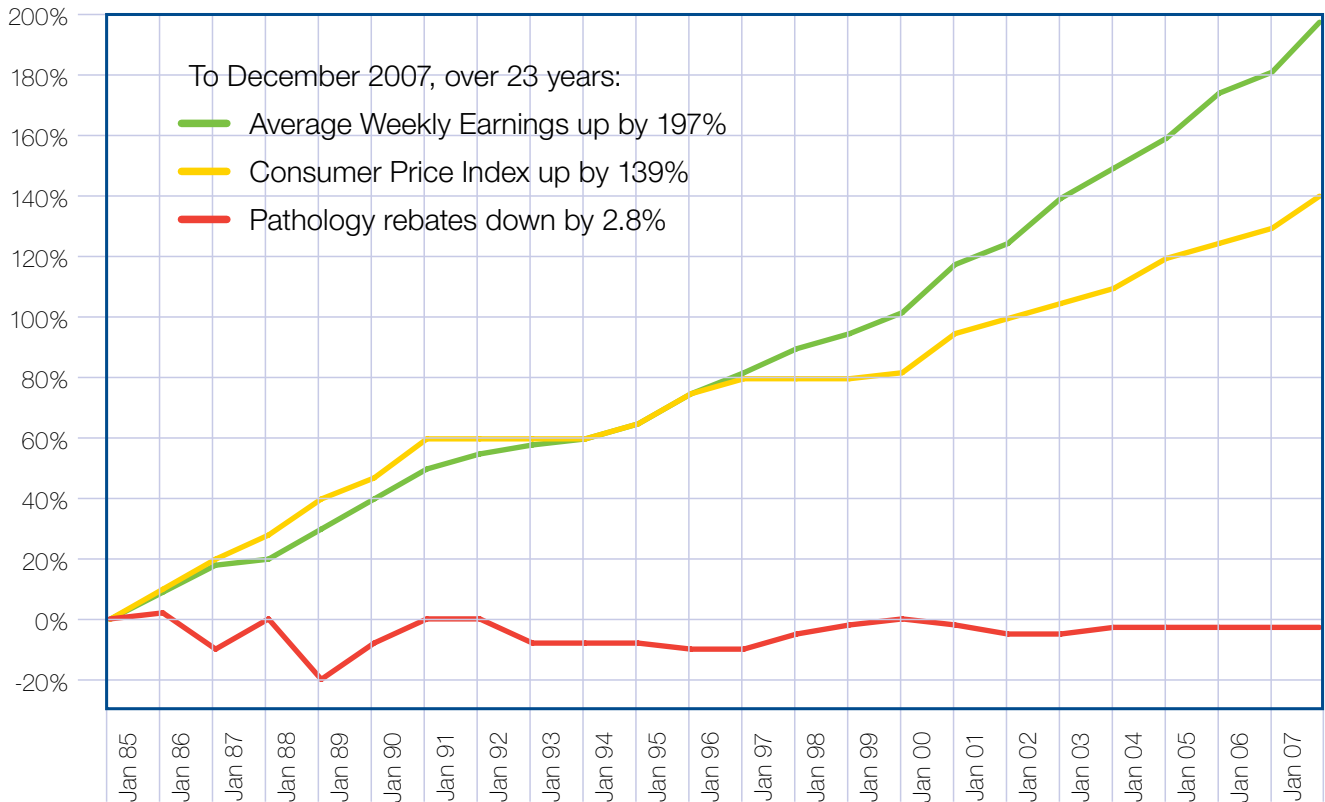


Medicare Pathology Terminology and Fee Restrictions

Successive Federal Governments have successfully (Figure 1) restricted pathology fee growth by:

- restricting patient access by limiting the number of collection centres, and
- manipulating the Medicare Benefits Schedule (MBS) to reduce fees.

Figure 1. Cost Indices and Pathology Rebates from January 1985



Historically, laboratories were paid for each test performed and changes such as ‘the cone’ were introduced to reduce fees. Up to 10% of Medicare pathology items are not paid or ‘coned out,’ and other payments are withheld for a variety of reasons.

Summary of the main restrictions

1. The Group Cone

Medicare pays for these tests singularly, as a ladder up to a maximum of 5 (previously 6) tests in a group and any additional tests cannot be charged. This restriction applies to many MBS items containing multiple tests, including basic biochemistry, hormones, antibodies and microbial antigens.

2. The Grand Cone

Medicare will only pay for the three most expensive MBS items requested by general practitioners, with no fee payable for other tests. Excluded from the 3 MBS items are the Patient Episode Initiation (PEI) fee, pap smears and the supplementary tests for Hepatitis B surface antigen or Hepatitis C antibody.

Tests ordered by specialists or tests on hospitalised patients are not included in the grand cone.

3. Medicare Payment Rejection

Medicare will not reimburse for tests performed in certain scenarios –

- A set number of permissible tests per year based upon the patients disease or previous results, e.g. if there is no history of prostate disease only an annual PSA is reimbursed. Refer to Table 1 overleaf for other examples.
- No Medicare payment unless supported by clinical history for some tests, e.g. thyroid tests and others detailed in Table 1.
- With the exception of Rule 3 repeat tests, no payment for outpatients if more than one request form is dated the same day.
- Test samples split between two laboratories as in general only one laboratory is paid.



Medicare Pathology Terminology and Fee Restrictions

continued

Summary of the main restrictions *(continued)*

4. Not recognising the Test

No payment for ThinPrep and strict conditions for Medicare payment for high risk HPV testing.

5. Patient Episode Initiation

The PEI fee was introduced in recognition of the fixed costs for the collection of pathology specimens. All fees were reduced concomitantly to allow for its introduction.

Table 1. Examples of Tests with Rules Enabling Medicare Payment Rejection

Test	Rule
HbA1c	4 tests in 12 months
HbA1c (in pregnancy)	6 tests in 12 months
IgE	2 tests in 12 months
PSA or free PSA	1 test in 12 months
PSA (monitoring diagnosed prostate disease)	> 1 test in 12 months permissible
Free T4 or Free T3	Only paid if: <ul style="list-style-type: none"> • TSH is abnormal; • psychiatric investigation; • infertility investigation; • pituitary dysfunction suspected; • monitoring thyroid disease; • on drugs interfering with thyroid function.

Ways to assist your pathology laboratory

- Always provide relevant clinical history.
- Only order what is clinically necessary:
 - avoiding the use of long test checklists, and,
 - resist patient pressure for a battery of tests.
- Limit multiple request forms made on the same day to Rule 3 Exemptions. Tests ordered on multiple computer generated follow up pathology request forms with the same date of request are not paid.
- Use only one laboratory and resist splitting tests between laboratories as only the first laboratory to submit the claim to Medicare Australia is paid.

The Medicare Benefits Schedule can be found on line at www.medicareaustralia.com.au. For more information on Clinipath Pathology billing policies please contact Dr Gordon Harloe.

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